HC-One Oval Limited

Admirals Reach Care Home

Inspection report

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23 August 2018

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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

The inspection was completed on 15, 16 and 23 August 2018 and was unannounced. This was the first inspection of the service since registering under new ownership in February 2017.

Admirals Reach is a 'care home'. People in care homes receive accommodation and nursing or 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.

Admirals Reach provides accommodation, nursing and personal care for up to 158 people in five separate units each with separate adapted facilities. At the time of inspection only four of the units (which the service called houses) were being used. These could accommodate up to 127 people. People requiring support with general nursing needs resided in Nelson House. Jellico and Benbow House were specialist dementia nursing units whilst Mountbatton House was home to people requiring residential care. At the time of inspection, a total of 121 people were living at the service across the four separate buildings.

There was a registered manager 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.

People felt safe living at the service. Staff and the management team understood their safeguarding responsibilities and knew what to do to keep people safe from the risk of abuse.

Risks to people had been assessed and were regularly reviewed. Staff were aware of the risks to people and how to manage them to ensure people's safety and well-being.

Medicines were managed safely and administered by senior staff who had been trained and assessed as competent. There were sufficient staff employed to meet people's needs who had been safely recruited.

Accidents and incidents were recorded and analysed to monitor people's safety. Lessons had been learned and systems and processes amended to improve the safety and quality of the service.

Staff received an induction, training and supervision to support them to be competent in their role. Staff felt well supported and were regularly observed to check their performance and identify any learning needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's consent was sought before care and support was provided.

People were assisted to have enough to eat and drink and received support to access treatment from

healthcare professionals to maintain their health and wellbeing.

Staff were kind and caring and listened to people. People were treated with dignity and respect and independence was encouraged. The service supported people to maintain relationships that were important to them.

People's needs had been assessed and care plans devised which provided guidance to staff on people's needs and preferences to support staff to provide person-centred care. People's needs and wishes for their end of life care were documented and understood.

There were systems and processes in place to respond to complaints. Feedback from people was listened to and acted upon to address any concerns.

The registered manager was supported by a longstanding deputy and newly appointed clinical lead. People and staff were positive about the management team who were 'hands-on' and visible within the service.

Quality assurance systems were in place to monitor the safety and effectiveness of the service. There was robust oversight of the service and clear lines of accountability at staff, management and provider level.

Further information is in the detailed findings below.

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 to protect people from the risk of harm.

Risks to people had been assessed and were well managed by staff who were aware of the risks and how to minimise them.

Medicines were safely managed.

There were sufficient staff employed who had been safely recruited.

Is the service effective?

Good

The service was effective.

Staff received the necessary training and supervision to be competent in their role.

People were supported to have enough to eat and drink and maintain their health and wellbeing.

The service operated within the legislation to ensure people were supported to have choice and control and were not unlawfully restricted.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and treated people with respect.

People were listened to and included in decisions around their care and support.

Independence was promoted and people were helped to maintain important relationships.

Is the service responsive?

Good

The service was responsive.

People's needs had been holistically assessed and their needs and preferences were known and respected.

The service supported people to engage in activities of their choosing.

There were systems in place to respond to complaints which were dealt with appropriately.

People's needs and wishes for their end of life care were met.

Is the service well-led?

Good

The service was well-led.

People were supported by a stable management and staff team who were committed to providing quality care.

Staff morale was good and there was clear leadership.

People and their relatives were included in the running of the service to drive improvements.

There was robust quality assurance mechanisms in place to monitor and improve safety and quality.

Admirals Reach Care 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.

The inspection took place on 15, 16 and 23 August 2018 and was unannounced. It was completed by three inspectors, a specialist nurse advisor and two experts by experience. An expert by experience is a person who has experience of using this type of service.

As part of the inspection, we reviewed information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Over the course of our inspection, we spoke with the registered manager, the deputy manager and 14 members of staff including the unit managers, nursing, activities and care staff. We spoke with 16 people who used the service and 19 relatives. We reviewed 12 people's care records, nine staff files as well as looking at other relevant documentation relating to the service such as training records, quality audits, surveys and minutes of meetings.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. A person told us, "I feel one hundred per cent safe here; they do all my medications better than I could and whenever I ring they come straight away." Relatives also stated they felt their family members were safe. One relative told us, "[Named person] is very safe; I am relaxed knowing they are cared for."

