Seaway Nursing Home Limited

The Adelaide Nursing Home

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

We inspected The Adelaide Nursing Home on 18 January 2018. We carried out this comprehensive inspection due to information of concern we had received. The Adelaide Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Adelaide Nursing Home is registered to accommodate up to 35 people, some of whom were living with dementia and other chronic conditions. The Adelaide Nursing Home is comprised over two floors, with a communal lounge/dining area and garden. There were 32 people living at the service during our inspection.

A registered manager was in post. 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 and associated Regulations about how the service is run.

We have made a recommendation about systems being implemented to comply with the Accessible Information Standards (AIS).

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector.

Staff were knowledgeable and trained in safeguarding adults and what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately.

Risks associated with the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, including the care of people with dementia and palliative care (end of life). Staff had received both supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place.

People chose how to spend their day and they took part in activities. They enjoyed the activities, which included one to one time scheduled for people in their rooms, bingo, exercise, quizzes and themed events, such as reminiscence sessions and visits from external entertainers. People were also encouraged to stay in touch with their families and receive visitors.

People felt well looked after and supported. We observed friendly relationships had developed between people and staff. Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible. People's end of life care was discussed and planned and their wishes had been respected.

Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where managers were always available to discuss suggestions and address problems or concerns.

People were encouraged to express their views and had completed surveys. They also said they felt listened to and any concerns or issues they raised were addressed. Technology was used to assist people's care provision. People's individual needs were met by the adaptation of the premises.

The provider undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement.

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.

Staff understood their responsibilities in relation to protecting people from harm and abuse.

Potential risks were identified, appropriately assessed and planned for. Medicines were managed and administered safely. The service was clean and infection control protocols were followed.

The provider used safe recruitment practices and there were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Good

The service was effective.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed. People's individual needs were met by the adaptation of the premises.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity were respected and their independence was promoted.

Is the service responsive?

Good

The service was responsive.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes, including on the best way to communicate with people.

People were supported to take part in meaningful activities. They were supported to maintain relationships with people important to them. People's end of life care was discussed and planned and their wishes had been respected.

There was a system in place to manage complaints and comments. People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Good

The service was well-led.

People, relatives and staff spoke highly of the registered manager. The provider promoted an inclusive and open culture and recognised the importance of effective communication.

There were effective systems in place to assure quality and identify any potential improvements to the service being provided. Staff had a good understanding of equality, diversity and human rights.

Forums were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement.

The Adelaide Nursing 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 18 January 2018 and was unannounced. We carried out this comprehensive inspection due to information of concern we had received. The inspection team consisted of one inspector.

On this occasion, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we observed the support that people received in the communal lounge and dining area of the service. Some people could not fully communicate with us due to their conditions, however, we spoke with six people, two relatives, three care staff, a registered nurse, the chef and the registered manager. We spent time observing how people were cared for and their interactions with staff and visitors in order to understand their experience. We also took time to observe how people and staff interacted at lunch time.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including four people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, training records and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

People said they felt safe and staff made them feel comfortable, and that they had no concerns around safety. One person told us, "There's no problem, it's all safe". A relative added, "I always feel [my relative] is safe when I leave her here".

We looked at the management of medicines. Registered nurses were trained in the administration of medicines. A member of staff described how they completed the medication administration records (MAR). We saw these were accurate. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed. We observed a member of staff giving medicines sensitively and appropriately. We saw that they administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Nobody we spoke with expressed any concerns around their medicines. One person told us, "They always give me my tablets". A further person added, "They know when I have my medicine. My alarm goes off and the nurse is always ready. The nurse is very good". Medicines were stored appropriately and securely and in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan (PEEP). There were further systems to identify risks and protect people from harm. Each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff supporting people to mobilise around the service.

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. We were told existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave and that agency staff were used when required. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "When I ring my bell they come in a reasonable time, they always show up". Another person said, "There are always staff around". A further person added, "I push the button, they show up. They are here all the time". Staff agreed with this, and one member of staff told us, "I feel we have enough staff". Another said, "We have our busy times, but [registered manager] has put more staff on and it makes life so much easier". Documentation in staff files supported this, and helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs. Records demonstrated staff were recruited in line with safe practice and

equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector. Files also contained evidence to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed had an up to date registration with the Nursing Midwifery Council (NMC).

