Care Quality Commission

Larchwood Care Homes (South) Limited

Diamond House

Inspection report

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13 December 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on12 and 13 December 2017.

Diamond House provides accommodation; support and care for up to 42 older people, some of are living with dementia. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Although the service is registered to provide nursing care, this is not provided as the service is not staffed to provide nursing care. At the time of our inspection 35 people were using the service and one was in hospital.

There was a registered manager in place. 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.

People who used the service and relatives were happy with the care provided and many praised the skills and kindness of the staff.

People received safe care but at times staffing was stretched which meant people living with dementia were left without staff supervision. The shortage of activities staff meant that some people were not meaningfully occupied during the day which had an impact on their quality of life. The manager had strategies in place to try and address the staffing concerns.

Medicines were mostly well managed and people received their prescribed medicines on time. Some stocktaking errors meant we could not be fully assured that all medicines were being given as prescribed. The provider had already identified this as an issue and was taking action to address the issue.

The manager assessed and managed risks well. People were supported to be as independent as possible and any associated risks were incorporated into their care plan.

Staff understood their responsibilities with regard to keeping people safe from the risk of abuse. Staff were confident and knew how to raise concerns. Individual safeguarding incidents were well managed and the provider was open and transparent when carrying out safeguarding investigations.

Infection control procedures were in place and staff demonstrated a good knowledge of how to reduce the risk and spread of infection.

Staff were well trained and supported in their roles. Sone staff had received specific training related to eating and drinking and this was managed very well.

People had good and prompt access to healthcare and staff worked well with other healthcare professionals to meet people's healthcare needs.

The service worked in line with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

Staff were kind and caring and demonstrated that they had built up good relationships with the people they were supporting and caring for. People were supported to be as involved in decisions about their care as they wished to be.

People who used the service had the opportunity to follow a variety of hobbies and interests, although it was hoped that this would improve further when new activity staff were recruited.

New care plans were person centred and reflected people's individual need and preferences. People confirmed that their wishes with regard to their care, were respected.

Care for people at the end of their life was good. There was a commitment to ensuring people had a dignified and pain free death and were not left alone, unless this was their wish.

The service was well-led by the newly appointed registered manager. There was a clear vision for the service and a structured approach to driving improvement. Staff, including the manager, were well supported and there were effective quality assurance systems in place. We had confidence in the manager to continue delivering the good practice we found and to address the concerns, which they themselves had already identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff to make sure people were safe.

Medicines were mostly well managed but some stocktaking errors meant records were not accurate.

The provider assessed and managed risks well.

Staff understood their responsibilities to keep people safe from abuse and were confident about reporting any concerns.

There were good procedures in place to reduce the risk and spread of infection.

Is the service effective?

Good

The service was effective.

Staff were well trained and knowledgeable.

People's rights were protected and the service operated in line with the Mental Capacity Act 2005. People were not unlawfully deprived of their liberty.

People's needs related to eating and drinking and to their health were well managed and the service worked in partnership with other healthcare professionals.

The design and layout of the building was suitable for the client group.

Is the service caring?

Good

The service was caring.

Staff were patient and treated people with kindness and respect.

People were involved in decisions about their care and were very positive about the care they received.

Is the service responsive?

Good

The service was responsive.

Care plans were being reviewed and replaced with a more person centred format which reflected people's individual needs.

There was arrange of activities for people but staff shortages had impacted on this. Recruitment for new activity staff was seen as a priority.

There was a complaints procedure in place and people were given opportunities to raise concerns formally and informally.

Relatives praised the staff for the end of life care the service provided.

Is the service well-led?

Good

The service was well-led.

The service was very well led by a management team who were open, inclusive and empowering.

People were consulted and involved in the running of the service.

There were robust systems in place to monitor the quality and safety of the service and drive continual improvement.

Care Quality Commission

Diamond House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 and 13 December 2017 and was unannounced.

The inspection was carried out by two inspectors on 12 December and by one on the following day. Prior to the inspection, we reviewed all information available to us. This included a Provider Information Return (PIR). A PIR is a form completed by the registered manager to evidence how they are providing care and documents any improvements they plan to make. We also reviewed notifications. Notifications are information about specific events that the provider is required to send us by law.

