Allandale Care Group Limited

Heathermount Residential Home

Inspection report

Heathermount
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14 February 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

This was an unannounced inspection carried out on 13 and 14 February 2017. Heathermount Residential Home provides privately funded personal care and accommodation for up to 17 older adults. Nursing care is not provided.

The home is a detached three storey house situated in Heswall, Wirral. The home is within walking distance of local shops and public transport. A small car park is available at the front of the home. Accommodation is in single occupancy bedrooms which have ensuite facilities. A passenger lift and stair lift enables access to all floors for people with mobility problems. Specialised bathing facilities are also available. On the ground floor, there is a communal lounge and dining room for people to use and a small garden for people to sit in and enjoy.

At the time of inspection there was a registered manager in post. They had been in post approximately six months on the day of our visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

The registered manager reported directly to the general manager. The general manager supervised the registered manager in the day to day management of the home. The general manager had also been in post for approximately six months prior to our visit.

During our visit, we looked at the care files belonging to four people. We found that some of the information in relation to people's individual risks was generic. This meant for some people, staff had general guidance about their care as opposed to specific information on how to manage their individual risks. This aspect of risk management required improvement. We saw however that staff did routinely mitigate risks in the delivery of care for example, by ensuring people had the mobility equipment they needed and responding promptly to people's needs when they needed help.

The home was clean and well maintained. We saw that the majority of the home's utilities had been regularly serviced and inspected as safe. The home's emergency lighting required improvement as identified improvements had not been completed. Some of the home's emergency lights had been identified as faulty but had not been fixed. We drew this to the registered manager's attention. Some improvements to the fire safety arrangements were also required and we were told by the general manager that this was in progress.

The registered manager told us that at times some people's medication had not been given to them by as prescribed by their doctor and we saw from people's care records that several incidences of this nature had occurred. The registered manager told us, in response to this, all staff administering medication had completed refresher training in medication administration, had their competency checked by the registered

manager and been supervised with regard to safe medication practices. Improvements in the way medication was administered however still needed to be evidenced. On the day of our inspection, the medications we checked were all accounted for and correct.

People we spoke with were happy with the care they received. They told us the staff were kind, caring and looked after them very well. They said they felt safe at the home and they had no worries or concerns.

Staff spoken with, were knowledgeable about types of abuse and what to do if they suspected abuse had occurred. They spoke about the people they cared for warmly. They were knowledgeable about people's needs and the care they required. It was obvious from our conversations and our observations of the service, that staff knew people well. The atmosphere at the home was homely and relaxed and it was clear that people who lived at the home had positive relationships with the staff on duty and felt comfortable in their company.

We saw that people who lived at the home were supported to maintain their independence and were able to choose how they lived their day to day lives. Activities were provided to occupy and interest people and on the day of our visit, a small group participated in and enjoyed a group quiz. Staff chatted socially to people throughout the day and these interactions were natural and spontaneous.

People had access to sufficient quantities of food and drink. People we spoke with told us the food was good and that they had plenty of choice. Where people had special dietary requirements these had been catered for and people who required adaptive cutlery to maintain their independence at mealtimes had this in place. People's nutritional health was managed effectively with appropriate action taken if people's nutritional needs changed.

Staff were recruited safely and there were sufficient staff on duty to meet people's health and welfare needs. Staff received the training they needed to do their jobs safely and were regularly supervised. No evidence could be found to show that staff had received an appraisal prior to the appointment of the new registered manager. The registered manager told us they had plans in place to do so.

The majority of people who lived at the home had capacity to make their own decisions. We saw elements of good practice in terms of the implementation of the Mental Capacity Act 2005 (MCA) but the way the provider assessed people's capacity required improvement in order to comply in full with this legislation.

People were given information about the service and regular resident meetings helped keep people informed about issues associated with their care. There were a range of quality assurance systems in place, the majority of which were effective in identifying and mitigating risks in the delivery of the service. We found that although some improvements were required with regards to the safety of the service, the overall management of the home was good.

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.

People's risks in the delivery of care were identified but risk management guidance was limited.

