Care Quality Commission

Davis Care Limited

Garland House

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 was carried out on 27 and 28 April 2015 by two inspectors and an expert by experience. It was an unannounced inspection. The service provides personal care and accommodation for a maximum of 19 older people. There were 19 people living there at the time of our inspection. One person was living with the onset of dementia. All the people living in the service were able to express themselves verbally.

There was a registered manager 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 2008 and associated Regulations about how the service is run.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce

Summary of findings

identified risks and guidance for staff to follow or make sure people were protected from harm. People told us, "Nothing bad happens here, the staff make sure we feel safe, they watch over us".

Accidents and incidents were recorded and monitored to identify how the risks of re-occurrence could be reduced. There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were safe recruitment procedures in place which included the checking of references.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

All fire protection equipment was serviced and maintained. The building was warm and welcoming. People's own rooms were personalised to reflect their individual tastes and personalities.

Staff knew each person well and understood how to meet their support needs. Each person's needs and personal preferences had been assessed before they moved into the service and were continually reviewed.

Staff's training was renewed annually, was up to date and staff had the opportunity to receive further training specific to the needs of the people they supported. All members of care staff received regular one to one supervision sessions and were scheduled for an annual appraisal to ensure they were supporting people based on their needs and to the expected standards.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no one living at the home was currently subject to a DoLS, we found that the manager understood when an application should be made and how to submit one.

Staff sought and obtained people's consent before they helped them. One person told us, "The staff ask for my consent when doing things for me".

The service provided meals that were in sufficient quantity, well balanced and met people's needs and choices. People told us, "The food is very nice, no fault with that; there is plenty of it" and "This is good and well cooked". Staff knew about and provided for people's dietary preferences and restrictions.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect. People were satisfied about how their care and treatment was delivered. They commented, "I am contented here", "The staff treat us with definitely with respect". and "I am the happiest here I have been in 15 years".

People were involved in their day to day care. People's care plans were reviewed with their participation and relatives were invited to attend the reviews and contribute.

Clear information about the service, the facilities, and how to complain was provided to people and visitors. Menus, activities programme satisfaction surveys were provided for people in a suitable format.

People were able to spend private time in quiet areas when they chose to. People's privacy was respected and people were assisted in a way that respected their dignity.

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

People's individual assessments and care plans were reviewed monthly with their participation and updated when their needs changed. Two people told us, "I know what is going on and what the workers are supposed to do as far as I am concerned" and, "They talk with me to check if I want anything changed".

People were involved in the planning of activities. An improvement of the programme of activities was scheduled so that people would be offered more varied options to choose from.

The service took account of people's feedback, comments and suggestions. People's views were sought and acted on. The registered manager sent annual

Summary of findings

satisfaction questionnaires to people's relatives or representatives, analysed the results and acted upon them. Staff told us they felt valued under the manager's leadership.

The registered manager notified the Care Quality Commission of any significant events that affected people or the service. The registered manager kept up to date with any changes in legislation that may affect the service and carried out comprehensive audits to identify how the service could improve. They acted on the results of these audits and made necessary changes to improve the quality of the service and care.

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?
The service was safe.

Staff were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs safely.

Safe recruitment procedures were followed in practice. Medicines were administered safely.

The environment was secure and well maintained.

Good

Is the service effective?
The service was effective.

Staff were trained and had a good knowledge of each person and of how to meet their specific support needs.

The manager understood when an application for DoLS should be made and how to submit one. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable and nutritious food and drink. People were referred to healthcare professionals promptly when needed.

Good

Is the service caring?
The service was caring.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness, compassion and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

People were consulted about and involved in their care and treatment.

Good

Is the service responsive?
The service was responsive.

People's care was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when needs changed. The delivery of care was in line with people's care plans.

A range of activities based on people's needs and wishes was available.

