Premier Care Homes Limited

Durham House Residential 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

Summary of findings

Overall summary

The inspection took place on 19 and 20 April 2017 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Durham House in February 2015, at which time the service was compliant with all regulatory standards and was rated Good. At this inspection the service remained Good.

Durham House is a care home in Chester-le-Street, Durham, providing accommodation for up to 31 older people who require nursing and personal care. There were 24 people using the service at the time of our inspection.

The service had a registered manager in place and a new manager in post, who was being supported through their probationary period.

Risk management processes were in place and regularly reviewed, such as risk assessments and falls analysis, protecting people against a range of risks.

There were ample staff on duty to meet people's needs and keep them safe. The provider used a dependency tool to ensure there were always ample staff to meet people's needs.

The management of medicines was safe and adhered to National Institute for Health and Care Excellence [NICE] guidelines. Where we identified an area that could be improved the provider responded promptly.

The service was clean throughout and the premises effectively maintained.

Staff were trained in safeguarding, health and safety, moving and handling, infection control, mental capacity, dementia awareness and food hygiene. Staff demonstrated a good knowledge of these topics.

There was a consensus of opinion that staff effectively supported and managed people's healthcare needs through ongoing liaison with external professionals.

All people who used the service we spoke with, relatives and visiting healthcare professionals stated staff demonstrated caring attitudes towards people.

There were patient and compassionate interactions displayed by staff throughout our inspection.

The atmosphere and culture at the service was homely and welcoming.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The manager and staff displayed a good understanding of capacity and we found related assessments had

been properly completed. The provider had fulfilled their legal obligations in relation to assessing and arranging requirements in the Deprivation of Liberty Safeguards (DoLS) for those people who needed them.

People's nutritional and hydration needs were met. Menus were varied and people had choices at each meal as well as being offered alternatives if they changed their mind. The provider agreed to look into implementing communication aids such as photographs to help people make choices about what they would like to eat.

Person-centred care plans were in place and were regularly reviewed. The activities co-ordinator was in the process of producing a one-page background for each person to ensure there was a concentrated amount of person-centred information available to any new staff.

The activities co-ordinator had made a range of external links in the community and ensured there was a selection of activities available that people found meaningful and enjoyable.

There were a range of quality assurance, auditing processes and policies and procedures in place. Auditing had identified and led to improvements in service delivery. The manager, director and provider had produced and acted on an action plan to ensure the service maintained good standards of care at a time of managerial change.

Staff, people who used the service, relatives and external professionals spoke positively about the approachability of the new manager, who demonstrated a good knowledge of the service and people's needs throughout the inspection.

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 remains good.

Is the service effective?

Good

The service remains good.

Is the service caring?

Good

The service was caring.

There was a strong consensus of opinion from people who used the service, their relatives and external professionals that staff had ensured a continuity of care during a time of managerial and staffing changes.

We observed numerous patient and affectionate interactions between people who used the service and staff, who had formed strong bonds with people.

Staff understood people's communication needs well. The provider agreed to look into the possibilities of assisting people to make informed decisions through the use of communication aids, such as pictures.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service remains good.

Durham House Residential 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 19 and 20 April 2017 and the inspection was unannounced. This meant the provider or staff did not know about our inspection visit. The inspection team consisted of one Adult Social Care Inspector and one expert by experience. An expert by experience is a person who has relevant experience of this type of care service. The expert in this case had experience in caring for older people and people living with dementia.

We spoke with ten people who used the service and eight relatives. We spoke with eleven members of staff: the owner, one of the directors, the current registered manager, the new manager, two senior carers, three care assistants, the activities co-ordinator and one domestic assistant. We also spoke with two visiting healthcare professionals.

During the inspection visit we looked at four people's care plans, risk assessments, staff training and recruitment files, a selection of the home's policies and procedures, quality assurance and auditing processes, meeting minutes and maintenance records. We also reviewed the service's IT systems.

We spent time observing people in the living rooms and the dining area of the home. We inspected the communal areas, kitchen, bedrooms, bathrooms and toilets.

Before our inspection we reviewed all the information we held about the service, including previous inspection reports. We also examined notifications received by the CQC since our last visit. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales.

