Barchester Healthcare Homes Limited

Lanercost House - Carlyle Suite

Inspection report

Berkley Grange
Newtown Road
Carlisle
Cumbria
CA2 7PW

Tel: 01228552550
Website: www.barchester.com

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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

This inspection took place on the 14 and 15 November 2017. the first day of the inspection was unannounced which meant the provider did not know we would be visiting. The inspection was carried out by one adult social care inspector.

We last inspected the service in August 2016 where we found the service was no longer in breach of any regulations we inspected and a number of improvements had been made. The service was rated requires improvement as we needed to be sure improvements would be sustained.

Lanercost House Carlyle Suite provides care for up to 15 people and specialises in providing care to people living with dementia. There were 14 people in the home at the time of the inspection.

The home is situated in the grounds of Lanercost House which is a separately registered home belonging to the same provider. A new registered manager was in post and registered with CQC in November 2016.

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. The registered manager had previous managerial experience and were considered a senior manager in the organisation which brought additional responsibilities. We found this did not detract from the running of the home as a stable management team was in post including a supernumerary deputy manager and a dedicated unit manager. There were clear managerial roles and responsibilities and effective systems were in place to monitor the quality and safety of the service.

Systems were in place to monitor the safety of the service. Routine maintenance checks were carried out on the building and equipment, and individual risks to people were assessed and plans put in place to mitigate these.

Systems were in place for the safe ordering, receipt, storage and administration of medicines. We found a small number of topical Medicine Administration Records (MARs) used to record creams and lotions showed creams had been applied more often than originally prescribed. Steps were taken to update these records by the second day of the inspection to reflect people's change in needs.

A record of accidents and incidents was maintained, and regularly reviewed for patterns or trends.

There were suitable numbers of staff on duty during our inspection. One member of staff was allocated during each shift to closely supervise and carry out regular checks on people. We have made a recommendation about reviewing the levels of observation for people at certain times of the day as we observed they could be more active at times.

Staff had received safeguarding training and were aware of the procedures to follow in the event of concerns. Issues of a safeguarding nature were responded to appropriately by the registered manager.

Staff received regular training and support to carry out their roles effectively. We recommended that skills and resources relating to the support of people exhibiting behavioural disturbance and distress should be further developed in recognition of the specialist remit of the service. Although we found people were supported well there was room for improvement in the detail of care plans and assessment methods.

People were supported with eating and drinking in ways that met their specific needs and preferences. People were supported to choose meals and receive support to eat when required which was sensitive and discreet.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were observed to be caring and attentive throughout the inspection. We received very positive feedback about staff from relatives of people using the service. We observed numerous positive interactions between staff and people, and it was clear staff knew people and their family members well. A number of visitors spoke highly about the way they were greeted by staff and the warm and friendly atmosphere in the home.

A complaints procedure was in place although most relatives told us they had not needed to complain but knew how to if necessary. Complaints had been responded to in line with the provider's complaints procedure and there were opportunities for relatives to escalate their concerns internally or to another body should they not be satisfied with the outcome.

We observed people partaking in activities both spontaneously and planned. We received mixed views about the equality of opportunity to access activities and the range available. We have made a recommendation therefore that the suitability and opportunities for activities remain under review.

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

There were suitable numbers of staff deployed to care for people effectively. We have made a recommendation about reviewing the levels of observation for people at certain times of the day.

Recruitment procedures were safe which helped to protect people from abuse.

Risks to people were assessed and plans were in place to mitigate these.

Staff had received safeguarding training and were aware of the procedures to follow in the event of concerns.

Is the service effective?

Good

The service was effective.

Staff received regular training, supervision and appraisal to ensure they were supported and competent to provide effective care. Nurses were supported to maintain clinical skills and their professional registration.

People were supported with eating and drinking in ways which suited their individual needs.

The service was operating within the principles of the Mental Capacity Act (MCA). Applications to deprive people of their liberty had been sought in line with legal requirements.

The premises were well maintained and suitable to meet the needs of people living there.

Is the service caring?

Good

The service was caring.

We saw numerous examples of caring and compassionate care.