Good

Summary of findings

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted on.	
Is the service well-led? The service was well led. There was an open and positive culture which focussed on people. The manager operated an 'open door 'policy, welcoming people and staff's suggestions for improvement. There was a robust system of quality assurance in place. The manager carried out audits and analysed them to identify where improvements could be made and action was taken to make these improvements.	**Good** 

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 was carried out on 27 and 28 April 2015 and was unannounced. The inspection team consisted of two inspectors 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 expert-by-experience who took part in the inspection had specific knowledge of caring for older people.

The registered manager had received and completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Before our inspection we looked at records that were sent to us by the manager or the local authority to inform us of significant changes and events. We reviewed our previous inspection reports. We consulted a local authority case manager, a district nurse, and a community psychiatric nurse who oversaw people's care in the service. We obtained their feedback about their experience of the service.

We looked at records which included those related to people's care, staff management, staff recruitment and quality of the service. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We looked at the activities programme and the satisfaction surveys that had been carried out. We sampled ten of the services' policies and procedures.

We spoke with eight people who lived in the service to gather their feedback. We also spoke with the provider, the registered manager, six care staff and two catering staff.

At our last inspection on 25 April 2013 no concerns were found.

Good

Is the service safe?

Our findings

People told us They felt safe living in the service. They said, "I definitely feel safe with the carers", "Nobody ill-treat us; the carers are kind and helpful" and, "Nothing bad happens here, the staff make sure we feel safe, they watch over us". One person told us, "There are enough carers around to call on if we are in difficulty".

There were sufficient staff on duty to meet people's needs. People's individual needs were assessed and this information was used to calculate how many staff were needed on shift at any time. Before people came into the service, the registered manager completed an assessment to ensure the home could provide staffing that was sufficient to meet their needs. This ensured staff were available to respond promptly to people's needs and ensure their safety. Additional staff had been provided to assist a person's recovery when they came back to the service following a period of hospitalisation. Rotas had been altered to ensure that two people who attended medical clinics appointments for treatment were accompanied by a member of care staff.

Our observations indicated that sufficient staff were deployed in the service to meet people's needs. Five members of care staff were in attendance during the day. There were three care workers in the evenings and during the night. A cook, a kitchen assistant and a cleaner were employed full time. An activities co-ordinator was employed part-time. Because these staff were employed care staff were able to concentrate on caring safely for people and spending time with them. The staff told us that there were sufficient numbers of staff on shift to meet people's needs. We observed the staff were not rushed, carried out their tasks in a calm manner and were able to spend time talking with people. As staff covered additional shifts in case of sickness no agency staff were used.

We checked staff files to ensure safe recruitment procedures were followed. We found that criminal checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the home until it had been established that they were suitable to work with people. Staff members had provided proof of identity, residence and of the right to work in the United Kingdom prior to starting to work at the service. References had been taken up before staff were appointed and we saw that references were obtained from the most recent employer where possible. There were gaps in three employment histories and we discussed this with the registered manager who told us they were in the process of obtaining this information from the staff in order to complete the documentation.

All staff received an induction that was appropriate to their role and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. They were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Staff were trained in recognising the signs of abuse and knew how to refer to the local authority if they had any concerns. A statement of commitment about equality, diversity, discrimination, dignity and 'zero tolerance' of abuse was displayed in a notice board in the entrance. Staff training records confirmed that their training in the safeguarding of adults was annual and up to date. Staff told us about their knowledge of the procedures to follow that included contacting local safeguarding authorities and of the whistle blowing policy should they have any concerns. One member of staff said, "The whole team is well aware of what to do if we have any concerns about the residents' safety" and, "If in any doubt that any form of abuse may be taking place, I would contact our manager straight away or the local authority; we have to protect the residents' rights".