We spoke with professionals in local authority commissioning and safeguarding teams, as well as Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe and we observed a number of interactions between people who used the service and staff which demonstrated they were comfortable in the presence of staff. We observed safe moving and handling practices throughout the inspection. One person told us, "There are no problems whatsoever."

Relatives we spoke with also confirmed they had no concerns regarding the ability of staff to ensure people were kept safe and protected from the risk of harm. One relative said, "The staff have people's wellbeing as a priority. We've never had any worries." Another told us, "We are in there daily and there has never been any cause for concern. There are always plenty of staff on hand."

With regard to this second point we saw the provider used a dependency tool which calculated the number of staff required to meet people's needs. We saw people's needs were independently assessed and then they were allocated a number of care hours, which were then used to calculate the amount of staff required. We saw the provider had consistently kept the staffing ratio at 15% above the level the tool indicated was necessary. The manager explained this was to ensure there was always sufficient staff available should there be unforeseen circumstances or times when a lot of people required support at once. We observed nurse call bells were responded to promptly throughout the inspection. This meant people were not put at risk through understaffing or poor rota management.

None of the healthcare professionals we spoke with had concerns about the service in relation to people's safety. One told us, "They are always in touch early. I'm here regularly and have never had concerns about people's safety – the staff look after them." Staff we spoke with had been trained in safeguarding procedures and it was apparent they were confident in how to raise concerns if they had any.

We found the service had systems in place for safely ordering, receiving, storing and disposing of medicines, including controlled drugs. We reviewed medicines storage and found, for example, open products were marked with a sticker indicating the opening date so they could be disposed of appropriately. Fridge and room temperatures were recorded daily to ensure they were within safe limits, whilst audits of medicines were undertaken regularly by senior care staff and by the manager. We sampled a range of Medicine Administration Records (MARs) and found them to be in good order, with no signatures missing, up to date photographs and allergy information clearly visible. Where people required topical medicines (creams or ointments applied to the skin) we saw there was a record of these being administered in the MARs and also in people's rooms, where the creams were kept. There were also body maps in place to ensure staff knew whereabouts on a person's body to apply the cream.

Staff we spoke with demonstrated a good knowledge of when people might need additional medicines that had been prescribed to be given 'when required,' for example paracetamol. We found the plans to support when such medicines might be needed and given could be improved to ensure they were in line with guidance issued by the National Institute for Health and Care Excellence [NICE]. The director of the service agreed to review these medicines plans.

We observed medicines being administered and saw safe practice was maintained throughout. Visiting nursing professionals confirmed they had never observed inappropriate medication practices. This meant people who used the service received medicines in a safe manner.

We saw risks to individuals were managed through personalised risk assessments and the use of recognised tools. Examples included epilepsy and warfarin risk assessments. We saw these were regularly reviewed and updated, with the involvement of people who used the service or their relatives where they did not have the capacity to understand the care planning process.

Accidents and incidents such as falls were monitored, reported and acted on. We saw each fall that had occurred was support by a completed accident form, and a 'post-fall huddle form'. This involved staff immediately discussing and documenting what had happened. We also saw the manager kept a record of the number of falls that had occurred each month. The audit did not accurately detail the cause of each fall. The director committed to reviewing the audit to ensure it gave sufficient information to enable the manager to identify and act on any emerging trends with regard to falls. We found however the approach of all staff towards falls and other incidents to be diligent and accountable.

We reviewed a range of staff records and saw that in all of them pre-employment checks including Disclosure and Barring Service (DBS) checks had been made. The DBS maintain lists of people barred from working with vulnerable groups and also share criminal history information with prospective employers. We also saw that at least two references had been sought, as well as proof of identity. This meant that the service had in place a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

Maintenance records demonstrated that all lifting and hoist equipment had been serviced, as had the boiler. Portable appliance testing (PAT) testing had taken place and the periodic electrical inspection was in date. We saw that fire extinguishers had been checked, fire maintenance checks were in date and the nurse call bell systems were regularly tested and serviced. We saw window restrictors were in place and Personalised Emergency Evacuation Plans [PEEPS] were easily accessible. These were up to date with information such as mobility needs and levels of capacity. The director told us they were also planning to include people's photographs in the PEEPs to assist the safe evacuation of the premises in the event of an emergency. This meant people were prevented from undue risk through poor maintenance and upkeep of systems.