The privacy and dignity of people was maintained and respected

by staff.

People had access to formal advocates and were supported by relatives when they lacked capacity to take part in discussions about their care in line with best practice.

Is the service responsive?

Good

The service was responsive.

Relatives told us communication was good and they were kept informed about the care of their loved ones.

Person centred care plans were in place. Some of these would benefit from being more detailed and were being reviewed by the unit manager. Staff knew people and responded to their needs well.

We observed people joining activities and received feedback that the variety and opportunity to take part in activities could be improved. We have recommended activities remain under review in light of mixed feedback we received.

Is the service well-led?

Good

The service was well led.

There were clear managerial roles and responsibilities and a number of relatives told us they had seen improvements in the running of the service.

Regular audits and checks were carried out to monitor the quality and safety of the service.

The views of people and relatives were sought via feedback surveys and meetings. Relatives told us they felt listened to.

Lanercost House - Carlyle Suite

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.

An adult social care inspector completed this inspection on the 14 and 15 November 2017. The first day of the inspection was unannounced. Lanercost House Carlyle Suite provides mental health nursing care for up to fifteen people living with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales.

During the inspection we spoke with eight people who used the service, nine relatives, the regional director, registered manager, deputy manager and unit manager, a cook, four care staff, a physiotherapy assistant, and maintenance staff member. We also spoke with the local authority commissioning and safeguarding team, a speech and language therapist and a nurse from the care home education and support service (CHESS) team.

We carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We reviewed three care plans, three staff files and a variety of records relating to the quality and safety of the

service.

Good

Is the service safe?

Our findings

Relatives told us their relations were safe. One relative told us, "I can go home and relax. I know they are in good hands."

There were safe procedures in place for the ordering, receipt, storage and administration of medicines. We reviewed an audit by the supplying pharmacist which found no serious concerns. Recommendations they had made including obtaining a kit for the disposal of controlled drugs had been followed. Controlled drugs are medicines liable to misuse and therefore subject to more stringent controls. We checked the stock levels of two controlled drugs and found them to have been regularly checked and the correct amount in stock.

We checked ten Medicine Administration Records (MARs) and found no gaps which meant medicines had been administered as prescribed. Topical MARs used to record the application of creams and lotions were in place. We found in a small number of cases these had been administered more frequently than recorded on the prescription due to the needs of the person. Prescriptions and instructions were updated to reflect this change in use by the second day of the inspection.

Before the inspection we received information to suggest there were not always suitable numbers of staff on duty. On both days of the inspection there were four care staff, a nurse and the head of unit on duty to support 14 people. In addition to this there was a physiotherapy assistant and separate domestic staff members working in the home. Staffing levels were determined by a dependency tool. Dependency tools support service providers to set staffing levels based on the support needs of people using the service. Staff and relatives told us there were suitable numbers of staff on duty. We observed that staff were deployed effectively during the inspection including to ensure people were adequately supervised.

One relative told us, "Staff respond promptly. If people ask they are never told to wait a minute. The staff are on the ball and have time to talk to you." A staff member told us, "Staffing is good at the moment. We struggled for a while for nurses and now we have our full complement. We have a peripatetic nurse employed by Barchester to help when required and they know the home and residents."

People using the service had complex emotional and psychological needs and were at risk of reacting adversely towards each other due to misinterpretation of situations or the way they were affected by their dementia symptoms. We observed that staff were alert to the risk of conflict between people and deployed a 'visible nurse' on each shift to observe and monitor people including regularly checking their whereabouts to ensure they were safe and not experiencing distress. The designated staff member carried out purely supervisory duties and were not distracted by carrying out additional tasks. We observed that some people's behaviour became more intense at specific times of the day which meant an increase in the frequency of checks on individuals would be beneficial at times.

We recommend staff deployment is considered in line with the changing needs of people throughout the day and levels of observation adjusted accordingly.

We checked staff recruitment and found suitable arrangements were in place for the recruitment and selection of staff. Staff completed an application form, references were sought, and a check on the identity of people and their right to work was carried out. Checks were also undertaken by the Disclosure and Barring Service (DBS) which ensures people are suitable to work with vulnerable adults. This helps employers to make safer recruitment decisions.

