Hampshire County Council

Oakridge House Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was unannounced and took place on the 2 and 8 August 2018.

Oakridge House Care Home with Nursing is a care home service which also provides nursing care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided. Both were looked at during this inspection.

Oakridge house is registered to provide nursing and residential care for up to 91 people who have a range of needs including diabetes, dementia and epilepsy.

At the time of our inspection 91 people were living at Oakridge House. Oakridge House is a two storey building set in secure grounds on the outskirts of Basingstoke. The home comprised two units; one for residential and one for nursing care. The units are further divided into areas. Each nursing area is managed by a registered nurse and includes a dining room with basic kitchen facilities as well as a lounge and quiet seating areas. There is a central, secure garden with seating and raised planting areas which are accessible to people living in the home.

The service was last inspected in July 2017 and was rated as 'Requires Improvement' overall. This was due to staff not taking appropriate steps to ensure people's safety and wellbeing, ineffective systems to support staff in giving people maximum choice and control over their lives, incomplete documentation relating to the care people received, and quality assurance systems which were not always effective in identifying risks.

The provider had not ensured effective systems were in place to make sure they assessed and monitored the quality of the service provided. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found the provider had made the required improvements so that they were no longer in breach of this regulation.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

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.

Effective systems and processes were in place to protect people from harm and abuse. Staff had completed safeguarding training and were knowledgeable about actions to take if they suspected abuse. The provider

deployed sufficient numbers of staff to meet people's needs and keep them safe.

The provider used safe recruitment processes to ensure only staff who were suitable to work in a care setting were employed. Medicines were stored, recorded and administered safely and people were protected from the spread of infection.

People received care from skilled, knowledgeable staff who had been appropriately trained. Staff were supported with regular supervision and training to help develop their knowledge.

Staff were aware of the legal protections in place to protect people who lacked mental capacity to make decisions about their care and support.

People were supported to maintain a balanced diet. Snacks and drinks were available at all times and risk assessments were in place for those at risk of malnutrition and dehydration. People were supported to access care from appropriate health professionals.

Staff had developed bonds with the people they supported and knew them well. Staff encouraged people to communicate their needs and protected their privacy, dignity and independence.

Care plans were written in partnership with people and their families or legally appointed representatives where appropriate.

There were procedures in place for investigating complaints. These were responded to promptly.
Plans were in place for delivering end of life care for people. Staff had undertaken end of life care training and an end of life register was used to assist staff in monitoring people if they needed end of life care.

The registered manager had a vision to provide care which met people's individual needs. This was shared by the staff team.

Effective systems were in place to monitor quality and safety within the service. Incidents were reflected upon to improve care for people. The provider used different methods to engage staff, people and the public in the service and actively sought feedback about the care provided in order to improve care for people

The provider worked effectively with health and social care professionals to meet people's needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from harm and abuse. Suitable numbers of staff were deployed to meet people's needs. Risks to people's safety were identified and managed.

Medicines were managed appropriately. People were protected from the spread of infection.

Staff reflected on incidents to improve care.

Is the service effective?

Good

The service was effective.

The provider trained staff appropriately to meet people's needs. People were supported to maintain a balanced diet.

Staff worked effectively with healthcare professionals to ensure people received healthcare support.

Staff sought consent from people before carrying out any care or treatment.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and had developed bonds with the people they supported.

People were supported to express their views.

Staff treated people with dignity and respect at all times.

Is the service responsive?

Good

The service was responsive.

People and their families were involved in planning care which met their needs.

People knew how to complain and their complaints were responded to promptly.

Plans were in place to provide end of life care to those who required it.

Is the service well-led?

Good

The service was well led.

The registered manager maintained a supportive culture and displayed clear leadership. Staff responsibilities were clearly outlined.

There were effective systems in place for monitoring the quality of the service.

The provider involved people, relatives and staff in decisions about the service.

The provider worked effectively in partnership with healthcare professionals to meet people's needs.

Oakridge House Care Home with Nursing

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.

The inspection took place on 2 and 8 August 2018 and was unannounced. The inspection team included two inspectors and two experts 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. Both experts had experience of caring for older people who use services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that 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 information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events, which the provider is required to tell us about by law.