We spoke with six people who used the service and three relatives. We also carried out a SOFI observation. This is a structured observation that helps us understand the experiences of people who are not able to communicate with us easily. We spoke with seven members of the care staff including one senior staff member, the head of housekeeping, the cook, an agency staff member, the registered manager and the regional manager. We also spoke with a visiting healthcare professional. We reviewed care records for eight people, nine people's medication records, four staff files and other records relating to the quality and safety of the service

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe and trusted the staff to look after them. One person said, "They come quickly when I press my buzzer. It's very good." Staff were very busy throughout our inspection visits but people all told us that they felt their needs were met. Another person said, "Sometimes you wait a little while but they always come. It's only when they're really busy."

We noted that staffing levels were stretched as there were a number of vacancies across both day and night shifts. Rotas confirmed that, as much as possible, regular agency staff covered these shifts which meant they were familiar with people's needs. We spoke with one regular agency staff member who told us, "It's great teamwork. I really love it here – the staff and the way it's run. It's great. The moving and handling is 'on point'." We observed that staff worked very well together and this created a harmonious atmosphere on shift.

The service used a recognised dependency tool to establish staffing levels and rotas confirmed that staffing was in place in accordance with this. Staff told us that they felt the staffing levels were appropriate, but struggled to meet people's needs promptly sometimes. One staff member told us, "We are rushed off our feet. It takes time to support people. The mornings are really busy." Senior staff did not always get their supernumerary time as they needed to cover shifts.

We observed that staff were very busy and that occasionally they left people living with dementia without supervision for short periods of time. There was a vacancy for an activity co-ordinator and we observed some people becoming increasingly restless as they had little to occupy them. We spoke with the manager and regional manager and it was clear that there was a strategy in place to manage staff vacancies and to continue to recruit high quality staff.

Prior to the inspection, we had received a high number of notifications about safeguarding incidents between service users. None of these had resulted in serious injury and all had been dealt with appropriately. However, the staffing levels may have been a contributory factor. These incidents were managed well and one relative commented on how well staff managed people's distress and any behaviour associated with this.

Staff recorded and reviewed incidents and accidents in detail to see if any learning needed to take place to reduce the likelihood of a recurrence. Care plans included a description of how people might behave if they were anxious or under stress and documented strategies to help to manage these occasions. The manager had a good overview of risk.

The service carried out a robust programme of risk assessment. This covered people's risk of falling, of developing a pressure ulcer, risks associated with eating and drinking and risks associated with people's particular health conditions. Risks relating to people's mobility and their moving and handling requirements were assessed and we observed good moving and handling practice. Pressure relieving equipment was made available to people as quickly as possible. We noted that pressure mattresses were on the correct

setting to help ensure people did not develop or worsen any pressure related injury.

The manager assessed risks associated with the environment and staff took action taken to mitigate these risks. For example, we saw window restrictors were in place to prevent people falling from height and the teapot was cool to touch to reduce the risk of scalding. Fire procedures had been reviewed and each person had their own emergency evacuation plan which covered their needs both during the day and at night, when staffing levels would be reduced. The service carried out regular fire drills and checks of equipment. Staff were clear about their responsibilities in the event of a fire and had had relevant training. One staff member said, "We have practiced with ski sheets and evacuation chairs. People are stationed around to prevent injury during drills."

Measures were in place to protect people from the risk and spread of infection. The kitchen was well organised and hygienic and staff had a good understanding of food hygiene. Domestic staff carried out a structured cleaning programme and we noted the service was clean, tidy and free from odour. A recent outbreak of a sickness bug had been contained and the head of housekeeping was clear that their good infection control practices had helped to minimise the impact of the bug. Staff had access to adequate stocks of protective equipment such as gloves and aprons and we observed them being routinely used. Staff were knowledgeable about infection control matters. However, we did ask for one sink to be cleaned as a priority as it was stained and the tiles were dirty. The manager assured us this would be carried out immediately and told us that there were plans to replace it.