We saw all areas of the building were clean and free from odour. One relative told us, "They have recently replaced some carpets and that definitely freshened things up – one of the areas had a bit of a smell before that." Ample signage promoted the importance of hand hygiene and hand sanitiser dispensers were well positioned throughout the home. There was one domestic assistant on duty on each day of our inspection. They confirmed they usually worked as a team but a colleague was on sick leave. They confirmed they had sufficient time, supplies and support to fulfil their role. This meant the service managed and reduced the risk of acquired infections.

Good

Is the service effective?

Our findings

All relatives we spoke with expressed confidence that staff at Durham House had the skills and knowledge to meet people's needs. One relative said, "Whenever we go in, it doesn't matter who we ask, they're up to speed and know how [person] is doing and always have an update." When we spoke with external professionals they agreed that staff demonstrated the appropriate knowledge and skills required to undertake their role. One told us, "I've always found the staff to be helpful. They are interested in good outcomes for people and we work together well." Another said, "Staff are all very good – the seniors have lots of experience."

We reviewed the training in place for staff and found it to be a balance of mandatory training, as well as specific training courses in order to ensure staff were able to meet people's specific needs. For example, we saw staff had been trained in epilepsy awareness and falls management. These courses were in addition to the core topics, such as safeguarding, infection control, moving and handling, food hygiene, dignity and respect. When we spoke with staff they demonstrated a good understanding of the topics they had been trained in and were able to show how the training enabled them to meet people's needs.

Staff had been using an online training provider since February 2017 and staff we spoke with were positive about the accessibility of the system. They also confirmed some training courses, such as moving and handling, remained a face-to-face programme. We saw there were specific induction checklists for each job description and staff in respective roles confirmed they had been supported in line with these inductions.

We found the manager had a good awareness of staff training needs and maintained a record of these on a training matrix. All staff training we viewed at the time of our inspection was up to date. This demonstrated people were supported and cared for by staff who received appropriate training.

We saw staff supervisions and appraisals had not happened as per the provider's policy prior to the current manager taking over four months ago. A supervision is a discussion between a member of staff and their manager to identify strengths and areas to improve. Appraisals are an annual review of staff performance. Since the new manager's arrival however, we saw they and the director had produced an action plan which set out supervision meetings and appraisal meetings for each member of staff. We reviewed the content of the newly introduced supervision meeting records and found they contained a mix of professional development, awareness of staff wellbeing, and an opportunity to raise any concerns about specific issues or the culture of the service. This meant, whilst staff had not received appraisal meetings as originally planned, the provider had identified this as an issue and put in place an effective plan to ensure staff were consistently supported. A manager was in place who planned and delivered appropriate staff support.

We saw there had been no team meetings since the current manager had joined the service, although we saw one was planned and advertised for the week following the inspection.

Staff liaised well with external healthcare professionals to ensure people achieved good health and wellbeing outcomes. Visiting nurses confirmed with us that staff sought and acted on their advice, whilst

relatives we spoke with confirmed they were aware of the regular involvement of external professionals such as GPs, occupational therapy and the speech and language therapy (SALT) team. We saw evidence in the care files we reviewed of input from these specialists, recorded on specific forms for ease of reference.

Staff on different shifts shared information through a daily recording system. We saw the director had encouraged staff to include more person-centred details in their daily notes recording and we found this had led to more comprehensive notes for each person. Staff confirmed they reviewed these notes before returning to work after an absence, and also that each shift reviewed the notes as a means of handing over to the next shift. This meant record keeping and information sharing within the service was comprehensive, person-centred and beneficial for any visiting external professionals.

With regard to nutrition, people who used the service confirmed they had a choice of meals at each mealtime and that staff acted on their preferences. For example, one person stated they did not like the side vegetables with their main meal and staff promptly replaced them.

