Mrs Rita Moors

# Culliford House

## Inspection report

Culliford House Residential Home
Icen Way
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Tel: 01305266054

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

Culliford House is a residential care home for up to 25 older people aged 65 and above with a range of needs including dementia. At the time of our inspection the home was providing support to 20 people. 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. The home has three floors with the top floor available for relatives or friends who have travelled a long distance to see people or who are wishing to spend more time with them if they are receiving end of life care.

The home had a registered manager. 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.

Culliford House was last inspected on 14 October 2015 and the service was rated Good.

At this inspection we found the service remained Good overall.

The home had safe recruitment practices. Checks had taken place to ensure staff were suitable to support people at the home. Pre-employment and criminal records checks were undertaken. Records included photo identification, interview records and two references.  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 risks were assessed and staff knew how to manage these without being overly restrictive. For example, where people's skin was at risk or they had problems swallowing; their care plans noted this and detailed how much support they required from staff and how much they were able to do themselves.

People's mental capacity and ability to consent to living at the home had been checked as part of the pre-assessment process. Staff were able to tell us when and who they would involve if a person lacked capacity. Best interest meetings had taken place in cases where an assessment had determined that a person lacked capacity. These meetings had involved family members with the authority to make decisions on their relative's behalf, staff who knew the person concerned and healthcare professionals. When necessary staff sought advice and input from the local mental capacity act team.

Staff received an induction programme which included being assigned a mentor and a probationary period involving shadow shifts with more experienced staff and regular competency checks.  New starters were given a learning style questionnaire to help inform training sessions and development plans. Training included health and safety, mental capacity, and dementia care.

Interactions between staff and people were natural and warm and there was a relaxed and happy atmosphere in the home. Staff told us that the rotas gave them enough time to spend with people and help meet their needs in a compassionate and person-centred way. They said they had enough time to get to know people, to listen and to respond to any questions they had.

People's need for privacy and dignity was respected and upheld. For example, we observed 'please do not disturb' signs on people's doors when they were being supported with personal care.

People's care plans were detailed and reviewed monthly with their involvement and input from family members and healthcare professionals when required. Care plans included what people had done in the past and what they enjoyed doing now.

People were encouraged to become involved in things affecting their quality of life at the home. For example one person had become the peoples' health and safety representative and attended staff training sessions. Another person was due to join the health and safety committee. The home told us they were planning to include people in the staff recruitment process.

People spoke highly of the senior management team particularly in terms of the support they provided and their collective vision and overview of the service. The service's values and vision were embedded within staff meetings and supervision and were shared by care staff. Senior management had a good understanding of their roles and clear lines of responsibility had been established.

The home had introduced an 'employee of the month' award. Both people, relatives, staff and healthcare professionals could nominate for this. Winners were displayed in the home and on the provider's website. The award recognised and rewarded the hard work and dedication of staff. Staff achievements were also acknowledged in staff meeting minutes. This included the home obtaining the Investors in People Silver Award.  Investors in People is a standard for people management, offering recognition to organisations that adhere to the Investors in People Standard. Staff told us that they felt motivated, valued and happy working at the home. A number of them had returned to the home after working in other care settings. One staff member said it was the best place they had worked with another saying the staff were "like a big family."

The home held improvement planning meetings. This had led to joint day and night staff meetings to foster consistency and cohesion across the staff team. Staff meetings included discussion about areas for improvement and how these would be achieved. Staff were encouraged to reflect on their practice for example following incidents or hospital admission. One senior staff member said, "we are supported to question practice."

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 remains Good.

There was a robust recruitment and selection process.

Risks people face were assessed and regularly reviewed.

Staff had a good understanding of safeguarding and what to do should they suspect or witness abuse or harm.

There were enough staff to meet people's needs and respond flexibly.

Medicines were managed safely.

### Is the service effective?

Good

The service remains Good.

Staff had a good understanding of mental capacity. People had assessments of their capacity and, where they lacked capacity, decisions were made in their best interests with involvement by relevant persons.

Staff received induction, mentorship, supervision, appraisal and training to allow them to meet people's needs.

People received support where needed to eat and drink sufficiently. Where people had complex needs in this area of their life they were well supported.

People received timely support from external professionals when required.