Staff had received training in the safeguarding of vulnerable adults. There were two concerns of a safeguarding nature under investigation at the time of the inspection, and the registered manager had followed the correct procedures once they were made aware of these. We will report on the outcome of these if necessary once complete.

Staff confirmed they had received safeguarding training and were aware of the procedures to follow. They told us they had never seen anything of concern. One staff member told us, "I know about the whistle blowing policy but I have never had to use it."

The home was clean and tidy and well maintained. New flooring was in place and there were no malodours. Cleaning schedules were available in the kitchen and we observed that infection control procedures were followed by staff. Food items stored in the fridge were clearly labelled and dated. There were ample supplies of personal protective equipment such as gloves and aprons for staff to use. A staff member told us, "Cleanliness is better, carpets have been replaced." A relative told us, "The home is always immaculate."

Individual risks to people were assessed, including their risk of falls or skin damage and plans were in place to mitigate risk. Environmental risks were also considered in relation to people, including access to hazardous substances. One risk assessment we read said, "(Name) explores the environment in an inquisitive manner and may accidentally ingest hazardous substances should these be accessible." All hazardous substances such as cleaning materials and toiletries were locked away.

A record of accidents and incidents was maintained and this was analysed on a regular basis by the registered manager to monitor for patterns or trends. One person had an accident resulting in a minor injury. We read supervision and staff meeting notes drawing staff attention to the cause. This showed the unit manager had shared learning from the review of the accident in order to prevent it from happening again.

Good

Is the service effective?

Our findings

People and relatives told us they were happy with the service they received. One person told us "I'm very happy. I'm well looked after; I like the food and my room." A relative told us, "I couldn't be happier."

People were supported with eating and drinking. Staff had received nutrition and dysphagia training to help their understanding of supporting people with swallowing difficulties. We joined people at lunch time and observed three mealtimes during our inspection.

The mealtimes were calm and unhurried. Some people were supported by relatives, some sat at a table and were supported by staff or preferred to eat in their bedrooms. Relaxing music was playing and tables were fully set. People were offered a choice of meals and a staff member told us, "If people want something different, the chef is always obliging and will make something else."

We spoke with the chef who told us, "We try to keep food choices the same for everyone so we adapt special diets so they can have the same as everyone else. If we know that someone fancies something specific (name of maintenance staff member) pops out to get it." A relative told us, "If (relation) doesn't like anything they will make them something else or if they are really enjoying something they can have more. They had three desserts!"

People living with dementia can experience difficulty in selecting menus due to problems with language and reading the choices available, and then remembering what they have ordered. Sample portions of meals were used to show people the choices of food available rather than picture menus, as these were deemed easier for people to select as they could also base their decision on smell. We observed people being shown choices of meals this way and indicating their preference.

A variety of special diets were catered for including pureed meals for people with swallowing difficulties, and high calorie meals for people who needed to gain weight. The chef was knowledgeable about how to fortify meals by adding cream and butter to increase calories. High calorie shakes were also made for people.

The nutritional needs of people were assessed and monitored. A monthly nutrition meeting was held including care and catering staff to discuss changes and suggestions. For example, more finger foods were provided due to the tendency for some people to find it difficult to sit to eat. Meeting minutes showed staff were reminded to use plate covers to keep meals warm and food related staff training statistics were reviewed. Where people were at risk of malnutrition, advice was sought from their GP or dietitian. Weights were recorded and monitored regularly.

Speech and language therapist (SaLT) assessments were carried out to assess the needs of people with swallowing difficulties. We spoke with a SaLT who told us, "I was impressed with the carer's knowledge of the resident and with the staff's approach to maintaining the resident's safety and promoting wellbeing."

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty

Safeguards. 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) authorisations. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Applications had been made to the local authority to deprive people of their liberty in line with legal requirements and a record of these was maintained. A record of DoLS authorised and those due for renewal was maintained. Decisions made in people's best interests where they lacked capacity were recorded including giving people medicines covertly. Medicines are administered covertly, for example hidden in food, when people lack the capacity to understand the risks associated with refusing to take prescribed drug treatments. We found best interests decisions related to covert administration involved the person's GP, family, staff and pharmacist in line with best practice guidelines.