We reviewed records which included 11 people's care plans and 11 staff recruitment and supervision records. We also looked at records relating to the management of the service such as the Service Improvement Plan (SIP), quality assurance audits, resident meeting minutes and the staff rotas as well as health and safety and medicines audits. After the inspection we reviewed further evidence sent to us by the provider which included risk assessments, the staff training tracker and equipment inspection records.

We spoke with the registered manager, two deputy managers, a registered nurse, nine relatives, 11 staff members and a visiting healthcare professional. We also spoke with 11 people living in the home and observed people receiving care and support in communal areas.

Good

Is the service safe?

Our findings

At our last inspection in July 2017 risks to people's health and wellbeing had not always been identified and documented with sufficiently detailed guidance for staff to manage these risks safely. Where risks were known staff did not always take the appropriate action to ensure people were kept safe whilst eating. We also found people's food allergies were not recorded.

At this inspection we found significant improvements had been made to mitigate these risks. Food allergies were recorded and choking screens were completed and documented in people's care plans. During mealtimes we observed that people were offered appropriate foods and assistance to eat to prevent the risk of choking. Domestic assistants had been trained and had their competency assessed by registered nurses so they were able to support people who required help to eat. This meant that more staff were available to ensure people had the support they needed at mealtimes to keep them safe.

At the last inspection we also identified that there was a lack of guidance for staff in managing behaviours that challenge. This placed both people and staff at risk of injury through not having the appropriate guidance to manage challenging situations. At this inspection we found steps had been taken to improve in this area. Care plans contained specific guidance for staff to help people remain calm when they displayed behaviours which may indicate anxiety. This meant there were clear strategies in place for staff to support people and reduce the risk of harm or injury.

People we spoke with told us they felt safe living at Oakridge house. One person told us, "I feel very safe." This was confirmed by relatives we spoke with. One person said, "[Relative is] very safe. My [relative] is not very mobile. [Relative] has always been safe."

The provider had effective systems and processes in place to protect people from the risk of harm and abuse. All staff completed an eight-day induction which included detailed safeguarding training. There was a nominated safeguarding champion who took responsibility for ensuring staff were up to date with the latest guidance and training. Safeguarding and whistleblowing policies were available on the provider's online system. Staff we spoke with confirmed they had accessed these.

Staff displayed thorough knowledge about the types of abuse and actions to take to protect people and had a good understanding of the provider's safeguarding and whistleblowing policies. One staff member told us, "We have a whistleblowing policy and we've also got the safeguarding contact numbers. Each member of staff knows if they're concerned about anything they can speak to me directly. [We're] very thorough…we all know what procedure to follow".

Allegations of harm or abuse were reported by the provider to the Care Quality Commission (CQC) and the local authority promptly. Any concerns were thoroughly investigated by the provider and required risk assessments and safety measures were put in place by staff to protect people from further harm.

Detailed, personalised risk assessments were in place to identify risks to people's health and wellbeing and

provide specific guidance for staff. One person's care plan contained a mobility risk assessment which specified the techniques and number of staff needed to aid the person as well as the size and type of mobility equipment required. Another person's care plan contained a risk assessment with information about managing their epilepsy. This included monitoring of seizures, emergency procedures and administration of emergency medicines. Records showed that these plans had been reviewed and signed by staff.

The provider deployed sufficient numbers of suitably qualified staff to meet people's needs and keep them safe. People's needs were regularly assessed and rotas were devised according to the number of care hours people needed and the number of staff required to support them. If there were staff absences due to sickness, the registered manager and deputy managers arranged for cover so that people receive the required level of support at all times. Agency staff were also used to cover shortfalls in staffing. As much as possible the provider ensured that they maintained continuity for people by requesting the same staff. Rotas for the four weeks prior to the inspection confirmed that there were enough care staff on shift to support people safely.

Robust recruitment checks were used by the provider to ensure that only staff who were suitable to work in a care setting were employed. Staff files contained evidence of previous employer references, right to work in the UK, photographic identity and checks with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions by identifying applicants who may be unsuitable to work with people made vulnerable by their circumstances.

Safe systems and processes were in place to record, store and administer people's medicines. We looked at the Medicines Administration Records (MARs) for 30 people living at the home. These included prescribed tablets, topical creams and ointments. There were no gaps in these records. All MARs contained relevant information, such as photographs for identification purposes, people's allergies and the ways in which they preferred to take their medicines. Staff conducted weekly and monthly medicines audits. No areas of concern had been identified over the last 12 months. The dispensing pharmacist also completed an annual audit. The latest audit had not identified any concerns.

