

Care UK Community Partnerships Ltd

Cherry Orchard

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

Cherry Orchard was registered to provide accommodation and nursing care for up to 40 older people. There is a 12 bedded unit for older people with mental health care needs and two units for 28 people living with dementia and complex nursing needs. The service is a purpose built property. The accommodation is arranged with all three units on the ground floor level. There were 36 people living at the service at the time of our inspection.

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.

At the last inspection on 14, 15 and 17 November 2014 we found people were not always safe at the service. There were poor arrangements for the administration of medicines and incidents and accidents were not reported or managed in an appropriate way. Risk assessments did not address the risk to people using the service relating to behaviour that challenges which put people at risk of harm. People were not protected against the risk of receiving inappropriate care and treatment because their medical conditions were not monitored. Meals were not always served in a timely manner and people's dietary requirements were not identified.

Staff did not always receive up to date training and we did not see evidence of regular clinical supervision for registered nurses. We were concerned about the staffing rotation at the service which meant people did not get to know their key worker well. The service did not send in notifications to the Care Quality Commission about applications to deprive people of their liberty.

We inspected Cherry Orchard on 10, 11 and 17 February 2016. This was an unannounced inspection. At this inspection we found the service had improved, however further improvements could be made regarding the nursing and care staff understanding of the Mental Capacity Act (2005). Some staff did not always receive regular one to one supervision. We have made a recommendation regarding this.

People and their relatives told us they felt safe using the service. Staff knew how to report safeguarding concerns. Risk assessments were completed and management plans put in place to enable people to receive safe care and support. There were effective and up to date systems in place to maintain the safety of the premises and equipment. We found there were enough staff working at the service and recruitment checks were in place to ensure new staff were suitable to work at the service. Medicines were administered and managed safely.

Appropriate applications for Deprivation of Liberty Safeguards had been made and authorised. Staff received appraisals and group supervisions. People using the service had access to healthcare professionals as required to meet their needs.

People were offered a choice of nutritious food and drink. Staff knew people they were supporting including their preferences to ensure personalised care was delivered. People using the service and their relatives told us the service was caring and we observed staff supporting people in a caring and respectful manner. Staff respected people's privacy and dignity and encouraged independence. People and their relatives knew how to make a complaint.

Regular meetings took place for staff, people using the service and their relatives. The provider carried out satisfaction surveys to find out the views of people and their relatives. The provider had quality assurance systems in place to identify areas of improvement. Staff, people and their relatives told us the registered manager was supportive.

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. People and their relatives told us they felt the service was safe.

There were robust safeguarding and whistleblowing procedures in place and staff understood what abuse was and knew how to report it. Staff were recruited appropriately and adequate numbers were on duty to meet people's needs.

People had risk assessments in place to ensure risks were minimised and managed. There were appropriate arrangements in place for the safe administration of medicines.

The provider carried out regular equipment and building checks.

Is the service effective?

Requires Improvement ●

The service was not always effective. Some staff did not have a clear understanding of the Mental Capacity Act (2005). Staff told us they did not always receive regular one to one supervision meetings.

People's health and support needs were assessed and reflected in care records. People were supported to maintain good health and to access health care services and professionals when they needed them.

People had access to enough food and drinks.

Staff received training, appraisals and group supervision to support them in their role.

We have made a recommendation about one to one supervision meetings for staff at the service.

Is the service caring?

Good ●

The service was caring. People told us the service was caring and staff treated them with respect and dignity.

Care and support was centred on people's individual needs and wishes. Staff knew about people's interests and preferences.

People using the service were involved in planning and making decisions about the care and support provided at the service.

The service enabled people to maintain links with their culture and religious practices.

Is the service responsive?

Good ●

The service was responsive. People's health and care needs were assessed and individual choices and preferences were discussed with people who used the service. Peoples care plans were regularly reviewed.

People were able to take part in a programme of activity in accordance with their needs and preferences.

People were encouraged and supported to provide feedback about the service.

There was a complaints process and people using the service and their relatives said they knew how to complain.

