Hallmark Care Homes (Billericay) Limited

Anisha Grange

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

The inspection took place on 8 and 12 June 2017 and was unannounced.

Anisha Grange is a nursing home that is registered to provide accommodation, nursing and personal care for up to 74 older people, some who may have needs associated with dementia. Care was provided in three units over three floors. Valentine, the nursing unit, was on the ground floor, people with dementia mainly lived in the Primrose unit on the first floor, whilst people who did not have nursing or dementia needs predominantly lived in the Autumn Way unit on the second floor. At the time of our visit there were 67 people living in the service.

A registered manager was not in post at the service. 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. We were told that the manager was applying to the Care Quality Commission to become the registered manager.

When we last visited the service we found that there were not enough staff to meet people's needs and minimise risk, in particular where people had the most complex needs. Morale was low amongst staff and the manager did not have sufficient oversight of the care people received. Whilst there were action plans in place to resolve the concerns we had found they were not leading to improvements.

At this inspection we found the service people received had improved dramatically and the provider had addressed our concerns openly and pro-actively. Whilst there had been an unsettled period following our last inspection the service was now running more smoothly and feedback from people, families and staff was overwhelmingly positive.

People were safe at the service. The checks on people's health and wellbeing had been enhanced. Staff and managers were more aware of where there were risks in the service which needed to be monitored or acted upon. Staff knew what to do if they were concerned about people's safety. There were enough staff on duty who were organised efficiently and worked well as a team. Staff were safely recruited, and the use of agency staff was proportionate. Medicines were administered safely.

There was a focus on developing staff skills through more effective and meaningful training. Staff were well supervised and supported. The service was meeting its responsibilities under the Mental Capacity Act (MCA) 2005. People were supported to make their own choices and where there were restrictions on their liberty, these were minimised and in their best interests. Improvements had been made in the dining experience and these were on-going. People who were at risk of malnutrition or dehydration were well monitored and supported. Staff worked well with outside professionals to meet people's needs.

Staff had an enthusiasm for the people they supported and this meant people felt valued and cared for.

There was a focus on the person rather than the task being carried out. People were enabled to make choices about the support they received. They were treated with respect and dignity.

People were supported to take part in varied activities or pastimes of their choice by enthusiastic staff. Support was more holistic and tailored around people's individual needs. Care plans provided staff with personalised guidance about people's needs which enable them to understand what support people needed. Families and significant people were welcomed at the service. Their feedback was encouraged and used to make a difference. People felt able to raise concerns and the manager and staff learnt from their complaints and feedback.

The manager had helped transform the culture at the service. There was an openness and transparency about what improvements were needed at the service, and a commitment to excellence. The staff team were now motivated and engaged. Checks on the quality had been inconsistent due to the changes in management but were now functioning well.

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.

There were enough safely recruited staff to meet people's needs and preferences.

Risks to people's safety were monitored and managed effectively.

Staff knew what to do to if they had concerns about a person's safety.

There were safe systems in place for the administration of medicines.

Is the service effective?

Good

The service was effective

People's experience of meals had improved.

Staff were well supported and encouraged to continue developing their skills and knowledge.

People were enabled to make their own choices where they had capacity. Decisions made on people's behalf took into account what was in their best interest.

Staff worked well with other health and social care professionals, where required.

Is the service caring?

Good

The service was caring.

People were supported by enthusiastic staff who had time for them and valued them as individuals.

Staff were respectful and treated people with dignity.

People's privacy was maintained.

Is the service responsive?

Good

The service was responsive.

People received personalised care and were enabled to take part in activities and pastimes in line with their preferences.

People's care was outlined in detailed support plans which provided staff with information to meet their needs.

People knew who to speak to if they wanted to raise any concerns and were confident something would be done as a result.

Is the service well-led?

Good

The service was well led.

The new manager was a strong and effective leader.

Communication with care staff had improved. Morale amongst staff was good and the culture was positive.

The systems in place to check the quality of the service were resulting in improved outcomes for people.

Anisha Grange

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 8 and 12 June 2017 and was unannounced.