For medicines given on an 'as needed' basis protocols were in place. These outlined how, when and why these medicines should be taken and included maximum doses over a 24-hour period. Where a person could be given varying numbers of tablets, for example one or two painkillers, this was clearly recorded on MARs. Pain assessment tools were used for those unable to express pain verbally; records gave information about how people behaved when they were in pain. There was clear guidance for staff concerning the management of people taking anticoagulant medicines which are used to prevent blood clots. Records showed GPs had authorised the use of 'homely remedies' or simple medicines which are not prescribed such as cough syrups.

The home was clean and free from unpleasant odours. We observed staff using the correct personal protective equipment such as aprons and gloves, when providing care. There were also individual infection control risk assessments in people's care plans. Communal and clinical areas, were clean and tidy. There were ample hand hygiene stations throughout the home. Bathrooms and toilets were clean and free of litter or debris. Staff we spoke with had a good understanding of infection prevention and control techniques.

The provider maintained a record of accidents and incidents and used these to reflect on ways to improve care. The registered manager told us that following a recent incident a discussion was held with the staff team to identify ways of preventing similar incidents occurring in future.

Good

Is the service effective?

Our findings

At our last inspection we found staff were not always able to clearly identify the principles of the MCA. We also found that where people had been assessed as not having the capacity to make decisions about their care, the provider had not always recorded that actions taken were in people's best interests. Best interest decisions are made in partnership with people close to the person deemed to lack capacity to make that specific decision. These processes ensure the decision being made on that person's behalf reflects their needs and that any action taken is for the benefit of the person.

Some applications to deprive people of their liberty had not always been discussed with relevant persons and documented fully as being in their best interests. This meant people were at risk of being deprived of their liberty without the appropriate processes to ensure this action was necessary, proportionate and in the person's best interest. For some people who did not have capacity to agree to their care their next of kin had signed documentation stating they had agreed to the care being provided. However, there was no evidence that those who signed the documentation had been identified as having a Power of Attorney (POA) for Health and Welfare. A person with a POA for health and welfare has the legal ability to make decisions about a person's care, a relative who is identified as next of kin does not have the legal authority to make decisions or agree to care on a person's behalf. For other people receiving medical care the appropriate MCA and best interest decision making processes had not been followed.

At this inspection we found provider had made improvements in record keeping to evidence that best interest decisions had been made appropriately by those with POA. Records also showed that where people had been deprived of their liberty this was done using the appropriate decision-making processes and documented accordingly.

People had received mental capacity assessments where this was appropriate as part of their decision-making care planning. Where a person did not possess mental capacity, up to date mental capacity assessments were in place in areas such as medicines management and support. There was also evidence of best interest meetings with relevant parties present and copies of POA for Health and Welfare, where appropriate. Applications to deprive people of their liberty were decision specific. They clearly outlined why the person was being deprived of their liberty and how it was to be achieved in the least restrictive way.

Staff we spoke with confidently identified the principles of the MCA and described how they put these into practice when providing care and support. One staff member told us, "We assume everyone has capacity until they're deemed not to…things change, it's about identifying the change…we give them choices." The provider's focus was on facilitating people to make some choices for themselves whenever possible, independent of whether they were deemed not to possess capacity.

At our last inspection in July 2017 we found that the provider had not maintained accurate records of the qualifications of registered nurses. At this inspection we found that records had been updated to include the qualifications of registered nurses.

People's needs and preferences were thoroughly assessed by the registered manager and suitably qualified registered nurses prior to them moving to the home. Assessments were completed in partnership with people and their family members where appropriate, and reflected people's individual health, wellbeing and communication needs. Care plans included detailed information about their life histories, such as their careers, hobbies and significant relationships. The care plans we reviewed were clear and logical and contained specific guidance to assist staff to support people according to their needs and preferences.

People we spoke with felt their needs were well understood and met by the staff who cared for them. One person said, "They look after me very, very [well] because I cannot walk myself. My hands are also weak. I press the buzzer and they are there [in] under three minutes." This was confirmed by relatives we spoke with. One relative told us, "The activities [person]…always makes time. The carers have been fantastic."

