Akari Care Limited

Bridge View

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

This inspection took place on 1 October 2018 and was unannounced. A second day of inspection took place on 2 October 2018 which was announced.

Bridge View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Bridge View can accommodate 61 people in one adapted building across two floors. At the time of the inspection 51 people were resident, some of whom were living with a dementia.

The service 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.

We last inspected Bridge View in January 2018 and rated it requires improvement. We made five recommendations for the provider to review procedures and processes relating to:

- Diabetes management and ketone testing.
- Ensuring effective training was delivered to meet the needs of people at the service.
- Ensuring they follow the principles of the Mental Capacity Act 2005 (MCA) fully.
- The confidentiality of information.
- The governance procedures to ensure dates set for compliance are fully monitored.

During this inspection we found improvements had been made.

Detailed information in relation to the monitoring of diabetes and ketone testing were maintained. Care plans, risk assessments and emergency health care plans referenced specific health conditions and how they should be managed.

The provider had identified that the training provider was not appropriately meeting their needs and a new provider had been contracted. Some staff still needed to complete refresher training however a plan was in place to ensure all training the provider deemed as mandatory was completed by mid-December 2018. We have asked for an update on the progress of this.

The principles of the MCA were understood and were being followed. We discussed with the registered manager the need to ensure everyone who was involved in making a best interest decision was recorded. 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.

The registered manager had completed training in the General Data Protection Regulations (GDPR) and had cascaded this information to the staff team. Information and records were stored securely.

Governance procedures had been reviewed and regular audits were completed which generated action plans to develop the service and ensure continuous improvements. A home development plan was also in place which was regularly updated with progress made against required improvements.

Staff were complimentary of the improvements made and the registered manager was open and responsive to feedback during the inspection and all areas where we identified minor improvements were needed were responded to immediately. The staff team were proactive in implementing this which we believe evidences a culture of development and learning.

Safeguarding, accidents and incidents, complaints and concerns were recorded, logged and investigated with outcomes and lessons learnt.

Risk assessments and care plans provided staff with guidance about people how to safely support people. Regular evaluations were completed but stated care records were 'still valid.' The registered manager and staff team responded to this immediately and on day two of the inspection detailed evaluations were being completed and recorded.

There were enough staff to meet people's needs and safe recruitment practices were followed. All new staff completed a thorough induction and staff said they were well supported and felt the registered manager was approachable.

Premises and equipment checks and servicing were completed including gas and electrical safety.

Staff were knowledgeable of people's nutritional needs, and a healthy balanced diet was provided with provision for vegetarianism and special diets. Food and fluid monitoring was in place and concerns responded to. People had access to healthcare professionals.

People said they were treated with kindness, dignity and respect. There were warm and caring relationships between staff, people and visitors and support was provided in a person-centred way. There was lots of laughter and engagement, with an unhurried, relaxed approach to providing care in a sensitive and discrete manner.

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.

Recommendations made during the last inspection in relation to the management of diabetes had been followed and improvements made.

Staff understood safeguarding and assessments had been completed to minimise any risks.

There were enough staff to support people and safe recruitment practices were followed.

Is the service effective?

Good

The service was effective.

The provider had a plan in place to ensure staff attended required training.

The principles of mental capacity were being followed.

A healthy balanced diet was provided and people had access to health care professionals.

Is the service caring?

Good

The service was caring.

People and visitors told us the staff were kind and caring.

Staff supported people in making decisions about their care and expressing their views.

People told us they were treated with dignity and respect and their independence was promoted.

Is the service responsive?

Good

The service was responsive.

Care plans were in place which provided staff with guidance on

the support people needed. Evaluations were completed regularly.

Concerns and complaints were responded to.

Care plans were in place, for some people, in relation to the support they wanted at the end of their lives.

Is the service well-led?

Good

The service was well-led.

The governance procedures had been reviewed since the last inspection and were effective in driving improvements.

The registered manager was establishing an open and transparent culture where they were trusted by staff, people and visitors.

There was evidence of the continuous learning and development of the service.

Bridge View

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 October 2018 and was unannounced so the provider did not know we would be visiting. A second unannounced day of inspection took place on 2 October 2018.