The inspection team consisted of two inspectors, a specialist nursing advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The nursing advisor was used to check that people's health and care needs were met in a safe and effective way.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with other information we held about the service. This included 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 focused on speaking with people who lived at the service and observing how people were cared for. Where people at the service had complex needs and were not able to verbally talk with us, or chose not to, we used observation as our main tool to gather evidence of people's experiences of the service.

We met with the manager, the clinical care manager, the new head of hospitality (who was currently the head chef), 13 members of care staff, 21 people who used the service and eight family members and friends. We also spoke with one health and social care professional to find out their views on the service.

To enable the service to address the concerns we had raised at the previous inspection the provider had brought together a range of senior staff from the wider organisation to drive improvements. As a result, during our inspection we met briefly with the director, plus the Care Quality, Compliance and Governance

Director, the Regional Manager for England, the Regional Care Specialist and the Group Lifestyles Manager. We also looked at documentation relating to the improvements the provider had made after our last inspection.

We reviewed a range of documents and records including the care records for people who used the service to see if the records were accurate and reflected their needs. We also looked at six staff files and documents relating to the employment of staff, complaints, accidents and incidents and the management of the service.

Good

Is the service safe?

Our findings

At our last inspection we found there were not enough staff to meet people's needs and risk was not well managed at the service. At this inspection we found that improvements had been made and people were being supported safely. A visitor told us, "We come twice weekly at all different times just to be a presence, and check up on our friend. I feel they are in safe hands when I leave. I never find anything to concern me."

When we last visited the service we found that although staff completed charts to monitor risks to people's safety and health, there was not sufficient oversight of these checks. As a result, senior staff had not picked up when the charts were not being used to keep people safe. We found the management of risk had now improved and checks were personalised and effective. There was a clear rationale behind which checks were carried out and they were completed in a proportionate manner, so people were not being monitored unnecessarily. For example, people were usually weighed monthly but this was increased to weekly if checks highlighted they were losing weight. The nurse on duty on each unit and other senior staff had clear oversight of the checks being carried out and knew where there were areas of risk and what was being done to mitigate that risk.

The monitoring charts used by staff had been completely revised since our last inspection and were now easy and clear to follow. Staff were confident about the checks and were able to explain who was being monitored, how often and why. They also knew what to do if the checks highlighted any concerns. For example, staff supporting a person who was at risk of dehydration now had a target for how much a person should drink over 24 hours and there were clear instructions detailing what to do if they were not drinking enough.

While we were on inspection the fire alarm was activated. We observed a calm and confident response by staff. Staff told us, "The fire training was brilliant, it was a real scenario and you have to get people out of the room and set a fire extinguisher off." Each person had a personal evacuation plan which outlined the support needed in the event that the building needed to be evacuated. One person's fire risk assessment stated they needed "guidance and support from team." We discussed this advice with the manager who agreed it was vague, especially if a person was being supported by a new or temporary member of staff who did not know them. They agreed to review the plans to ensure staff had clearer advice.

At our last inspection we had concerns regarding the level of staffing at the service and found staff were not deployed effectively across the service. There was an impact on people in relation to managing any potential risks and to their quality of life, in particular for those people who had the most complex needs. At this inspection we found there were enough staff to meet people's needs and we also found they worked better as a team.

Feedback from families or people regarding the levels of staffing was now overwhelmingly positive. People told us that their call bells were answered quickly. People said, "We all know about the buzzers to press, they're in all areas of the lounge, and carers soon come running. That makes us feel safe" and "I think the call bells have got better recently – I mean they seem to come quicker." When visiting a person in their room

they told us they had just pressed their bell after spilling some food. A member of staff arrived immediately and the person later told us, "I never have to wait very long for assistance, and they don't make you feel you're a nuisance when you need help."

At our last inspection there had been a lack of communication about how staffing decisions were made, which had led to low staff morale. The manager gave an example of how this had now improved. Staff in one of the units had raised concerns about a recent reduction in night time staffing. The manager reviewed the support being provided during this period. They also met with staff and had an open discussion about how busy they were at night time. As a result, additional staffing was reinstated during the periods where people were most likely to need support, for example as they woke up and were getting ready for the day.