Improvements to the way medication was accounted for and administered were needed and were in progress.

People told us they felt safe and held the staff in high regard.

Staff were recruited safely and the number of staff on duty were sufficient to meet people's needs.

Is the service effective?

Good

The service was effective.

People told us they were well looked after and that staff supported their needs.

People told us the food was good. People's nutritional needs were met and monitored effectively.

Staff received suitable training and supervision but staff appraisals needed to take place.

There was evidence of good practice with regards to the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Everyone we spoke with said staff were kind, caring and respectful.

Staff were observed to support people in a patient and compassionate manner and chatted to people socially throughout the day. It was clear staff knew people well.

People's independence was promoted and people chose how

they lived their life at the home.

Care plans showed people had been involved in discussing and deciding upon their own care.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised to the individual and people's day to day preferences and wishes in relation to their care were documented for staff to follow.

Staff we spoke with were knowledgeable about people's needs and the people they cared for.

Records showed people had access to a range of healthcare professionals in support of their health and wellbeing.

Activities were provided by staff and the atmosphere at the home was social and inclusive. This promoted people's well-being.

People and relatives we spoke with had no complaints but the provider's complaints policy required improvement.

Is the service well-led?

Good

The service was well led.

The majority of quality assurance systems in place were effective in monitoring the quality and safety of the service.

Regular staff meetings took place and people's satisfaction with the service was sought. People's feedback was positive.

The culture of the home was positive and transparent. Staff worked well together as a team and people were happy with the support provided.

Some improvements to the service were required but overall the management of the service was good.

Heathermount Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on the 13 and 14 February 2017. The inspection was unannounced and was carried out by an Adult Social Care Inspector.

Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection.

At this inspection we spoke with four people who lived at the home, a senior care assistant, a care assistant, the registered manager and the general manager. We looked at a variety of records including four people's care records, three staff files, staff training records, a range of policies and procedures, medication administration records and a range of audits.

We looked at the communal areas that people shared in the home and visited some people's bedrooms. We observed staff practice throughout our visit.

Requires Improvement

Is the service safe?

Our findings

We spoke with four people who lived at the home. They all told us they felt safe and well looked after at the home.

During our visit, we looked at the care files belonging to four people. The registered manager told us that they were in the process of reviewing and changing the format of each person's care file to a new system introduced by the provider. They told us that they had not yet had chance to complete this for everyone who lived at the home.

Of the four care files we looked at, two had been reviewed and updated onto the new format. In all four care files we saw that people's risks were assessed but found that some of the information in relation to how these risks should be managed was generic. This meant they contained general risk management advice in respect of everyone's care as opposed to specific advice about the care of the individual.

For example, two people had swallowing difficulties that placed them at potential risk of choking. Some risk management advice was given, but this was brief and the same risk management advice was stated for each person. There was also insufficient guidance on what staff should do to should a choking incident occur. This aspect of risk management required improvement.

We observed however during our visit several instances were staff acted appropriately to mitigate risks. For example, one person was observed to have a coughing episode whilst having a drink. A staff member responded immediately. They encouraged the person to sit upright and explained to the person that sitting upright may ease their discomfort.

We saw that another person who mobilised with a rollator had fallen asleep in a chair without their rollator nearby. We saw that a member of staff noticed this and retrieved the rollator for the person. They placed it next to the person so that should they wish to mobilise when they awoke, they had the equipment they needed to do so safely.

We spoke with the registered manager and general manager about the lack of specific risk management information in some of the care files we looked at. They assured us they would review this without delay.

We saw that personal emergency plans were in place to advise staff and emergency personnel how to evacuate people safely in the event of an emergency. Each person also had a personalised summary (pen picture) of their needs and wishes at the front of their care file. This gave staff a good overview of the person they were supporting and summarised the most important information about their care. This was good practice as it gave staff a quick reference guide about the people they supported.

Staff we spoke with spoke warmly about the people they supported. They were able to tell us about potential signs of abuse and what they would do if they thought abuse had occurred. We reviewed the provider's safeguarding records and saw that potential safeguarding incidents had been recorded,

investigated and responded to appropriately. This showed that effective safeguarding procedures were in place to protect people from potential abuse.

