Coast Care Homes Ltd

Whitecliff Care Home

Inspection report

Whitecliff
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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?	Requires Improvement

Summary of findings

Overall summary

About the service
Whitecliff Care Home is a nursing home providing nursing and personal care to up to a maximum 28 people. The service provides support to older people, most of whom lived with dementia and other conditions associated with older people for example, diabetes and people with mobility needs. Some people living at the service were living with a learning disability in addition to other conditions associated with older people. The service was split over three floors with communal areas, kitchen, and dining room on the ground floor. At the time of the inspection there were 22 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right support
People were supported by staff that had been trained in most key areas. However, staff had not received training in respect of supporting people with learning disabilities. This was highlighted to the registered manager who took immediate steps to enrol all staff on learning disability training. Two members of staff had completed Makaton (a type of sign language) training and people were supported in communicating their needs by a staff team that knew people well.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, in some care plans mental capacity assessments were not decision specific and referred only to 'consent to care.' We found some gaps in best interest decision recording relating to people sharing rooms.

Right culture
There was a positive culture at the service and everyone spoke well of the registered manager and wider management team. People, relatives, and staff all had opportunities to feedback about the service and raise issues and suggest improvements if needed. There were auditing processes in place that had the oversight of the registered manager. However, auditing had failed to identify the lack of training for learning disabilities and the lack of specific mental capacity assessments. The registered manager was responsive to the issues raised and took immediate steps to improve, however these improvements needed time to complete and to embed. The registered manager had established positive working relationships with other health and social care professionals which resulted in timely referrals for support for people which had resulted in positive outcomes.

Right Care
Care and support was person centred and staff knew people well. People were treated with respect and dignity and were supported to be as independent as possible without compromising their safety. We observed numerous interactions between people and staff during our inspection. People were treated with kindness and were given the time they needed during personal care or when being supported with meals. Relatives told us they were very happy with the support provided one saying, "The care is excellent, they make it feel like their own home." A professional added, "The staff know people so well."

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 4 February 2017)

Why we inspected
The inspection was prompted by a review of the information we held about this service and the age of the last rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the effective and well-led sections of this full report.

The provider took immediate action to mitigate risk to people during the inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Whitecliff Care Home on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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. Details are in our safe findings below.	**Good**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Whitecliff Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
Whitecliff Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Whitecliff is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time looking around the service and spending time talking with people and staff. We spoke with 6 people living at the service and 10 staff. Staff included the registered manager, acting manager, deputy manager, chef, maintenance and domestic leads and 4 carers. We spoke with 5 relatives and 3 professionals.

We looked at a range of documents including 6 care plans and associated documents relating to risk and safeguarding. We looked at medicine records for 6 people and documents relating to complaints, auditing, training and quality assurance. We looked at 4 staff files and staff rotas.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Processes were in place to ensure people were safe and protected from harm. Staff had received safeguarding training and were able to tell us the steps they would take if they felt someone was at risk. Records confirmed safeguarding training had been provided with regular refresher training scheduled.
- People and their relatives told us they or their loved ones felt safe. Comments from relatives included, "I am confident this is a safe home," "They take great care of them, no problem, it's very safe" and "It feels very safe there."
- Safeguarding and whistleblowing policies were in place and information was displayed and was easily accessible to staff if they needed to raise concerns. Staff told us they were confident to use the whistleblowing process if needed. This facilitates staff to raise issues anonymously.
- The registered manager and wider management team had established a good working relationship with the local authority and had raised safeguarding concerns when appropriate.

Assessing risk, safety monitoring and management

- Risks to people had been identified, assessed and were regularly monitored and reviewed. Care plans contained risk assessments relevant to people and specific to their needs. These included for example the risks associated with falls, developing pressure sores and diabetes.
- The registered manager used recognised assessment tools for measuring and monitoring risks for example, Waterlow for skin integrity and the Malnutrition Universal Screening Tool (MUST) for people's nutrition. Body maps, repositioning charts and food and fluid intake charts were used where appropriate.
- Staff were aware of risks to people and took steps to mitigate these without compromising people's safety or independence. For example, people at increased risk of falls were still able to mobilise and walk around the service but where there were increased risks, they were supported by staff.
- Regular checks on fire equipment had been carried out including emergency lighting, extinguishers and fire doors. A weekly fire alarm test was carried out. Staff knew what to do in an emergency and we saw personal emergency evacuation plans (PEEPs) for people that were easily accessible in the event of an emergency. Safety certificates relating to legionella, electricity and gas were all in date.