### Is the service caring?

Good

The service remains Good.

Staff were attentive and compassionate in their approach.

Staff respected people's privacy and dignity.

Staff knew people well including their previous occupation, hobbies, likes and dislikes.

People were supported to make decisions by staff who understood the importance of offering choice.

Visitors felt welcomed and could visit when they chose.

Relatives felt consulted and involved.

## Is the service responsive?

Good

The service remains Good.

Care plans were person-centred, detailed and regularly reviewed.

Activities were person centred and varied. These included the offer of 1:1 time with people less able or who were more private.

People were encouraged to become involved in the running of the home and participate in staff training sessions.

Complaints were responded to in good time and resolved to people's satisfaction.

People had advanced care plans in place which detailed how they wanted to be supported at the end of their lives.

## Is the service well-led?

Good

The service remains Good.

The home had clear lines of responsibility and a management team that was capable, cohesive and approachable.

There was a culture of learning and continuous improvement.

Staff felt happy at work and supported by management. Their contribution was recognised, valued and rewarded.

Meetings were used to develop and embed a shared understanding of key challenges, concerns, policy changes and achievements.

Regular audits and checks were carried out to help ensure that quality performance, risks and regulatory requirements were understood and managed.

# Culliford House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 comprehensive inspection took place on 9 February and 12 February 2018. The first day was unannounced and the second day was announced.
The inspection team included a lead inspector and a second inspector.

In planning the inspection we used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we contacted the local safeguarding and quality improvement teams for their views on the home.

During the inspection we spoke with five people using the service and three relatives. We also spoke with the registered manager, deputy manager, quality manager, a head of care and four care staff.

We looked at five people's care plans. We also looked at records relating to the management of the home including staff rotas, medicine administration records, meeting minutes and the recruitment information for three staff.

After the inspection we contacted the mental capacity act, district nursing and speech and language teams for feedback on their visits and contact with the home.

We pathway tracked two people. Pathway tracking is where we review records and do observations to see if people are supported in line with their assessed needs. We carried out general observations and also 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.

Good

# Is the service safe?

## Our findings

Staff had a good understanding of how to safeguard people from harm or abuse. They understood what signs to look out for and were confident in what they needed to do if they had a concern. Training included safeguarding of vulnerable adults and children. People told us they felt safe. One person said "I feel very safe here." Their relative said "I am really happy with the care that [name] receives. I feel [name] is safe and well cared for."

People's risks were assessed and staff knew how to manage these without being unnecessarily restrictive. For example, where people's skin was at risk or they had problems swallowing; their care plans noted this and detailed how much support they required from staff to maintain their health and well-being. This included the offer of specialist equipment such as a pressure-relieving air-mattress or supporting a person to eat food and fluids of a certain consistency and at their pace.

Staff handover meetings were used to share information about risks and people's day to day well-being. These meetings included person-centred discussions about people's care preferences, relatives' views and whether there was a need for referral to healthcare professionals.

Equipment within the home was routinely serviced. Visible checks of equipment and the home environment were carried out daily. This included the fire system and fire alarms. Maintenance and hazard logs were completed and outcomes recorded. People had Personal Emergency Evacuation Plans (PEEPS) in place which guided staff on the most appropriate way to support people to get out of the home safely in the event of an emergency such as a fire or flooding. These were reviewed monthly.

There were sufficient numbers of staff to keep people safe and meet their needs. People said that staff had time for them and did not rush around. When people used their call bells to request staff support they received help in good time. One person told us, "staff come in no time at all. If it's where there is an emergency [elsewhere in the home] they pop in to let me know it may be longer." The staffing rota matched the number of people on duty. It also showed the service used a flexible approach when peoples' needs changed, activities needed to be supported and to cover staff sickness.

The home had safe recruitment practices. Checks had taken place to ensure staff were suitable to support people at the home. Pre-employment and criminal records checks were undertaken. Records included photo identification, application forms with details of work experience and qualifications, interview records and references.

Medicines were managed, administered and stored safely by staff who were trained. Medicine records were complete. Stock checks were completed daily to help identify any discrepancies at the earliest opportunity. Medicines in use were within their expiry dates and bottles of liquid medicine had the date of opening recorded on them. Temperatures of stored medicines were checked daily and these were observed to be within a safe range. After any medicines errors staff had supervision, retraining, three observations and spot checks to ensure they were competent and confident to resume administering medicines.