We were told by staff of the improvement in staffing numbers and effectiveness since our last visit. Staff told us, "The teams work together a lot better now" and "Yes, there are enough staff. We all pull together we sometimes go onto other communities to help out if need be."

We received some feedback about the continued use of agency staff. One person said, "I don't like having agency staff, the night staff are often agency and of course they don't know us, or how we like things done." We discussed this with the manager who told us a large number of staff had left since the last inspection. Whilst new staff were being recruited, there was a commitment to recruiting the right staff, and an understanding that this might take some time. As a result, agency staff were being used in the meantime to plug the gap in staff numbers.

We looked at the recruitment files of six staff members and saw that the service had a robust recruitment policy in place to ensure that staff were recruited safely. Each staff member had to attend a face to face interview and all the required employment background checks, security checks and references were reviewed before they began to work for the organisation. This process ensured that the provider made safe recruitment choices. Prior to starting employment, new employees were also required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people.

Staff had completed training which provided them with the knowledge about how to recognise signs of abuse and they understood their responsibility to report any concerns to senior staff and, if necessary, to the relevant external agencies. We spoke to the manager and looked at documentation relating to a number of safeguarding concerns which had been raised since our last inspection. Investigations had been thorough and open. A visitor told us, "If I was worried about my friend in any way, I'd talk to any of the staff on duty, or if it was more serious I'd pop downstairs and talk to the manager. It would be taken seriously, they don't ignore you."

The service used an Electronic Medication Administration Records (EMAR) system monitor the administration of medicines. Staff understood the system and told us it worked well. At the last inspection staffing deployment lead to delays in the administration of medicines. At this visit we found people were supported to have their medicines on time. We observed that the nursing staff responsible for the administration of medicines were well trained, competent and respectful.

People's care plans had a list of medicines they were on which provided useful guidance to staff, such as what the purpose of the medication was and any possible side effects to look out for. There were risk assessments in place for people who self-medicated and checks were carried out to ensure they could still manage to administer their medication safely.

Medicines were stored in a locked trolley and storage room and the member of staff was able to clearly explain the medication signing in and out procedure. Senior staff checked the EMAR to ensure there were no mistakes or gaps in people receiving their medicines.

Good

Is the service effective?

Our findings

At our last inspection we found staff were not always effective in supporting people with more complex needs at the service, for example they did not ensure and monitor whether people had access to enough food and drink. Also, staff did not all have the necessary skills to work with people with Dementia. At this inspection we observed an increased focus on the needs of more complex people. People told us, "They do all they can to look after us well, and would know what to do if I was unwell" and "My needs are very well looked after."

Central to the effectiveness of the staff team was an improvement in staff morale and in how well the staff team worked together. Staff told us, "I really enjoy my job, things have greatly improved staff morale is good and we all work as a team", "Things are much better than they were a year ago there is so much support and team work now" and "We all support each other and work as a team. You are never made to feel you have asked a 'silly question'."

Training and skill levels were improving. Staff told us the training was comprehensive and constantly being revised. During our visit we observed two members of staff undergoing a training experience where they had to sit a wheelchair, whilst wearing ear plugs and glasses smeared with cream. They were left alone for 30 minutes before being 'fed' a bowl of soup and given their 'tablets' (sweets) with very little interaction. Staff later told us, 'It was the most awful experience, I desperately wanted to stop it, but I kept with it. I will never forget how it made me feel, and I'll view people in a different light now.'

We received feedback that improvements in training were having a positive effect on the level of staff skills. A visitor told us, "If you'd asked me 6-9 months ago I felt training wasn't good but training's got better." All new members of staff completed an induction programme, which had been revised in line with the concerns raised at our last inspection. The programme included training sessions on health and safety, safeguarding and whistleblowing as well as completing shadow shifts with more experienced staff members before being included onto the rota. Before working alone observations of practice on new staff were carried out to ensure that they had the necessary skills to care for people.

