Akari Care Limited

Westerleigh

Inspection report

Scott Street
Stanley
County Durham
DH9 8AD

Tel: 01207280431

Date of inspection visit:
02 May 2017
03 May 2017

Date of publication:
09 June 2017

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 3 and 4 May 2017 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Westerleigh in January 2015, at which time the service was compliant with all regulatory standards and was rated Good. At this inspection the service remained Good.

Westerleigh is a residential home in Stanley, County Durham, providing accommodation and personal care for up to 55 older people, including people living with dementia. There were 53 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

There were sufficient numbers of staff on duty in order to keep people safe, meet their needs and ensure the premises were well maintained. All areas of the building were clean, with infection control risks well managed.

The storage, administration and disposal of medicines was safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). The service had recently introduced an electronic medicines administration system and we found this to be working well, with no errors identified. Where people administered their own medicines, this was risk assessed.

Other risks people faced, such as trips and falls, were managed through risk assessments and associated care plans. These were reviewed regularly and incorporated advice from healthcare professionals to keep people safe.

Safeguarding principles were well embedded and staff displayed a good understanding of what to do should they have any concerns. People we spoke with, their relatives and healthcare professionals consistently told us the service maintained people's safety.

There were effective pre-employment checks in place to reduce the risk of employing an unsuitable member of staff.

There was prompt and regular liaison with GPs, nurses and specialists to ensure people received the treatment they needed.

Staff completed a range of training, such as safeguarding, health and safety, dementia awareness and

moving and handling. Staff displayed a good knowledge of the subjects they had received training in and had a good knowledge of people's likes, dislikes and life histories. Feedback regarding the face-to-face training provider was extremely positive.

Staff had built positive, trusting relationships with the people they cared for. Staff were supported through regular supervision and appraisal, as well as confirming the registered manger was willing to talk at any time.

People enjoyed the food they had and confirmed they had choices at each meal as well as being offered alternatives. We observed staff supporting people calmly and attentively to eat and drink, both at mealtimes and throughout the day.

The premises benefitted from some aspects of dementia-friendly design, although we found the registered manager was yet to fully incorporate person-centred care into the design of communal areas. Likewise, whilst care planning documentation was extensive, this had yet to be translated into easily accessible person-centred care documentation. Person-centred care means ensuring people's individual likes and preferences are considered and acted on when planning all aspects of care and people's environments.

Group activities were varied, well advertised and well attended. The activities co-ordinator required additional support to ensure the activities they planned were done so from a person-centred perspective.

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.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The manager and staff displayed a good understanding of capacity and we found related assessments had been properly completed and the provider had followed the requirements in the Deprivation of Liberty Safeguards.

The atmosphere at the home was relaxed and welcoming. People who used the service, relatives and external stakeholders agreed that staff were caring and compassionate. We saw numerous instances of such interactions during our inspection.

The service had built and maintained some good community links, although there was scope to make further community links that would benefit the service and keep people involved in the communities they were a part of.

Staff, people who used the service, relatives and external professionals we spoke with were positive about the registered manager's impact on the service. They confirmed the registered manager had improved staff morale and the continuity of care people received. We found the culture to be one where people received a good standard of care in a setting they found homely.

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 remained good.

Is the service effective?

Good

The service remained good.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service held good levels of information regarding people's likes, dislikes and personal histories but had yet to fully incorporate this information into delivering and documenting person-centred care.

Staff liaised promptly with external healthcare professionals and incorporated their advice into care planning to ensure people's changing healthcare needs were met.

The service had in place a range of activities, which included regular group activities, although had yet to ensure people's personal preferences were fully incorporated into activity planning.

Concerns were taken seriously and responded to consistently. People who used the service and their relatives were aware of who to complain to if they had concerns.

Is the service well-led?

Good

The service remained good.

Westerleigh

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.

We visited the service on 2 and 3 May 2017 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector, one specialist advisor and one expert by experience. A specialist advisor is someone who has professional experience of this type of care service. An expert by experience is a person who has relevant experience of this type of care service. The expert and specialist advisor in this case had experience in caring for older people and people living with dementia.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We spoke with professionals in local authority commissioning and safeguarding teams, as well as Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

During the inspection we spoke with nine people who used the service and six relatives. We spoke with 11 members of staff: the registered manager, the deputy manager, two senior carers, four care assistants, the cook, the activities co-ordinator and a domestic assistant. We spoke with two visiting nurses. Following the inspection we contacted three health and social care professionals via email to seek their feedback.