Some people presented a risk to others due to the nature of their illness. This meant it was important for staff to have knowledge of their whereabouts at all times. This was achieved in the least restrictive way possible in line with MCA guidance. The use of the 'visible nurse' supported this, and infrared sensor alarms also alerted staff when people had left their room in case they inadvertently went into the wrong bedroom and caused distress to another person. Some people chose to lock their bedroom door and staff had keys to lock their room behind them according to the wishes of the person. The lock allowed free access from the inside of the room, meaning people could leave if they wished to. Where people chose to lock their door, this was documented in care records.

Staff received regular training and supervision. Training considered mandatory by the provider included; fire safety, food safety, falls prevention (footsteps), health and safety, skin integrity, and infection control. We checked the staff training matrix and spoke with staff and found percentages of most training received by staff to be between 90 and 97%. Plans were in place for training which was not fully up to date.

Dementia training and training in behaviours that may challenge others was provided. We spoke with a nurse from the Care Home Education and Support Service (CHESS) team who told us that as a specialist unit, they would expect the Carlyle Suite to have advanced dementia awareness and knowledge of interventions to support people experiencing behavioural disturbance and distress. They provided training in care homes and told us the registered manager had signed up to training sessions and demonstrated a level of commitment necessary for this to be successful.

We found that not all staff had advanced knowledge of behavioural interventions and resources available to assess and monitor behaviour and we discussed this with the registered manager, unit manager and regional director. They were keen to develop further in this area and already had a range of books and materials to support staff.

We recommend that the knowledge of staff and resources to monitor behavioural disturbance continues to be further developed to reflect the specialist nature and remit of the home.

Staff supervision was carried out on a regular basis, including routine scheduled supervision and spontaneous group discussions with groups of staff in response to new information to cascade or a concern being raised. This meant supervision was being used proactively to meet the support and development needs of staff. Staff told us they felt well supported and could seek advice and support at any time. Annual appraisals were also carried out.

Qualified nursing staff competencies were monitored and assessed by the deputy manager who was clinical lead for the home. Nursing staff were supported with their requirement for Revalidation. Revalidation is the process nurses must go through to remain on the professional register and demonstrate they have maintained up to date knowledge and skills.

The design of the premises took into account the needs of people living with dementia including effective signage. The home was secure and safe yet non clinical. There were areas of interest for people to explore in corridors, and there was access to a first floor outdoor patio area with glazed front under supervision.

Good

Is the service caring?

Our findings

We observed kind compassionate and attentive care throughout our inspection. The atmosphere was warm and welcoming and a number of visitors commented that they were always made to feel welcome. One relative told us, "The staff are all good. It is like a home from home." Another told us, "Staff are fantastic. I'm a people watcher and they show real compassion. It's a good establishment, the atmosphere is pleasant."

Information was provided to people's friends and relatives including a newsletter and booklets published by the provider. The newsletter we read reported news about staff and people, including the commemorative celebrations of the life of a person who had passed away. Staff news included the announcement that the maintenance staff member was a divisional winner in the provider's staff awards and had a trip to London, and the wedding of another staff member. Publications such as these can promote a sense of belonging and help people to feel part of the home.

Booklets were available to the younger visitors of people to support them with questions they may have. These included 'Visiting Gran's or Grandad's new home.' They contained information to help children understand why their relation may behave in particular ways and explained the term dementia.

We spoke with a number of relatives during the inspection, some of whom visited daily. They all spoke highly of the staff and care provided. They were able to bring their pet dogs which people were very pleased to see and this added to the homely and inclusive atmosphere. They provided a source of comfort to some people who sat contentedly stroking their pet.

Many of the people using the service were unable to tell us their views about the care they received. We observed that people were generally relaxed and comfortable, and appeared tidy and well cared for. We observed staff supporting a person with lunch. They took their time and were patting and holding the person's hand between mouthfuls. They regularly checked the person was okay.