We saw that the premises were well maintained and provided a clean and comfortable environment for people to live in. The provider had recently employed a maintenance person who carried out routine repairs and maintenance and external contractors were employed to test and maintain the home's systems and equipment. Records showed that the systems and equipment in use, with the exception of the emergency lighting system were safe and suitable for use.

The home's last electrical emergency lighting test in October 2016 showed that some of the home emergency lights had failed the test. We spoke to the registered manager about this. They acknowledged that some but not all of the faulty emergency lights had been fixed. This meant that some of the home's emergency lights would not work during an emergency situation to assist people's safe evacuation.

We also saw that the a fire risk assessment had recently been completed by an external supplier competent to do so. The fire risk assessment outlined that a number of fire safety improvements were required at the home to ensure that people who lived at the home were sufficiently protected in the event of a fire. We spoke to the general manager about this, who told us that the necessary improvements would be completed without delay.

Records showed that people's accident and incidents were recorded and managed appropriately. We saw that where people had had several falls, they had been referred to the NHS falls prevention team for advice and support. We also saw that people's health and well-being was monitored for 48 hours following an accident and incident to ensure their safety and welfare was maintained.

The registered manager told us that they had recently had a turnover of care staff and that at times this had left them a little short of staff on shift. They told us they had used agency staff to cover these gaps in order to ensure safe staffing levels were maintained. We looked at staff rotas which confirmed that staffing levels were consistent. We asked people whether they thought there was enough staff on duty at all times. All four people replied yes. Staff told us that staffing levels were sufficient to enable them to meet people's needs safely.

We looked at the personnel files of three staff member to check that they were recruited safely. We found that they had. Each staff member's file contained evidence of a formal application process, previous employer references and a criminal records check (DBC). This showed that the provider had checked the safety and suitability of staff prior to employment.

We looked at the arrangements for the safe keeping and safe administration of medicines at the home and found that some improvements were required. We saw that people's medications were stored securely. Daily temperatures checks of the environment in which medication was stored in were taken, to ensure that medicines were stored at safe temperatures.

The majority of people's medication was dispensed in blister packs that contained the required dose of each person's medication. Some medication was also boxed for example, 'as and when' required medication such as painkillers and prescribed creams. We saw that there were 'as and when' required care plans in place for boxed medication which provided staff with clear information on how and when these medications should be given. There was however a lack of adequate 'as and when' required care plans for prescribed creams. This meant that staff did not have clear information on how, when and where to apply these medications.

We found that some people's care files contained evidence that they had not received their medication correctly at all times. We also saw evidence that prior to our visit, some medications could not be properly accounted for. We spoke to the registered manager about this. They showed us the new system that they had put into place to assist all staff to account for the medications they had administered during their shift. They told us that all staff had received medication refresher training, had their competency to safely administer medications checked and had received medication supervision in relation to the medication discrepancies identified. They advised us that should further medication discrepancies be identified the provider's disciplinary policies would be put into force.

During our visit, we checked a sample of people's boxed medications to ensure that the amount of medication left matched what had been administered. We found that the balance of medication was correct. This meant that all of the medications we checked during of visit, could be accounted for.

Good

Is the service effective?

Our findings

People we spoke with told us were pleased with the support they received from staff. One person told us staff were "Very good. They look after us well" and another said that staff looked after them "Very well indeed".

We spoke with the registered manager, general manager, a senior carer and a care assistant during our visit. All of the staff we spoke with spoke warmly of the people they looked after and were able to tell us about people's support needs in accordance with their care plans. This indicated that staff knew people well. People were relaxed and comfortable with staff and conversations between them were natural, spontaneous and jovial.

Staff training records showed that the provider had a training programme in place which offered staff training in topics relevant to the needs of the people who lived at the home. For example training was provided in the safe administration of medications, moving and handling, safeguarding, dementia awareness, pressure area care, managing challenging behaviour, falls prevention, first aid and food safety. Records showed that the majority of staff had completed the training provided. Those who still had some of the training to complete had been booked on training courses to enable them to do so.