At our previous inspection we found staff did not always have the skills to work with people with dementia. Whilst we observed that staff skill levels had improved, for example during meal times, we noted that there was scope for further improvement in line with best practice in the specialist dementia unit. For example, bedroom doors were not personalised to enable people to recognise their own rooms. Peoples' names had been printed onto paper, and stuck on the doors, but several were missing and had presumably been ripped off. We did not observe any memory boxes in use, which we had previously been told were being set up. We spoke to the new senior member of staff who had been recruited to focus specifically on improving the support to people with dementia. They told us of the improvement plans in place such as improved signage for toilets and people's doors to help people with memory loss.

All of the staff we spoke with told us that they felt well supported and confirmed that they had regular planned supervision sessions and an up to date annual appraisal. Supervision and observations of staff

practices were completed for all staff on a regular basis to ensure staff were putting into practice the training they had undertaken.

At our last inspection we found people had a mixed dining experience. We also found staff did not adequately monitor the eating and drinking of people most at risk of malnutrition and dehydration. At this inspection we found the care of people who were at risk had markedly improved and on the whole the dining experience had improved significantly from our last visit. Whilst there was scope for continued improvement, we could see the manager was continually driving improvements, resulting in positive outcomes for the people being supported. In particular, we noted how highly motivated the chef and other kitchen staff were and how they integrated well with other staff in caring for the people at the service.

We observed lunch in four different units. In Autumn Way, a group of people had a glass of wine and chatted whilst waiting for their meal. Other people sat in silence and there was minimal chatting and banter from staff. Whilst people were offered a choice of drinks, they had made their food choices prior to the meal. One member of staff reminded people what they had chosen but other staff placed plates in front of people without interaction. People on this unit told us they disliked ordering in advance, we discussed this with the manager so they could explore whether there were improved ways of offering choice.

In the other units there was a more consistently positive meal experience. For example, we observed lunch in the Primrose unit, where most people had dementia and saw staff were skilled in providing choice in a personalised way. There were enough staff to support people and promote a pleasant, unhurried atmosphere. Plates of food were brought to the table so that people could see the meals on offer before making their choices. This was good practice as it offered people with dementia the opportunity to make a choice of which meal they wanted. One person told us, "The foods improved recently, they've got better chefs now." The chef told us, "People can always ask for something different and we will accommodate them it is never a problem."

At our last inspection, the manager had said they did not want a tea trolley, but had not assured us that people were offered enough drinks and snacks throughout the day. At this visit, we observed that staff offered a choice drinks and snacks to people throughout the day. We observed one person asked for a hot chocolate which was provided. People confirmed drinks and snacks were always made available to them.

People's specific dietary needs were now met effectively by care and kitchen staff. We observed one person being supported with their lunchtime meal and saw this was done respectfully. Time was given and the staff member sat next to the bed and chatted about everyday things whilst gently encouraging the person with their food.

The chef was knowledgeable about people's dietary needs and told us that communication between themselves and the manager and staff was excellent and they were kept fully informed about people's nutritional requirements. For example, they were involved in monitoring any variation in people's weight gain or loss. The chef held a 'food matters' meeting every three months with people at the service prior to changing the menus to get feedback and suggestions. They visited the units daily and individually spoke with all new arrivals to the service. They were well trained and run training days for staff, on subjects including how to provide a fortified diet (a diet which is high protein and high calorie for people at risk of losing weight) and how to make pureed food appear more attractive. We looked at some pureed food and it was attractively presented and in line with people's individual requirements.

Care plans outlined personalised food preferences and dislikes, and stated any risks, for example, whether a person was at risk of losing weight and any known allergies. The chef gave some excellent examples of how

they supported people to make choices. For example, they asked a vegetarian person what their 10 top vegetarian meals were and asked a resident living with dementia what their mother used to cook for them.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). We noted the manager had applied to the relevant authority for DoLS authorisation where people lacked capacity and needed constant supervision to keep them safe. There were personalised DoLs applications, which related to people's individual needs, for example, the correct process had been followed where bed rails were in place and people did not have capacity to consent to their use. DoLs applications were monitored effectively to ensure DoLS were requested in a timely manner and in line with
legislation

During our last inspection we found staff had attended training but did not have a consistent understanding of the implications of the MCA. The manager told us they were moving away from on-line training to a more intensive, challenging face-to-face training course. We found staff understanding in this area was improving. People were asked for their consent by staff before any care was given. For example, we observed staff asking people if they would like an apron on to protect their clothes whilst eating their meal. We noticed people making choices about where they spent their time, moving freely between their bedrooms and communal areas. Whilst staff were quick to notice if somebody needed some assistance or reassurance they did not attempt to unnecessarily restrict people or curtail movement.