Staff followed best practice guidance when planning and delivering care for people. Assessments were completed using guidance from appropriate sources such as the Six Steps end of life care model in combination with advice from a clinical nurse specialist. If people required input from social workers staff promptly made the appropriate referrals.

Staff completed a comprehensive eight-day induction prior to starting work which was based on the Care Certificate. The Care Certificate is a structured induction programme which ensures staff are sufficiently trained and skilled to meet the needs of the people they support. The provider used appraisals and regular supervisions as opportunities to identify training needs. Staff competencies were checked regularly. Staff told us they had sufficient training to be able to meet people's needs and felt comfortable requesting additional training when appropriate.

Staff we spoke with were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating and special diets. The care plans we looked at reflected this. We noted a variety of referrals and assessments had taken place, including those involving dieticians and speech and language therapists. There were several people living at the home who were at risk of choking; care plans contained up to date choking risk assessments with clear instructions for staff on how to prevent or manage emergency situations.

Records we reviewed showed people were supported to access a wide variety of core and specialist health services. For example, referrals had been made on behalf of people to hospital consultants, dieticians and speech and language therapists. Staff continually reviewed people's health needs and referred them to appropriate healthcare professionals.

One of the home's deputy managers told us the provider had devised a new way of working with General Practitioners to ensure effective care. Most of the people living at the home had consented to register with one GP practice. Twice a week, either a GP or Advanced Nurse Practitioner visited the home to attend a multi-professional meeting with staff to review people's care and medicines. Changes were then explained to people and where appropriate, their relatives. This was confirmed by people's relatives. One person said, "[Deputy manager] kept me up to date with the change in surgery, straight away."

The home was suitable for the needs of the people living there. The home consisted of a ground floor and first with lifts to access floors. There was also a garden with raised beds which the deputy manager told us were used for vegetable growing. Corridors, doorways and rooms were wide enough to allow wheelchair access. Nursing rooms had en-suite bathrooms and there were shared bathrooms for people. People's rooms contained personal objects and furniture and photo boxes had been placed outside their doors to personalise them Communal dining spaces were painted in neutral, attractive colours. There was also an

arts and crafts area for people. Certain spaces in the home had been adapted for the needs of people living with dementia and contained significant objects from past eras to help people reminisce.

Good

Is the service caring?

Our findings

Relatives we spoke with told us that staff were caring and attended to their needs promptly. One person said, "These staff care about the residents, they're there on the dot."

Staff had developed kind and compassionate relationships with the people they supported. It was evident staff knew people well; staff knew people's daily routines without referring to documentation. We observed many instances of genuine warmth between staff and people. We saw that staff often gently placed their hands on people's arms to communicate that they were being spoken with. On these occasions, staff took time to explain their actions to minimise people's anxiety.

There was a calm and inclusive atmosphere in the home. The staff we spoke with were knowledgeable about the people they were caring for and could explain people's individual needs and requirements. It was evident staff saw people as individuals and interacted with them accordingly. For example, the provider had assembled a 'dignity board' on display for staff to read, which contained quotes from people living at the home concerning how they would like to be treated and what made them an individual.

We observed care and support given to people throughout the day. We observed interaction between people and staff who consistently took care to ask permission before intervening or assisting. Staff were responsive to people's needs and addressed them promptly and courteously. Staff upheld and promoted people's dignity through supporting their wish to maintain their appearance. One staff member told a person, "I booked you for a haircut. I'll give you a lovely shave. I will get some shaving cream in my break." This showed that staff recognised and respected people's individuality and were attentive to their needs.

The deputy manager showed us a piece of collaborative artwork which had been completed by people and staff called 'welcome to dignity'. People had made suggestions about how to maintain their dignity such as 'speak to me as an equal, not a child' and 'remember I was like you'. The deputy manager told us this activity had been enjoyed by people and staff as it promoted ways of interacting respectfully and encouraged staff to consider people's individual needs. Throughout the inspection we saw that staff treated people appropriately and respectfully and addressed them by their preferred names.

There was also recognition that the men living at the home may want a 'space' of their own as they were in a minority within the home. A regular men's 'get together' had been organised, the function of which was left entirely to the men to lead on. During the inspection we observed men taking part in a 'guess the celebrity' game.