We looked at six people's care plans, risk assessments, staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

Good

Is the service safe?

Our findings

People who used the service and their relatives confirmed they felt protected from harm. One person told us, "I have no complaints and have never had any real problems." Another person told us, "There are always staff to help." They showed us their call bell system but stated, "I never really need to use it as there is always some about to help." Relatives we spoke with also confirmed they had no concerns about the ability of staff to keep people safe. One told us, "Safety is a top priority – they're thorough." No concerns were raised by any of the health and social care professionals we spoke with.

We observed staff discreetly supporting and calming people who began to display signs of anxiety by gently talking to them or distracting them. This led to a notably calm and relaxed atmosphere where people were regularly reassured. People responded positively to staff attention and we observed people evidently trusted the staff they interacted with, meaning they felt safe.

There were sufficient staff on duty to meet people's needs. Care hours were calculated using a dependency tool which factored in people's needs. The registered manager then planned a rota on the basis of the hours required.

The majority of people we spoke with felt there was ample staffing and confirmed staff responded promptly if they used the call bell system. We observed this in effect throughout our inspection. Two people we spoke with felt staff were, "Rushed off their feet sometimes," and, "Spread a bit thin," respectively but we found this was not the consensus and the majority of staff, people who used the service and visitors agreed staffing levels were safe, during the day and night. This meant people using the service were not put at risk due to understaffing.

We saw medicines were stored securely and kept in locked rooms where the temperature and fridge temperature were regularly checked to ensure they were within an appropriate range. The service had recently introduced an electronic medicines administration recording system and we found this to be working well. The deputy manager was the medicines lead for the service and we found them to be knowledgeable regarding people's individual needs and the new electronic system in place. We reviewed medicines information for 12 people who used the service, including four people who were administered controlled drugs. Controlled drugs are medicines that are liable to misuse. We found no errors in these records.

Where people required a medicine that required special instructions, for example, alendronic acid, we saw this information was clearly displayed and had been adhered to. Alendronic acid is used to treat osteoporosis and, if doses are not timed and administered correctly, can cause serious harm.

Where one person was receiving medicines covertly, we saw this had been implemented following a capacity assessment and the involvement of people who knew them best, including clinical input, to ensure the decision to administer medicines covertly was in their best interests. This meant the provider had ensured the administration, storage and disposal of medicines was in line with guidance issued by the

National Institute for Health and Clinical Excellence (NICE).

We saw risks were managed through an initial assessment then ongoing review, with the involvement of healthcare professionals where necessary. For example, where people self-administered their own medicines, we saw relevant risk assessments had been undertaken. We saw appropriate help had been sought from external professionals where the risks people faced changed, and that care plans had been updated to ensure staff knew how to lessen the risks people faced.

The registered manager had introduced a schemed called 'Pimp my zimmer'. People who used walking aids and their relatives had been invited to bring in brightly coloured decorations and some people now had these attached to their frames. The idea is to make the walking aids much more visible and thus reduce trips and falls when mobilising. Whilst the scheme had only just started the registered manager was optimistic about the longer term benefits and stated that falls had reduced significantly in the first month of trialling the system. This demonstrated that the registered manager was keen to try new ideas to help reduce the risks people faced.

Staff we spoke with had been trained in safeguarding and displayed a practical understanding of their safeguarding responsibilities. They described potential risks, types of abuse and what they would do should they have concerns. Staff were confident they could raise concerns with their line manager or the registered manager.

We reviewed staff records and saw pre-employment checks including enhanced Disclosure and Barring Service checks had been made. The Disclosure and Barring Service maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. Where one person disclosed a historical offence we saw further context had been sought by the registered manager and the risk assessed prior to employment. References had also been obtained from previous employers and proof of prospective staff member's identity was also on file. This meant that the service had in place a thorough approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

We found all areas of the home to be clean and free from odours. People who used the service and their relatives commented on the cleanliness of the service. One relative said, "It's always this clean – I come in all the time and they keep the same standard." We observed staff washing their hands before and after delivering personal care and ample supplies of personal protective equipment (PPE), such as gloves and aprons. The service had an infection control champion in place and we found staff demonstrated an awareness of the importance of protecting against the risk of infections.