Staffing and recruitment

- There were enough staff on duty every shift to support people safely. This included a registered nurse on every shift, supported by care and domestic staff. We observed that call bells were answered promptly and any requests form people in communal areas were immediately attended to by staff.
- We were shown staff rotas that confirmed staffing levels to be safe and that the nursing staff had

registered with the Nursing and Midwifery Council (NMC). The registered manager told us they ran a sponsorship programme to support new staff and that they were over staffed for most shifts.
● Recruitment processes for new staff had been carried out safely. We looked at 4 staff files and each contained the required documents. These included, references, photographic identification, employment histories and Disclose and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Using medicines safely
● Medicines were administered and recorded safely by staff trained in medicine management. Medicine Administration Records (MAR) had been completed accurately, signed and dated by the staff member concerned, clearly showing the amount of medicine given and where necessary, counter signed by a manager. Medicines were administered from a locked trolly with people receiving their medicines one person at a time.
● Medicines were stored safety in temperature controlled rooms that were monitored daily. Similarly, medicines that needed to be kept refrigerated for example, insulin, were stored in temperature monitored fridges within the medicine room. Controlled medicines were kept in a locked cupboard in the medicine room and each entry on the MAR charts had been counter signed.
● People's medicines were regularly reviewed by professionals from the medicine optimisation team and people's GP's.
● Separate protocols were in place for PRN or 'as required' medicines for example, pain relief. These were recorded on the MAR charts, clearly indicating they had been administered as PRN. Staff told us they knew the steps to take if PRN medicines were requested by people and would always seek advice if needed.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

There were no restrictions in place to limit when loved ones could visit people at the service. During the recent pandemic government guidelines had been followed. A relative told us, "During lockdown, visits were managed carefully when we were allowed. It was all done for their safety. We were happy they were taking great care of them."

Learning lessons when things go wrong
● Accidents and incidents had been recorded with copies of reports being attached to care plans. Incidents were discussed at staff handover meetings each day to ensure that staff starting their shifts were fully up to date with recent events.
● Apparent causes of accidents and incidents had been recorded and initial steps taken by staff and any support sought form other health and social care professionals documented. The registered manager had

carried out reviews and audits of accidents and incidents and of any trends or patterns were apparent, steps were taken to minimise a recurrence. For example, times and locations of falls had been examined.

● Any learning from accidents and incidents were shared with all staff. A person was identified as being at greater risk of falling when using the bathroom, this had been further risk assessed and staff now ensured they were not left alone when mobilising in the bathroom.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance. Staff support: induction, training, skills and experience
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 MCA 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Care plans contained a section showing whether a mental capacity assessment was required and whether one had been completed. In some plans assessments were not decision specific, as required but were generic and only referred to a decision relating to the place of care.
- The registered manager and staff we spoke with understood the importance of gaining consent from people. However, there was nothing recorded relating to people sharing bedrooms as to whether they had consented or whether it was considered in their best interests to share a room.
- The service supported some people that lived with a learning disability. Although some staff had been trained in the use of Makaton, a recognised means of supporting people with learning disabilities to be able to communicate, staff had not received training in learning disabilities itself. This potentially left people vulnerable to not being supported in the best way to meet their needs.

The registered manager acknowledged these issues and took immediate steps to improve the mental capacity assessments and to register all staff for on-line learning disability training. (see our well-led section for more about mental capacity and staff support.)