The inspection team was made up of one adult social care inspector, one assistant inspector and a specialist advisor who was a nurse.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We did not request a Provider Information Return as one had been submitted in November 2017 before the last inspection. 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. We took this into account when we inspected the service and made the judgements in this report.

We contacted the local authority commissioning team, CCG and the safeguarding adult's team. We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with eight people living at the service and three visitors. We spoke with the registered manager and the deputy manager who were nurses, the regional manager and the estates manager. We also spoke with a nurse, five members of the care staff, the talk and listen support worker, the maintenance person, the cook, a kitchen assistant and one domestic.

We looked at six people's care records and five staff files including recruitment. We also looked at medicine records and records relating to the management of the service.

We looked around the building and spent time in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

During the last inspection we recommended the provider review their procedures in connection with diabetes management and ketone testing. We also found people at risk of particular health conditions had not received proper monitoring and the administration of 'as required' medicines were not always fully recorded.

Improvements had been made and the registered manager explained how the provider had introduced new systems for closer monitoring of health needs, specifically for people living with diabetes. All the nursing staff and 57% of care staff had attended training in diabetes care. Some staff had also been nominated to complete a diploma in diabetes care. For staff who had not attended the training they had read a resource file put together by the registered manager. A staff member said, "I haven't had training but I have read a file. If I was at all concerned I would get the nurse." A nurse was able to describe the symptoms of ketoacidosis which is a serious complication of diabetes. They were appropriately monitoring and recording blood sugars and ketones. The nurse and registered manager discussed with us an incident where they had identified a person was showing the symptoms of ketoacidosis and called 999 due to the urgency of the condition.

People had individual kits for ketone and glucose testing and hypo kits were available for people who were at risk due to their diabetes. Care plans and risk assessments were detailed in relation to diabetes management and referred staff to supplementary documentation such as emergency health care plans.

Medicines were stored safely with opened dates documented on liquid medicines and eye drops. Medicine administration records were completed correctly and protocols were in place for 'when required' medicines. We discussed recording the maximum dose of 'when required' medicines with the registered manager as this was not always clear. The registered manager had systems in place to ensure controlled medicines, which are at higher risk of abuse, were managed and documented appropriately.

The provider had systems in place to safeguard people from abuse. One person said, "I feel safe here, the staff are great." Staff were knowledgeable about the potential signs of abuse and were confident that action would be taken if they raised concerns. Incidents, accidents and safeguarding concerns were logged and investigated and action taken to minimise the risk of reoccurrence such as referrals to other professionals or the introduction of specialist equipment. Any concerns relating to staff were addressed.

Risk assessments were completed and action taken to minimise the risk of harm, such as ensuring people wore lap belts when using their wheelchairs. Risk assessments were also completed for mobility, falls and nutrition and hydration including the risk of choking. If people had capacity and were choosing to make unwise decisions the risks were clearly explained to people in a variety of ways to ensure people understood the potential consequences. One person with a history of falls said, "I did have one on my seat (sensor mat) but I didn't like it so we talked about and now I only have the one near my bed."

Moving and handling equipment such as hoists were kept in storage rooms however the doors were open so people could walk in. We discussed the potential risk this may pose if people or visitors walked into the

room and tripped. The registered manager immediately responded by arranging for a keypad to be installed.

Premises checks were completed by the maintenance person and a buddy system had been introduced to ensure these were completed if they were away from work or on holiday. Appropriate servicing of equipment was completed including gas and electrical safety and equipment checks.

Fire drills were completed and staff were aware of the procedures to follow in the event of the fire alarm sounding. Some staff had completed fire warden training and fire wardens were on site 24 hours a day.

The registered manager used a dependency tool to make sure there were enough staff to meet people's needs. The staffing provided exceeded the level identified by the dependency tool and staff confirmed there were enough of them to meet people's needs.

Staff spent time with people in an unhurried way and the atmosphere was calm. People and visitors were positive about the staff. One person told us, "The staff are lovely and very nice, they provide me with assistance and I don't have to wait." Another person told us they "feel safe" and "the staff respond quick when I need something."