We saw Portable Appliance Testing (PAT) had been undertaken, whilst all hoisting equipment and lifts had been serviced recently. Emergency systems such as the call bell system and emergency lighting were tested regularly, fire extinguishers/equipment had been serviced and window restrictors regularly checked. An external fire assessment had been completed in 2016 and a further assessment had been booked in for this year. We saw actions had been taken in light of this. Where one action remained, the registered manager ensured it was completed during our inspection. We saw water temperature checks had been undertaken regularly to protect against the risk of burns. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

We saw incidents and accidents were acted on, documented and analysed to try and identify any trends and patterns.

With regard to potential emergencies, we saw there were personalised emergency evacuation plans (PEEPs), detailing people's communicative and mobility needs. This meant members of the emergency services would be better able to support people in the event of an emergency.

Good

Is the service effective?

Our findings

We found people who used the service received effective care from staff who had sufficient knowledge and skills to perform their roles. We saw the registered manager had made improvements to the planning and delivery of training, introducing a training matrix to keep a check on which staff needed to refresh training and ensuring this was up to date. Staff confirmed they regularly attended refresher training and a number of staff also confirmed they were being supported to complete vocational qualifications. One member of staff told us, "I am learning new skills every day from the team at Westerleigh," and, "[Registered manager] gives us the opportunity to broaden our skills and encourages us."

With regard to the provider's mandatory training staff told us, "The trainer is great – really interactive and really interesting. They have a way of making anything interesting and I think it sinks in more when it's face to face," and, "They really get the message across well. We get plenty of training."

We saw staff had received recent training in safeguarding, fire safety, first aid, infection control, moving and handling, nutrition and dementia awareness. This demonstrated the registered manager had ensured people's needs were met through the provision of relevant training, as well as support for staff to pursue further vocational qualifications.

People who used the service, relatives and external professionals we spoke with were complimentary about the abilities of staff and their knowledge of people's needs. One professional told us, "We see most of the staff regularly and they are receptive to advice," whilst another said, "The staff are keen to help and generally act positively to our requests." When we reviewed care plans we saw these had been updated with advice from professionals.

We saw further evidence in care plans of regular input from external healthcare professionals such as GPs, nurses, dietetics, speech and language therapy (SALT) and physiotherapy. Where people had a specific condition, for example diabetes, we saw they had a specific care plan in place which set out additional information for staff, such as how to meet their dietary needs, and what potential warning signs to be mindful of.

We saw people were regularly weighed to protect against the risk of malnutrition and staff used the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. We found one anomaly in people's weights records and noted staff were using an in-house weight recording tool alongside the MUST tool. We raised this with the registered manager who agreed to review this in order to ensure the process was a simple and effective as practicable.

We spoke with the cook who displayed a good knowledge of the specialised diets required by people who used the service, for example, soft diets and fortified diets. There was corresponding information on a whiteboard in the kitchen, which was accurate, in line with people's care plans and up to date. People who used the service told us they enjoyed the food and had a range of choices at each meal. We found mealtimes to be calm, relaxed experiences for people who used the service, with sufficient staff who were

attentive to their needs. One relative told us, "The chef is great. When [person] wasn't eating well they came to their room and went through all kinds of options to see what they might like." We observed people regularly being offered hot and cold drinks and snacks throughout the inspection.

The registered manager was proactively looking into ways to ensure people continued to receive nutritious and healthy diets. For example, they had ordered new moulds for people who required a pureed diet, which would help to make the food look more appetising. We saw these moulds arrived on the second day of inspection. They had also ordered red plates in order to trial their use with people who were at risk of malnutrition, in order to remind staff that people were at risk and may need additional prompting. The registered manager agreed to plan the trial of this carefully to ensure people were fully involved in the decision and there was no detrimental or labelling impact on people.

We noted the kitchen had two staff for the majority of the week, except for 10-2 on a Tuesday, when food orders arrived. This meant there were two staff to prepare meals for 53 people, across three floors, in addition to people attending the day centre which was adjacent to the home. This was evidently placing a significant strain on resources. We recommend the provider reviews staffing levels in the kitchen in light of this.