Help was offered sensitively and discreetly and people were asked before support was given. We saw one staff member ask a person if they could help and they didn't reply. They then explained, "I'm going to help you, is that okay?" People responded to staff with warmth and recognition.

Staff told us they enjoyed working in the home. One staff member said, "A smile is very important. If you smile people feel safe, if they feel safe they are happy." Staff showed an awareness of the importance of non-verbal communication particularly when supporting people who could become easily bewildered and upset. We observed staff using diversion and distraction to good effect.

Relatives were able to be involved in the care of their relation such as supporting them with meals, and as most people lacked capacity, they were included as a representative of their loved one in discussions about their care. Formal advocacy services could be sought for people if required. An advocate provides impartial support to people to make and communicate decisions.

The dignity of people was promoted. Staff knocked on doors and offered help with personal care discreetly. Clothing protectors were provided when necessary and people were supported to wipe their hands and faces following meals.

Good

Is the service responsive?

Our findings

People and relatives told us staff responded to their relations needs and communicated with them well. They told us, "Communication is good. We are told what is happening and kept informed." Another told us, "They (staff) come straight away and greet you. (Name of unit manager) is brilliant. He will sit with you and explain things to you."

We received mixed views about the activities available in the home, with some relatives and staff saying they felt the range and availability of meaningful activities could be improved. One comment included that activities were primarily a source of distraction and diversion which although effective, meant there was a risk that some people received more attention than others due to their need to be redirected. Other relatives and staff felt there were sufficient opportunities for people to have their social needs met.

We observed planned and spontaneous activities during our inspection. This included diversion such as blowing bubbles and playing with balloons, and listening to music. One person reacted to the bubbles by saying to a staff member, "We have had a nice day. You make me laugh." The staff member said, "You make me laugh too." Resources such as a television playing recordings of age appropriate music videos and other interests such as the royal family were situated in the corridor to attract people in passing. It was recognised that some people would find it difficult to join structured group activities.

We recommend that access to and the variety of activities available is kept under review in light of concerns raised.

A physiotherapy assistant employed by the provider worked into the home and supported people with mobility issues. A qualified physiotherapist was not in post but the assistant had close links with the hospital and community physiotherapists which enabled them to seek advice and support and respond to the needs of people in a timely manner. They worked Tuesday, Friday and Sundays and told us working at the weekend helped them to maintain contact with relatives who may only visit at weekend which enhanced communication.

Care plans were in place which were person centred. This meant they reflected people's personality, behaviour, likes, dislikes and previous experiences. We found care plans contained adequate detail but could be further enhanced and personalised. We spoke with the unit manager who said they would review care plans and add additional information where possible to demonstrate the care we observed being carried out and knowledge of people in practice was reflected in the level of detail in care plans.

A key worker system was in operation which meant people were allocated a named staff member who maintained an overview of their care records, needs, and liaised with relatives. The unit manager told us, "I am reviewing key workers and allocating staff to people based on their interests and compatibility." This meant account was taken of who certain people responded best to or had common interests with.

Advance care plan information was available for some people which described their wishes with regards to

hospital treatment. For example, they said they would be happy to go to hospital with broken bones or certain acute illness, but would prefer to stay in the home for treatment of anything else.

A complaints procedure was in place and relatives we spoke with told us they were aware of how to make a complaint but said they had not needed to. We reviewed complaints records and found these had been responded to in line with the company policy. There were opportunities for people to escalate their complaint higher in the organisation should they be unhappy with the outcome. They also had the opportunity to report complaints to the local authority and Local Government Ombudsmen (LGO). The LGO is the final stage for complaints about adult social care providers.

People were not routinely supported at the end of their lives in the Carlyle Suite. The remit of the home was to provide psychological support and mental health nursing care to people particularly those with a tendency to become distressed. We were told that when people's physical needs became primary and they would move out of the home, often to the main care home on the same site run by the provider, Lanercost House. Staff could support this transition to help people to settle due to the proximity of the home. We were told however, that should a person suddenly deteriorate and it would be distressing to move them, they could be cared for in the home with support from Lanercost House. This would however be exceptional circumstances. Where possible end of life wishes were recorded in people's care records.