Where people required pain relief patches or topical creams staff used body maps and application records/charts in order to support people safely and according to their needs. For example a person who required pain relief patches said, "I have [these] every three days…they always do this and move [the location] where they put this." Any unused medicines were returned to the pharmacy. GP advice was sought appropriately including when people required a review, declined their medicines frequently or when a person's medicines had not improved their health. Two people managed their own medicines and had risk assessments in place covering this.

There were systems in place to reduce the risk of cross contamination and maintain cleanliness. There were automatic hand sanitisers and a supply of personal protective equipment around the home and staff made appropriate use of these. Staff understood their responsibilities in relation to infection control. Their competency in this area was reviewed each month by an infection control lead. There was an infection control policy and an infection prevention information leaflet had been produced for people and visitors to the home. The home was visibly clean and free from odours. One person said the home was "kept beautifully clean."

The home conducted monthly accident and near miss audits. This included what had happened, the time of day and the treatment required. It also detailed when accidents/incidents had needed referral to healthcare services. This meant that the home could identify potential patterns to prevent more serious incidents occurring. Outcomes were discussed at management meetings and cascaded to staff. For example when a person had left the home on a number of occasions, and become confused because of their dementia, a best interests meeting was held and the person was supplied with an electronic tracker that alerts staff when the person leaves the home. Where a person had experienced a fall staff had encouraged them to use the lift rather than the stairs. Another person had experienced a fall which resulted in the home seeking advice from the falls prevention team. Safeguarding alerts had been reported appropriately.

Good

# Is the service effective?

## Our findings

People had their needs assessed prior to moving to the home. This included their care needs and how they liked to live their lives. People were involved in their pre-assessments, care plans and reviews. We observed staff offering people choice throughout our inspection and this approach was also evident in people's care records and from what people and staff told us. For example, a person's care plan noted that '[name] goes to be bed when [name] is ready.' One person told us that they liked to have breakfast in their room and chose when they wanted to get up. Another person said that staff recognised that they liked to get up at a particular time and then enjoyed tidying their room and doing the bed linen themselves. People were also offered choice about whether they wanted to take their medicines. One person told staff that they would take it after lunch rather than before and this was respected.

Staff received an induction programme which included being assigned a mentor and a probationary period involving shadow shifts with more experienced staff and regular competency checks. Training included health and safety, mental capacity, and dementia care. A number of methods were used to deliver training. These included staff logging onto a dedicated area on the home's website, completing workbooks and attending face to face sessions. A relative said they felt staff were "competent and knowledgeable." Another said that the staff were "really conscientious and work hard." Staff had supervision every two months which included time for reflection on achievements, challenges and goal setting. All staff had received an annual appraisal. Group supervision was held to address organisational and team practice issues as and when they arose.

Staff had a good understanding of people's dietary needs including where people needed their food or drink of a particular consistency. There was a daily menu from which people could choose a number of options. These included traditional favourites and healthy options. People could request something different if what they wanted was not on the day's menu or they changed their mind. People who were vegetarian or had diet controlled diabetes had their needs met. The staff kept a record of people's food allergies and noted allergens in all foods on the menu to reduce the risk of people having an adverse reaction. One person told us, "the food is excellent…it really is. There is a choice. On Sundays we have wine and sherry." Another person told us that staff had made them a salad to help them lose weight. When required people's eating and drinking intake was monitored and, where there were concerns, healthcare professionals were contacted for advice. Some people required support at meal times. We observed them being supported in line with their care plan.

The home worked with other organisations and teams to ensure care was effective. This included support from district nurses, speech and language therapists and the mental capacity act team.

Staff supported people to attend appointments for example at the GP, hospital or eye clinic. People had visits from healthcare professionals such as chiropodists, district nurses and occupational therapists. Care plans noted previous visits and people told us that they were kept informed of when next appointments were scheduled.