The premises were generally appropriate to meet the needs of people who used the service, with en suite bedrooms, ample additional bathrooms, toilets and wide, brightly lit corridors. There was a cinema room that was well used. For the most part there was clear signage throughout to help people orientate themselves, whilst hand rails and toilet fittings contrasted with other surfaces. There were some pieces of tactile wall art on one floor but few other interactive items or artefacts. We found at the end of one corridor there was a bathroom with no sign, positioned where people living with dementia may have walked. Similarly, this area had a hat stand, seating and an electric organ, though these had not been placed or designed with a specific purpose (such as a meaningful day-to-day distraction) in mind. The registered manager agreed to address this. This demonstrated that the premises benefitted from some aspects of dementia friendly design, although further improvements could still be made. The registered manager agreed to review best practice resources by the University of Stirling and guidance by the Department of Health ('Dementia-friendly Health and Social Care Environments,' March 2015). The registered manager also confirmed they planned to introduce a dementia champion to ensure the needs of people living with dementia were further represented.

Staff confirmed they received regular supervision and appraisal meetings and we saw evidence of this in staff files. We also saw evidence of regular staff meetings and, where staff could not attend, for example because they were on night shift, they confirmed the registered manager shared the minutes of these meetings.

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 saw appropriate applications had been made to the local authority and that the manager and staff we

spoke with demonstrated a good understanding of mental capacity issues, including DoLS.

We saw that people who had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision in place had been involved in the decision, as had family members and local medical professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. We also saw people had Emergency Health Care Plans (EHCPs) in place. An EHCP is completed by external healthcare professionals and makes communication easier in the event of a healthcare emergency. We saw the EHCPs in place detailed specific potential occurrences, for example a delirium, and how staff should react in those circumstances. This demonstrated staff worked with external professionals to ensure people's needs were planned and met.

Good

Is the service caring?

Our findings

People who used the service gave consistently positive feedback about the caring attitudes of staff. One person told us, "I am quite happy here and get on well with them. I sell the raffle tickets on special occasions and make sure I catch everyone coming in and out." Another said, "It's really nice here – they make you feel at home."

We saw there was a range of comfortable seating in the entrance foyer and in an adjoining lounge and that these were used well throughout the inspection. This gave the service a welcome, open and homely feel and this was a consistent theme in the feedback we gathered.

We found staff at all levels had successfully maintained a welcoming atmosphere in which people felt at home. Relatives consistently told us they could visit at any time of the day and visiting professionals confirmed they were always warmly welcomed. People who used the service were encouraged to make their rooms feel homely, for example by bringing their own furniture, curtains, bedding and photographs with them. One person had brought their carpet from home. This meant people were more able to feel at home.

Throughout our inspection we observed staff taking time to ask people how they were and to patiently wait for a response. Staff behaved in the same manner when they were conscious of being observed as part of our inspection but also when they were unaware of this. We saw staff giving people a range of options, for example, where they would like to go and what they would like to do after lunch, and waiting for them to choose. Staff engaged in humorous interactions with people who used the service where appropriate and there was a vibrant, homely atmosphere on both days of our inspection. One staff member told us, "I love the residents – they love to chat and so do I. They sometimes tell me to shut up if I talk too much but we have a great laugh." This demonstrated staff had developed and maintained meaningful bonds with people who used the service and that people knew and trusted the staff who cared for them.

Feedback from relatives we spoke with was consistently positive, for example, "The staff are really lovely, whatever time you visit, and I'm here every day, at all times. Even at eleven at night they're the same." Another relative told us, "If I have to move to a care home it'll be this one. All the carers understand my [relative] even though their speech is not good. We are happy when we leave here as we know they are being looked after well."

We observed numerous instances of staff at all levels interacting discreetly and sensitively with people who used the service in a manner that upheld their dignity. For example, when someone needed help with personal care we saw staff support them away from a communal space in a dignified manner.

People were encouraged to play a part in the running of the home, for example leading the residents' committee, taking part in interviews for prospective staff and selling raffle tickets.

The registered manager told us they were planning to appoint a dignity champion. This is good practice

and would help to ensure people continue to be treated in a way that upholds and respects their dignity and affords choice as much as practicable. We saw the registered manager had already taken other steps to ensure this was the case, for example additional observations at mealtimes. These identified, for example, whether people were offered choices, whether they enjoyed the food and whether staff spoke to them in a dignified manner. We saw these observations documented that people were supported to say grace if they wished and that one person chose to do this in their room prior to going to the dining room. We saw the home also held a church service monthly in the home for people who wished to attend. This demonstrated staff had regard to people's religious beliefs and helped them to pursue them.