People were supported to mobilise safely and had the freedom to move around without restriction. We observed people walking around the building and accessing communal areas including the garden. A relative told us, "[named person] is safe here; in the evening they like to walk around; it's an excellent place for them, I have no concerns and can walk away knowing they are safe."

The registered manager understood their duties and responsibilities to report safeguarding concerns and completed their own investigations to protect people from the risk of abuse. Staff had received training in how to protect people from abuse. Staff could recognise signs of abuse and knew how to report concerns. One staff member told us, "I have never seen any abuse here although I did see a staff member not holding a person correctly so I told them, 'do not do that as people are fragile'. If there was something worrying me I would report it straight away to the nurse or manager and I know I can call CQC." There was a whistleblowing policy in place which provided guidance for staff on how to report concerns about poor practice within the workplace. Staff told us they had read the policy and would feel confident to report any concerns.

People had detailed risk assessments in place which were reviewed monthly or sooner if something changed. The risk assessments were person-centred which means they were specific to each individual. Management plans were in place which provided guidance to staff on how to minimise risks. Staff we spoke with were able to tell us about risks to people and what was needed to minimise them.

The provider had signed up to a project to improve people's safety called Prosper; a local authority initiative aimed at reducing the incidents of falls, urinary tract infections and pressure ulcers. At the time of inspection there were no incidents of pressure ulcers acquired by people living at the service. On the nursing unit we reviewed the records of one person who had been admitted to the service with severe pressure ulcers. A risk assessment was in place along with a detailed skin integrity care plan. This stipulated the use of pressure relieving equipment and two hourly turns by staff which we observed was happening in practice. The person's care was overseen by the tissue viability nurse who had reviewed the person's care routinely. Photos and body maps were kept and updated monthly. These evidenced progress with the pressure ulcers and dramatic improvements from admission to the present date. We spoke with the person who told us they were comfortable and had been given pain relief so was not in pain. They were aware of the progress made to resolve and prevent further skin breakdown. This showed that people were receiving good quality pressure care.

Staff were recruited safely. Checks on the recruitment files for four members of staff evidenced they had completed an application form, provided proof of identity and satisfactory references were obtained. The

provider had also undertaken a Disclosure and Barring Service (DBS) check on all staff before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

On the day of inspection, we observed there were sufficient numbers of staff employed to safely meet people's needs. People and staff we spoke with confirmed there were enough staff. A person told us, "Staffing is more than adequate." A staff member said, "We have enough staff here." Staff told us that if they were short staffed they had a very good staff team and could arrange cover which meant people had continuity of care. A senior told us, "We very rarely use agency; if I'm short staffed I ring my staff and ask them to come in; five minutes later they are here and I make them a cup of tea." We did note that on one of the dementia units (Benbow) staff were more pressed and staff working on this unit told us they would like extra staff, particularly at busy times. One staff member told us, "Benbow is a really demanding unit, I think we could do with some help first thing in the morning and at meal times as it can be really busy and I worry that we are rushing people's food sometimes."

We discussed the feedback we received with the deputy manager who told us that Benbow unit had lost some permanent staff so there was more reliance on agency usage than in the other units. Furthermore, people living on Benbow had particularly complex needs which resulted in more demands placed on staff. We were advised that the registered manager was aware of the issues and new permanent staff had just been recruited to work on the unit. In the meantime, the activities staff had been re-deployed to Benbow to help out at lunchtimes. In addition, we were advised that members of the management team had started working at weekends on this unit, covering shifts to provide continuity and leadership.

Medicines were safely managed. Only staff who had been trained and assessed as competent administered medicines. On the nursing unit where large amounts of medicines were administered, the provider had employed a second nurse whose role was to administer medicines in the mornings to ensure staffing was sufficient to safely meet people's needs during a busy time. Medicines were stored cleanly and safely and room and fridge temperatures were clearly recorded. People had medicine administration records (MAR) and these were all signed indicating that people had received their medicines as prescribed. Protocols were in place for 'as needed' (PRN) medicines. A PRN protocol provides written guidance to staff on how to administer PRN. Staff responsible for administering medicines demonstrated a good knowledge of how to give PRN and the reasons why.