Is the service well-led?

Good ●

The service was well led and had a registered manager. Staff told us they found the registered manager to be approachable.

Records were accurate and kept up to date.

Effective systems were in place to monitor the quality of the service. The service sought the views of people who used the service.

Cherry Orchard

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.

On the first day of the inspection the inspection team consisted of two inspectors and two specialist advisors. A specialist advisor is person who has professional experience in caring for people who use this type of service. On the second day an inspector and a specialist advisor visited the service. Before the inspection we looked at the concerns raised and information we already held about this service. This included details of its registration, previous inspections reports and information the provider had sent us. We contacted the host local authority to gain their views about the service.

During the inspection we spoke with four people and two relatives of people who used the service. We spoke with the registered manager and deputy manager for the service, a senior manager, two domestic assistants, the chef, assistant chef, activity co-ordinator, maintenance person, a health professional, three nurses and ten care assistants.

We looked at 15 care records relating to people who used the service, six staff recruitment, training and supervision records, minutes of staff meetings, eight medicines records, audits and various policies and procedures including adult safeguarding procedures.

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 to us.

Is the service safe?

Our findings

At our last inspection of this service in November 2014 we found the provider was not managing or reporting accidents and incidents affecting staff and people using the service. Individual risk assessments were in place but did not clearly define triggers for behaviour that may challenge resulting in injury to staff or other people using the service. Risk assessments did not identify risks relating to falls. Staff did not always wear personal protective clothing including gloves and aprons when cleaning the service. Safeguarding training was not always completed by all the staff. The provider did not have an adequate system in place to cover staff absences. Staff were allocated to work on different units each day which meant they did not get to know people's needs. We also found there were poor arrangements for the management of medicines that put people at risk of harm. During this inspection we found these issues had been addressed.

People we spoke with and their relatives told us they felt safe living at Cherry Orchard. The service had a safeguarding policy and procedure to guide practice. This was updated in April 2015 and included a flow chart of actions to take in the event of suspected abuse. Records showed and staff told us they had completed safeguarding training. Training records showed a small number of staff had not completed the training but we saw this had already been identified and arranged to take place in March and April 2016. The staff we spoke with had a good understanding of safeguarding adults and gave examples of the different types of abuse. Staff were knowledgeable about the process for reporting abuse and knew who to notify. The service notified the Care Quality Commission of safeguarding alerts raised with the local authority. The registered manager was able to describe the actions they had taken when the incidents had occurred which included reporting to the Care Quality Commission (CQC) and the local authority. The service had a whistle blowing policy and procedure. Staff knew how and where to raise concerns about unsafe practice at the service. This meant that the service reported safeguarding concerns appropriately so that CQC was able to monitor safeguarding issues effectively.

Risk assessments were carried out for people using the service and reviewed monthly or sooner if a new risk was identified. People had risk assessments documented in their care files which identified the risk and detailed actions needed to minimise and manage the risk. These assessments included risks associated with specific medical conditions, pressure areas, mobility and falls, behaviour that challenges the service and nutrition. Peoples risk assessments identified triggers for behaviour that may challenge the service and how these should be managed. Staff we spoke with were knowledgeable about peoples individual risk management plans and knew the actions needed to minimise the risk.

Infection control policies and procedures were in place. The registered manager told us and records showed audits were carried out monthly and infection control procedures discussed in monthly staff supervision. We saw staff wearing aprons and gloves when carrying out cleaning or preparing to support people with personal care. Cleaning rotas included cleaning of all areas of the service and weekly cleaning of beds and mattresses. The domestic staff we spoke with told about the process for ensuring the service was clean and the risk of infection minimised. One staff member said, "I feel the cleaning is very important. I take pride in keeping this home clean." We observed staff washing their hands and removing aprons before leaving peoples rooms or moving to different areas of the service. This meant the service had processes in place to

minimise the risk of the spread of infection.

Medicines were stored securely in locked cabinets which were kept in locked treatment rooms. Controlled drugs were stored in designated controlled drugs cabinet which had an extra degree of security. We checked the stock of controlled drugs found the amounts matched those that were recorded. Two staff signed each time a controlled drug was administered and the amount stored at the service was checked at each staff shift handover.