Medicines were largely well managed. However, stocktaking errors meant we could not be fully assured that people always had their medicines as prescribed. Stocks of some medicines had not been carried over from one month to the next, and in two cases the recorded numbers of tablets did not match the stock records. We saw that the provider's medication audit, carried out a few days before our inspection, had identified this issue. There was an action plan to address the concerns.

Controlled drugs were administered appropriately and all stocks of these drugs were accurately recorded. However, we noted that one person's controlled drug patch for pain relief had not been administered according to the manufacturer's instructions. This had no impact on the level of pain relief but did risk the person's skin integrity. We alerted a senior member of staff who assured us they would review this.

We saw that medicines records were mostly very well organised and clear. PRN protocols were in place to guide staff about when exactly certain medicines needed to be given. PRN medicines are those which are needed only occasionally, such as for pain relief, rather than those which are routinely prescribed and needed on a regular basis.

Diabetes medication was well managed with blood sugar monitors checked weekly.

Staff who administered medicines had received training in administering medicines. Staff's competency to administer medicines was assessed regularly and we saw records confirming this. Some staff were overdue for refresher training but the manager was aware of this and was arranging this as a priority.

We checked staff recruitment records and found that there was a robust recruitment procedure in place. This included face to face interviews, job references, proof of identity and a full history of the applicant's previous work experience. The provider also carried out Disclosure and Barring Service (DBS) checks to make sure applicants did not have any convictions which would mean they were not suitable to work in this setting. The manager also checked to ensure agency staff had all the appropriate checks and training in place to make sure they were safe to work at the service.

Staff received training in keeping people safe from abuse and knew how to recognise the signs that someone might be at risk of harm. Staff were clear about how to raise a safeguarding concern formally and some had done so. The service had notified CQC and the local authority of any safeguarding concerns and had cooperated fully with any subsequent investigations. We found that the service responded quickly and comprehensively to any potential safeguarding issue. Where the service looked after monies on behalf of people, we found there were robust procedures in place to protect them from financial abuse. We reviewed two financial records and found them to be accurate.

Good

Is the service effective?

Our findings

People, and their relatives, trusted the staff to look after them and praised their expertise and skill. One person who used the service said, "I didn't know what to expect....This is a very good place. I find the staff very friendly. They are great…I'm pleasantly surprised".

Staff received the training they needed to carry out their roles effectively. When staff were first employed they underwent a comprehensive and structured induction. One staff member told us, "I shadowed [more experienced staff] for more than two weeks and they asked if I needed more time. Everyone gets involved – I shadowed basically about a month".

We saw good examples of partnership working across the service. Agency and permanent staff worked well together and staff had an appreciation of each other. New staff spent a day shadowing a senior staff member as part of their induction. The manager told us, "It makes people aware of each other's job roles". A visiting healthcare professional praised the way staff worked with them saying, "They can tell me the information I need to know quickly. A senior comes round with us which is good. This is one of our better homes. The manager rings for advice."

Staff received a variety of training including moving and handling, fire safety, first aid, equality and diversity, food hygiene and dignity. One staff member said, "There's a lot of learning – there's always more. You don't just do it once, it's refreshed…The maintenance man and the cleaners all do the training. We all have to be prepared and trained." Each course staff had attended was evaluated to assess whether it was meeting development needs. A visiting healthcare professional commented, "They have done lots of training.

We saw that specialist training was provided for some staff, such as training in the use of the defibrillator. The cook had undertaken training regarding meal planning for people with swallowing difficulties and those living with dementia. They talked knowledgeably about how their practice had changed following this training. A programme of training was being delivered to staff to help them manage people's distressed behaviour positively and successfully. Staff welcomed the training opportunities. Several staff remarked on how much training provision had improved since the registered manager had started work at the service.

Staff told us they felt supported and we saw that there was a supervision and appraisal system in place. In recent times, supervisions had not been as regular as the provider wished. The manager had identified this as an area for improvement and had a timetable of sessions going forward. The manager also told us they felt supported by the organisation and had been given a local mentor to help them learn their role. Peer support was also in place for the manager who linked in with other managers in the local area.