Where people received their medicines covertly we saw that the service worked in accordance with best practice which dictates that medicines are offered to people first before resorting to covert methods, if appropriate. We saw that the GP and pharmacist were consulted on how to dispense people's medicines covertly and staff were very knowledgeable about covert practice and were aware that some medicines should not be crushed.

Lessons had been learned to improve the quality and safety of medicine management. In response to a past incident where a person did not receive their pain medication, the process was changed so that when the GP visited to prescribe anticipatory drugs, the service now requested the prescription straight away. Staff would then go in a taxi to collect the medicine immediately from the pharmacy.

Staff had received training in infection control and we observed good infection control practices in place. Staff wore gloves and aprons when providing care and support to prevent the spread of cross infection. People told us the service was clean and hygienic. On the day of inspection we observed the service was generally clean and tidy with no bad odours with one exception. On Benbow we found several examples of poor cleanliness in people's bathrooms. We reported our concerns to the deputy manager and were

subsequently provided with assurances that these issues had been dealt with.

Accidents and incidents were logged on each unit and sent to the registered manager to review. Copies were also sent to the provider for analysis to look for themes to prevent re-occurrence. Lessons had been learned regarding how accidents and incidents were managed after a person had been found with bruising that could not be explained. The service had introduced a close observation chart which was used for people identified at risk of unexplained injuries to improve the investigation and risk management process.

There were arrangements in place to manage and maintain the premises and equipment both internally and externally. We saw that health and safety, maintenance, fire drills, accidents and incidents were all recorded and any necessary action taken. People had individual personal evacuation plans (PEEPS) which were updated weekly. These provided guidance to staff on the support people would need in the event of an emergency evacuation.

Good

Is the service effective?

Our findings

People's physical, mental, emotional, cultural and social needs were assessed prior to them coming to live at Admirals Reach to ensure the service could safely and effectively meet all of their needs. The management team gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to gender, ethnicity and faith. These needs were recorded in care plans and staff we spoke to demonstrated a good awareness of people's needs.

People told us they received an effective service from skilled and knowledgeable staff. One relative told us, "They [staff] have the expertise and can deal with people's deterioration with dementia." Another relative said, "The staff are observant and looking out all the time; nothing is too much trouble; every time I come in [named person] is never wet which means they are changed on a regular basis."

Staff were supported to acquire the skills and knowledge to be effective in their role. When new staff joined the organisation they were provided with an induction which included the opportunity to read people's care plans and shadow existing members of staff. This meant that staff were allowed the time to get to know the people they would be supporting and understand how best to meet their needs. The induction provided was based on the care certificate which helps to ensure care staff have a theoretical knowledge of good working practice within the social care sector.

Due to the fact the service was under new ownership, a new training programme was being implemented, designed to meet the needs of people who used the service. The transition period meant that some staff had yet to complete the new programme of mandatory training. However, we were advised that all staff training had been booked and should be completed by the end of August 2018. Computers had been installed on two units to support staff learning. Not all staff were positive about the new training method which had changed from classroom based face to face training to predominantly E-learning. In addition, some staff told us they would like more specialist training, relevant to people's particular health needs, for example, training in diabetes.

We discussed staff feedback with the registered manager. They told us that the more practical subjects would still be delivered face to face such as manual handling and basic life support and fire safety training. In addition, it had already been identified that there were gaps in the new training programme and specialist training was currently being organised. Training in dysphagia had just been provided and further training was being organised which would be delivered by the clinical lead. Topics to be covered included diabetes and Parkinson's disease.

Staff had received practical training in manual handling and we observed their competence when moving and positioning people using equipment such as slings and hoists. Feedback from people and relatives confirmed that people received competent support with their mobility needs. One relative told us, "[named person] is at high risk of falls so staff ensure they have their walking frame and put them in a visible position near the nurses station; staff help [named person] in and of out bed using a hoist; sometimes they do it manually making a judgement on the day depending what will cause the least pain or anxiety."

