Care UK Community Partnerships Ltd

Silversprings

Inspection report

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Date of inspection visit:
11 May 2016
09 June 2016

Date of publication:
01 November 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 11 May 2016 and was unannounced. A second out-of-hours inspection took place on 6 June 2016 and this was also unannounced.

Silversprings provides accommodation and personal care for up to 64 older people and people who may be living with dementia. The service did not provide nursing care at the time of our first inspection but preparations were in hand to open a nursing unit. At the time of our inspection there were 46 people using the service.

There was a registered manager 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.

People were safe because the management team and staff understood their responsibilities identifying abuse. People received safe care that met their assessed needs.

People were safe because staff supported them to understand how to keep safe and staff knew how to manage risk effectively. However, there were occasions where risk management plans were not always followed effectively.

There were sufficient staff who had been recruited safely and who had the correct skills and knowledge to safely meet people's needs.

The provider had systems in place to manage medicines and people were supported to take their prescribed medicines safely.

People's health and social needs were managed effectively with input from relevant health care professionals and people had sufficient food and drink that met their individual needs.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) which apply to care homes. We found the provider was following the MCA code of practice.

The management team supported staff to provide care that was centred on the person and staff understood their responsibility to treat people as individuals.

People were treated with kindness and respect by staff who knew them well.

Staff respected people's choices and took their preferences into account when providing support. People

were encouraged to enjoy pastimes and interests of their choice and were supported to maintain relationships with friends and family so that they were not socially isolated.

Staff had good relationships with people who used the service and were attentive to their needs. People's privacy and dignity was respected.

There was an open culture and the management team encouraged and supported staff to provide care that was centred on the individual.

The provider had systems in place to check the quality of the service and take the views and concerns of people and their relatives into account to make improvements to the service.

People were aware of how to raise concerns and there were opportunities available for people to give their feedback about the service.

The manager was visible and actively involved in supporting people and staff. Staff were positive about their roles and their views were valued by the management team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

There were sufficient staff who had been recruited appropriately and who had the skills to manage risks and care for people safely.

Staff understood how to protect people from abuse or poor practice, but there were occasions when advice could have been obtained to improve practice. There were processes in place to manage risk but these were not always followed in practice.

Systems and procedures for supporting people with their medicines were followed, so people received their medicines safely and as prescribed.

Is the service effective?

Good

The service was effective.

Staff received the support and training they needed to provide them with the information to support people effectively.

People's health and nutritional needs were met by staff who understood their individual needs and preferences.

Where a person lacked the capacity to make decisions, there were correct processes in place to make a decision in a person's best interests. The Deprivation of Liberty Safeguards (DoLS) were understood and appropriately implemented.

Is the service caring?

Good

The service was caring.

Staff treated people well and were kind and caring in the way they provided care and support.

Staff treated people with respect, were attentive to people's needs and respected their need for privacy.

People were encouraged to express their views and these were

respected by staff.

Is the service responsive?

Good

The service was responsive.

People's choices were respected and their preferences were taken into account when staff provided care and support.

Staff understood people's interests and encouraged them to take part in pastimes and activities that they enjoyed. People were supported to maintain family and social relationships with people who were important to them.

There were processes in place to deal with people's concerns or complaints and to use the information to improve the service. People were confident their concerns would be listened to.

Is the service well-led?

Good

The service was well led.

The service was run by a competent management team who demonstrated a commitment to provide a service that put people at the centre of what they do.

Staff were valued and they received the support they needed to provide people with good care and support. Teamwork was encouraged and the management team led by example.

The service had an effective quality assurance system. There were systems in place to obtain people's views and to use their feedback to make improvements to the service.

Silversprings

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 11 May 2016 and was unannounced. The inspection team consisted of two inspectors 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 service. A second inspection visit was carried out of hours in June 2016. This visit took place at night to assess staffing levels and was carried out by three inspectors.