Records were maintained of medicines entering the service and of those that were disposed. Medicine administration charts were in place. These included details of the name, strength, form and dose of medicines to be administered. We examined these for a six week period leading up to the date of our inspection and found them to be accurate and up to date. We found that for 'as required' (PRN) medicines guidelines were in place about when staff should administer them. We observed medicines being administered. The nurse made sure people had a drink to take with their medicine and that they locked the medicine cabinet when they were away from it. This meant medicines were administered and managed safely.

The premises were safe. Building safety checks had been carried out in accordance with building safety requirements with no issues identified. For example, records showed water hygiene, gas safety and portable appliance checks were carried out annually and records showed these were up to date. Monthly checks for hoists, bedrails, and fire alarms and extraction systems were carried out monthly and weekly.

Accidents & incidents were managed by the service. Records showed incidents that had taken place involving people who use the service and staff. All incidents and accidents were recorded. The deputy manager or registered manager checked the records daily for incident reports, spoke with people or staff involved and ensured it was recorded in risk assessments. Serious incidents were reported to the local authority safeguarding team as appropriate. Plans were in place to minimise the risk of re-occurrence. Staff we spoke with knew the procedure for dealing with and for reporting accidents and incidents. They were able to give examples of actions taken to minimise further incidents from occurring.

People we spoke with told us they felt there were enough staff to meet their needs. One person said, "Yes, you can always get help when you need it." Staff told us and records confirmed there were sufficient staff on each shift to meet people's needs. The registered manager had devised a rota system which meant staff worked on the same unit for longer periods. Rotas were created four weekly in advance. We looked at the rotas for the previous eight weeks for each unit. There were sufficient staff and we saw changes were made to cover staff sickness. Any significant changes to the rota were communicated to staff by memo and stated the reason for changes. The night rota had been changed to include additional staff so that online training could be completed. Staff told us they liked the new system for allocation as it was better for people using the service. One staff member said, "You really get to know people now and it's great for building a relationship with them and your colleagues." Another staff member told us, "I enjoy working on this unit. It's good for team work and you get to know people's needs well." Staff responded quickly and appropriately to people if they needed support.

The provider had a staff recruitment procedure in place. This made clear that staff were only to be employed subject to various checks including references, proof of identification and criminal records checks. Staff we spoke with told us they had undertaken these checks. Criminal records checks were carried out on all the staff and the provider had systems in place to verify whether it was suitable to offer the person employment. We found proof of identification in the form of passports, were checked for all staff. We were satisfied that the service had robust recruitment processes in place.

The registered manager told us and records confirmed that appropriate disciplinary action had been taken to address poor practice and ensure safety of people using the service.

Is the service effective?

Our findings

At our last inspection of this service in November 2014 we found there was minimal documentation relating to how peoples relatives or advocates views of interventions or goals were used to plan their care or decisions made in their best interests. We found the provider had not sent in notifications to the Care Quality commission about the decisions of applications submitted for Deprivation of Liberty Safeguards. Mandatory training was not completed by staff and nursing staff did not always have clinical supervision to ensure their practice was monitored. New staff were not supervised to ensure they were able to carry out their role competently. We also found people living at the service did not receive their meals or support to eat their meals in a timely manner. People with special dietary requirements did not receive meals that were suitable for the management of their medical condition. There was a lack of consideration in the design and décor within the service for people living with dementia. During this inspection we found these issues had been addressed.

Nursing staff told us they received clinical support from either the deputy or registered manager, both of whom were registered nurses. They told us they attended a weekly clinical meeting led by the deputy manager. We saw minutes of these meetings that included both general discussions about clinical issues and issues that related to individuals. Topics discussed included medicines, diabetes, dementia and pressure ulcer care.

The registered manager told us and records confirmed that new care staff were expected to complete the Care Certificate. This was monitored by designated senior care staff. The Care Certificate is a training programme designed for staff that are new to working in social care.