The provider ensured that the premises were maintained to ensure hazards were reduced. The building was well maintained and the provider followed an ongoing improvement plan of the decoration and maintenance. Appropriate windows restrictors were in place to ensure people's access to windows was safe. Portable electrical appliances were serviced regularly to ensure they were safe to use. All equipment that was used to help people move had been regularly serviced. People's call bells were checked daily and regularly maintained. Bedrooms were warm, spacious and clutter-free so people could move around safely. The bathrooms were equipped with aids to ensure people's safety. The premises were kept secure and

Good

Is the service safe?

were protected from inappropriate access with a keypad entry system. People were escorted when they needed to use the passenger lift to access other floors. The lift was regularly serviced and maintained

Staff were trained in first aid and fire awareness and they knew how to respond in the event of a fire to keep people as safe as possible. Fire drills were practiced regularly and recorded. There were fire doors throughout the premises. All fire protection equipment was maintained, regularly serviced and had been checked in March 2015. There were clear signs throughout the premises to indicate fire exits and exits were fully accessible. People had individual evacuation plans that took account of their specific needs in case of emergencies or evacuation of the building. The staff knew the contents of these plans and how to put them into practice in an emergency.

The service had an appropriate business contingency plan that addressed possible emergencies such as fire, gas or water leaks. It included clear guidance for staff to follow. The staff knew where this plan was kept and how to use the plan in practice. The service had a mutual contingency arrangement with a neighbouring residential home for the temporary housing of people, if some or all of the premises were uninhabitable. The registered manager and the provider were available during out of hours to respond to any emergencies.

Accidents and incidents were recorded and regularly monitored by staff and the registered manager to ensure hazards were identified and actions taken to reduce future risks of these reoccurring.

Risk assessments were centred on the needs of the individual. Each person's environment had been assessed for possible risks such as risk of falls and action had been taken to eliminate hazards and reduce the risks. There was a risk assessment for a person who had visual impairment which addressed reduced access to sunshine and a possible lack of vitamin D. Measures were identified and implemented to encourage them to go outside during warm weather.

The service's policy on the identification of risks recommended staff to consider those relating to loss of independence, identity and privacy. Staff used a 'red alert' form to inform their immediate response when a risk to people's health had been identified. The forms included an assessment of relevant risks and clear detailed actions for the staff to take in order to reduce the risks. These forms were reviewed daily by the registered manager and senior staff to monitor people's progress. For example, a person's health had declined and a risk to their skin integrity had been identified. As a measure to reduce the risk, specialist equipment had been provided. Another person had an infection and a risk to their health and sense of dignity had been identified. The staff followed the measures identified in the risk assessments and ensured the monitoring of their recovery in a sensitive manner.

The people we spoke with confirmed they received their medicines on time and as prescribed. One person said, "I always get my tablets on time they never fail". People's medicines were managed so that they received them safely. We observed medicines being administered. Staff followed requirements as indicated in people's individual Medication Administration Records (MAR) and signed to evidence the medicine had been taken. The MAR charts included people's photograph for identification, allergy information and there was a weekly sheet at the front of the file that detailed any changes to each person's medicines. Staff who administered medicines were assessed to check their competency to carry out this task safely. Checks of medicines were carried out to ensure that supplies were sufficient in meeting people's needs. All medicines including those that were prescribed 'as required' were kept securely and at the correct temperature to ensure that they remained fit for use. The staff we spoke with were knowledgeable about the steps that should be taken if an error was made. Monthly audits of all records relevant to medicines were carried out. The MAR charts were completed accurately and no errors had been noted in the last 12 months. The deputy manager told us that if any audits of medicines administration highlighted any omissions, staff would be supervised and re-trained when necessary.

Good

Is the service effective?

Our findings

People's needs were assessed, recorded and communicated to staff effectively. The staff followed specific instructions to meet people's individual needs. One person told us, "I do not have to wait for a care worker to come when I press the buzzer". Another said, "They call a doctor when there is a need". People were positive about the food provided, they said, "The food is very nice, no fault with that; there is plenty of it", "This is good and well cooked".

Specific communication methods were used by staff to converse with people when necessary. For example, a care plan for a person who had visual impairment included guidance for staff about how to encourage them to converse and how to support effective communication. The staff followed this guidance, ensured they talked clearly to them and checked that they understood what was said.