We reviewed all the information we had available about the service including notifications sent to us by the manager. This is information about important events which the provider is required to send us by law. We used this information to plan what areas we were going to focus on during our inspection.

During the inspection we spoke with 11 people who used the service and four relatives about their views of the care provided. We also used informal observations to evaluate people's experiences and help us assess how their needs were being met and we observed how staff interacted with people. We spoke with the management team, including the registered manager, the care manager and the regional director. We spoke with six members of care staff and housekeeping staff and a visiting health professional.

We reviewed seven people's care records, including medicines records and risk assessments, and examined information relating to the management of the service such as health and safety records, three sets of recruitment and personnel records, staff rotas, quality monitoring audits and information about complaints.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the service, one person said, "I feel quite safe, thank you." and another person said, "I feel safe and secure."

The regional director explained the measures that had been put in place to maintain people's safety following an incident the previous year. They explained that they had involvement from their health and safety team and carried out a fact finding exercise. The concerns were discussed at executive level and these included night time staffing levels, on-call arrangements and security checks. Changes had been made to ensure people were safe at the service at all times.

Staffing levels were assessed using a formal tool based on assessing the dependency needs of the people using the service at the time and calculating the number of staff hours required to meet those needs. We noted that five members of staff were on night shift. There were clear on-call arrangements that included the expectation that a senior member of staff would step in and cover if a member of staff went off sick. The care manager explained that they had recently covered a night shift so that staffing levels were maintained. Rotas examined confirmed that these levels had been maintained.

More controlled night security checks had been put in place and staff kept a record of the checks they made of the building, in particular the exits on the ground floor. All alarms were activated at night, checks were carried out and this was recorded at the beginning of the shift. We examined the records from the previous night and found they had been completed.

A system had been implemented to maintain security when staff wished to exit the building for cigarette breaks. Staff were permitted to smoke in specified areas outside only during official breaks and were required to account for their whereabouts by recording their name and time of going outside. During the day staff were permitted to access a designated smoking area at the side of the building and had to access this area by going past the reception desk and exiting by the front door. At night, to maintain security, staff were permitted to use the smoking shelter located in the back garden which was accessed by a door with a keypad lock which was not accessible to people without the code. Staff were clear about the arrangements in place and told us that the arrangements were overseen by the manager on shift.

Maintenance workers made daily checks of external doors and alarms and we saw that records of these checks were up to date. As part of the inspection we checked a number of the external doors on the ground floor and found that these were secure.

Some of the downstairs bedrooms had patio doors. One person told us they had to leave the key to their patio doors with reception and pick it up when they wanted to open the doors. They were happy with the arrangement and told us, "I'm fine with that, I understand it's necessary for security." Another two people had decided they would prefer not to do this as they wished to keep their keys so that they could go out of the patio doors to visit one another. The management team discussed the issue with them and included their family representatives so that the risk could be assessed. Measures were put in place for people to

retain their keys safely. The regional director explained that possible risks as a result of patio doors being left open were further mitigated because people with more complex needs who were living with dementia were always supported when they came downstairs and were not unaccompanied if they left the dining room or the activities room. In this way the risk was reduced and people were able to retain a level of independence which was important to them.

We noted that the downstairs rooms with patio doors did not have windows that opened independently of the doors to allow for ventilation and fresh air. One room had a strong odour present. Although consideration had been given to the security aspect of the patio doors, further consideration could be given to how security impacts on people's comfort. Other proposed security measures being considered by the provider included additional fencing and CCTV. At the time of our inspection no decision had been made about these options.

Staff had received training in safeguarding and understood their responsibilities to keep people safe and protect them from harm. They were able to outline what steps they would take to protect people and who they should report concerns to if they saw or heard anything which they were worried about. Staff also told us they were confident they could raise concerns and they would be addressed by the management team. We saw records that showed that a member of staff had responded appropriately to a comment from an individual and had spoken to a member of the management team. The individual was spoken to, to clarify the comments but contact was not made with the safeguarding team. We discussed this with the manager who agreed that moving forward they would take advice from the safeguarding team.