Staff worked well with other professionals to meet people's health and social care needs. In our discussions with the manager we observed a more positive and open attitude to involvement with other organisations, such as social workers, with the focus being on enhancing people's quality of life. People's care records outlined the involvement of external healthcare professionals, for example, GPs, dieticians, podiatrist, opticians and nurse specialists. Where people had specific conditions such as diabetes staff were given advice both in writing and from the nursing staff at the service.

People fed back that that any changes in their physical or emotional well-being would quickly be noticed by staff. A relative told us, "Communication is good with families, they would notice if my relative had a rash or something. They'd get the GP in if necessary and would always let me know too. I appreciate that."

Good

Is the service caring?

Our findings

At our last inspection we found that although there were many compassionate staff at the service, the impact of low staffing and morale meant people could not be assured they would be treated with kindness and respect. At this visit, we found the improvement in morale and staffing had had a positive impact on the way people were cared for and treated.

We received overwhelmingly positive feedback from people and their families. They told us, "Staff here could not be more caring", "I would describe staff as kind, caring, respectful – I've got no complaints about them" and "I would say staff are very caring, and they do a good job."

Some staff and people specifically credited the manager with the improvement in the atmosphere which directly affected the way people and staff felt about the service. A person told us, "I think there's a warmer attitude here now – I mean since the manager changed" and a member of staff said, "Working here is wonderful, I love it, and our manager is fantastic." As a result, staff displayed an added commitment, for example, some of the domestic staff had come in at 4am to clean a communal area, to ensure this did not disrupt people during the day.

At our last inspection we receive feedback that people felt staff did not always have time for them. In addition to the positive feedback we received at this visit, we observed that staff spent more time with people, talking about their families, their hobbies and other interests. A visiting relative told us, "They are very hands-on, know them very well and show genuine affection and care."

We saw examples of warmth and affection between staff and those in their care, for example staff put an arm around a shoulder as they walked down a corridor together. Where appropriate staff demonstrated their caring nature by giving people space, for example one person told us, "They leave me alone to do my own thing, sit where I want and they don't interfere with me. They're good, never unkind, nothing like that here."

We observed staff calling out to people by name as they passed by and saw they were quick to notice when people who were in need of support or reassurance. A person said, "It's excellent here with lovely people – they're very friendly, and will often say, 'I wish I could chat more but I've got to get on.' They do chat to me though."

Staff spoke with enthusiasm about the people they supported. One member of staff said, "People have such interesting life stories it is great to be able to chat about them. Amazing what they can remember." Staff focused on the person rather than the task in hand. We observed a member of staff supporting two people to go into the lounge and encouraging them to have some fruit to eat. The staff member laughed and joked and as a result, when they left the lounge the two people sat chatting and eating a banana.

People were offered choice about the kind of service they wanted to receive. For example, they told us that they felt listened to with regard to their personal care preferences. For example, one person told me, "I don't

really like baths, I prefer a shower which I have every morning." Another person told us, "Despite having had a stroke, I still feel in control of my own life here."

People were involved in discussions on how to make the service a more caring place to live. The manager told us that they had been asked at a residents meeting if, with agreement, people could be told of any new arrivals and of their interests and hobbies so they could be welcomed to the service in a personal way.

We observed throughout the day that staff respected people's right to dignity and privacy. Staff knocked on doors before entering people's rooms. A person described how staff supported them with their personal care. "They treat me well, and respect my privacy as much as they can." Staff had asked recently the manager for a screen to purchased so they could offer greater options for privacy, for example where a person needed some assistance, such as with cutting their nails, but chose not to move from where they were sitting. The layout of the building meant there were separated areas where families could meet with people in privacy.

Good

Is the service responsive?