Staff we spoke with gave examples of how they respected and promoted people's privacy, dignity and independence. One staff member said, "It's about knocking on doors, you don't just walk into someone's room." Staff told us about how they promoted people's choice, control and independence. One staff member said. "It's about talking to the resident [it's] their support plan, they need control over their life - that's very important."

Good

Is the service responsive?

Our findings

At our last inspection we found people had mixed views about the number and types of activities available. There was a lack of evidence to show that a range of activities were on offer to suit different needs and preferences. At this inspection we found that the provider had made significant improvements to the choice of activities on offer.

The provider arranged a varied programme of activities for people and employed three activity coordinators to deliver these. These included gardening, coffee mornings with relatives, entertainers, arts and crafts and 'Pets as Therapy' visits from dogs and cats. Activities were chosen and arranged according to people's interests.

Staff had arranged a multi-cultural celebration day as a number of people from different nationalities and cultural backgrounds worked at the home. There was also a monthly birthday celebration which was enjoyed by people and their relatives. One relative told us, "They had a birthday party for [relative] and [relative] shared it with another resident whose birthday it was in June…we all enjoyed ourselves."

The registered manager told us that people's opinions about activities were sought during residents' meetings so activities could meet people's preferences. The latest resident satisfaction survey had indicated a 92% satisfaction rate with the provision of occupations and activities.

Prior to arriving at the home people received a thorough assessment from a registered nurse. Care plans were then written in partnership with people and their family members where appropriate. They captured personal details and included information about people's backgrounds, how they wished to be addressed, communication needs, behaviour, cultural and spiritual needs and preferred ways of receiving personal care. Personal and social histories were very detailed; it was possible to 'see the person' in care plans. The staff we spoke with were knowledgeable about the people they were caring for. The daily records we reviewed were person centred. We gained an insight into people's daily lives could be obtained by reading them.

People's care plans contained relevant information about their health, wellbeing and communication needs. One person's care plan contained information about how they should be supported to communicate, such as using signs and gestures to indicate their wishes. Another person's care plan had detailed guidance on nursing interventions to manage their diabetes, such as regular blood sugar monitoring. The staff we spoke with understood their responsibilities in this area. For those people who lacked capacity and needed bed rails for safety reasons, appropriate risk assessments were completed and signed by relevant healthcare professionals and the person's legally appointed representatives.

Care plans we reviewed contained relevant and up to date information. There was guidance in the care plan to aid staff in the management of possible emergencies. For example, one person's care plan described the symptoms and management of high and low blood sugars and showed that blood sugar levels had been recorded appropriately.

We spoke with a visiting health professional who attended the home frequently about the care provided. They told us staff referred to them appropriately and that they knew people's needs well. They said, "There was someone who the staff asked me to see whilst I was here a while back. They were concerned that the person was just not right. They had an infection, which shows how well staff know the residents here." We also noted from care plans that staff followed any advice or guidance given by the professional.

People we spoke with knew how to complain but had no issues with care at the home. One person said, "I have had no complaints. No complaints at all." The provider had a complaints policy in place which was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. Staff we spoke with were clear about their responsibilities in the management of complaints and told us that if they could not deal with someone's complaint themselves they would contact the deputy manager or registered manager. The provider's complaints log showed there had been four formal complaints in the past year. All had been managed in a timely and satisfactory manner, in line with the provider's policy. In the same time span, the provider had received 26 compliments, in the form of cards, letters and e-mails.

If people needed care as they reached the end of their lives suitable arrangements were put in place by registered nurses. The registered manager had arranged for staff to receive additional training in end of life care. They completed the 'Six Steps Programme'. The Skills for Care 'National end of life qualifications and six steps guidance' describes the six steps programme as, 'The qualifications developed are for those working in social care and can equip workers not only to recognise end of life situations but to manage them more effectively.'

At the time of our inspection, no-one living at the home was receiving end of life care, however, advanced care plans were in place which outlined what the person wanted to happen both at and beyond the point of death. Care plans demonstrated people's relatives and representatives were fully engaged with the process, where appropriate.

Staff we spoke with were also aware of the people's wishes and knowledgeable about their care needs. The registered manager spoke to us about arranging spiritual care for a person of a particular faith as they neared the end of their life. Staff had arranged for the person to engage in the cultural and spiritual practices which were an integral part of their religion. A memorial book had been placed in the foyer at the home so people who had passed away would be remembered.