Staff had received food hygiene training and demonstrated a good knowledge of people's favoured foods, dislikes and whether they were on a specialised diet, such as a soft diet. We saw this information was displayed prominently in the kitchen and was up to date. One relative told us, "We visit every day at around teatime to help feed [person]. There are never any problems with the food."

We saw people were regularly weighed and staff used the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. We found staff had used the tool as directed to protect people against the risk of malnutrition by ensuring they were given additional foodstuffs and supplements. We also saw a range of snacks and drinks being offered to people throughout the inspection. One visiting healthcare professional told us, "I have never come in here and found anyone dehydrated. It's an easy thing to overlook but they know the importance of it."

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 saw appropriate applications had been made to the local authority and that the manager and staff we spoke with demonstrated a good understanding of mental capacity issues, including DoLS.

We saw that people who had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision in place had been involved in the decision (where they were able to be), 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. This meant people's needs had been reviewed appropriately with those who know them best. We also saw people had Emergency Health Care Plans (EHCPs). An EHCP is completed by an external healthcare professional and makes communication easier in the event of a healthcare emergency. This demonstrated staff worked well with external professionals to ensure people's needs were planned and met.

With regard to the premises, we saw there was a refurbishment plan in place and that carpets and other flooring had been replaced recently. We saw new chairs, tables and other furnishings had also recently been ordered, demonstrating the provider was committed to ensuring the home was furnished appropriately. We noted the premises would benefit from hand rails in corridors to help people who struggled to mobilise to move around independently. The director agreed to incorporate hand rail planning into a meeting they were having in the subsequent week regarding the refurbishment plan.

We saw there were ample bathing and toileting facilities and that these rooms were suitably equipped to meet people's physical needs.

Good

Is the service caring?

Our findings

People who used the service told us they were well cared for by staff. One person told us, "They're fine, really nice with me." We spent time observing people who were unable to verbally communicate their opinions and saw staff engaging with people in a patient, compassionate manner. For example, we saw one member of staff noticing that a person was slightly slumped in their chair and promptly provided them with a cushion and ensured they were comfortable. Another member of staff sat with a person who was unable to speak and held their hand at length whilst giving them reassurance. We observed a familiarity and contentment between people who used the service and members of staff, who shared jokes where appropriate and helped to maintain people's individualities.

Relatives and external professionals were consistent in their praise of the caring attitudes of staff. One relative told us, "The staff are excellent and I am very settled for my [person] to live here. I feel less guilty as I know they are being well looked after." Another relative said, "I can't fault them and can't speak highly enough. [Person] really settled there within a month and I put a lot of that down to how settled the atmosphere is and the staff, of course."

A visiting friend told us, "I am not aware of any problems and my friend is always very happy and well cared for."

We found staff understood people's communication needs well and we observed them interacting with people in a way that meant people could engage in interactions and be helped to make their own decisions. For example, when staff were preparing to move people to the dining room for lunch, they crouched and explained this to people who were sat down in order to maintain eye contact at their level. We observed staff knocking on people's doors and awaiting a response before entering.

We also saw people being asked their food preferences for the next day. We spoke with staff about this, who acknowledged there could be other means of assisting people to make informed decisions about such things as food choices and activities choices. For example, picture could be used to help people understand the meal and activities options available to them. The director agreed to look into this area of supporting people's communication needs.

Thank-you cards we saw contained evidence of the caring attitudes of staff, as described by relatives of people who had previously used the service. They read, for example, "The light-hearted atmosphere allows everyone's sense of humour to shine through," "Thank you – you made [person's] time with you as happy and comfortable as possible," and, "Our thanks and gratitude for your kind and attentive care. When we turned up on your doorstep that first day the welcome we received was very friendly and accommodating." Visitors we spoke with agreed they were always warmly welcomed on arrival and we found this helped contribute to the homely atmosphere of the home, with staff demonstrating a knowledge of the names of all visitors, and vice versa.

On both days of our inspection we noted people were well presented, clean and supported by staff who

regularly checked on their wellbeing.

We saw staff had received training in end of life care and in people's care files they had end of life care plans in place. Staff at the provider's other service had previously received additional end of life care training from a local hospice and this was something the director would consider for this service. We found staff understood people's individual preferences well and relatives we spoke with confirmed they had been involved in discussions about how people's end of life care might look.