One staff member who had recently joined the service told us they were happy at Cherry Orchard, got on well with everyone and enjoyed the working environment. They said the induction programme was structured and well delivered lasting four days. They told us they were also attending training sessions and working through e-learning modules. They said, "I want to develop myself and learn as much as I can. I am sure it is possible to do that here"

We saw that staff received regular training. This was divided between required training for all staff and essential training which was just for staff that required it for their specific role. The training included moving and handling, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, infection control, health and safety and dementia. Additional training included medicines, first aid, wound care and pressure care. We found that most staff were up to date with required training and there was a system in place to monitor when staff were due to refresh their training. We found two staff were significantly overdue for training. One staff member had not had comprehensive training about administering medicines since 2006 even though they had responsibility for administering medicines. Another staff member had not received pressure care or wound management training since February 2013 even though they worked as a nurse at the service and wound management and pressure care were routine parts of their duties. We spoke with the registered manager about this. They told us and records confirmed this had been identified and further actions had been taken and bookings made to ensure the members of staff completed the training. Staff working at the

service had the opportunity to undertake further training appropriate to their role and there were opportunities for staff to develop and change roles within the service.

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 are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and deputy manager were knowledgeable about the MCA and how to obtain consent before giving care. However, we found that nursing and care staff did not always have a clear understanding of the MCA or how the assessment process was carried out or information required to do so. We spoke with the registered manager about this who told us they had identified gaps in staff understanding of MCA. The registered manager told us training had been scheduled to address this and we saw records to confirm this after the inspection.

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. At the time of inspection 30 people who used the service had authorised DoLS in place because they needed a level of supervision that may amount to deprivation of liberty. We found the home had completed all appropriate assessments in partnership with the local authority and any restriction on people's liberty was within the legal framework. We found the provider had sent in notifications to the CQC about the decisions of applications submitted for Deprivation of Liberty Safeguards. Records relating to best interest decisions were well recorded and a contribution from and signature of significant others such as their relative.

Staff were knowledgeable about how to obtain consent. They told us they would ask and explain what they were about to do before carrying out care and we observed staff asking people before they carried out any aspect of care. People's care records showed they had signed consent to care where able to do so.

People told us they enjoyed the meals at the service. When asked what they thought of the food one person said, "Very nice." People who needed support with their meals were assisted patiently and with respect and dignity. People were able to decide if they wanted to eat at the dining table or in their armchair. People who chose to sit in an armchair used a table on wheels which was adjusted to the correct height for them to use. Some people living with dementia found it difficult to sit and complete a meal. They were offered a balanced diet of small sandwiches and finger foods from the main menu options which meant they could move around supported by staff during mealtimes.

We observed staff talking with people during meal times and offering them more food. The meals were not rushed and people appeared to be enjoying their dining experience. The food looked fresh, well prepared and presented. Several jugs of fruit and water were available for drinking with the meal. Tea and coffee was offered after the meal.

The chef told us they had joined the service in November 2015 and since joining had reviewed the menu options to include a wider variety of meals. We looked at the menu plan which changed every three weeks. The chef told us and we saw different menu options available to people with special dietary requirements. The chef was knowledgeable about people's requirements for example, those who required a softer diet or

were diabetic. Menu choices included vegetarian and culturally specific options. The chef told us fish was now an option on the menu four times a week and other high protein options for people who enjoyed or required this. People who had poor appetite or were at risk of malnourishment due to their medical condition were offered smoothies and milk shakes.

Snack trays were offered to people during the morning and afternoon. People were able to select crisps, biscuits and fruit along with milkshakes, smoothies and hot drinks. People were encouraged to drink and were offered water and fruit squash throughout the day. People's food and fluid intake was monitored. Records showed this was completed daily and showed that people received the recommended amount of fluid daily. People's weight was monitored monthly or more often if necessary. We saw records of this and referrals made to the dietician if required.