People who used the service had their needs assessed before they began to receive a service. This helped to ensure the service could meet their needs and took into account information handed over from families or other healthcare services. Assessments documented people's needs and preferences and what was important to them. One assessment we saw had some blank sections but we noted that all care plans were in the process of being reviewed and put into a more comprehensive format by the registered manager.

People's needs were assessed in line with recognised industry tools such as the malnutrition universal screening tool (MUST) and Waterlow. These assessments determine people's level of risk relating to nutrition and to pressure care respectively. We found that the service assessed people's needs and acted on the level of risk they found to reduce them. One relative explained how much their family member's health had improved since coming to the service. They attributed this to the attentive monitoring of the staff and the fact that staff acted quickly when their family member showed signs of being unwell.

People's healthcare needs were met. Staff reported and discussed any health concerns with professionals such as district nurses, speech and language therapists, opticians, GPs, psychiatric nurses and occupational therapists. Staff also received specific training about certain health conditions and were knowledgeable about people's needs relating to their health. We found good practice and really clear guidance for staff supporting people with diabetes. Staff were knowledgeable about what they should look for if they suspected someone's blood sugars were too low or high.

People told us they were happy with the food. One person, who was at risk of losing weight, said, "They always try to get you to eat – all the time!" We observed the lunchtime service and saw that staff worked as a team to ensure people received their food promptly. Food was attractively presented and staff offered people a visual choice by showing them plated options. Staff encouraged people to be independent but offered discrete support when needed.

Staff monitored people's food and fluid intakes when needed and kept a record of people's weights if they were at risk of gaining or losing too much. Clear information about the capacity of cups and glasses meant that staff would know exactly how many millilitres each drink was when recording people's fluid intake. Staff had a good understanding of people's needs related to their eating and drinking and promoted fluids for those people whose dementia meant they did not always recognize when they needed to drink. Meals were fortified with cream to provide extra calories for those at risk of unplanned weight loss and milk shakes, finger foods and snacks were made available. Staff contacted the GP and dietitian promptly when people had a significant weight loss and reduced appetite. They also arranged referrals to speech and language therapists for advice where there were concerns about people's ability to swallow.

Staff demonstrated a good knowledge of the Mental Capacity Act 2005 (MCA) and we found that people's capacity to consent to aspects of their care and treatment had been assessed. People were involved in decisions about their care as much as possible but if this was not possible Best Interests meetings were held. For example one person regularly refused their medicines and did not understand why their medicines were needed to support their health. A meeting had been held with relevant healthcare professionals and family to discuss the issue and make decisions about how best to support the person.

People who lack the mental capacity to consent to care and treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).The manager had made appropriate DoLS applications to the local authority and monitored these carefully.

The building was well suited to the needs of the people living there. The corridors were wide and people could walk independently around their part of the service. Access to the stairs was via a keypad to keep people safe. There was lots of information around the service for people who used the service and visitors. Upstairs a number of bedrooms had gates across the threshold to stop others going into the room. This had been appropriately risk assessed and relevant consent sought. The main lounge was well used and staff encouraged people to come to the main dining room for meals. People told us they went out into the garden in summer but those upstairs were reliant on staff to take them.

Good

Is the service caring?

Our findings

People who used the service, and their relatives, were very happy with the way staff provided care and support. A relative commented, "This is one of the best homes ever. They keep us informed. They treat [my relative] brilliantly. So caring. [They are] so friendly and there is a good atmosphere from everyone, from the caretaker upward."

Staff were kind and spoke to people with compassion, empathy and respect. Although staff were clearly busy, they took time to stop and talk to people and listen. They were patient with people who took a long time to communicate with them. Staff provided people with guidance, reassurance and eased their distress. We noted how staff supported a person who did not want to have a bath. They explained that, once in the bath, the person really benefitted from the relaxation and peace. They demonstrated patience and perseverance in supporting this person.