The service utilised technology such as sensor alarm mats to alert staff when people who were at risk of falling, stood without supervision or support. However, we observed one example where a person did not always receive timely support from staff to ensure their safety when mobilising. This person was identified at high risk of falls though had not had a fall since June 2018.We discussed our observations with the registered manager who agreed to immediately review the person's mobility support plan to ensure their continued safety.

On the nursing unit we found that nursing staff had the necessary knowledge and skills to meet people's nursing needs. For example, where people were supported to eat and drink via percutaneous endoscopic gastrostomy (PEG tube). Staff were aware of the care requirements for best practice in PEG care and ensured that people's PEG was clean, turned and viable. The equipment used was clean and in full working order.

We did find that the service used a multi-use syringe to flush the PEG tubes. Best practice suggests that these types of syringes should be dated and replaced as part of the routine schedule to ensure infection control protocols are consistently assured.

We made a recommendation that the service reviews best practice guidelines in relation to PEG care.

Staff told us they felt well supported by management and staff. One staff member told us, "There is always someone around to ask for support, we work as a team on this unit." Records showed that staff received direct observations of their practice to monitor their performance. The outcomes of the observations were discussed during regular one to one supervision sessions to improve practice. Supervision provides an opportunity for staff to talk about any practice issues and identify learning needs. Staff also received twice yearly appraisals which provided feedback on their performance and identified goals for the coming year to support staff's professional development.

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 who lack mental capacity to consent to arrangements for necessary care or 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). We found that the provider had made appropriate DoLS applications to ensure that people were not being deprived of their liberty unlawfully.

People's care plans without exception included extremely detailed documentation in relation to consent and capacity. The principles of the MCA legislation were interwoven throughout people's care plans, emphasising the importance of giving people choice and control. Care plans identified people's abilities to make their own decisions and reminded staff to support people to communicate and express their wishes. For example, one person's care plan stated, "[named person] can choose their own clothes, staff to support by offering a choice." Care records identified whether a family member or appointed person had the legal responsibility for making decisions on a person's behalf.

Staff we spoke with demonstrated a good awareness of the level of support people needed to help them make their own choices. A staff member on the dementia unit told us, "People here have choices, [named person] knows what they want and chooses their food, [named person] and [named person] are able to say what they want to do; We will always ask people what they want, offer options and some we give a visual choice. As we know people we know what they enjoy." Staff understood the importance of gaining consent.

Throughout the day we observed staff asking permission before providing care and support.

People were supported to have enough to eat and drink that met their health needs and preferences. We saw that people were regularly offered hot and cold drinks and had drinks left within reach. Meals were prepared on site and delivered to each unit via a trolley system. Menus were available on information boards and on tables. Feedback regarding the mealtime experience was positive. A person told us, "Food is very good, always sufficient, get good choice, nearly always fish and meat choice, they have the menu up for you to see and the food is always hot."

Detailed care plans around nutrition and hydration were in place which identified the level of support people needed to have enough to eat and drink. Where people were identified at risk, food and fluid charts were introduced so people could be monitored. Where necessary, referrals were made to appropriate healthcare professionals to provide support and guidance. We saw that the service was vigilant in ensuring people got the help they needed. This was confirmed by feedback we received. One relative told us, "Staff recognised when [named person] had difficulty eating and drinking, they put [named person] on weekly weighing, got a dietician in and asked for advice; I am always kept informed; [named person] cannot eat without help so is always fed." Another relative told us, "Staff know the foods [named person] likes and they try their utmost to tempt them; they are very patient, nothing is too much trouble, they are a good crowd."

Care records identified people's health needs and how they should be met. There was evidence that advice from health professionals was recorded and acted upon within people's care notes and care reviews. Regular input from health care professionals was provided as and when required. We saw that people had access to a range of health professionals such as optician, GP and dentist on a regular basis and people's care plans gave details of any health appointments and the outcomes. This demonstrated that people were supported to maintain their health and wellbeing which was confirmed by feedback we received. A relative told us, "[Named person] has put on a stone since they came in March, they were poorly and now they look really healthy."