We saw that risk assessments were carried out to identify areas of risk for individuals. Assessments were carried out using nationally recognised assessment tools, for example the Waterlow assessment to evaluate the risk of a person developing pressure ulcers, the Malnutrition Universal Screening Tool (MUST) to assess any risks relating to eating, drinking and nutrition and the Falls Risk Assessment in the Elderly (FRASE). We saw a range of risk assessments that included moving and handling, falls and the use of pressure mats, not being able to use a call bell and sleeping with the door open at night.

Where risks were identified there was a plan in place to minimise the risk. For example, we noted that the plan for a person who had been identified at risk of developing pressure ulcers included use of a pressure mattress. The care plan clearly recorded the setting for the pressure mattress which was calculated according to the person's weight. We checked and the setting was correct. However staff were not consistently following the risk management plans. For example we saw that the plan for one individual who had a pressure ulcer was that they should be repositioned on a two to four hourly basis, but when we checked the records on the first day of our inspection this was not being followed. We raised this with staff but when we looked at repositioning charts on day two of our inspection we continued to find large gaps and therefore we could not be confident that staff were following the plan.

People who were identified as being at risk of dehydration had their fluid intake monitored and the management plan stated that staff should push fluids however the target intake was not clear nor any additional actions that staff should take.

We saw that an individual had recently fallen through a sling when they were using the stand aid. They had subsequently been referred for an assessment but staff had not identified that this individual's needs had changed and they were no longer safe to use this equipment.

A relative explained that their family member had a series of falls following a change to their prescribed medicines. Their relative was happy that staff and the management team picked up on this quickly and the

doctor reviewed and changed the prescribed medicines. The relative told us their family member had had no further falls.

Where people required support for mobility, this was recorded in their moving and handling risk assessment. The care plans specified what equipment was necessary, such as a hoist and what size of sling was required to move the person safely. We observed staff assisting two people get up from their chairs with the help of a 'stand aid'. Staff spoke with each person, explaining what they were doing and giving the person clear instructions. Staff took their time and supported the person carefully, paying attention to their comfort and safety. We also noted that staff took care that people were settled safely in their wheelchairs and their feet were resting safely on the footplates before the person was moved.

Incidents of falls were logged on the computer system and we also saw that information was collated on urinary tract infections (UTIs) which can be a contributing factor in people having a fall. The manager collated data on falls on a monthly basis to identify patterns and put measures in place to reduce the risk of falls.

We looked at staffing levels and discussed them with the regional director and the management team. The regional director explained about the dependency tool that they used to assess the number of staff required for people currently using the service. We were provided with a copy of the most recent assessment which related to the people using the service at the time of our inspection and we noted that staffing levels on rotas were consistent with what was identified in the assessment. The regional director explained, "We are constantly reviewing as people's needs change and as new admissions come in." The management team were in the process of recruiting new staff. The care manager explained that they were reviewing staffing levels on a weekly basis and were recruiting to 20% above assessed staffing levels to provide flexibility for covering annual leave and sickness.

A person told us that staff came to their assistance when they pressed their buzzer. They said, "Sometimes they take a bit of time but not always." They confirmed that this did not happen frequently and they were, "not bothered by it." Another person said that staff came, "very promptly to the alarm bell being rung." We observed during our inspection that call bells were answered promptly and were not ringing excessively. We saw staff checking whether people needed anything.

We received some mixed feedback from people about staffing levels. One person told us that staffing levels were not always consistent. They said, "The staff varies, there are some good ones. If they can't come in it is a bit of a problem." Two relatives told us that they felt staffing levels had improved. One relative said, "Staffing levels have been increased by one in the dementia wing and this has made a difference." We also saw evidence that the management team and senior staff were on-call and were able to step in if a member of staff was unable to turn up at short notice.