We observed staff treating people with kindness and sharing a joke with them, which we saw was greatly welcomed. One person said, "You can have a laugh with [the staff]. They are very, very caring." One staff member had a relative at the service and told us, "My [relative] is here. The reason is because I work here and I am happy with how my colleagues work with [my relative]."

People were involved, as much as possible, in making decisions about their care and support. Where people had capacity to do this we saw that they had been fully involved in reviews of their care and had signed their own care plan. Care plans included details about how staff should promote choice and how to successfully communicate with people. Staff were reminded to ensure people had hearing aids and glasses in place so that people were not effectively excluded from the society around them. Care plans also documented how to encourage people living with dementia, whose comprehension skills were compromised, to share their views. Information was available for people in formats they could understand, such as an accessible complaints form which included pictures.

Staff respected people's privacy and their personal space. We observed staff knocking and waiting before entering people's rooms and asking people's permission to provide care and support. Staff spoke respectfully to people throughout our inspection and people confirmed this was always the case. We observed staff providing discreet support for a person who needed help with their personal care. Support was offered with minimal fuss in order to preserve the person's dignity as much as possible

Good

Is the service responsive?

Our findings

The service was responsive to people's individual needs. The registered manager was in the process of reviewing care plans and putting information onto a new format. We saw that the new style care plans included comprehensive information and specific details about how people liked to receive their care and support. When people's needs changed, we found that care needs were reviewed and updated to reflect the new circumstances. There were clear procedures for handing over information from shift to shift. One staff member told us, "If a new resident comes in – the minute you walk in you are informed. You are always told. If there's a lot to tell you the team leader will take you into a room and talk privately so I know who to watch and what to do. She makes sure." This contributed to staff understanding how to meet each person's needs.

People told us the staff provided care which reflected their choices and preferences. For example, one person's care plan stated that it was important to them to have a daily shower. We asked them if the staff supported them to do this and they said, "I have a shower every morning – I need it to wake up!"

Care plans included specific details to help guide staff to provide individualised care and staff knew people's needs well. For example, one care plan said that the person had requested no further hospital admissions as they found this very unsettling. Another plan had detailed guidance relating to a person's distressed behaviour. A number of strategies, detailing how staff should reassure the person, were documented and the use of medication was seen as a final option. This showed us that staff were being encouraged to identify, respond and calm people without the need for medication to sedate them.

Although short of activities staff at the time of our inspection, we saw that there was a commitment to enabling people to follow their hobbies and interests. We observed people doing craft activities and listening to music. Other activities regularly offered included visiting singers, outings, gardening, flower arranging and baking. The provider hoped that once new activities staff were in place, more activities could be offered to people. This would be of particular benefit to those people living with dementia, who lacked meaningful occupation at times during our inspection.

We spoke with one of the activities co-ordinators. They told us about plans to set up a choir and expand the link the service already had with a local school. They were also in the process of gathering materials for a sensory box for one person who used the service as they liked to feel the different materials when the craft sessions were on. The staff member told us, "[They] can then take part when we're doing fabric but in [their] own way". This staff member demonstrated a good understanding of people's needs and had lots of ideas which they hoped would enhance people's daily lives.

The registered manager was committed to ensuring that end of life care was the best it could be and we found it was well managed. Staff told us that they made sure that a person was not left alone and, if family were not able to be present, a staff member would sit with them. We observed staff discussing the needs of a person receiving end of life care. They were very mindful of ensuring the person's pain was well controlled and that medication was in place and had been given time to work before they gave the person a change of position. This demonstrated an extremely caring attitude.

Information about people's wishes and plan of care for the end of their life was collated into one folder. Families were involved as much as possible, if appropriate, and staff respected people's wishes. Medicines to control any pain and anxiety were arranged as soon as it was clear a person was coming to the end of their life. We spoke with one relative who was visiting a family member who was approaching the end of their life. They told us, "It's absolutely brilliant. We wouldn't have left [my relative] here otherwise."

The service had a complaints policy and procedure in place. People told us they knew how to make a complaint and information on how to do this was displayed. There was an accessible complaints procedure with pictures for people who struggled to process written information.