Our findings

At our last inspection we found people with more complex needs were not consistently supported to develop their interests and did not have equal access to the wide array of activities and pastimes at the service. The activity staff, also known as 'lifestyle' team members did not always work closely with the care staff to provide a seamless service.

At this visit we found the provider had addressed these concerns in a positive manner. For example, they were implementing a tool which mapped out people at risk of isolation and were therefore able to target support more effectively. A member of staff was being supported to attend a training course around improved activities and pastimes. We later observed them playing an innovative game with a large group of people, involving balloons and lagging pipe. There was a lot of laughter and interaction between people and staff, including those passing by, who were encouraged to join the game.

The management team were encouraging staff to work more closely together to provide a more holistic service. For example, they were highlighting activities, such as a quick quiz, which care staff could pick up and do with people when they were not providing direct care. In the same way, 'lifestyle' staff also spent time interacting with people outside of formal activities. One member of staff told us, "I've just been wandering around talking to people as we moved the Art Appreciation session to this afternoon." We later observed the Art Appreciation activity which was relaxed and interactive. One person told us, "I don't really know much about art, but I like coming here for a chat anyway."

There were many activities for those people who chose to take part. We spoke with the provider's 'Lifestyle Lead' about some of the improvements which were being implemented. They told us activities were being shaped by people's interests, for example a knitting group had recently been set up at the service. One person told us, "They're starting up a Board Games club soon which I'm looking forward to. They're happy to try anything if we ask for it." On the day of the inspection a small group of people were visiting Southend. One person told us they were, "Looking forward to some fish & chips and maybe we'll go to the Sealife Centre." Another person told us, "Last time we went to Hyde Hall which was a great day out – we look forward to trips out, but of course we have to take our turn."

We found staff were skilled at developing natural, non-institutionalised pastimes. We observed a member of staff looking through a historical picture book with two people. The staff member facilitated conversation in a gentle, natural manner asking probing questions, encouraging discussions about experiences of early family life, gardening tips, family discipline and general interests. When the member of staff left in order to sort out lunch they asked the people, 'We're going in the garden later – would you come and help me? I need someone to fill the bird feeders for me.'

The focus was not only on activities but also on positive interaction so that people received a more person centred service. We observed a member of staff deep in conversation with a person who we had seen appear distressed earlier in the day. The member of staff was asking their job, and exactly what it involved. These conversations were replicated throughout the day, where staff took great interest in those they were

caring for in a meaningful manner.

People told us they appreciated this personalised support, which enabled them to thrive. One person told us, "A carer took me to the shops recently to buy a dress for a family wedding – how lovely was that! I've also written a book since I've lived here about my early life. They're trying to encourage me to write another about my war memories."

People's families were welcomed to the visit the service. As well as being involved in special activities such as birthday parties, there were two areas which had been set up as traditional tea rooms where families could sit and chat to their relatives in comfort.

People's care needs were assessed by senior members of staff before moving into the service. Care and support plans outlined the support each person needed. We found the care plans to be individualised and thorough. They provided detailed guidance to staff about the level of support a person needed. For example, they stated whether a person needed one or two staff depending on what they were doing. There were care plans, with associated risk assessments, for all areas of support a person needed. By providing this level of detail, staff were able to keep people safe but also not provide support which would restrict a person's independence. One person told us staff encouraged them to be as independent as possible, saying, "They only do the things that I can't do for myself."

People's care was evaluated monthly by staff or as needed when their circumstances changed, for example if they had a fall. There were more formal reviews of care with involvement of people, their families and professionals as appropriate. Senior staff had effective ways of checking that care plans described people's needs and were kept up to date. For example, senior staff had highlighted when a choking risk assessment was not in place.

Complaints were responded to well and led to improvement. For example a member of staff was booked onto additional training as a result of a concern raised by a family member. People felt able to raise concerns to the manager and staff. A family member said, "If I have a concern I go to [member of staff] they are our 'go-to' person. They are very approachable, and will always listen to us." In our discussions with the manager we were impressed by their commitment to spend time understanding why people and families might complain and how they could work with them to deal with their concerns.

Good

Is the service well-led?

Our findings

At our last inspection we found the service was not consistently well led and the manager had not resolved many of the concerns we highlighted in our report. At this visit we found the provider had invested heavily in time and resources to address the concerns we had raised and as a result we found a changed culture and improved service.