A care worker told us, "Staffing levels are OK. There are two on Bluebell and three on Tenpenny and this is manageable. Sometimes at weekends it can be a bit short staffed." Another care worker explained, "There has been a lot of turnover of staff and sickness. Sometimes they get agency, but the manager and clinical lead get on the floor." During our inspection we observed that there were sufficient care staff available to meet people's needs. We also saw that additional staff including the management team provided support at busy times such as during mealtimes.

There were clear systems in place to recruit staff and check their suitability for the role they were to carry out. Personnel records confirmed that recruitment processes had been followed and appropriate checks had been carried out, including Disclosure and Barring Service checks and taking up appropriate references.

We noted that the environment was well maintained, passageways and corridors were clear of hazards and obstacles. Housekeeping workers kept the premises clean and tidy.

We examined processes around medicines and saw that there were clear processes in place for ordering, storing, administering and disposing of medicines. People's care records contained profiles which set out how they preferred to take their medicines. We observed two members of staff administering medicines during the course of our inspection. Overall staff practice was good but there was one instance of a member of staff carrying two medicine pots at the same time to be given to two different people. We discussed this with the care manager who addressed the issue with the member of staff. We also saw good practice, with staff taking their time to speak with people about their medicine and ensuring they had drinks. We saw that staff had received training to administer medicines and competency checks were undertaken by the management team. When an issue was identified this was addressed following the service's supervision processes.

Some people were prescribed medicines that were not taken routinely but only when required, which are referred to as PRN medicines. Care records confirmed that there were PRN protocols in place and any medicines administered were recorded on medicines administration record (MAR) sheets. We examined people's MAR sheets and found they were completed correctly.

Where people had been prescribed medicines that required an enhanced level of secure storage we saw that these medicines were stored appropriately and safely. Records had been completed correctly and the balances recorded in the records tallied with the stock of medicines in the secure cupboard. We saw that there was a record of daily checks when the responsible member of staff handed over to the person who had responsibility for medicines on the next shift.

Good

Is the service effective?

Our findings

Relatives expressed satisfaction with the standard of care and support provided for their family members and were complimentary about improvements under the new management team. A relative told us that the standard of care had improved and "staff seem to know what they were doing."

Staff were able to demonstrate an understanding of their role and spoke with confidence about how they carried out their duties. We saw that a range of training was provided and staff files contained evidence that staff had completed training which included moving and handling, fire safety, infection control, health and safety, food safety and dementia. Staff had also received training around the mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The majority of training was e-learning and a senior member of staff told us that the e-learning was supplemented by face-to-face training in areas such as moving and handling and DoLS. The manager had an oversight of training and the electronic system flagged up when staff were due for updates.

Most staff spoken with were satisfied with the training and thought it gave them the knowledge to carry out their roles, although one member of staff said, "The staff induction is the main weakness, it is pretty much straight in. I did some shadowing but not much. It was not impressive." A senior care worker explained that new staff now complete the care certificate. The care certificate is a set of standards that social care and health workers follow in their daily working life. It is the new 'minimum standards' that should be covered as part of induction training of new care workers. New care workers retained their evidence booklets when they were completing them, so we did not see an example of this work during our inspection.

A recently recruited member of staff was more positive about the training. They said, "I feel I've got a future here. Training was delivered well, in a way that suited me." They were particularly positive about the manual handling training. "I received manual handling training. This included being hoisted and moved." The staff member explained that this made them appreciate just how unnerving an experience this could be and they could understand how people were nervous. We observed two members of staff using a hoist to transfer a person from a chair to a wheelchair. The procedure was unhurried and the person appeared relaxed and unconcerned whilst being supported to move.