We noted the turnover of staff had been high from the middle of 2016 onwards as the new registered manager had made changes. Relatives we spoke with agreed they had noticed the turnover and felt this did for a time have an impact of people feeling unsettled, but that this had improved again recently as people got to know staff. An external professional we spoke with shared a similar view, stating, "The staff are more permanent, less transient, and this assists in continuity of care." This demonstrated the registered manager had ensured people who used the service were able to build relationships with the people who cared for them through establishing a settled workforce.

When we reviewed care plans we found them to contain good levels of information regarding people's preferences and wishes. We saw people had consented to their care plans and, where they lacked capacity to consent to the care given, we saw family members had been involved as advocates. Information regarding formal advocacy services was also available to people who used the service, although at the time of inspection nobody was using these services.

We saw people's personal sensitive information was securely stored in locked rooms.

Requires Improvement

Is the service responsive?

Our findings

We found care files contained a good amount of information specific to individuals, including their likes, dislikes and personal histories. Pre-assessments were undertaken prior to people moving to the home and ensured there was information available to staff regarding, for example, people's medicinal, dietary and mobility needs. We found this information was not always easily accessible as care files were bulky and sometimes difficult to navigate. We also found people's individual preferences had not always been fully incorporated into their care to ensure person-centred care was delivered consistently.

The service user guide stated, "The philosophy of care that we apply in our care home is the belief that we aim to develop an atmosphere of person centred care for all our service users." We found, whilst progress had been made towards this, the registered manager had yet to fully implement aspects of person-centred care. The registered manager acknowledged that care plans were still in the process of being reviewed, improved and streamlined and was able to talk us through how they would look when complete. We saw some people's care files had 'one page profiles' at the front, although not all of these had been completed. A One Page Profile is a short introduction to a person, which captures key information on a single page which gives for example family friends or staff an understanding of the person and how best to support them. On reviewing care files we were able to find a range of details that were relevant to these easily-accessible one page documents but they had not yet been completed. When we spoke with staff however, we did find they demonstrated a good understanding of people's likes, dislikes and personal histories.

The need to improved person-centred care was also evident with regard to activity planning and delivery. We spoke with the activities co-ordinator, who worked at the service for 30 hours per week. They had in place a weekly range of activities which were advertised on the notice board in the entrance lobby. A number of people who used the service confirmed they enjoyed the activities, for instance bingo, visiting musical entertainers, armchair exercises, cinema afternoons and baking. People who used the service, staff and other relatives were complimentary about the activities coordinator's efforts. One relative said, "They are very encouraging and try very hard to get residents to join in with things." We saw evidence of this during our inspection, with the activities co-ordinator facilitating a film afternoon in one area of the service and a baking afternoon in another.

The activities co-ordinator acknowledged they had not had the opportunity to pursue some of the ideas they would like to, nor ensure activities were planned with full regard to people's individual preferences. Whilst they had recently received some support from a volunteer from a local college, they currently struggled to be able to dedicate enough time to all aspects of the role, because they needed to support up to 55 people, over three floors. The registered manager agreed they would discuss with the provider whether there could be additional support for the activities co-ordinator, whether through protected time or additional help. In line with the ongoing review of care plans to ensure they were more person-centred, the registered manager agreed the planning of activities needed to have regard to this person-centred information. For example, they would explore the use of memory boxes. The Department of Health guidance document, 'Dementia-friendly Health and Social Care Environments' (March 2015) gives a range of examples of how memory boxes, memorabilia and rummage boxes can enhance people's involvement and

meaningful inclusion in their environment.

We saw people's health needs were responded to promptly and with the ongoing involvement of a range of healthcare professionals, for example GPs, visiting nurses, chiropodists and dentists. Professionals we spoke with were complimentary about the levels of responsiveness displayed by staff. One healthcare professional told us, "I'm here most days and they get in touch if anything else crops up."

Relatives we spoke with were similarly positive about individual staff, the deputy manager and registered manager with regard to their communication. Relatives confirmed they were regularly involved in people's care plan reviews. One told us, "They always get in touch and update us with anything – that didn't use to happen but it's great now."