● Staff had completed mental capacity and dementia awareness training and did know people well. Staff did support people making day to day decisions for example about what food to have and what clothes to wear.
● Some people had DoLs decisions recorded and the registered manager had applied for these in a timely way and in most cases following best interest meetings with people, their loved ones and where appropriate, professionals.
● New staff had an induction period with opportunities then to shadow more experienced staff. Ongoing support to staff was provided with regular supervision and appraisal meetings. Staff told us that they could approach managers at any time for advice.
● We were shown a training matrix and staff confirmed with us that training was provided in other key areas for example, safeguarding, diabetes and end of life care, which meant staff could support people safely in these areas.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law
● People and their relatives were involved in the initial pre-assessment process and subsequent reviews. A relative told us, "The manager and deputy came out to assess and I was there. Very thorough process." They went on to say, "After the initial assessment we were invited in for lunch, it was a very thorough process."
● A form called 'initial needs' was used for people's pre-assessment process. This was carried out by the registered manager or one of the management team. The form was comprehensive and covered aspects of peoples care and support needs so managers could make informed decisions about whether staff could support them.
● Care plans provided details of people's care and support needs. The pre-assessment document went on to form the basis of the initial care plan for people. Care plans developed over time and were updated when peoples care and support needs changed. Care plans were subject of regular reviews and were further updated following accidents, incidents or a change in needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutrition and hydration needs were met. At the time of the inspection the kitchen was in process of being refurbished and main meals were being prepared at the service sister home and transferred to the home in heated containers. People still had a choice each mealtime and the chef had enough working space to make an alternative if needed.
● People's needs were met using a 4 week seasonal menu, offered by an experienced chef who knew people well. There were charts in the kitchen which indicated people who were diabetic and a few that required their food cut up and who needed some support when eating. Food arriving was clearly marked and was double checked by the chef before being given to people.
● People's food and fluid intake was recorded in care plans and those at risk of not eating and drinking enough had food and fluid charts in place and were closely monitored. Risk assessments were in place for people that needed the most support and we saw that regular contact had been made with nutritionists and GP's when appropriate.
● A relative told us, "There was an issue with them not eating enough. Staff actually went and took their breaks and sat in their room and had lunch with them to encourage them."

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● The front page of people's care plans contained details of key health and social care contacts associated with the person for example, contact details for GP's, district nurses, chiropodists and social workers.
● Multi-disciplinary team professionals were involved in supporting people. Health and social care appointments were scheduled and relatives told us that the service managed most appointments for people

well. A relative told us, "I took them to the dentist today, but they made all the arrangements. They always help with appointments." Another relative said, "The other day (person) was poorly. I could not believe how quickly they arranged for a doctor to come."

● Staff worked well with other services and professionals to communicate the needs of individuals on admission to hospital. Care plans had a front page link to a hospital pack. This contained a summary of their support needs and important medical information and past medical history for you in the event of a hospital visit.

● We spoke with professionals who told us of a positive relationship with the service with good communication leading to timely appointments for specialist support if needed. A professional said, "From a professional standpoint, all relevant information regarding residents is given and communication is good between staff, any problems highlighted are always taken care of and followed up on if necessary."

Adapting service, design, decoration to meet people's needs

● The service was adapted to meet people's needs. The service is split over three levels with stair lifts and a lift linking each level. People living with greater mobility needs in most cases occupied rooms on the ground floor. Two communal areas and a dining room were available on the ground floor where people could meet other residents if they wished. We saw the larger communal space being used for group activities during our inspection.

● People's bedrooms contained personal items of furniture and photographs and other personal effects that made each room feel homely and familiar to people. New people arriving could choose how they wanted their rooms decorated.

● A large patio area and garden extended at the back of the service which people told us they enjoyed during the warmer weather.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were treated with respect and dignity. We observed interactions between staff and people that were positive and supportive. Staff were patient and spent time with people, speaking to them kindly whilst supporting them. A staff member supporting a person with their lunch said, "Can I help?" "Let's make you comfortable first" and "Let me help you with that."
- Similarly we observed the chef and the activities lead showing patience and support to people and was clear that both know people well and responded to their needs appropriately.
- Relatives confirmed that their loved ones were treated with kindness and respect. A relative said, "They know her so well. Even though she does not speak very much they know her and treat her with kindness." Another relative added, "The home has been amazing. The outstanding difference is kindness, it's like they are in their own home."
- People's differences were highlighted and respected. Equality characteristics were recorded within people's care plans and any needs or wishes for example, relating to diet or faith, were met.

Supporting people to express their views and be involved in making decisions about their care

- People were consulted about their care and support needs and what things in their lives were important to them. The front of care plans had a section called 'social information,' which detailed how people liked to spend their day and day to day preferences for example, whether they wanted group or one-to-one activities, what they liked to watch on television and where they wanted to spend their time each day.
- Each care plan had a daily timeline across the front page which staff updated information hour by hour. Information included when support had been given with personal care, when medicines had been provided and details of meals taken. If people's health or mood changed this was also recorded providing all staff immediate access to any changes to people or their needs.
- People were given choices each day for example, what food they wanted, what they wanted to wear, whether they wanted to have a shower or to have a quiet day in their rooms. People had been given the opportunity to discuss their future care and to make decisions in advance.
- Care plans were regularly updated and reviewed and people and their relatives were involved in this process. A relative told us, "I'm kept up to date with changes and asked my views."