Staff we spoke with told us they felt supported in their job role and that they received adequate training to meet people's needs. We reviewed staff appraisal and supervision records. We found evidence that since the registered manager had come into post approximately six months ago, staff had received regular supervision. There was however no evidence to show that staff had received a regular appraisal prior to, or after the new registered manager had come into post. We asked the general manager about this. They told us that they had been unable to find the previous manager's records in relation to staff appraisals. Both the general manager and registered manager assured us there were plans in place to ensure that staff appraisals took place.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the majority of people who lived at the home had the capacity to make decisions about their care themselves. We looked at the care file of one person who the registered manager told us had been

assessed as lacking capacity to keep themselves safe outside of the home. They told us that a deprivation of liberty safeguard had been applied for and granted by the Local Authority.

When we looked at the person's care file, we found that the way the provider assessed people's capacity to make decisions required improvement to ensure it complied fully with the MCA. This was because the provider's assessment of the person's capacity did not clearly identify the specific decision the person's capacity was being assessed for. We spoke to the registered manager and general manager about this. They told us they would review their internal assessment process without delay.

We found however other evidence of good practice by the provider in relation to the MCA and DoLS. It was clear from looking at the person's records that the provider had considered this legislation when planning their care. For example, a capacity assessment of the person's ability to keep themselves safe outside of the home had been completed by the person's GP. An additional capacity assessment for the DoLS had been undertaken by an independent DoLS assessor to ensure it was in the person's best interests. Access to an independent mental capacity advocate (IMCA) had been facilitated to give the person the opportunity of independent support during the assessment process. This indicated that the MCA had been followed.

An IMCA s role is to safeguard the rights of people who lack capacity to make some important decisions. They provide support and represent the person in the decision-making process and make sure that the MCA is being followed.

There were systems to ensure people were supported to have a nutritious diet. We observed the serving of lunch. We saw that people sat where they liked in the dining room or chose to remain in their rooms for lunch. People's meals were served promptly and pleasantly by staff and the dining room tables were nicely decorated with tablecloths, napkins and china dinnerware.

The four people we spoke with told us the food was good. One person said the meals were "Marvellous" and that the cook "Knocks up some lovely dishes". People told us they had sufficient choice at mealtimes and that they could always ask for an alternative if they did not like what was on offer. We saw that people's likes and dislikes with regards to food and drink were noted in the planning and delivery of their care. We saw that the menu was displayed and that a three course meal was provided at lunch time with two different options available for starter, main and dessert.

On the day of our visit, an agency cook was on duty. The registered manager told us that the home's permanent cook was currently off work and that they had organised for an agency cook to cover in the meantime. We spoke briefly to the agency cook and asked them how they knew about people's special dietary requirements. They showed us the information they were given about people's nutritional needs and we saw that they had prepared a person's meal in accordance with this advice.

Records showed that people's weight was monitored to ensure their nutritional needs were met. The registered manager monitored people's weights monthly by using an audit tool which tracked people's weight gain and loss. This was good practice as it ensured any changes in people's nutritional well-being were picked up quickly. We saw that where people's dietary needs changed, a referral to the community dietician had been made to ensure people received the support they needed.

The care plans we looked at contained brief details about people's health conditions but lacked information on how people's health conditions impacted on their day to day life and the signs to spot in the event of ill health. We spoke to the registered manager about this. We saw however that people's care records showed they had access to a variety of healthcare professionals, in support of their health and well-being. For

example, district nurses, falls prevention team, hospital consultants, opticians, dentists, community dieticians and their own GP. This demonstrated that people's health needs were supported and acted upon effectively. Where people had attended appointments in relation to their physical health or where they had received support from visiting healthcare professionals, these visits were noted and any advice given in relation to people's care clearly documented for staff to follow. This ensured staff remained up to date on people's needs and care.

Good

Is the service caring?