We saw residents meetings took place and we spoke with the leader of the residents' committee. They were positive about the way the registered manager encouraged them to be involved and to continually provide feedback about the service. They said, "[Registered manager] is lovely – you can always go to them and they always listen."

In terms of routinely ensuring people's views were considered, we saw the registered manager had produced surveys and these were ready to share with people who used the service and relatives as a means of gathering additional feedback.

With regard to complaints, we saw information regarding how to make a complaint was clearly displayed in communal areas, whilst there was a suggestions box on the registered manager's door. People we spoke with and their relatives knew how to make a complaint and who to approach, as per the provider's policy. We reviewed two recent complaints and found the registered manager had looked into each issue and responded appropriately, to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

The service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had relevant experience in health and social care and a sound knowledge of the day-to-day workings of the service. They had been in post for 7 months. There was a strong consensus of opinion that they were responsible for ensuring the culture of the service had improved following a period of instability with a deputising manager in place in 2016.

Members of staff we spoke with consistently told us they had confidence in the registered manager and deputy manager and that they were well supported. One staff member told us, "[Registered manager] had encouraged us all to work with each other and to voice our opinions – no opinion is ever wrong and they listen to everyone." Another staff member told us, "They are firm but always fair – I have a lot of respect for what they have done here," whilst another said, "They are the best manager I've ever had."

There was a consensus that staff had been well supported through a time of managerial change by a registered manager who recognised the importance of autonomy and ongoing career development for staff. Another staff member said, "I have faith in myself due to their leadership skills and belief in all their staff, regardless of their position." All staff we spoke with agreed they had been encouraged to work as a team and that this was beneficial for people who used the service. For example, day and night staff shared all relevant information during handovers, ensuring people received the continuity of care they needed. One staff member confirmed, "It used to be a little 'us and them' but [registered manager] changed that. We are one team."

When speaking with staff we found their goals to be in line with those shared with us by the registered manager and deputy, namely to ensure people received high levels of care in a place they considered home. This demonstrated the registered manager had successfully embedded a caring culture whilst stabilising the running of the service.

People who used the service also had an awareness of the registered manager, stating, for example, that they, "Always have a chat." Another person who used the service knew that the manager was in and said, "I get on very well with them. They are good at involving everyone." This demonstrated the registered manager was approachable to people who used the service and took an interest in their day-to-day needs, as well as the managerial responsibilities they held. We found the registered manager and deputy manager to have a good knowledge of people's individual needs and preferences.

We saw the registered manager and deputy were working to an action plan which set out the main areas to continue to improve, including care plans, better documentation regarding the involvement of people's relatives and the need to ensure a consistent approach to prevent the risk of malnutrition. Alongside this the registered manager and deputy manager completed a range of audits and checks. These included daily health and safety walk-arounds, mealtime observations, medicine audits, audits of the kitchen and care plan audits. We saw evidence of these audits highlighting areas for improvement and ensuring corrective action was taken within specific timeframes.

With regard to establishing aspects of best practice, we found the registered manager had begun to do this, although acknowledged they had more work to do. For example, they were able to demonstrate that aspects of best practice with regard to dementia friendly design were present, although this had not yet been linked to best practice regarding person-centred care. Similarly, they had introduced a 'pimp my zimmer' scheme in order to increase the visibility of walking aids, although this was yet to be tested over a significant period of time.

The registered manager was in the process of introducing range of champions, although only an infection control champion was currently in place. The registered manager told us they planned to have similar roles for dementia and dignity. These roles had yet to be fully implemented but the registered manager was able to explain how they would complement existing staff meetings and auditing systems.

External professionals we spoke with all confirmed they had positive working relationships with the management at the home, with one stating, "They settled well," and confirming that the registered manager was proactive in approaching them for advice earlier in their appointment. Another stated, "There has been a general improvement in the home and the manager is generally available."

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. These were promptly provided and we found the registered manager had ensured records regarding people's person care were accurate and up to date, albeit the formatting and accessibility of these required further review.

We saw good relationships were in place with a local church, which held a monthly service in the home for people who used the service and visitors to attend. The registered manager acknowledged there were further opportunities through making better connections with the local community. The home was centrally located, near to business, a community centre and a number of colleges. The registered manager agreed to explore these potential relationships further.

Services that provide health and social care to people are required to inform the Commission of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way and responded promptly to any queries. This meant we could check that appropriate action had been taken.