A member of staff was able to demonstrate a good understanding and awareness of the needs of people on the unit where they were working. They explained in detail the specific needs of one person following a fall and understood how the person needed to be supported. Another member of staff also spoke with knowledge and enthusiasm about how they met people's individual needs. We observed this member of staff speaking with a person in a caring manner, getting down to eye level to listen to them.

Staff told us they had received supervision and we saw records that confirmed this. Staff told us they felt well supported by both the manager and the care manager.

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. Care records confirmed that MCA assessments were carried out to assess people's ability to make day-to-day decisions. The management team demonstrated a clear understanding of their responsibilities under the MCA .

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 found that they were.

Care records examined contained MCA assessments that had been completed correctly. We saw that there was input from family representatives when assessments were carried out. When an individual was identified as lacking the capacity to agree to their care and treatment, a DoLS application was submitted to the local authority and we saw that DoLS authorisations had been granted.

We saw from people's care records that there were signed consent sheets to confirm they had given consent in areas such as being supported with their medicines or having their photographs taken. One person had bedrails and we noted that a risk assessment had been undertaken but we did not see evidence in the care records that the person had consented to the use of bedrails. Staff informed us that the person had the capacity to make decisions and had consented to their use.

At the last inspection we identified that some people felt that breakfast was served too late and, if they were early risers, it was a long time to wait for breakfast. The care manager explained that most people had breakfast from 9 o'clock but the chef was in the kitchen an hour earlier than this and if anyone wanted a cooked breakfast it was prepared for them. Staff had been instructed by the management team that if people wanted food at any time, even if it was in the middle of the night, then something was prepared for them. A relative told us, "The food is always good with plenty of choice and [my family member] can have something to eat when [they] get up even if it's not official breakfast time."

One person said they enjoyed the food and could, "eat as much or as little as I like." They said that there were set times when food was served but they were happy with those times. Someone else told us, "The food is good and tasty with plenty of choice." A person explained that they had lost a lot of weight before they moved to Silversprings but since they moved in they have been putting it back on. They said they enjoyed the food and they can always ask for more.

One person told us they could choose to have their meals where they preferred. They said, "I eat in my own room. I'm not used to eating in public. I'm quite satisfied with the food. There are always at least two choices, sometimes three." They went on to explain that the food portions were too large as they had a small appetite so they discussed it with care staff who made sure the portions were appropriate for the persons needs and preferences.

We carried out an informal observation of people's experiences of lunch in Tenpenny unit. We saw that one person required full support to eat their food. This was carried out by care staff with sensitivity and in an unhurried manner. People were regularly offered drinks throughout the day. The food appeared well presented and people were offered a choice. Where people needed assistance to understand what was available, some members of staff showed people the meal to help them make a choice.

Another person told us that they liked the food and said, "I can have a cooked breakfast, eggs bacon and

tomatoes." Other comments were that the food was, "Passable and there was plenty to eat." and " It varies but you get used to it." We observed that people were offered lots of drinks throughout the day and snacks and cold drinks available in lounges.

People were supported to maintain their health and appropriate referrals were made to professionals when people's needs changed. We observed that one individual was unwell and saw that a request had been made for a GP visit. Records evidenced that staff were alert to urinary tract infections and the impact on people. Referrals were made to Physiotherapy and dieticians. One person told us that. "They were due to see the chiropodist," and another said they could see the GP when they needed to.

Good

Is the service caring?

Our findings

People were generally happy with their care and told us that staff were helpful. One person said, "If you have to stay in a place like this, then it is as good as any. Once you get used to it, it is ok." A person told us that they didn't have any complaints and that staff treated them well; they said, "Staff are kind." Other people told us, "The staff are very good. They are caring and friendly and look after me well." and "Staff are lovely and caring."

We saw care staff speaking with people in a kind and caring manner, where necessary sitting down beside them and making eye contact to engage their attention. We observed another two care staff treating people with deference and respect. Throughout our inspection we noted that care staff addressed people by their names and had a good rapport with people.