Our findings

People told us the staff were kind, caring and friendly. One person told us "They are all so friendly and helpful". Another person said the staff were "Very good". Everyone we spoke with thought highly of the staff that supported them.

We asked two care staff about the care they provided and the people they cared for. We found they knew people well and were able to tell us about the things that were important to them. For example one person's care file indicated that they liked a structured daily routine and when we spoke to staff, they were able to tell us what this routine was and how they supported the person in accordance with their wishes. Another staff member told us about one person's passion for animals and their care plan and personal life history confirmed this.

Personal life stories capture the life story and memories of each person and help staff deliver person centred care. They enable the person to talk about their past and things that are important to them. They give staff and other professionals an improved understanding of the person they are caring for. Personal life histories have been shown to be especially useful when caring for a person with dementia. It was clear from our conversations with staff that this information was used to develop positive relationships with the people they supported.

During our visit, we observed staff to be warm, kind and compassionate. People's needs were supported discreetly and in an unhurried way. Staff and people who lived at the home chatted socially, their conversations were spontaneous and relaxed and the atmosphere at the home was homely. We saw staff promoted people's rights and choices through these everyday conversations.

There were many positive interactions between the staff and people who lived at the home which showed that staff cared about the people they looked after. For example, during lunch we saw that one person who was visually impaired had their meal described to them by staff. Staff were heard describing the position of the different types of food on the person's plate by using the positions of the numbers on a clock. For example, the vegetables are at six o'clock. This was good practice. It enabled the person to form a mental image of what they could not see.

People's records provided guidance to staff on the areas of care that people could do independently and how this should be promoted and respected. We observed that staff were patient and respectful of the need for people to take their time to achieve things for themselves.

We saw that the service had ensured one person's independence was promoted through the purchase of adaptive equipment and that staff had ensured this equipment was used routinely in their day to day life. For example, at lunch staff served the person's meal on a special plate with a raised edge which prevented food from falling off their plate and the person's hot drink was put in a non- spill drinking container to avoid spillages. This showed that staff cared about the person's ability to be independent and eat and drink in a dignified way.

We saw that people moved confidently around the home choosing where and with whom to spend their time. We also saw that those people who were able to do so where supported to access the community independently. People's bedrooms were personalised according to their individual choice and contained items of personal and sentimental value to help people feel 'at home'.

From looking at people's care files, we saw that people were supported to have their say about the care and supported to participate in any decision-making that affected them. There was however limited information in people's care files about their wishes in relation to their end of life care. This meant there was a risk that staff would not know what there end of life wishes where should their health decline. We saw that some people had declined to discuss this and this had been rightfully respected.

The home had a service user guide for people to refer to. We looked at the information provided and saw that it was easy to read. It included information about the home, its staff and the services. This showed us that people were given appropriate information in relation to their care and the place that they lived.

We saw that the provider and registered manager cared about people's views and opinions about the service provided. Regular residents' meetings took place where people were able to express their views about the care at the home and suggest improvements. For example, the minutes of last resident meeting in December 2016 showed that people had been given information about the running of the home. For example, people had been given information in relation to staff changes, the employment of a new maintenance person and their suggestions for new activities had been sought.

Good

Is the service responsive?

Our findings

Everyone we spoke with was happy with the care they received. One person told us "I can't complain about anything" and told us that staff had made them feel very welcome when they had first come to live at the home. Another person said "I'm very happy here. I wouldn't be anywhere else".

We saw that in the entrance area of the home, there was a noticeboard that displayed photographs of the staff team and their job role which gave people and visitors a good visual overview of the staff team. It also helped people with memory loss identify staff members. There was a nice seating area for people to sit and chat if they wished or to simply relax.

We found people's care plans to be person centred with clear information about the person, their likes and dislikes and wishes in relation to their care. They included details of the social interests and the activities they enjoyed and it was clear from reading people's care plans that they had been involved in deciding how they wished to be cared for. People we spoke with confirmed this and said they could choose how they lived their life at the home. People's needs had been regularly reviewed with any changes documented appropriately.