Good

Is the service well-led?

Our findings

At our last inspection a registered manager had been newly appointed. At this inspection we received positive feedback about the registered manager, deputy manager and Lanercost House Carlyle Suite unit manager. A number of relatives told us they had seen improvements and were very happy with the leadership in the home. One relative told us, "The report displayed downstairs (last CQC report) is out of date and doesn't reflect how good the home is at all."

Staff also regularly mentioned the regional director who visited the home on a regular basis. Staff reported they were supportive, knowledgeable and friendly. This meant the senior management team were a visible presence in the home and known to staff. A staff member told us, "The managers are all approachable and the regional director keeps an eye on things." Staff told us they enjoyed working for the provider. One staff member said, "I wouldn't work anywhere else. I love it here and it's a brilliant company to work for.

Changes had been made to the way the service was managed. The registered manager was an experienced home manager and therefore had senior manager status within the organisation. This meant they had a wider remit including supporting other homes at times with specific pieces of work. Systems in place meant this did not detract from the day to day running of the home. The deputy manager who was a qualified nurse was responsible for the clinical oversight of the Lanercost House Carlyle Suite and Lanercost House was entirely supernumerary to enable them to carry out this task effectively. They told us, "I think improvements have been made in the Lanercost House Carlyle Suite. (Name) is a very good unit manager. They are very proactive and enthusiastic and has put regular meetings in place. Although supernumerary, the deputy manager continued to work shifts alongside staff to maintain an overview and role model best practice.

A system was in place to audit the quality and safety of the service. In Lanercost House Carlyle Suite, the unit manager was responsible for audits which the deputy manager also repeated and randomly sampled. Ultimate responsibility for ensuring audits and checks were carried out rested with the registered manager. We checked audits that had been carried out including medicines and care records.

Regular unannounced visits were carried out by managers, including out of hours. One record we read showed a manager had visited the home at five o'clock in the morning and found the unit was secure, staff were all present and wearing the correct uniform, food and fluid charts and daily records were up to date and correctly completed.

A daily meeting took place in Lanercost House care home, which included all heads of department, managers and senior care staff from both homes. This took place at 10.30 each morning and staff provided the registered manager and colleagues with an update including care related issues such as people who were unwell, professional visits expected and feedback from catering, housekeeping and maintenance staff. This enabled the registered manager to keep up to date with what was happening in each home.

Systems were in place to obtain the views of people, staff and relatives. Most people were unable to

participate in surveys and the home had access to an observational audit tool called Dementia Care Mapping designed to assess the quality of care provided to people living with dementia, via the CHESS team who told us they would be happy to carry this out at the request of the home. The unit manager said they welcomed any support and would discuss this with the team.

Relatives told us their views were sought and they were invited to regular meetings. One relative told us, "We see the manager monthly. Communication is good. We discuss the home and they listen to us, we had a letter after the last meeting telling us what it was about and who had attended. We fill in surveys and are very happy with things."

We observed cooperative and supportive relationships between staff. They asked for help from each other politely and there was a calm and relaxed atmosphere between the staff team. Staff we spoke with told us they were happy in their work and morale appeared good. We observed staff being thanked by the unit manager who was friendly and approachable yet professional in their manner with staff people and visitors. They were observed sharing humour with people and staff and the atmosphere was light despite responding and reacting promptly to episodes of potentially escalating conflict or distress. We judged the overall influence they had in the home was reassuring and calming.

Regular meetings were held with staff to propose and discuss new ways of working and the development of the service. We read staff meeting minutes that reflected the involvement of staff in these discussions.

A staff reward programme was in place to recognise the commitment and achievements of staff including profit sharing and staff awards. An employee of the month could be nominated with the winner receiving a £25 voucher. There was also a staff benefit scheme including discount in certain shopping outlets.

There were good links with the local community and the registered manager had recently been approached to take part in some work with a local school. Intergenerational relationships between older and younger people have been shown to have real benefits for all parties. The registered manager was aware of this concept and keen where possible to be involved.