The environment was suitable for people with regard to safety and general cleanliness. Bathrooms were suitably equipped to meet people's needs for example, a walk-in shower and a bath chair were in place for one person. Dementia friendly items were available and in use on Jellico unit to stimulate and engage people. There was also a sensory room which could be used to calm and relax people with dementia who have become distressed. Feedback from relatives confirmed that this room was regularly used by staff to alleviate people's distress. However, we did find on Benbow that there were insufficient tables and chairs available if more people were to choose to sit at the dining table for their meals. We also found the service was in need of some general re-decoration in communal areas such as lounges and corridors.

We discussed our findings with the registered manager. They told us that the service was soon to undergo a period of significant refurbishment and there were plans to re-arrange Benbow house to make it more 'user-friendly'. We were advised that people had been informed and consulted regarding the proposed plans. This was confirmed by feedback we received. A relative told us, "The new owners are getting to grips with improving it; it is a bit dated and needs an element of refurbishment."

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. A person told us, "You can feel the love; it's the way they [staff] touch you; they help me process bad thoughts with thoughtful words." Another person said, "Overall the care is good and the staff are kind and attentive." A relative told us, "It's very good here, staff are excellent, compassionate, very caring and so warm."

We observed kind and caring interactions between staff and people throughout our inspection with staff using touch appropriately to express warmth and reassure people. Staff were seen stroking people's faces, holding their hands, singing to people, smiling and talking. This demonstrated that staff had built meaningful relationships with people. People told us staff were very friendly and that they had formed positive relationships. One person said, "I'm happy here. They're a great bunch of staff. You can have a laugh with them; a bit of banter which I like."

People were supported by a longstanding and stable workforce. Consequently, staff knew the names of people and were very familiar with their needs. This was confirmed by people we spoke with. A person told us, "They [staff] have got to know me and I'm quite happy here."

People were involved in making day to day decisions and planning their care and support and told us they were listened to and their choices were respected. This included choices about where to spend their time, what to wear, what to eat and drink and whether or not to join in social activities. We observed a staff member helping a person to get more comfortable in their chair. They said, "Here is your little teddy, shall I get your little teddy, shall I get you a pillow, here can I help you, it will make you more comfortable."

People were treated with dignity and respect and their privacy was maintained. Staff were observed to always knock on doors before entering rooms and ask permission before providing assistance. People confirmed that staff treated them appropriately and respectfully.

People and relatives told us that communication between themselves and staff was good. A relative told us, "The staff are very good and everyone is approachable." Another relative said, "Staff are superb, attentive and if I am worried I can go and talk to them anytime."

Friends and relatives told us they felt welcome at the service and could visit whenever they wanted. A relative told us, "The care here is really what [family member] needs; staff are very attentive and caring and I can come and go as I please and help as I need to." The caring nature of staff extended to relatives which supported people to maintain relationships that were important to them. For example, one relative told us "When [named person] came here I wanted to do his washing. After the first week a nurse told me 'you don't want to be spending your time washing, spend the time with your husband.' I was in such an emotional state staff were wonderful, with cups of tea and attentive to him and me."

Staff were aware of the importance of supporting people to remain as independent as they could be. We observed staff encouraging and motivating people to do things for themselves. Feedback from people and

relatives confirmed that staff promoted independence. A relative told us, "[Named person] is independent and does not want help; they [staff] are maintaining their independence and only help with the things they cannot do."

Where people required support from an advocate this had been organised. An advocate is an independent person who helps people make choices and represents their views to others. Information on advocacy was made available. The service arranged for an advocacy service to give talk at a residents meeting to provide information and advice.

Good

Is the service responsive?

Our findings

People received support that was tailored to meet their personal preferences and individual needs. People's likes, dislikes and how they liked things done were explored and incorporated into their care plans. Information was also recorded about people's life history including hobbies, interests, past employment and important people and places. This information helped staff to get to know people well and understand how best to support people in the way they wanted and provide person-centred care. Person-centred care means care that is tailored to meet people's individual needs rather than the needs of the service.

Staff were able to demonstrate that they knew people's life history and likes and dislikes and used this to engage in meaningful interaction with people. One staff member told us, "We have a couple of residents that were born in the East End the same as me so we talk about the East End and sing some old songs. Another person went to school in Brighton and if they are upset I know when I talk about Brighton they immediately cheer up."

Care plans were reviewed monthly or sooner if something changed for people. We saw that care records had been signed to indicate the person or their family member, if appropriate, was included in the review and had agreed with the care and support provided.