The home was decorated in a way that made it feel homely and people, relatives and healthcare professionals all commented positively about this. People were able to sit out in a large conservatory and said they enjoyed the view on to the enclosed garden. There was seating and a summer house in the grounds where people could choose to spend time either alone, with other people, or when family visited. The home had purchased an additional ramp alongside an existing one to allow people easier access into the garden. A fence had also been put around the garden to give people privacy and to make it a quieter space to sit out in. People's rooms were personalised. One person said, "I like my room as it is. I have my own photos up, my files, and my TV. I am happy with the layout." Another person told us, "I love my room… I'm very lucky I have my own photos and ornaments and my laptop."

Staff understood the principles of the Mental Capacity Act 2005 (MCA 2005) and how it applied to the people there. The MCA 2005 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's mental capacity and ability to consent to living at the home had been checked as part of the pre-assessment process. Staff were able to tell us when and who they would involve if a person lacked capacity. Best interest meetings had taken place in cases where an assessment had determined that a person lacked capacity. These meetings had involved family members with the authority to make decisions on their relative's behalf, staff who knew the person concerned and healthcare professionals. When necessary staff sought advice and input from the local mental capacity act team. The mental capacity act team manager told us that the staff at the home were keen to keep their practice in this area up to date.

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). For a person that required DoLS we saw that it had been applied for and authorised. A review date had also been set.

Good

# Is the service caring?

## Our findings

Interactions between staff and people were natural and warm and there was a relaxed and happy atmosphere in the home. One relative said that when their family member was unwell staff "spoke quietly" to them and were "very understanding." They also said that when they themselves had become upset a member of the senior management had consoled them and said, "I'm here for you as well." One person told us, "staff are all very nice" while another said, "[staff] are always very, very kind by the way they talk to me, they have a little joke, it's nice to have a laugh with them." Another person said that the staff were "gentle" when they helped them with personal care and that they and the staff "solve things together." On one of the feedback questionnaires a person had expressed, 'not only do they treat me with respect, they are always marvellously kind and patient and I feel they almost treat me like their own granny!" Another person noted, 'I can hear from my room how kind, patient and hardworking they all are." A healthcare professional told us that, 'staff have demonstrated a caring commitment to the residents. The atmosphere in the home is warm and friendly. Our impression is that the staff all really do know their residents.'

Staff told us that the rotas gave them enough time to spend with people and help meet their needs in a compassionate and person-centred way. They said they had enough time to get to know people, to listen and to respond to any questions they had. Most people confirmed this although one person said that it would be good if staff had more time as they felt staff had a lot of paperwork to complete. People were involved in meetings with the cook to review the monthly and seasonal menus.

People's need for privacy and dignity was respected. For example, we observed 'please do not disturb' signs on people's doors while they were being supported with personal care. This helped maintain people's privacy and dignity. People were also encouraged to say if they preferred a female or male staff member to support them and told us this was accommodated. One person said, "staff put a towel over me to keep my dignity." We observed staff using people's preferred names and always knocking and asking for consent to enter before going into people's rooms. One person told us that the staff respected that they wanted to keep their door closed for privacy when they were in their room.

Staff had participated in dignity challenges to develop a better understanding of what impact their practice could have on people. This included staff taking blind taste tests of pureed food, using a wheelchair, and being hoisted by equipment operated by other staff.

The service minimised risks to people's privacy and confidentiality by keeping their information securely. Staff were reminded of the importance of this during team meetings and when they attended training. New starters were required to sign a confidentiality agreement. This helped them understand their responsibility to keep people's personal information confidential. When people moved in they were given an information leaflet that explained how their information would be handled.

Good

# Is the service responsive?

## Our findings

People's care plans were detailed and reviewed monthly with their involvement and input from family members and healthcare professionals when required. Care plans included what people had done in the past and what they enjoyed doing now. People had one page profiles which noted 'what's important to me', 'what others like and admire about me', and 'how best to support me.' One person liked going to the pub for a drink and, at their request, had been supported by a staff member. Handover meetings noted how much support people required and what they preferred or liked to do themselves. For example, staff were asked to check a person's skin as it was causing them discomfort but were reminded that the person wanted to do their own personal care.

Staff had developed ways to support people with particular communication needs, for example, food and drink picture cards were available to make it easier for people to know what was on offer that day and what they might like. The home also had picture cards available for when people had personal care or visited the home's hair salon. These helped to reduce levels of anxiety, and provide choice, when supporting people with dementia or sensory loss. The home continued this approach with pictures on communal bathroom or people's ensuite doors to illustrate to people what equipment would be found in the room and the room's purpose. The home's communication policy advised staff to 'select a tone [of voice] that match[ed] the [person's] hearing ability.' We observed staff doing this during the inspection.