The registered manager in place at the time of our previous inspection had departed shortly after our visit to the service. We met with a peripatetic (temporary) manager and they assured us of their commitment to resolve our concerns by making immediate and tangible improvements. There was then a period of disruption during which two replacement managers were in place for a brief period of time. The same peripatetic manager provided stability throughout this period and we were told they had now agreed to apply to become the registered manager at Anisha Grange. This appointment provided continuity for people and staff. We found the manager to be of an exceptional quality, with the skills to balance the improvement in staff morale and deal with poor practice.

The provider had invested greatly in the service in terms of senior managerial support. We received some feedback that this could result in confusing messages as there were such a large number of senior staff communicating changes and implementing action plans. This appeared to be being resolved by the appointment of a strong registered manager who could provide a consistent message to people, families and staff.

We received overwhelmingly positive feedback regarding the changes in the service. Relatives told us, "I've recommended this home to my friends, especially now when it seems to be a happier, more settled place without all the changes to staff" and "We've seen big improvements recently. Staff seem happier, and the place seems more stable. Everyone always seemed very unsettled and on edge, now there's a much better atmosphere which has to be good for the people who live here."

Staff also told us about improvements at the service, citing the manager as key to the changes. A member of staff told us, "The service has improved a lot since your last inspection and our new manager has turned things around." They told us they felt very supported by the manager. One member of staff said, "I like working here. The manager is great, really makes you feel valued." A member of staff told us, "The manager is always walking around making sure everything is okay, talking to people and the staff."

The manager was very visible and had good oversight of what was happening at the service. The manager was now part of the staff induction and took a keen interest in 'relatives and residents' meetings. These meetings were aimed at making a practical difference to people's lives, for example at one meeting there had been a discussion on how to make sure the background music at the service was chosen by people, not automatically put on by staff.

At our last inspection we found staff did not feel assured that there would be improvements if they spoke to the management team. This had now improved. Staff told us, "I'm comfortable enough that if I need support

I can just go and ask someone" and "Any problem the manager and clinical leave always listen and try and sort it out." The manager had developed new staff surveys which were designed to improve the communication and understanding of the different expectations and roles at the service.

Communication across the staff team had improved since our last inspection. A member of staff told us, "I think we're all settling down, and working together as a team in a much better way. We were all a bit stressed before because communication wasn't as good." We saw from the minutes of staff meetings that there was a focus on improving staff morale alongside driving up standards, for example there had been a focus on improving how the fluid charts were completed. During our inspection we had found staff had taken these comments on board and fluid charts were of a better standard.

We observed the daily meeting where all the heads of departments, such as kitchen and care staff met the manager to look at risk issues, any incidents, staffing levels, and any relevant updates. This was an effective meeting which brought everyone up-to-date with key issues and offered an opportunity for any contingencies which needed to be planned or actioned. We noted the focus in this meeting on individual people's physical and mental health needs. This demonstrated the changing culture in the service to one which was centred on the people being supported was being led from the top.

The manager was honest when something was not working. Therefore we noted that the 'resident of the day' scheme was not in place. The manager told us they had realised that the scheme was not really improving the life of people at the service and so it was under review.

We met with the regional care specialist who was supporting the manager to deal with the concerns raised at our last inspection. For example, they had analysed information about when people had falls within the one of the units, which had resulted in an increase in staffing during the period of time identified that most of the falls had occurred. The manager told us they found this input useful as it helped them target support more effectively and make a difference to people's safety and quality of life.

There was a wide array of audits and quality checks which were thorough and wide ranging. There was some inconsistency due to the turnover in managers and input from different senior managers. However, now that the responsibility for oversight was being handed over to the new manager we were assured they would ensure greater consistency. Though the manager was an effective delegator, we noted they had personally repeated an audit when they were not assured it had been carried out to a sufficiently robust standard. In our discussions with the manager we were assured that outcomes of audits were being used to improve the safety and care people received. For example the regular health and safety checks included monitoring of all bedrails in place and the management team was reviewing these checks to ensure they were completed correctly.