Records confirmed all staff had received safeguarding training as part of their essential training and this had been refreshed regularly. There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse was displayed around the service for staff and people. Documentation showed that the provider cooperated fully and transparently with relevant stakeholders in respect to any investigations of abuse.

People were cared for in a clean, hygienic environment. During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. The service and its equipment were clean and well maintained. We saw that the service had an infection control policy and other related policies in place. People told us that they felt the service was clean and well maintained. One person told us, "It's spotlessly clean here, they are always cleaning". A further person said, "It's always very clean, my bed and my room, they are always cleaning". Staff told us that protective personal equipment (PPE) such as aprons and gloves was readily available. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed around the service to remind people and staff of their responsibilities in respect to cleanliness and infection control. The registered manager told us that infection control training was mandatory for staff, and records we saw supported this. The service had policies, procedures and systems in place for staff to follow, should there be an infection outbreak such as diarrhoea and vomiting. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

Staff took appropriate action following accidents and incidents to ensure people's safety and this was recorded. We saw specific details and any follow up action to prevent a re-occurrence was recorded, and any subsequent action was shared and analysed to look for any trends or patterns.

Good

Is the service effective?

Our findings

People told us they received effective care and their individual needs were met. One person told us, "They are well trained, they listen and do what I tell them". Another person said, "They look after me, they are very knowing. It is not an easy job, but they do it very well". A further person added, "They are all very good [staff].

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. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. DoLS applications had been sent to the local authority. Staff understood when an application should be made and the process of submitting one. Care plans reflected people who were under a DoLS with information and guidance for staff to follow. DoLS applications and updates were also discussed at staff meetings to ensure staff were up to date with current information.

Staff had a good understanding of equality and diversity. This was reinforced through training and the registered manager ensuring that policies and procedures were read and understood. The Equality Act 2010 covers the same groups that were protected by existing equality legislation prior to 2010 - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected. A member of staff told us, "There is no discrimination. This is a good home".

Staff had received training in looking after people, including safeguarding, food hygiene, fire evacuation, health and safety, equality and diversity. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. They also received training specific to peoples' needs, for example around the care of people with dementia and those at the end of their life. Staff told us that training was encouraged and was of good quality. Staff also told us they were able to complete further training specific to the needs of their role, and were kept up to date with best practice guidelines. Feedback from staff and the registered manager confirmed that formal systems of staff development including one to one supervision meetings and annual appraisals were in place. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have.

People's individual needs were met by the adaptation of the premises. Hand rails were fitted throughout the service, as were slopes for wheelchairs and other parts of the service were accessible via a lift. There were adapted bathrooms, wet rooms and toilets had hand rails in place in these to support people. Visual aids in communal areas helped to support orientation of people with dementia to move around the home and increase their awareness of their environment.

Staff undertook an assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The pre-admission assessment were used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews.

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. We observed lunch. It was relaxed and people were considerately supported to move to the dining areas or could choose to eat in their bedroom or the lounge. People were encouraged to be independent throughout the meal and staff were available if people required support or wanted extra food or drinks. People ate at their own pace and enjoyed the company and conversation. All the time staff were checking that people liked their food and offered alternatives if they wished. People were complimentary about the meals served. One person told us, "The food is lovely, I've got lots of favourites". Another person said, "The food is very good, I am putting on weight. I must stay off the biscuits". A further person added, "The food is good, you can have what you like. I don't like a big meal at lunchtime, so they do me something lighter. One day I wanted corned beef, mash and beans. I know it's not very elegant, but they made it for me". We saw people were offered drinks and snacks throughout the day, they could have a drink at any time and staff always made them a drink on request. People's weight was regularly monitored, with their permission. Staff had liaised with the Speech and Language Team (SALT) to ensure that specialist diets were catered for, such as for people who required pureed food. We saw that culturally appropriate dishes had been made for one person, however staff stated that any specific diet would be accommodated should it be required.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's, chiropodists and social workers. Access was also provided to more specialist services, such as opticians and podiatrists if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. One person told us, "They get the GP for me". Staff told us that they knew people well and were able to recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support. Staff ensured when people were referred for treatment they were aware of what the treatment was and the possible outcomes, so that they were involved in deciding the best course of action for them. We saw that if people needed to visit a health professional, for example at hospital, then a member of staff would support them.