Safe recruitment practices were followed, including an application form, interview notes, employment references, identification checks and background checks by DBS (Disclosure and Barring Service). Nurses who were employed at the service had valid and active NMC Registrations. The home regularly checked the validity of nurse PINs for all nurses, including agency nurses who worked at the service. Agency staff profiles were securely stored as well as documentation reflecting an induction.

The home was clean and tidy. Housekeeping staff were present and observed relevant infection control procedures. Records containing cleaning schedules and management audits demonstrated the home were performing well at maintaining a clean and pleasant environment. Housekeeping staff we spoke with said they, "loved their job, it's just lovely working with the people here." A 'resident of the day' system was used so each day a named person had their room deep cleaned and an evaluation of risk assessments and care records, nutritional needs and any maintenance checks completed. Housekeeping staff explained they had received COSHH training and were aware of how to handle and store chemicals safely.

The kitchen area was clean and correct procedures were followed for food preparation and storage. On 19 April 2018 the service received a Food Hygiene Rating of 'Very Good' following an inspection carried out by the Food Standards Agency. Documentation was checked which contained details of food temperatures, storage temperatures and cleaning tasks being consistently carried out.

Good

Is the service effective?

Our findings

During the last inspection we made recommendations that the provider review their training programme to ensure effective training was delivered to meet people's needs. We also recommended the provider review their processes to ensure they followed the principles of the Mental Capacity Act 2005 (MCA) fully. Some improvements had been made and the provider had taken steps to ensure further, required improvements were made.

The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. Capacity assessments and best interest decisions were made and recorded before applying for a DoLS. When outcomes of applications were received these were logged and notified to the Commission.

Whilst capacity assessments and best interest decisions were documented they did not always evidence consultation with other people. The registered manager acknowledged this and offered reassurances that this was part of the process and would be recorded. Some people had an authorised lasting power of attorney (LPA) which gives authority to a named person to advocate on their behalf. The registered manager had requested copies of any approved LPA's so they could ensure they were supporting people appropriately and within the remit of the LPA. Where copies had not been provided frequent requests for the documentation had been made.

Staff said they had attended training. One staff member said, "I've done lots of training, safeguarding, end of life care, capacity, moving and handling." Staff who were relatively new in post said, "I had induction, did moving and handling training, hygiene, infection prevention, safeguarding, capacity, fire. I had a buddy and gave assistance to others, shadowing as people were comfortable with other staff."

The registered manager explained there had been some concerns with the current training provider and a new provider had been sourced. It had been identified on a home improvement plan that improvements were needed with regards to ensuring staff had completed refresher training. For example, the providers training matrix identified that only 44% of staff were compliant with moving and handling training. All the nursing staff had current moving and handling training and we did not observe any risks to people who were transferred during our site visit. Further training was also needed in areas including safeguarding, nutrition and hydration and dementia care. The registered manager and the deputy manager were often seen

working on the floor observing staff practices and we did not see any evidence that staff lacked knowledge or skill in relation to meeting people's needs during the inspection. We have asked the registered manager to keep us informed of progress made in relation to the completion of training.

Supervisions were held every other month and discussion included safeguarding, performance and training. A staff member said, "Supervisions are helpful. You can ask anything you want to." They added, "[Registered manager] is class, mint, open to new suggestions, really approachable. Not a clock watcher, you can go to her with anything."

A staff member said, "There are no rules for one and different for someone else, we are all important to [registered manager]. They make you feel valued, are quick to say you are doing it right and I suppose would advise if you were doing it wrong. I love it here." Another staff member said, "We have a good team, we have a laugh and a joke with staff and the residents." We were also told, "Everyone gels together and helps each other."

People's needs and choices were assessed prior to people moving to Bridge View with reviews happening at least every six months. The principles of human rights were discussed in training, induction, supervisions and team meetings. The registered manager said, "We do observations to make sure people's rights are being respected and staff are asked about people's rights. Residents have the same rights as you and I." People's rights to make unwise decisions was respected and steps had been taken to ensure people understood the risks. Steps had also been taken to minimise the risk within people's rights to decide. People were supported to have private time with their significant other.