Good

Is the service well-led?

Our findings

At our last inspection we found that the provider's quality assurance systems were not always effective in monitoring quality and safety within the service. Required improvements were not identified through the provider's audits. This included food temperatures not being recorded, a lack of up to date records of nursing qualifications for registered nurses and a lack of evidence that actions identified through senior manager's quarterly quality audits had been completed.

The provider had not ensured effective systems were in place to monitor the quality of the service provided. This was a breach of Regulation 17 (Good Governance) HSCA 2014.

At this inspection we found that the registered manager had made sufficient improvements and was no longer in breach of this regulation.

The registered manager maintained a detailed oversight of quality and safety within the home. The 'Management Quality Assurance Auditing Framework' consisted of a comprehensive set of audits which were used to monitor areas such as health and safety, medicines, equipment and care plan reviews. Minutes from quality improvement meetings contained records of previous actions identified, completion dates and additional actions raised through quality assurance audits. These evidenced that actions had been completed within their specified time frames which showed improvements were made promptly to maintain quality and safety in the service

The provider's senior service manager completed regular inspections of the home and assessed areas such as staff training and end of life care. The latest inspection report showed that the registered manager had ensured these areas were meeting expected levels of quality and safety.

There was a clear management structure within the home and roles were well defined. The registered manager was supported by three deputy managers, two of which were registered nurses. The registered manager retained overall responsibility whilst the deputy managers took the lead in all aspects of nursing care within the home. The registered manager delegated tasks appropriately to deputy managers who completed regular service audits. Deputy managers audits of areas such as medicines, finances, events and incidents were monitored each month. Records showed that the results from audits were incorporated into the overall improvement plan for the service, which enabled the registered manager to maintain a full understanding of all required improvements and ensure all required actions were completed within identified timescales

The cook took responsibility for monitoring food safety in the home. Oakridge House achieved a food hygiene rating of five from the Food Standards Agency, which is the highest rating. Food preparation areas were clean and health and safety checks were completed at regular intervals such as food temperature checks. These were recorded for all hot foods and for refrigerators and freezers.

The registered manager had a vision to provide care which promoted and upheld people's individuality, in a

friendly, homely environment. This was shared with the staff team as there was a calm and relaxed atmosphere throughout the home. Staff attended to people's needs promptly and were cheerful and respectful in their approach. The provider invited people's relatives into the home at any time. Relatives were welcomed by staff and felt comfortable in the home. One person said, "The nicest thing here…you can come and go as you please…it feels like home so you tend to visit more." Visitors to the home seemed relaxed and happy.

The provider used various methods to engage people, staff and the public in the service. The registered manager told us that links had been developed with the local community, such as fundraising by a supermarket and visits from children at a nursery. A monthly 'faith gathering' was held in the home for people and their relatives and a local minister frequently attended the home to give people communion. Communion is the service of Christian worship at which bread and wine are blessed and shared.

The provider sought regular feedback from people about the quality of care provided. Responses to the resident satisfaction survey from April 2018 showed there was an overall average 94% approval rating. People were also invited to express their opinions about care provided in monthly residents' meetings and during regular coffee mornings.

We looked at the minutes of recent staff meetings. There were several different meetings convened, in addition to the general staff meetings, which were open to all and well attended. Minutes included staff who attended as well as records of discussion and views expressed. Issues discussed were relevant to staff and people.

The registered manager promoted an open, reflective culture in the home to help staff reflect on incidents as a means of improving people's care. Records showed that following a recent incident, staff discussions had taken place about maintaining the person's safety. Appropriate care plans had been written and safety measures put in place to protect the person from further incidents. Staff had observed the duty of candour by maintaining open discussions with the person's family and social worker.

All services registered with the CQC must notify the CQC about certain changes, events and incidents affecting their service for the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. The service had notified CQC about all incidents and events required.

The provider worked effectively in partnership with a range of professionals to meet people's needs and communicate changes in their care. We observed a staff handover between a deputy manager and a registered nurse following a meeting between staff from the GP surgery and staff at the home. It was person-centred and contained information relevant to the care needs of the person. One person was an insulin dependent diabetic. We noted evidence of good care day to day, such as referrals to podiatry for foot care and regular eye checks to maintain health.