The home had established regular visits to and from a local nursery. People said they had enjoyed working together with the children to produce arts and crafts objects. These were on display in the home. The children and people at the home had recently done some separate work on what dignity meant to them and had planned a get-together to share their thoughts. The home actively encouraged people to maintain contact with their family and friends. One person said, "I have two friends who visit and come whenever they choose." Another person had enjoyed visits from past colleagues. Relatives said that they were always made to feel welcome. One person told us that when their family came to visit they enjoyed sitting outside in the garden with them. People had their own landlines and could access the internet to stay in touch with family, friends and the wider community.

The home had a people and relatives noticeboard which included details of items available in the people's shop, minutes from a recent peoples' meeting and a list of the week's events. The year and the season were detailed above the noticeboard to help people with dementia orientate to time. Weekly activities included pamper sessions, pre-dinner drinks and reminiscence sessions at the local library. The home had two part-time activity coordinators. People had individual activity plans that reflected their preferences. The plans were regularly reviewed with people's involvement to help ensure that the activities offered continued to meet people's need for social stimulation.

The quiz that we observed was well attended and people were engaged. There were enthusiastic participants and others that chose to do their own thing. People were free to do whatever they chose. People who preferred not to participate in group sessions were offered 1:1 sessions in their rooms. One person told us that staff supported them to read poetry supplied by a mobile library service. They said that

staff ensured this was in large print to make it easier for them to read. Another person said, "there is always something going on here." There were examples where staff and people shared a common interest in things such as books or films and had lent each other these to enjoy and chat about afterwards.

People and relatives told us they knew what to do if they had a complaint. One person said, "if I had a complaint I would just speak to staff." The home had drop boxes where people could get advice on raising concerns and post their comments about the service. 'Concerns, compliments and complaints' leaflets were available around the home. One relative said that the home "often asks for feedback and we can give it at any time." A relative who visited the home to stay with their family member had fedback 'it is obvious to us that the staff work together in total harmony.' On the inspection one person told us that they felt cold in their room. We told staff and they immediately got an electric heater to make the person feel more comfortable. An entry in the complaints log showed that when another person had complained about the temperature in their room a new thermostat had been fitted. An information poster advised people and their relatives how the home had responded to particular feedback given. This tied in with things people had raised in feedback questionnaires. For example, a monthly singing group was created after people had requested more regular musical entertainment.

In March 2017 the home was awarded the Gold Standard Framework (GSF) Platinum Award. The GSF is a systematic, evidence based approach to optimising care for people approaching the end of life. The award celebrates sustained excellent practice in end of life care which has been embedded into a care home's core working practices. The home had a GSF lead coordinator who had produced 'bereavement baskets' which contained items that a person and their family could use when they were nearing the end of their life. The baskets included sensitively written guides for people and their relatives about changes to how a person may look or feel, a bereavement brochure for staff, and scented beauty products. In addition the home had made a third floor room available for relatives who wanted to be near their family member at this time. One of the staff told us that they felt it was a "privilege" to be involved in helping support people at this time.

There was a book of remembrance in reception which included photos and profiles of people who had lived at the home. People were encouraged to continue practising their faith, should they wish to, with some people telling us that they attended local church services with friends and family. Every year the home holds a service for relatives who have lost a family member at the home in the past 12 months.

People had Advanced Care Plans (ACP) which had been put together with their involvement, on their move to the home. ACPs can be put together after staff and family members have supported a person to think and talk about how they want to be cared for in the final months of their life. These had been regularly reviewed. People's plans included details of what made them most happy, any special requests and what they did not want to happen. A number of people had left the home legacies on their passing and these were detailed in a legacies log. A relative had complimented the home on how they had looked after their family member at the end of their life, stating, 'we are very grateful for the wonderful care that Culliford provided.'

Good

# Is the service well-led?

## Our findings

People spoke highly of the senior management team particularly in terms of the support they provided and their collective vision and overview of the service. The service's values and vision were embedded within staff meetings and supervision and were shared by care staff. Senior management had a good understanding of their roles and clear lines of responsibility had been established.