People were supported to eat and drink to maintain a balanced diet. People were offered choice and were supported to make their own decisions in relation to what they wanted to eat and drink. One person commented that they would like to be offered lighter meals such as soup or a toasted sandwich. They said they knew they could have them but didn't like to ask. We raised this with the registered manager who said they would remind the staff to offer alternatives. One person said, "The food is lovely, you can have whatever you want within reason." Throughout the day there were regular drinks and snacks offered to people. Staff were also happy to fulfil any request people had at any point of the day for a drink or snack.

Some people had swallowing difficulties and were at risk of choking and aspiration. Care records contained relevant risk assessments and referrals to dietician and/or other professionals. Care plans were in place and staff understood how to support people. There was evidence of the service monitoring people's nutrition and hydration and staff recorded daily food and fluid intake to ensure targets were reached. Regular weight checks were carried out. One person had been losing weight but the staff had responded by making a referral to the dietician and GP to investigate further.

The cook and kitchen staff made sure people were getting nutritious meals. The kitchen was responsive to any special requests and had a good understanding of everyone's likes and dislikes. The cook took time to visit people around the home as much as possible to see how they were and if they were enjoying what was being served. Food was prepared and presented in an appetising way. People who required food to be puréed had their meals portioned into moulds so that they could taste and feel different texture when eating.

People were referred to healthcare services when required, including district nurses and tissue viability nurses, diabetes specialist nurses and consultants. If people had specific healthcare needs the appropriate professionals were involved.

Rooms were well decorated and personalised for people. The home had various lounges and dining areas for people to use. One lounge area was a reminiscence room which had the furnishings, décor and ornaments from people's younger days. Communal bathrooms and toilets were clean and free from clutter with dementia friendly signage on the doors to support people to recognise the rooms. A five-stage plan was in place to develop the environment further to ensure it was dementia friendly.

Good

Is the service caring?

Our findings

We spoke with people about the care they received. Comments included, "It's nice in here," "The staff are excellent and very good" and "I'm well looked after." One person said, "I'm happy here, the staff are lovely, [staff member] is great!" Another person said, "The staff are there if you need anything, they are really good to me. I'm glad I came here, let's put it that way."

A staff member said, "We are here for the residents. If they are happy I'm happy and if they aren't I want to know why. Everyone is treated really respectfully." Compliments cards had also been received and included comments such as, "Thank you for your care and compassion. [Person] came to think of you all as friends which means a lot to us" and "The love and compassion shown to [person] was a great comfort to us."

The staff respected people's privacy and dignity. One person told us, "Staff respect me and promote my independence as much as possible." Whilst in the lounge a staff member had noticed that one person's blanket had moved which was exposing bare legs so they took time to speak to the person and cover their legs to respect their dignity.

Staff involved people in making decisions. Staff were discrete in providing care and support and spoke with people to explain what they were proposing so the person could give their consent and understand what was happening and why. During moving and handling support staff spoke with people at every opportunity, explaining what they were doing and provided ongoing reassurance whilst also taking their time.

People and families were encouraged to be involved in making decisions about their care. The registered manager said, "We discuss with people and family prior to doing the care plan. Some relatives chose not to sign them but I do ask them to go through and let us know if there's any area of change. Some family have care plans on line and email changes which are made and then signed by people and relatives. It's agreed individually to follow that procedure. Some family are here daily so get involved." We saw some people who had capacity had signed their care plans and risk assessments.

A visitor told us, "[Family member] trusts them, we trust them, I can sleep at night. Communication is great they let me know things. The assessment was done straight away, when we came in to have a look around."

Relatives and resident's meetings were held where attendees received updates from the registered manager and were then open to raise any issues or concerns. There was an active residents committee and the president of the committee spoke on behalf of people living at the home, raising some concerns and requesting the regional manager attend the meeting. This had been arranged however the meeting had needed to be rescheduled so had not yet taken place.

All the staff were quick to acknowledge people and engage in conversation, asking people how they were and if they wanted anything. One person who appeared quite unsettled was treated kindly and compassionately by all the staff. Each time the staff saw the person they acknowledged them and spent time with them offering reassurances and gentle conversations to which they responded positively.

Whenever people were sitting in lounge areas there was a staff member present chatting with people, involving everyone in conversations about various things including their interests, family and friends and upcoming events.