The service had received no formal complaints since our last inspection. The manager addressed and resolved any informal concerns as quickly as possible. There were regular relatives' meetings where people could raise issues about the care of their family member. We saw that the service sent out surveys to gauge the views of people who used the service. The manager told us they were in the process of reviewing the food survey to make it more accessible and ensure it captured the views and concerns of the widest group of people.

Good

Is the service well-led?

Our findings

The relatively new manager was open, transparent and honest. They had recently been registered with CQC and were fully aware of their responsibilities to report significant information to CQC and to work within the regulations. We also noted that they understood their responsibilities to report any safeguarding concerns to the local authority and we saw that they carried out appropriate investigations when asked. The manager demonstrated an eagerness to learn, having come from a previous management role with a different client group. This was commented on by a visiting healthcare professional and the regional manager.

We received very positive feedback about the management team from people who used the service, relatives, staff and visiting professionals. The manager had gained the confidence of the staff with one staff member describing her as approachable and another saying, "They want the best for people." A relative explained that the service had previously been very well regarded by them but had then declined in their opinion, and in the opinion of some others we spoke with. However, they were very positive about the new manager saying, "Then this manager came and it all went back to how it was before. It's brilliant." This echoed the feelings of others who were relieved that the service was now committed to ongoing improvement.

The manager had quickly identified the areas for improvement at the service and had begun to take action to address these with the help of the staff and the regional manager. We found a shared commitment to continued improvement at the service and honesty about the issues which still required attention. The vast majority of the issues we found on inspection had already been identified by the manager and actions were already planned or in place. For example, the manager was clear that there needed to be a more structured approach to supervision and care plan formats needed reviewing. Both these actions were underway. The manager had delegated some duties to other staff, which both increased their skills and helped to ensure targets were met. They had also just begun to develop staff champions based on their skills and interests.

Staff told us they felt supported by the management and included in decisions about the way the service was run. The manager held regular staff meetings and people were expected to attend. One staff member said, "The team works very well together. I have come in on my annual leave. People tend to come in to help. I love working here." We saw evidence in staff records of a supportive management style which valued staff and encouraged improvement, although poor performance was robustly managed. The manager had recognised that change can be difficult for any organisation and was planning to introduce initiatives such as 'Moaning Mondays', protected time for staff to bring up issues which were concerning them. There were also plans to relaunch a scheme to reward staff for going the extra mile.

The manager had plans to create a closer link with a dementia support group, which had already visited the service. This was intended to benefit relatives who might be struggling to understand or cope with the issues raised by their family member's dementia. Other community initiatives were planned such as a visit from a local funeral director and a talk from a local solicitor about lasting power of attorney and DoLS. It was recognised that engagement with the local community was relatively poor given the situation of the service in the centre of the town. There were no volunteers at the service but again this was an area the new

manager hoped to develop.

The manager was well supported by the regional manager. They sent a very detailed weekly report to the regional manager which aimed to ensure that they had good oversight of all the issues at the service. The regional manager also told us about a recent impact audit they had carried out. This is a detailed assessment of the service similar to a CQC inspection. The assessment had shown areas for improvement and areas where the service was performing well. The manager was now working through the action plan drawn up following this audit. The manager was focussing on staffing levels and recruitment and retention of staff. These were the most significant issues we raised as a result of this inspection. This meant we were assured that the provider was robustly assessing the quality of the service and taking action.

There was a robust system of audits in place in addition to the impact audit. We saw that an external auditor carried out a financial audit on looked after monies; an annual fire audit was conducted by an external contractor. The service also conducted its own quality checks including medication audits and staff competency to administer medication as well as audits of the dining room experience. We also saw that the provider asked people who used the service for feedback via survey forms. People told us the manager carried out regular walk rounds and knew people's needs and understood the pressures on staff. This also gave staff and others the opportunity to raise issues with the manager, although no records of these walk rounds were kept. The manager led by example and staff told us she often provided practical help.

Records were clear, well organized and kept securely. There was a commitment from the manager to trying to ensure that information for staff and the people who used the service was as clear and detailed as possible while remaining accessible, often with the addition of pictures and large print.