There was a full and stable staffing team. Some staff had chosen to return to the home after working in other places. They said they had been motivated to do that as they had enjoyed working there. One person said that the management were "very nice and would do anything for me." People and relatives knew who the registered manager was and were complimentary about how they and the rest of the management team ran the home. Senior management were visible during the inspection and it was evident to us that they worked well together and people and relatives felt at ease in approaching them.

The home had introduced an 'employee of the month' award. Both people, relatives, staff and healthcare professionals could nominate for this. Winners were displayed in the home and on the provider's website. The award recognised and rewarded the hard work and dedication of staff. Staff achievements were also acknowledged in staff meeting minutes. This included the home obtaining the Investors in People Silver Award. Investors in People is a standard for people management, offering recognition to organisations that adhere to the Investors in People Standard. Staff told us that they felt motivated, valued and happy working at the home. One staff member said it was the best place they had worked with another saying the staff were "like a big family." A college student on work experience told us, "I love it here." Staff performance reviews included positive and constructive comments. On occasions where staff had failed to follow good practice guidance the disciplinary procedure was used to record and resolve issues.

The home regularly sent out questionnaires to people, public and the staff to get their views on the service and used these to develop the service. One relative said "I absolutely feel involved. They always phone me to update and encourage me to visit." People were encouraged to become involved in things affecting their quality of life at the home. For example one person had become the peoples' health and safety representative and attended staff training sessions. Another person was due to join the health and safety committee. The home told us they were planning to include people in the staff recruitment process. A person on work experience at the home told us, "management are on the ball if you raise things. I never feel awkward. I can always ask somebody if I don't know what to do and they help me.' A senior member of staff said the registered manager had been "very receptive" when they had suggested trying a different way of administering people's medicines in order to reduce the chance of errors.

The registered manager had established a dedicated quality manager responsible for ensuring all policies were kept up to date and staff were informed of changes. The quality manager said that the registered manager was "very, very receptive of me in my role." A range of audits and quality assurance assessments had been carried out. Audits covered areas including care planning, supervision, and support to people at the home with dementia. Findings from these were shared with staff during team meetings, supervision and training sessions. Auditing of supervisions had resulted in them being revised to include reflection on how

the staff member felt the service could be improved. The auditing of support to people with dementia had led to the introduction and use of pictorial communication cards.

A training matrix allowed management to track what courses staff had completed. One senior staff member said the registered manager was "very encouraging and supportive" to staff who wanted to do extra courses for their professional development adding, "the management here really have time for you." Lead roles had been introduced in areas such as safeguarding, end of life care and nutrition. This meant that staff had an identified contact point and the person concerned had the opportunity to develop a better understanding of an area of care aiding their professional development.

The home logged compliments, concerns and complaints. This included a relative thanking the home for sending photos of their family member on her passing away, a handrail being fitted on the landing to help people who became unsteady waiting for the lift, and a person being compensated when an item of their clothing was lost.

The home held improvement planning meetings. This had led to joint day and night staff meetings to foster consistency and cohesion across the staff team. Staff meetings included discussion about areas for improvement and how these would be achieved. Team meetings minutes showed staff had reflected on care scenarios that senior management had put together. Staff were encouraged to reflect on their practice for example following incidents or hospital admission. One senior staff member said, "we are supported to question practice." The home received a scheduled visit from the local quality improvement team in April 2017. Of the four recommended actions identified from the visit all were promptly resolved after an action plan was drawn up and implemented.

Healthcare professionals told us that information sharing and communication with the home's staff was "consistently good" and that their recommendations had been followed, for example when some people had needed safe swallow plans. One healthcare team commented that their work with the home had left them 'quite impressed with the home and its staff.' It gave an example where the home had worked in partnership with them and family members to help manage the risks, and retain the benefits, of a person with dementia being able to continue accessing the community independently.

The registered manager and other senior managers held relevant qualifications in leadership in health and social care. They were members of a countywide association which provided a network of support and learning. Senior management at the home also attended local learning hub meetings where they could meet with other managers and healthcare professionals. They said this kept them up to date with changes in social care, legislation, training and funding opportunities.