People's hearing aids were checked every month to ensure they remained in good order. A person who had some hearing impairment was accompanied to their G.P. for regular treatment and the staff gave them clear and calm instructions, positioning themselves at eye level to facilitate communication. Two people had been provided with specialised equipment to help them read.

Updates concerning people's welfare were appropriately communicated between staff at handover to ensure continuity of care. For example, information about people's individual health, moods, behaviour and appetite was shared by staff when a new shift of care workers took over.

Staff had appropriate training and experience to support people with their individual needs. Staff confirmed with us they had received a comprehensive induction and had demonstrated their competence before they had been allowed to work on their own. Essential training included first aid, manual handling, health and safety, mental capacity and safeguarding. This training was provided annually to all care staff and was up to date. A training recording system was in place that alerted when staff were due for refresher courses. This ensured staff were adequately trained to meet people's needs effectively.

Staff were positive about the range of training courses available to them. One staff member described the training as 'very thorough'. Staff told us that the training helped them to understand and meet people's needs. The staff completed evaluation forms to ascertain whether they had acquired an appropriate level of knowledge and were re-trained if necessary. Staff had the opportunity to receive further training specific to the needs of the people they supported. For example, staff had been trained to carry out urine infection tests and to begin treatment out of hours when people could not see their G.P.

Staff were supported to gain qualifications and study for a diploma in health and social care. One staff member told us" I have been really encouraged to do the studies and my tutor comes in the home to give me support sessions during my work-time". This meant that staff were able to develop their skills and knowledge.

One to one supervision sessions for staff were regularly carried out in accordance with the home's supervision policy. A member of staff said, "I can talk at length about any anxiety or concerns I have and get the support I need during my supervision sessions". Staff's performance and training needs were discussed at supervision. However, annual appraisals had not been completed according to the home's policy. The last appraisals had been completed in 2011 and in 2012. We discussed this with the registered manager who was aware of this shortfall and who had scheduled formal appraisals in 2015 for all staff to meet this shortfall. Staff were subject to a probation period and disciplinary procedures if they did not meet the required standards of practice. This meant the staff were clear about the expected standards and how to care effectively for people.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the Mental Capacity Act (MCA) 2005 and DoLS with the registered manager and they demonstrated a good understanding of the process to follow when people did not have the mental capacity required to make certain decisions. Staff were trained in the principles of the MCA and the DoLS and the five main principles of the MCA were applied in practice. This ensured people's right to make their own decisions was respected and promoted. There had been no cause for assessing people's mental capacity since our last inspection and no one was deprived of their liberty.

Staff sought and obtained people's consent before they helped them. One person told us, "The staff ask for my consent when doing things for me". When people declined,

Good

Is the service effective?

for example when they did not wish to get up or go to bed, their wishes were respected and staff checked again a short while later to make sure people had not changed their mind. Before people came into the service, the registered manager assessed whether they had agreed to this change of residence.

We observed lunch being provided. The meal was freshly cooked, well presented and looked appetising. It was hot and in sufficient amount. Condiments were available. People were able to have second helpings and sherry or wine if they wished. People were consulted when menus were planned and specific requests were taken into account. People's allergies, dietary restrictions and preferences were displayed in the kitchen.

There was not a choice of main meal however an alternative such as an omelette was cooked when people preferred. The cook told us that a daily choice of meals was scheduled to be introduced in the following menus and this had been discussed and agreed with the registered manager. Homemade cakes and scones were ready for the afternoon tea round, Fresh fruit was in the lounge area for people to help themselves and drinks were available at all times both in the lounges and in people's rooms. People were supported by staff with eating and drinking when they needed encouragement. Staff monitored and recorded people's intake of food and fluids when their appetite declined. Their weight was monitored and people were referred to health professionals if necessary such as when substantial changes of weight were noted.

Visitors were welcomed to join their relatives at mealtimes. There was ample of amount of fresh food available in the kitchen and storage area, which was kept at correct temperature. The service held a current Food and Hygiene Certificate at the highest possible rating level of 5 in December 2014.