We saw information regarding advocacy services was available in the Service User Guide. At the time of our inspection no one who used the service had an advocate but the manager and provider displayed a sound knowledge of advocacy support available and also actively encouraged people's families and friends to help them make decisions. This meant people's best interests could be supported, recognising the importance of advocacy services.

We saw people were asked about their religious beliefs when first moving to the home and that preferences were met, for example through a monthly Church of England service held in the home. This meant people's right to religious beliefs and freedoms were respected and enabled.

At the previous inspection we noted people who used the service had been involved in interviews for prospective new members of staff. Whilst this had not happened recently, the new manager stated they would be interested in implementing this, whilst the director confirmed that prospective members of staff were given a tour of the premises, during which they would meet people who used the service.

We saw people's confidential information, for example care records containing medical information, was securely stored in the manager's office.

Good

Is the service responsive?

Our findings

The service had an activities co-ordinator and they were responsible for planning and delivering a range of group and individual activities. They had only been in post for ten weeks but were passionate about their role and demonstrated the learning they had applied from the work they had previously undertaken in other services. For example, on starting at Durham House they removed the monthly activities planner and introduced a weekly planner, allowing for more flexibility and the opportunity to respond to people's preferences.

We saw they had sought a range of innovative means of bringing people who used the service new experiences. For example, they had arranged a trial of a virtual reality headset, whereby people experience the sights and sounds of an environment familiar to them through the use of IT equipment. Whilst this had only been used once in the service, feedback was positive. We also saw the activities co-ordinator had arranged for a local coffee provider to visit the service, give people who used the service a talk on the history of coffee, as well as provide free samples.

On a day-to-day basis, we saw the activities co-ordinator had arranged activities such as bingo, singing, armchair exercises and arts and crafts. People who used the service confirmed they enjoyed participating in arranged activities and we observed people smiling and laughing when doing so.

Another role of the activities co-ordinator was to complete a one-page 'background' profile of each person, to ensure staff had a range of person-centred information available, such as people's employment history, family history and favourite things. We saw not all of these had been completed. Whilst all staff we spoke with demonstrated a good knowledge of people's individualities, the activities co-ordinator and the director agreed the completion of these background documents was a priority. This would mean new staff would have better access to information about people's preferences.

We saw people's needs were assessed prior to them using the service and care files were set up to cover people's medical, dietary, religious, mobility and other needs. Each care plan we reviewed contained a recent photograph and a good level of information about people's needs. We saw that care plans were reviewed monthly and staff demonstrated a good understanding of people's needs. Relatives we spoke with confirmed they were regularly involved in the review of people's care needs. One told us about how staff had helped their relative settle after not being able to at another service. They stated, "They were resistant initially and had a lot of problems. They are settled now. They were comfortable before long and were kept involved. I feel like we got some of [them] back." This demonstrated that people received good health and wellbeing outcomes through the responsive and regularly reviewed care provided by staff.

Where people's needs changed we saw staff responded and sought clarification from either other staff who were appropriately skilled or external professionals. One relative told us, "My [relative] only needs to mention something's wrong and they're onto it straight away." Another told us, "They are always in touch about any changes, even if it's nothing major. I review the paperwork and am always updated." Another relative told us, "They know what to look for. [Person] is prone to UTIs [Urinary Tract Infections] and they

know the warning signs before we do." A UTI is an infection that can cause people to become unsteady or display unsettled behaviours. This meant people's changing needs were identified and met by staff who consistently involved the people who knew them best.

With regard to more formally involving people who used the service and their relatives in providing feedback, the manager and director acknowledged that service user and relative surveys had not happened since January 2016 but that they had planned them. We saw this was noted on the action plan. We were also assured by the range of feedback we received from people who used the service, relatives and external professionals, that seeking and acting on feedback from people was something staff did habitually as part of the culture of the service. This meant, whilst formal surveys had yet to take place, staff had ensured people's changing needs and feedback were regularly listened to and acted upon.

We saw the service had a complaints policy in place and this had been followed when a complaint had been made. All aspects of the complaint had been considered and responded to comprehensively. All people and relatives we spoke with were confident about how to make a complaint should they need to and we saw this information was incorporated into the service user guide and available in communal areas. This meant people were supported to raise concerns and that their complaints were handled as per the provider's policy.