Respecting and promoting people's privacy, dignity and independence

- People's privacy was respected. Care plans and other sensitive information relating to people were held on password protected computer systems and any paper records were kept in a locked office. We observed

staff knocking on people's bedroom doors and only entering if they were invited in or if they had concerns.

● People were treated in a dignified way by staff at all times. We observed several interactions between people and staff and staff always spoke respectfully but in a way that was friendly and supportive. A relative told us, "They (relative) are always clean and well presented. They spend their time in bed now but whenever I visit, they are always dressed smartly."

● People were encouraged to be as independent as possible without being unsafe. People were encouraged to carry out personal care tasks but staff were close by if support were needed. A relative told us, "From what I've seen independence is encouraged. My (relative) returned after breaking their hip and at first could not mobilise. They got them moving again." Another relative said, "The occupational therapist could not believe the progress made when they visited."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plan documents were person-centred. People's personal preferences as well as their day to day health and social care needs were clearly recorded. Daily notes recorded by staff were entered onto a live computer program which was instantly shared with all staff and managers. This enabled staff to view updates and managers to maintain an oversight.
- We observed a mid-morning, daily staff meeting where staff came together to give verbal updates about people they were assigned to that day. The meeting discussed if there were any remaining support tasks for people to complete and discussed how people were feeling that day and if there were any medical concerns.
- Staff knew people well and could identify and changes to people's health and care and support needs. A relative said, "They know just by looking if there are changes."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People were supported by staff who communicated with them in their preferred manner. Some people were living with dementia or other conditions that affected their ability to communicate. Some people were non-verbal and relied on facial expressions to be able to communicate. Staff had complete dementia training and knew people well and were aware of how best to communicate.
- People who had sensory needs for example, were hard of hearing or sight, were treated patiently by staff. They took their time to sit with people and explain what was happening and what personal care tasks they wanted to carry out. We saw staff spending time with people and there were enough staff not to be distracted from communicating with people until they knew they had been understood or people had been able to communicate their needs.
- There were communication tools available if needed for example, picture boards and writing materials.
- Some people lived with learning difficulties and sometimes used Makaton to pass messages to staff. Although only 2 staff had completed Makaton training they had cascaded some of this learning and key signs to staff so that they could also communicate with people.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to participate in their chosen social and leisure interests on a regular basis. An activities co-ordinator was employed and provided a range of group and one to one activities for people. People's involvement in activities were recorded in daily notes.

● During the inspection we saw various group activities taking place and people engaging happily with singing, playing games or just talking with staff or other residents. There was a positive atmosphere in the communal area of the service.

● A relative told us, "They are always getting them involved. They helped them decorate their room. Even the cleaner and chef pop in and speak." Another relative added, "They always seem to have company. They go through photos, paint her nails, they have company every day."

● The service had a mini bus and cars that were adapted to carry people's mobility aids and during the warmer weather regular trips were made to the seaside, coffee shops and other local places of interest.

Improving care quality in response to complaints or concerns

● A complaints policy was in place and people and relatives told us they knew how to raise complaints, issues or concerns if they needed to. Comments from relatives included, "I did once raise an issue about a meal being cold. This issue was addressed straight way," "I raised a minor issue once and the manager was straight on it and gave me all the information I needed" and "I'd go straight to the manager, I know they would sort it."

● We saw documents relating to complaints that showed that the registered manager had addressed issues raised in a timely way, keeping complainants informed of progress and outcomes. Everyone we spoke with told us they had confidence that if they raised an issue it would be dealt with quickly.

● Not enough complaints had been made about the service for any meaningful audit to be carried out. However, the registered manager kept an oversight on all complaints and issues raised and if any learning was apparent then this would be shared with all staff.

End of life care and support

● Staff had received training in end of life care and were able to tell us the important aspects of supporting people at this important time of their lives.

● Care plans had sections that covered end of life arrangements where known. Relatives were involved in these discussions and each plan had been reviewed monthly noting any changes to people's wishes.