People's wellbeing was promoted by regular visits from healthcare professionals. A GP visited when people's health changed and reviewed people's medicines when needed. A chiropodist visited every five weeks to provide treatment and an optician and a dentist visited when required. Vaccination against influenza was carried out when people had provided their consent. District nurses visited people regularly when they needed to provide treatments such as dressings. Staff administered treatment for a person as recommended by their G.P. to help alleviate a hearing impairment.

People were supported with their health needs when they became unwell. Emergency services had been called when necessary. Follow-up appointments with healthcare professionals were scheduled and attended. A person had been referred to a mental health clinic when they experienced anxiety and to their G.P. for a review of their medicines. A person who approached the end of their life had been referred to a hospice team. Records about people's health needs were kept and information was effectively communicated to staff so effective follow up was carried out. This ensured that staff responded effectively when people's health needs changed.

Good

Is the service caring?

Our findings

People told us they were satisfied with the way staff cared for them. They commented, “I am contented here”, “The staff treat us definitely with respect”. One person said, “I am the happiest I have been in 15 years”. Staff told us, “There is a homely feel about this place; the residents’ wellbeing is our priority”.

We spent time in the communal areas and observed how people and staff interacted. The staff displayed a polite and respectful attitude and the care that was provided was of a kind and sensitive nature. One person who needed help when moving around was assisted by staff and the staff ensured the person’s pace was respected. Staff spent one to one time with people if they needed company or reassurance. A person who was unwell and who remained in their room was visited several times during the day and was asked whether they needed anything or company. There was a friendly and appropriately humorous interaction between staff and people.

All staff knocked on people’s bedroom doors, announced themselves and waited before entering. People chose to have their door open or closed and their privacy was respected. People were assisted with their personal care needs when needed in a way that respected their dignity. A person told us, “They are respectful when I need help with washing and dressing”.

The staff promoted independence and encouraged people to do as much as possible for themselves. People dressed, washed and undressed themselves when they were able to do so. A person told us, “I do as much for myself as I can and the staff do not take over” Staff were aware of people’s history, preferences and individual needs and these were recorded in their care plans. People were able to spend private time in quiet areas when they chose to. Some people preferred to remain in the lounges, others in the conservatory or their bedroom.

Clear information about the service and its facilities was included in a welcome pack which was available on request in a different format for people with visual impairment. The procedure to follow about how to complain was provided to people and visitors and displayed in the entrance. There was a notice board for people’s use that included current information about the menus, activities and events. The information was provided in a large print format that met people’s needs.

People were involved in their day to day care. The registered manager and people discussed and agreed on a contract with clear terms and conditions before they came into the service. This included arrangements for their information to be shared with visiting health care professionals when necessary, according to Data Protection Act 1998 requirements. People’s care plans and risk assessments were reviewed monthly to ensure they remained appropriate to people’s needs and requirements. People were involved if they chose and their relatives were invited to participate in the reviews with people’s consent. People’s end of life wishes were recorded in their care plans when they came into the service.

Good

Is the service responsive?

Our findings

People's individual assessments of needs and their care plans were reviewed monthly with their involvement. Two people told us, "I know what is going on and what the workers are supposed to do as far as I am concerned" and, "They talk with me to check if I want anything changed". People confirmed staff were consistently responsive to their request for assistance. They told us, "I don't have to wait long, the workers come straight away". A district nurse and a community psychiatric nurse who oversaw people's care in the service told us, "This home is very good at communicating with us without delay whenever there is a need for our intervention" and "They know how to reduce anxiety and provide reassurance".

Each person's needs had been assessed before they moved into the service in respect to their morning, afternoon, evening and night-time care. This ensured that the staff were knowledgeable about their particular needs and wishes. Individualised care plans about each aspect of people's care had been developed and included a personal profile, their likes and dislikes, needs and relevant risk assessments. Attention was paid to what was important to people. A person had stated that they liked to "Take their time when washing in the morning as likes to chat and not feel rushed", another stated, "I like the commode by the bed, lights off and door kept ajar at night" and people had expressed their preference in nutrition, for example, "Love chocolate" and, "Not keen on sweet or high fat food", "Dislike tea", "Like to read papers" or "I like to watch TV". Care plans promoted staff's understanding of people's individuality and how to respond to meet each person's care needs and wishes. People told us their wishes were respected in practice.