Good

Is the service well-led?

Our findings

There was a consensus among staff that the provider was genuinely concerned about ensuring the service retained a homely feel and ensuring the care people received was of a high standard. One member of staff told us, "I have seen a lot of changes and different residents and really love working here it is like a real home". We also noted there was a consensus of opinion among all relatives and external professionals we spoke with that the provider had taken a range of measures to ensure the service had in place the necessary leadership to ensure the service remained effective.

This included the appointment of the new manager, who was supported by the existing registered manager. This existing registered manager currently covered both of the provider's two services but it was the intention of the new manager at Durham House to register with CQC. They were also supported in the short-term by a director and the nominated individual, who regularly visited the service whilst the new manager gained the necessary experience to take over the day-to-day running of the service. A registered manager is a person who has registered with the CQC to manage the service.

The new manager had been at the service for four months. They told us, "The support is excellent, I've never had support like it." They confirmed they had received significant support in their role. They acknowledged the first four months in the role had involved creating and acting on an action plan to ensure the service continued to meets the needs of people using the service and achieved compliance in a time of managerial change.

We reviewed this action plan and found they had completed a significant majority of the actions set out, for example planning supervisions and appraisals for all staff, planning resident and relatives meetings, ensuring the training matrix was accurate and reviewing Deprivation of Liberty Safeguards (DoLS) to ensure they were re-applied for with the local authority.

We asked a range of staff about the new manager and they told us, "They seem really good," and "They're not always locked away in the office and they are hands on." Relatives we spoke with were of a similar opinion, with one telling us how they first met the new manager when they answered the front door. They told us the manager then went to get the person the relatives were visiting and brought them to the door. Their relative said, "This was a nice touch and good to know they know people and are not just managing from a higher level." One visiting healthcare professional told us, "The new manager seems good and I'd say the service as a whole are on the way back up." Another told us, "The culture is good – it's run as a tight ship and very disciplined." When we spoke with the manager they also told us existing staff had, "Welcomed me really well – there is a lot of experience here." This showed the new manager and staff had begun to successfully develop as a team.

We saw the manager was responsible for a range of quality assurance and auditing work at the service. Regular audits they completed included those relating to care plans, medicines, the operation of the kitchen, record keeping and food and fluid recording. These audits had identified, for example, where staff needed to include more detail when documenting people's daily food and fluid intakes. We saw the

manager had identified this need for improvement and shared their expectations with staff via the supervision process.

We also saw the manager was required to provide the provider with a weekly update including a range of information such as occupancy levels, staffing issues and incidents or accidents. The standard of auditing was generally strong and we saw the care plan audit template was particularly instructive for anyone completing it. The manager said, "It's very detailed and makes sure you can't miss things." We saw the auditing of falls could be improved by recording more information in the audit and the provider and manager agreed to look into this. The quality assurance systems within the service demonstrated a drive towards continuous improvement. Auditing and checks identified areas for improvement and action plans were used to effect change

The service's website stated they aimed to be the standard against which other residential care homes are judged. We discussed this with the director, who agreed they would review current established best practice, particularly with regard to dementia-friendly environments, where there was scope for additional improvements. The manager also stated they would look into the prospect of establishing 'champions' in areas such as dementia, so that members of staff could take a lead in areas they had a particular interest and contribute to new ideas within the service and keep abreast of industry-wide developments.

We found that staff had ensured people received a continuity of care through a time of managerial change and that the culture remained focused on ensuring people felt at home whilst receiving good standards of care. All staff we spoke with valued the continuity of care they were able to deliver and the management of the service equally valued the importance and impact of providing a continuity of care for people who used the service.

During the inspection we asked for a variety of documents to be made accessible to us. The manager was able to provide all the relevant information and we found records were clear, easily accessible and contemporaneous. Policies and procedures were regularly reviewed and we saw the previous CQC report displayed in a communal area, as well as other pertinent information, such as the service's complaints policy. We also saw that appropriate notifications had been made securely to CQC in a timely fashion.