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. People told us caring relationships had developed with staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. One person told us, "You can't fault the staff". Another person added, "They are lovely and they are kind".

Throughout the day, there was sociable conversation taking place and staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed staff being caring, attentive and responsive and saw positive interactions and appropriate communication. Staff appeared to enjoy delivering care to people. One person told us, "They treat me better than I think they should do sometimes". A member of staff added, "I like sitting and talking to the residents and getting to know them. We get time to just sit with them and it's fun".

Staff demonstrated a strong commitment to providing compassionate care. From talking with people and staff, it was clear that they knew people well and had a good understanding of how best to support them. One person told us, "They shower me and get me dressed. I am wearing my nice dress today as I am having family come in". We also spoke with staff who gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for, what time they liked to get up, whether they liked to join in activities and their preferences in respect of food and drink. Most staff also knew about peoples' families and some of their interests.

Staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do very much what they wanted throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their day. One person told us, "Everything is up to me. I'm an early riser and they respect that". Another person said, "I have freedom, I have a friend downstairs. I go and sit in her room and she comes up to mine. I didn't get to bet until 1:30am the other night as we were chatting". A further person added, "I go to bed at 8:00pm that suits me. I chose that time, not them". Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "I always offer people choices, would they like a shower and what would they like to eat". Another added, "I pick some clothes for people and ask what they want, but it's their choice. I wouldn't like it if somebody took my choices away".

Peoples' equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs and preferences. There were individual person-centred care plans that documented peoples' preferences and support needs, enabling staff to support people in a personalised way that was specific to their needs and preferences. Staff told us how they adapted their approach to sharing information with some people with communication difficulties. One member of staff told us, "We get to know people and that helps us to communicate with them". Staff also recognised that people might need additional support to be involved in their care and information was available if people required the assistance of an advocate. An

advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People looked comfortable and they were supported to maintain their personal and physical appearance. People were well dressed and wore jewellery, and it was clear that people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. One person told us, "They always knock, they are respectful. They let me know that they are there and let me know what they are going to do". Another person added, "They [staff] always knock and say who they are".

Staff supported people and encouraged them, where they were able, to be as independent as possible. We saw examples of people being encouraged to be independent. For example, some people were encouraged to administer their own medication and mobilise independently, other assisted with chores. One person told us, "I do my own medication now, they support me to get it right". Another person said, "I sometimes help to clean my room". Care staff informed us that they always prompted people to carry out personal care tasks for themselves, such as brushing their teeth and hair. One member of staff said, "I always offer help, but ask if they want to do it themselves".

People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process. People told us staff would arrange for a priest to visit if they wanted one. Staff encouraged people to maintain relationships with their friends and families and to make new friends with people living in the service. People were introduced to each other and staff supported people to spend time together, in this way friendships were formed within the service. Visitors were able to come to the service at any reasonable time, and could stay as long as they wished. Visitors told us they were welcomed and always offered a drink. Staff engaged with visitors in a positive way and supported them to join in the communal activities in the lounge, or have private time together.

Good

Is the service responsive?

Our findings

People told us they were listened to and the service responded to their needs and concerns. One person told us, "The manager comes and sits with me and listens". Another person said, "If there is anything I want, they come to me and get it". A relative added, "They always contact me if the need to, for example if [my relative] has been poorly".

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Staff ensured that the communication needs of people who required it were assessed and met. For example, we saw a member of staff writing things down for a person who was struggling with their hearing and staff understood the best way to communicate with people. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these. For example, one person's first language was not English and it was detailed in their care plan for staff who spoke the same language to spend time with them. However, none of the day to day staff at the service were aware of the AIS and no policy, procedures or training around this had been implemented.

We recommend that the provider obtains information, sources training and implements policies and procedure in relation to compliance with the AIS.