Care plans were reviewed monthly or as soon as people's needs changed and were updated to reflect these changes to ensure continuity of their care and support. For example, after a person had a fall, they had been referred to a G.P. to review their medicines and they were closely monitored by staff. The registered manager completed a 'red alert' form when urgent response was identified to meet people's needs. For example, when a person's health had declined and they remained in bed, or when they had an infection and needed regular checks. These forms were monitored at least once a day and used as a temporary plan of care until the risk to people's health was reduced. When changes to the delivery of care became permanent, the main care plan was updated accordingly.

People's care plan included guidance from health care professionals for staff to follow. A district nurse had given instructions about preserving a person's skin integrity and regular repositioning. A G.P. had recommended thickened fluids to boost a person's nutrition intake. These instructions were followed by staff in practice.

People's bedrooms reflected their personality, preference and taste. For example, some rooms contained articles of furniture from their previous home and people were able to choose furnishings and bedding. People were offered choices and options. They had choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do.

Daily activities were available and were provided by an activities coordinator who was assisted by two members of staff. The activities coordinator was absent on the day of our inspection and activities were provided by staff. Activities included art and crafts, music and movement, painting, bingo, quiz and sing-along. People who enjoyed gardening were encouraged to plant and maintain potted plants. One person had expressed the wish to go out and walk in the town every day and this had been facilitated. Staff from the local library provided books in a suitable format. This included talking books for people with visual impairment. People were consulted when the activities were planned and their preferences and suggestions were acted upon. Monthly resident meetings were held and recorded. At the last resident meeting, people had made a specific request for knitting to be included in the activities programme and a weekly knitting club had been introduced. When people did not wish to partake in activities, their wish was respected. A person said, "I don't join in the activities I prefer to be on my own; they always ask me if I want to join though". People had a television and music playing equipment in their bedrooms when they wished.

Although people's feedback on activities was positive, two people told us they would like to choose from more options of activities. We discussed this with the registered manager who told us staff were scheduled to attend training in 'therapeutic activities' and that a wider variety of activities will be introduced. Regular outings were taking

Good

Is the service responsive?

place to local shows, garden centres and pubs. An outing to the cinema was scheduled. People had come back from a pub lunch and we noted that staff took cushions with them to make people more comfortable. One member of staff said, "Last time, we realised the seats were not comfortable so this time we went fully prepared and it made such a difference for people". This staff's approach ensured that people's needs were pre-empted and responded to. People's friends and families were welcome to visit at any time and people's birthdays were celebrated. Local neighbours had been invited to the service's annual fete. People were accompanied by staff whenever they requested to be supported to go to town. This ensured that people's social isolation was reduced.

People's views were sought two weeks after they came to live in the service. They were again sought at each monthly review of their care plans. The registered manager visited daily each person living in the service to find out how they felt. Annual questionnaires were provided to people and their relatives to gather their views on the care and support provided the activities, the food, the environment and the staff. People were specifically asked whether they had suggestions, ideas or special requests. People's views were listened to and acted on. At the last survey, people had commented that meals were not as hot as they would like them to be. As a result, plates were warmed and food was served more quickly. Some people had requested more Chinese food and this had been included in the menus. Other people wished to do some gardening and the provider had purchased pots, plants and vegetables to be grown by people. All the comments indicated that people were satisfied with the quality of the service. Comments included, "I enjoy everything", "People are kind and helpful" and "This is a very comfortable home; well run", and "So welcoming and helpful too".

People were aware of the complaint procedures. People told us they did not have cause to complain. One person told us, "No need to fill forms, I just speak to the staff if anything needs to be put right and they do it". No complaint had been received in the last 12 months before this inspection.