We saw from the minutes of the residents' meeting in July 2016 that people had fedback that the activities provided at the home could be better but acknowledged that a lot of people at the home declined to take part whatever the activity was. We saw that the registered manager had asked for suggestions for new activities at each resident meeting to try to ensure the activities provided met everyone's tastes.

On the day of our visit, we saw that people actively participated in a quiz with staff at the home. People were team spirited, helping others when they didn't hear or struggled to answer and staff encouraged everyone's participation. It was clear people enjoyed this type of social activity.

A staff member told us that people had enjoyed a trip out at Christmas to Gordale garden centre and a trip to the cinema. They also said the home had its own volunteer group called 'The Friends of Heathermount' who also organised activities for people who lived at the home.

We reviewed the provider's complaints procedure and found two different versions of the procedure in operation. Neither policy gave clear information on how to make a complaint or which organisations people could contact should they wish to take their complaint further. We spoke with the registered manager and general manager about this. The general manager told us that they would review the procedure without delay.

We reviewed the provider's complaints records. Complaints about the service in the last 12 months were minimal but we saw from the records that the registered manager had responded to two verbal complaints in a sensitive and empathetic manner.

Good

Is the service well-led?

Our findings

The home had previously been run by an alternative provider and transferred to the new ownership of Allandale Care Group in October 2015. Both the registered manager and the general manager were fairly new and had been in post approximately six months prior to our visit.

We asked the people and staff we spoke with, if they thought the service was well led. Both parties said yes. One person told us that the registered manager was "Very obliging" and a staff member told us that the management of the service had improved considerably since both the registered manager and general manager had come into post.

There were a range of audits that checked the quality and safety of the service. For example, there were care plan audits, medication audits, environmental audits, equipment audits and accident and incident audits. We found the majority of audits to be effective with the exception of the provider's care plan audits which failed to pick up that some people's care files lacked sufficient risk management information. Some people's care files also still needed to be reviewed and updated to the provider's new format. We spoke to the registered manager about this.

We saw that each month the general manager visited the home to undertake an audit. This visit checked that the registered manager had completed the necessary audits to monitor the quality and safety of the service. It also included informal talks with people who lived at the home and staff to gain their feedback on the service provided. During the general manager's visit in November 2016 we saw that discussions with the registered manager had taken place with regards to the improvements required in the way staff administered and accounted for medications. This discussion had resulted in the implementation of a new system of accountability which meant that staff now had to count and ensure stock levels were correct for any medications they had administered at the end of their shift. This indicated that the audit system in place was being used effectively by the registered manager and general manager to identify and mitigate risks to the health, safety and welfare of service users.

Records showed that regular staff meetings took place to discuss the running of the service. This included information sharing with regards to the welfare of people who lived at the home, activity planning, policies and procedures update and discussions relating to the introduction of new paperwork for example, the new care planning format and personal emergency plans. These meetings ensured that the staff team remained up to date on any changes in the way the service was delivered.

We found that people who lived at the home were encouraged to share their views about the quality of the service provided. There were lots of opportunities for them to do so. For example, regular resident meetings took place to discuss the running of the service. An activities audit was undertaken regularly to seek people's feedback on the activities and entertainment provided and a satisfaction survey was sent out to people to seek their views on all aspects of service delivery. This enabled the provider to come to an informed view of the quality of the service provided.

We saw that the results of the latest satisfaction survey were displayed in the entrance area of the home. This information was displayed in a 'You said', 'We did' format so that people could see how their feedback had been acted upon. We saw that 24 surveys had been returned by people who lived in one of the provider's three residential homes in Heswall. This included the feedback provided by people who lived at this home. We saw that people's feedback was positive and that the provider had taken action where improvements were suggested.

During our visit, we found the culture of the home to be positive and transparent. We saw that people's needs were met promptly and kindly by staff. The staff team had a 'can do' attitude and we found that the running of the service was smooth and relaxed.

The registered manager and general manager were open and transparent about the improvements still to be made to the way the service was delivered. They talked about the plans they had in place to improve various aspects of the service and both the registered manager and general manager demonstrated that they were committed to continuous improvement. Overall we found the service to be well-led.