The dining experience was calm and pleasant and people were not rushed to eat their meal. There was plenty of choice and people were positive about meals. Staff respected people's decisions if they wanted to remain in their own room or lounge for their lunch. One person said, "The meals are top class." The cook was very passionate about nutrition and spent time in the dining rooms chatting with people before meals were served. We heard conversations the cook was having with people about specific requests for meals and also offering support in relation to dietary needs for one person with diabetes and another person who was at risk of choking. Staff respected people's decisions if they wanted to remain in their own room or the lounge for their lunch.

Information was on display in the reception area of the home in relation to advocacy services, complaints and safeguarding procedures.

Good

Is the service responsive?

Our findings

Staff told us they had access to all the information they needed about people's care and support needs. One staff member said, "Care plans and risk assessments are written by nurses and seniors so they are there for reference and guidance. We can ask for them to be reviewed if needed but I've never had to as they have all the information we need."

Care needs assessments were completed which provided a summary of people's needs and the areas where care plans were required. This was reviewed every six months.

Skin integrity care plans were detailed and provided information on potential risk factors, how to provide personal care to reduce the risk and what prescribed creams needed to be applied, when and where. Care plans relating to diabetes care were detailed and referenced other pertinent documents such as the emergency health care plan. Food plans were also in place for people with diabetes which detailed any specialist advice in relation to their diet and their personal preferences, including where they liked to have particular meals.

Whilst most care plans were detailed and provided staff with guidance on how to support people safely as well as providing information on people's preferences we found evaluations had not always been robustly completed. Evaluations were completed regularly however comments were purely that the care plan 'remained valid.'

A couple of care records, which had been evaluated, would have benefited from further information. For instance, one person moved around the home in a wheelchair with no lap strap or foot plates. This could have been a potential falls risk but had been appropriately care planned and risk assessed. However, the evaluation had not identified that the moving and handling assessment had not been updated to reflect the current equipment they used. Likewise, another person's care plan stated specific procedures should be completed 'if possible'. Through discussions it was identified that it wasn't always possible to complete the procedures due to the person becoming distressed. However, it had not been identified through an evaluation that it should be explained why the procedure was not always possible and what steps should be taken if it wasn't possible. A specific care plan was in place for their distressed behaviour.

We raised this with the registered manager and the regional manager and by day two of the inspection documents had been updated and care staff were recording detailed reviews of care plans. The regional manager said, "We could add prompts on the care plan audits so staff know to ensure care records are specific and all linked documents are updated if anything changes."

Some people were sitting in wheel chairs on the first floor for lengthy periods of time. Whilst some people chose to do this staff were not routinely asking people if they would like to be transferred. The registered manager said, "We have a choice chart and people are asked during the day." They added that referrals had been made for seating assessments however there were long delays. The regional manager advised this would be raised again, especially for people who may be at risk of pressure damage.

Some people had care plans in place which detailed their end of life wishes. The registered manager was aware this was a sensitive subject and respected that some people did not wish to discuss it. The care plans that were in place were detailed and respectful.

Some people had emergency health care plans which specified their wishes with regards to medical treatment. Care plans referred staff to this document and the Do Not Attempt Cardio Pulmonary Resuscitation order if there was one in place. End of Life anticipatory medicine had been prescribed for some people but was not in use. This medicine was stored appropriately.

Staff had access to palliative care services for support if necessary and there were plans to develop Bridge View to include a palliative care wing, with a chapel and bereavement room.

The registered manager was aware of the accessible information standard, and explained that anyone with specific communication needs would be assessed to ensure their needs could be met. They said they currently did not support anyone with specific needs. Some of the staff we spoke with explained they had specific learning needs and were afforded the time and support they needed to ensure they understood documentation and recording appropriately.

Complaints had been logged and investigated. Where investigations had been completed the outcomes were shared with the complainant verbally and in writing. Specific actions had been taken in response to some complaints such as ensuring people were offered one to one time with the activities co-ordinator, and ensuring refusals of activities or personal care were logged so it could be monitored. Actions such as group supervisions with staff had also been held to ensure staff understood the approach needed when speaking with people.

Where concerns were more general they were discussed within resident and relative's meetings with the regional manager being invited to the meeting to hear people's views and provide a response from a senior manager perspective.