● Most people had Respect forms in place. These documents contained details of agreed actions made between the person, their relative's and professionals in the event of the person not being able to make decisions in the future.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Auditing processes were in place and were either carried out by or had the oversight of the registered manager. Although auditing covered all aspects of the service, the process had failed to identify the lack of decision specific mental capacity assessments for some people. The auditing process had also failed to identify that some best interest decisions had not been recorded.
- The registered manager had a comprehensive pre-assessment process and had correctly identified for some people that they had support needs relating to their learning disabilities. However, the service was not registered to support people with learning disabilities nor did they provide training to staff to cover supporting people with these needs.
- We saw one set of notes for a person that spent all of their time in their room. This showed that a person had only received two one to one activity sessions in the past month. We brought this to the attention of the registered manager and activities co-ordinator who told us that some sessions had not been recorded correctly. Since the inspection the registered manager has put a communication book in the person's room to make recording easier for staff.

The registered manager was responsive when these issues were raised and took steps address our concerns. However, time was needed to embed any changes the registered manager made and for the training to be completed. At the time of our inspection these were areas that required improvement.

- Auditing processes that had been completed and that showed that actions had been taken if discrepancies found, including, care plans and risk assessments, personal care managers spot checks, call bell response times and infection prevention and control.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service had a friendly, homely atmosphere where staff and people interacted in a positive way and where people had choices about how they spent their time. Support was given in a person-centred way and staff spent their time in-between key tasks, chatting and spending time with people.
- The registered manager and other members of the management team all presented a visible presence throughout the home and people and their relatives spoke well of them. A person told us, in respect of the

service managers, "They are all good." Comments from relatives included, "I can't speak highly enough of them" and "The managers run the service well. What I like is when they call you, they always start saying, 'Please don't worry,' it always puts my mind at rest."

● Similarly, staff told us of a positive relationship with managers at the service. They described them as approachable and always available. A staff member said, "I trust the manager, she has been amazing since she arrived." Another said, "Manager is very good and supportive."

● Care plan reviews were carried out monthly and highlighted any changes to people's care and support needs. This ensured that people received the best care, tailored to their needs and achieved positive outcomes for them.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and the whole management team understood their responsibilities under the duty of candour. They were open and honest with us throughout the inspection and responded quickly to any issues we raised.

● Legally services are required to inform the local authority and CQC of certain significant events that affect their service. This obligation had been met with notifications being sent in a timely way.

● The most recent CQC report was displayed close to the entrance of the service and a link to the report was accessible from the service website homepage.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and relatives had opportunities to feedback about the service and to raise concerns and suggestions. Regular meetings were held with people and relatives and we were shown meeting minutes that were also made available to those unable to attend. Meetings included updates about the service from mangers but allowed plenty of time for discussion and for people or relatives to raise issues. Most comments recorded were positive with only minor concerns being raised and these then being addressed by the service.

● Comments from relatives included, "I have been to a residents meeting, it is a chance to raise issues," "I could not attend the most recent meeting but was still able to input my thoughts" and "Feedback, yes they ask me for feedback."

● The registered manager made changes in response to feedback. We were shown minutes from regular meetings with staff including day and night staff meetings, activities and kitchen meetings and managers meetings. Staff told us they had day to day opportunities to feedback and ask questions of managers who were described as, "Visible and approachable." Staff also told us that supervision meetings were a further opportunity to give feedback and discuss issues with managers. Staff surveys were regularly completed. The most recent was very positive but had a section for staff suggestions which were then followed up by the registered manager.

● Care plans had a section that considered people's equality characteristics. People's preferences were discussed but this was managed sensitively and details recorded only if people were happy for this to happen.

Continuous learning and improving care. Working in partnership with others

● The registered manager and wider management team were committed to continuous improvement. Business and continuity plans were in place and the care and support of people and improving care was at the centre of plans moving forward. Suggestions made by the inspection team were quickly considered and introduced.

● The registered manager kept themselves up to date with bulletins and updates from then local authority

and CQC and registered managers forums. Any learning or new practices were shared with all staff.

● Positive working relationships had been established with partners from health and social care. Comments from professionals included, "The coms (communication) is very good. They are responsive and raise concerns quickly," "The manager is involved within the home, not shut away in an office, she is friendly and available at any time needed" and "It has taken a while for the new registration of nursing to bed in. Fortunately experienced staff that know the resident swell can fulfil this role."