One person told us about the changes to their circumstances that meant they had to leave their previous home. They said they were "very delicate" emotionally but that staff had been really good providing emotional support as well as practical care. They said, "Staff look out for me and will walk up and down the corridor with me. If they see I have a tear in my eye they come up and give me a hug."

Other people also made positive comments about how staff treated them and helped them when they needed it. One person told us that they didn't have any concerns but, "If I did have a problem I think the staff would do their utmost." We observed one person calling out that they were in pain. Staff were attentive and promptly sought assistance for them. Later we saw the individual and they looked more comfortable and saw that staff had administered pain relief.

One person gave an example of how staff made sure they did not have unnecessary anxieties. They explained that they were aware when the fire alarm was usually tested. When it went off at a time when it was not expected, care staff came to tell them that it was not a fire it was just that the toast got burnt so they were quite safe. They told us it was reassuring that they did not have to worry because care staff explained things to them.

We noted that people's independence was promoted by staff. For example when staff were supporting people to transfer from one place to another they were encouraged to do as much as they could do independently. Where people required equipment to enable them to be more independent it was available, such as double handled cups to help people with their drinks if they could not grip an ordinary cup.

One person told us, that they made their own coffee and breakfast and said, " You can be independent and do what you want."

People's care records contained 'preferred place of care' documents (PPC), which recorded their wishes for end of life care. We observed staff supporting an individual who was in receipt of end of life care and saw that they received regular mouth care and had good access to fluids.

Good

Is the service responsive?

Our findings

A relative told us that on the whole, the standard of care was good and staff provided care that was individual, but they wanted to single out a specific named member of staff. "Some of the new staff such as [named a staff member] are brilliant too. Exceptional."

Another relative told us that they were consulted and involved in their family member's care. They explained that they had recently agreed with the manager to meet on a regular basis twice a month to discuss any changes.

People's needs were assessed prior to admission and this information was used as a basis for their plan of care.

People were asked for their preferences relating to the gender of staff providing their care and this preference was respected. People's interests were recorded and most staff spoken with were able to demonstrate that they knew people well.

The main care records were kept electronically and there were also back-up paper copied that could be used in the event of computer problems.. The care records we examined were detailed and informative, documentation was up to date and had been reviewed on a regular basis. The service used a 'resident of the day' system to look in depth at an individual's care needs.

We observed people undertaking a variety of activities including scrabble and art. People looked happy and relaxed. People told us that they try to go out on a trip once a month. One of the staff showed us the newsletter which was produced on a bi monthly basis, this included photos of people enjoying the activities and what was planned for the coming month, which included five entertainers, a trip out and other in-house events.

During our inspection we saw that staff respected people's wishes about what they wanted to do. People were encouraged to be sociable and join in activities, but if individuals preferred their own company this was respected. A person told us that they had recently moved to the service and were, "still getting used to it." They explained that they had been used to living alone and preferred their own company but said, "I do like to join in some of the organised activities. I don't mind the word games." They showed us the list of planned activities and said they could pick and choose what they wanted to do. They told us they were quite private and they were satisfied that their individual choices were supported at the service. "Staff understand what I prefer and they respect that. They have arranged a landline for me so that I can keep in touch with my relatives." They told us they liked their room and enjoyed watching the birds outside the patio doors. They pointed out a small bird and said, "Was that the little wagtail? I think that's a pied wagtail. I am quite content."

Another person told us that they preferred to sit slightly apart from other people because they liked to read. They said that other people took part in activities like craft making but they were not interested. They said

they were happy reading and dozing in a comfy chair and staff understood that.

One person told us they had been shy and a bit withdrawn at first but they were beginning to gain confidence and they had started to join in with some activities. We saw that staff encouraged the person to join in some of the activities after lunch and the person's facial expressions confirmed that they were enjoying themselves.

People's spiritual needs and wishes were respected and supported by the service and one person told us that was very important to them and explained how they were assisted to follow their faith..