To support people to engage in meaningful occupations a team of activities staff were employed who organised a programme of activities on each of the units. Photo boards were displayed around each unit showing pictures of people enjoying the activities they took part in. There were activity schedules displayed on each unit and identified special events such as birthdays, cultural, spiritual, and religious dates, outdoor events and external services such as hairdressing and chiropody. There was also a new fruit and vegetable growing area for people to enjoy. To meet people's spiritual needs regular visits had been arranged to the service by clergy of various different denominations.

Throughout out inspection, we observed activities staff running various groups such as singing, reminiscence, sensory stimulation, quoits and quiz sessions. Feedback about activities was positive. One relative told us, "The activity ladies are very good. There's one for every house and they get to know their residents. They're good at getting people involved in things to get them stimulated."

Outside entertainment was also organised which people enjoyed. On the first day of inspection we saw an Elvis impersonator had been booked. People were invited from all of the units to attend the event. Staff supported and encouraged people to join in. We heard one staff member say to a person in their room, "Do you want to go to the lounge, I can bring you a chair, Elvis is singing." On the second day of inspection, a 'pat' dog visited the unit and people became animated, they obviously enjoyed this interaction.

There was a system in place for managing complaints and we saw that any complaints were dealt with appropriately. People told us they knew how to make a complaint and found the staff and management team approachable. One person told us, "Everyone here is approachable, I would have no problem raising a concern if I had one."

Staff had received training in end of life care. Where appropriate people had end of life care plans in place which provided guidance to staff on how to meet people's needs. People's preferences for their end of life care were explored and formally recorded using 'preferred priority of care' booklets which were kept in people's care records. This allowed the service to support people in the way they wanted and respect their wishes.

Good

Is the service well-led?

Our findings

There was a registered manager in post who understood their registration requirements including notifying us of any significant events to help us monitor how the service keeps people safe. The registered manager was supported by a long-standing deputy manager and the recent appointment of a clinical lead. Together they made up the management team and were responsible for the day to day running of the service.

The service had recently come under new ownership. Feedback from people demonstrated that this had been managed well. A relative told us, "From a customer point of view it's been a seamless change of company and has gone very smoothly." The registered manager reported that the new provider was supportive and listened to them for the benefit of people who used the service. They told us, "I will ask for what's needed, it's not for me it's for the people in my care; I am really committed, along with my staff, to give 100% to the residents in my care; I have stated we need to treat people the way they want to, not how we want, and so far so good; they [the provider] have listened and responded positively."

The service worked in partnership with other organisations such as the local authority, charities, local churches, schools and hospice. These links supported people to have their cultural, social and spiritual needs met and promoted inclusion within the local community.

Staff spoken with said they felt supported by the registered manager and deputy manager. Staff said the management team were visible within the service and they felt they could approach them at any time for advice or support if they needed to. One staff member told us, "I have had some personal issues and the management have been very supportive."

There was a positive culture within the service which was person-centred and had resulted in good outcomes for people. The service was open and transparent with people. Feedback from people about the service and the actions taken in response was displayed publicly on notice boards around the building in the form of 'You said; We did' posters.

Staff felt valued which resulted in good levels of staff retention. The majority of staff had worked at the service for many years. This benefitted people as they received continuity of care by staff who knew them well. Throughout the visit staff and management were observed in friendly interactions with each other as well as with people and relatives. Staff told us they enjoyed working at the service and were well motivated. People and relatives commented on the staff team as being "a happy bunch."

Staff, management and the provider were clear about their roles and responsibilities and we saw evidence of robust oversight of the service at management and provider level. Quality assurance systems were in place to monitor the safety and effectiveness of the service. We saw that a range of audits were completed such as infection control, health and safety, catering and medicine audits. Where issues were identified these were included in an 'improvement plan' which was in place for each unit and was signed off as the appropriate action was taken.

Regular residents and relatives meetings and twice annual satisfaction surveys were used to include people in the running of the service. In addition a regular newsletter was provided to people to keep them updated and informed on the service and any proposed changes and improvements. People's feedback was actively sought and used to make improvements. For example, where people had requested more shrubs and flowers for the garden, this had been arranged.