Keeping occupied and stimulated can improve the quality of life for a person, including those living with dementia. We saw a varied range of activities on offer, which included, bingo, gentle exercise, quizzes and themed events, such as reminiscence sessions and visits from external entertainers. People told us that they enjoyed the activities. One person told us, "I like to watch TV, but we do activities, they are very good". Another person said, "I go to some of the activities, like bingo and when the children come in and the singers. I often choose to stay in my room as I like watching telly and using my I-pad and Kindle". The service ensured that people who remained in their rooms and may be at risk of social isolation were included in activities and received social interaction. We saw that staff set aside time to sit with people on a one to one basis in their rooms. One person told us, "They come and sit with me and watch the snooker". Another person said, "They are kind, they sit with me".

People's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together by the person, their family and staff. One person told us, "I know that they talk to my wife about my care plan". A relative said, "I was involved with [my relative's] care plan at the beginning". Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. One member of staff told us, "I think the care plans have enough information and if I need any help I ask the nurse, they are brilliant". Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the

support required to meet those needs. Care plans contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. People were given the opportunity observe their faith and any religious or cultural requirements were recorded in their care plan.

Technology was used to support people to receive timely care and support. The service had a call bell system which enabled people to alert staff that they were needed. We saw that people had their call bells within reach and staff responded to them in a reasonable time.

Peoples' end of life care was discussed and planned and their wishes had been respected if they had refused to discuss this. People were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes, with regard to their care at the end of their life, had been respected. Anticipatory medicines had been prescribed and were stored at the service should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life. A relative told us, "My [relative] has not got long to go. They have counselled us, the staff have been excellent and very dignified. I can't thank them enough".

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. One person told us, "I'd speak to the manager, she often pops in to see me". The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required.

Good

Is the service well-led?

Our findings

People, relatives and staff spoke highly of the registered manager and felt the service was well-led. Staff commented they felt supported and could approach the registered manager with any concerns or questions. One person told us, "I think it's well run, I wish I'd been brought here sooner". Another person said, "The manager is very good, she is always walking around". A relative added, "[Registered manager] has been in charge for a long time, she listens to everything".

The provider undertook quality assurance audits to ensure a good level of quality was maintained. We saw audit activity which included health and safety, infection control and medication. The results of which were analysed in order to determine trends and introduce preventative measures. Up to date sector specific information was also made available for staff including details of norovirus and flu, and the MCA. We saw that the service also liaised regularly with the Local Authority, the Dementia In-Reach Team for advice and guidance around dementia care, and the Clinical Commissioning Group (CCG) in order to share information and learning around local issues and best practice in care delivery. Additionally, the service engaged with the local community and representatives from local churches, schools and nurseries visited the service to spend time with people.

We saw that people and staff were actively involved in developing the service. There were systems and processes followed to consult with people, relatives, staff and healthcare professionals. Meetings and satisfaction surveys were carried out, providing the registered manager with a mechanism for monitoring satisfaction with the service provided. Feedback from the surveys was on the whole positive.

Staff said they felt well supported within their roles and described an 'open door' management approach. They were encouraged to ask questions, discuss suggestions and address problems or concerns with management, including any issues in relation to equality, diversity and human rights. Management was visible within the service and the registered manager took an active approach. A member of staff told us, "We can go to [registered manager] at any time of the day, with any problems, she is a great manager". Another member of staff said, "I get more support here than in any other job". The service had a strong emphasis on team work and communication sharing. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift. Staff commented that they all worked together and approached concerns as a team. One member of staff told us, "We are a close team and get on well together and with the residents".

We discussed the culture and ethos of the service with people and staff. One person told us, "It's fantastic [the service] it's five star quality". A further person added, "It's a nice home, not as nice as my own home, but a good second". One member of staff told us, "I love my job and love working here". A further member of staff added, "I would put any member of my family in this home". There was also a 'philosophy of care' displayed in the service, so that staff and people would know what to expect from the care delivered and the standards that the service wished to deliver.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had.

They reported that managers would support them to do this in line with the provider's policy. We were told that whistleblowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services. Staff had a good understanding of Equality, diversity and human rights. Feedback from staff indicated that the protection of people's rights was embedded into practice for both people and staff living and working at the service.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.