Good

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people. People and members of staff were welcome to come into the office to speak with the registered manager at any time. The staff we spoke with were positive about the support they received from the provider, the registered manager and the deputy manager. One staff member described the registered manager as "Really lovely and totally approachable". All of the staff spoken with told us that they communicated well with the management team and that they felt valued by the registered manager. A local authority case manager who oversaw a person's care in the service told us, "This place is well managed and there is a good family-like atmosphere in the home".

The registered manager spoke to us about their philosophy of care for the service. They said, "It is of the utmost importance to make sure our residents and staff are happy. Now is the time for our residents to live their lives as if they were still in their own home albeit in a different setting and with a support system that enables them to live as full a life as possible". We noted that the registered manager communicated their philosophy of care to the staff at team meetings. They told staff, "The home is not an institution and we need to balance maintaining security with the dangers of becoming authoritarian and clinical, driven by paperwork rather than caring and nurturing". A member of staff said, "The manager is good at getting us on board, she does inspire us to keep up with the good work and do better".

The provider spoke to us about their vision and values. They told us, "There is a local demand for further residential care facilities; we have plans to expand our premises and will employ additional staff to meet people's needs when we increase our number of residents. We want to develop our model of care further without losing this important homely feel". From what people and the staff told us and from our observations, the staff knew about the aims of the home. The staff took action to make sure these were used in practice.

Staff team meetings were held every six weeks to discuss the running of the service. Staff contributed to the agenda and were able to speak freely. Records of these meetings showed that staff were reminded of particular tasks and of the standards of practice they were expected to uphold. When an action had been identified and scheduled, the registered manager monitored the progress of the action until it had been completed. For example when a need for increased security in the premises had been identified, action had been taken and security measures had been implemented in order to protect people and staff's belongings. A member of staff had suggested a system of coloured labels on people's bedroom doors to alert staff to measures to be taken in case of emergencies, and this had been implemented.

The registered manager regularly researched relevant websites that included 'Skills for Care', the 'National Institute of Clinical Excellence' and the Care Quality Commission, to obtain updates on legislation and useful guidance relevant to the management of the service. The registered manager had discussed implications of new legislation with staff, had provided informative booklets to staff and had explained how this impacted on their practice. They attended regular local forums where they met other home managers, shared their knowledge, attended lectures and discussed practice issues. This ensured that the registered manager kept informed with latest development in the delivery of health and social care in order to improve their service.

All the policies that we saw were appropriate for the type of service, reviewed annually, up to date with legislation and fully accessible for staff guidance.

The registered manager carried out regular audits to monitor the quality of the service and identify how the service could improve. There were monthly audits of medicines, infection control, incidents and accidents, staffing levels, staff training and environment. Monthly audits of people's files ensured that records such as care plans and risk assessments kept were accurate, reviewed, updated appropriately and fit for purpose. An audit of incidents had led to the installation of a sensor mat to alert staff when a person might need help with moving around at night. The registered manager carried out random checks and observation of staff practice to monitor the quality of care. One of these observations led to a reminder for staff to remain vigilant about discretion and confidentiality.

The provider and registered manager did a daily 'walk around' and recorded any maintenance issues. This had led to a replacement of fitted carpet, grip rods, a tumble drier and security lights.

Good

Is the service well-led?

Additional health and safety checks of the environment were carried out quarterly to identify whether all areas and equipment used were suitable for purpose. As a result, mobility aids had been upgraded. Audits of satisfaction surveys were carried out and any suggestions that had been made by people had been implemented, for example when they requested a specific activity or food on the menu. The manager consistently notified the Care Quality Commission of any significant events that affected people or the service. Records indicated the manager took part in safeguarding meetings with the local authority when appropriate to discuss how to keep people safe, and kept people's families involved in decisions concerning their family members' safety and welfare.

All records were fit for purpose and kept securely. Archived records were kept for the appropriate period of time and disposed of safely.