An activities coordinator was in post as well as a talk and listen support worker. The talk and listen support worker explained their role as, "One to one support, talking and listening, reading papers with people, reminiscence." They added, "There is nothing I would change. I'm proud of my residents and what they do. I know I've done a good job if I've made people smile." They told us they spent a lot of time getting to know people and what makes them happy. They said, "People will seek me out if they are upset or want to share something. I can spend time with people, give them a hug and reassure them." They explained that they worked with the activities coordinator to arrange events and entertainers. There were also quarterly meetings with other activity coordinators working for Akari Care Limited so they could share ideas and suggestions.

Some people were knitting Christmas decorations and engaged in conversations about how Christmas used to be when they were children. One person said, "We are making knitted garlands it didn't used to be how it is now. Knitting keeps you busy." Due to the activities coordinator being off work at present the talk the listen support worker was also offering group activities such as games and baking.

Good

Is the service well-led?

Our findings

During the last inspection we recommended the provider reviewed procedures in connection with the confidentiality of information. We also recommended reviews of governance procedures to ensure dates set for compliance were fully monitored. During this inspection we found improvements had been made.

The manager who had been in post during the last inspection was now registered with the Commission. They were aware of their responsibilities as the registered manager and were able to discuss notifications and current legislation with us. They described how partnerships were being developed by attending various forums and meetings. They said, "Since the last inspection we have improved a lot. Whatever was highlighted we tried to do straight away. We reviewed all care plans and charts. Implemented closer monitoring of personal care as it wasn't clear what people wanted and when. We are trying to bring all the staff together and go through assessments and people's needs before they move in."

They also said, "All procedures have been renewed and are in place. I've done General Data Protection Regulation (GDPR) training." They explained that details of GDPR had been cascaded to staff with regards to the confidentiality of information and said, "I need to ensure staff have the understanding." Care records, and other records relating to the management of the service were kept securely in offices with only relevant personnel having access to the information.

Quality assurance and governance systems were effective. A range of audits were carried out consistently and action plans were in place which identified improvements and who was responsible for their completion. The home improvement plan was used as an overarching action plan to monitor progress against actions identified through for instance audits, regional manager visits and fire service audits. The registered manager was proactive in updating action plans and the home improvement plan in response to works that had been completed or were ongoing.

The registered manager said, "Audits are now done in a timely manner, the company changed some audits and new ones have been implemented. They are completed with an action plan which is signed off and monitored for completion. We have separate action plans for the audits and an overall home development plan." Audits were also completed by the regional manager and the provider's quality team. A staff member said, "There's nothing that needs to change, [registered manager] has turned it around, they're open, chatty, supports residents directly and go out of their way to make sure people get the things they need."

The registered manager was open and responsive to feedback from the inspection team. They were able to provide clarity on areas raised in relation to people's care records and steps were taken immediately to develop systems and processes based on the feedback. For example, recording on the daily walk around was instantly made more specific to include details on which daily charts had been reviewed and which rooms had been checked. Evaluations of care plans had been discussed with the nursing and senior care staff who had immediately taken on board the feedback and on day two of the inspection had recorded detailed evaluations of care records.

The registered manager was visible throughout the home and took time to speak with people, visitors and staff. This demonstrated they had developed positive relationships with people. Staff, people and visitors spoke highly of the management team and everyone worked well together. Staff said, "They [managers] are firm but fair and are able to sort anything out, they are approachable and it's a privilege to have strong management." Other staff commented, "the culture is good" and "'we are supported by the manager." Visitors told us they knew who the management team were, that they were communicative and open and there were no concerns. A staff member said, "I'm happy with the way things are run. There are no changes I would make. The manager is supportive and approachable."

There were regular meetings with the staff. Staff told us meetings were positive and helpful. Minutes of meetings were produced and evidenced open and transparent discussions about lessons learnt from any safeguarding concerns, complaints or incidents. Resident and relative's meetings were held regularly and minutes evidenced that any issues had been taken on board and discussed. 'You said we did' information evidenced that were people or visitors had made suggestions these were tried and feedback was provided. For example, it had been suggested that more stimulating morning activities were needed. The registered manager had responded by providing morning activities however there was limited take up so a more relaxed 'café' environment was made available for people to enjoy a drink and a pastry.