We carried out an informal observation of people taking part in an organised activity in the Caroline lounge. The activity took the form of a word quiz where participants were encouraged to make words from a 'letter wheel' on a white board. The activity was delivered by the care staff with good humour and everyone was encouraged to contribute to the game. The member of staff facilitating the game was supportive and people were actively contributing to the session. We saw that people were smiling and there were good humoured conversations.

People told us that they had no complaints but they would speak to staff if they had any concerns. We examined the complaints records and found that complaints were investigated and responded to promptly. There were for example two recent complaints about the availability of staff. The manager assured us that changes had now been made and staff breaks were more tightly managed. This showed us that the service was learning from concerns that were raised with them.

Good

Is the service well-led?

Our findings

Since the last inspection there was a new management team in place. The new team, which consisted of the registered manager and the care manager who were supported by the regional director, presented as positive and proactive. Staff told us that they were approachable and supportive. The service was planning on taking people with nursing needs in the month following our inspection and recruitment was under way to employ qualified nurses. The care manager explained that they had already employed some experienced nursing staff and they were confident that the new nursing unit would play and important role in driving improvement at the service.

We spoke with a relative who had raised concerns with us in the past. These concerns included the standard of care, lack of communication from the manager and dissatisfaction with both staffing levels and staff skills. The relative told us how things had changed since then and they expressed a high level of praise in particular for the management team. They told us, "What a transformation. [The manager] is brilliant, [the care manager] too. They haven't been here long but they are both brilliant. They are straight talking and honest, which is what you need."

A member of care staff told us they felt appreciated and supported by the management. They said that they had noticed changes for the better since the new manager had arrived. Two other staff also commented that recent changes in the management team had led to changes for the better. These staff said that they could approach the manager with any issue and both felt the management team was supportive and available.

A visiting professional told us that the home had improved under the new management team. "[The manager] is a breath of fresh air. She knows what she is doing. She is approachable and when you want to meet it is arranged within a short time and she is available when she says she will be."

We examined processes in place to monitor the quality of the service and assess whether the provider sought the views of people using the service and their representatives and whether this information was acted upon to drive improvement. The regional director explained that they had a new 'relatives and residents satisfaction survey' process in place. Telephone interviews had been carried out between September 2015 and February 2016. The responses were collated and a report of the results was prepared. We saw that the report identified strengths, areas for attention and action priorities. When any area for improvement was identified an action plan was decided upon and actions put in place to address the issue.

Actions taken were openly communicated to people using the service, relatives and visitors using a 'feedback noticeboard' which was prominently displayed in the reception area. We saw that the information displayed explained to people that their opinion counted, the service listened and they encouraged people to "talk to us". When feedback had been received and actions taken we saw that the feedback noticeboard was updated with "What you said" and "What we did". We saw that recent actions included displaying details of staff on duty in each unit so that people and visitors knew who to go to if they wanted to discuss something with a member of staff. Regular weekly outings had been put in place at the request of people

living at the service and in response to feedback from one person a bird table was erected in the garden.

In addition to the satisfaction surveys the provider had a range of meetings to give people opportunities to discuss their views of the service. For example, we saw records of regular 'Residents activities meetings' so that people could discuss the organised activities that they had taken part in and were able to make suggestions for other activities or entertainment.

Relatives also had opportunities to attend group meetings to discuss the service and the manager held 'relatives surgeries' provide a forum to discuss specific issues relating to their family member. We saw records of examples of individual issues that had been raised and what actions had been taken in response to the feedback.

The management team carried out a 'home manager's self-audit' addressing a separate area each month, for example medicines, care records or health and safety, and carrying out detailed checks on the relevant processes. In addition, the regional director made regular visits to the service to check that the provider's processes and procedures were followed and to monitor the quality of the service. Records we viewed confirmed that when an area was identified for improvement, actions were put in place to address the issue.