The décor within the service had been updated since our last inspection. There were pictures and different colours used on the units which made different areas more recognisable to people living at Cherry Orchard. There were brightly coloured stencils on the walls. There were no unpleasant smells and furniture in the lounges was well maintained and comfortable. There was an area on each unit which was a focal or destination point. For example one unit had a large wall hanging with various tactile items. Another unit had a conservatory looking out into the garden and people were able to access this area freely.

Staff did not receive regular one to one supervision. The registered manager told us their expectation was that staff had at least six supervisions a year, of which at least three should be one to one supervisions. Whilst we found that staff had up to six supervisions in a year, most of these were group supervisions. These were used to discuss a particular topic such as dementia care or moving and handling. Supervision records showed that four out of six staff had only had one individual supervision in the past year. This meant staff did not always have the opportunity to discuss their personal development. We spoke with the registered manager about this and they told us this was an area they had been working to improve. Staff told us and records confirmed annual appraisals had been completed for staff working at the service. We recommend the service carry out individual supervision meetings for all staff working at the service to enable staff to discuss their personal professional development in a formalised way.

Is the service caring?

Our findings

At our last inspection of this service in November 2014 we found that staff were allocated to different units daily. This meant people did not have the opportunity to get to know staff well. During this inspection we found these issues had been addressed.

Each person using the service had a keyworker. A keyworker is a staff member who is responsible for overseeing the care a person receives and liaising with other professionals involved in a person's life. Staff were able to describe how they developed relationships with people which included speaking with the person and their family to gather information about their life history, likes and dislikes. People were enabled to take part in their cultural or spiritual practices.

People using the service and their relatives told us staff were caring. One person said, "I like them [staff]." Another person said, "They [staff] are very caring here." Staff we spoke with told us they felt it was a caring service. One staff member said, "We are all here for the residents. They have their good and bad days but you must always treat them gently and show you care about them." Another staff member told us, "I always think that could be me or my family so I treat people well."

We observed staff interacting with people in a kind, respectful and personalised way. One staff member knelt beside someone's chair while talking and laughing with them. Another staff member was observed comforting someone who had become upset, speaking quietly with them and holding their hand.

Staff told us how they promoted people's dignity, choice, privacy and independence. They said they ensured doors were closed when assisting people with personal care. We observed staff discretely speaking with people who required personal care during the day and supporting them back to their rooms where personal care could be carried out.

Staff provided information and explanations when supporting people with daily living activities. We observed a staff member explaining to one person the reason they needed to slow down and take a moment to have a drink as they had been moving around the home and becoming quite warm.

We observed staff supporting people to remain independent. For example, one person liked to help staff to tidy away items and we saw this was supported by giving the person small items to put away. People living at Cherry Orchard were able to walk around different areas of the home including visiting staff in the nurses' office. We observed staff encouraging people to move around and supporting them from a safe distance to maintain their independence.

Care records showed plans were in place for end of life care. These plans were reviewed annually and included people's wishes for preferred place of care and specific funeral plans. Staff we spoke with knew people's wishes. Staff told us about end of life training they had attended and about the process for arranging support for people and their family with end of life facilitators in the borough.

Is the service responsive?

Our findings

At our last inspection of this service in November 2014 we found some people were not protected against the risk of unsafe or inappropriate care and treatment by not always monitoring their medical condition. During this inspection we found these issues had been addressed.

All care records reviewed had details of an initial assessment carried out when people came to live at the service and up to date person centred care plans for each person. Staff were knowledgeable about people's individual care needs and were able to explain how they used the care plans and risk assessment to ensure appropriate care was given to meet their needs. Care plans were comprehensive and personalised. Plans had details of people's likes, dislikes and preferences including how often and when they wanted support with personal care, and their bed time and morning routines.

Records showed care plans were reviewed each month by senior staff and updated as necessary. We noted some care plan reviews had not been signed by the staff member carrying out the review. We spoke with the deputy manager about this. On the second day of our inspection we noted this had been addressed and added to the care plan auditing tool, staff had been informed and notes had been put on people's care files reminding staff to ensure plans were signed.

People we spoke with said there were enough activities to do at the service. The service had a full-time activity co-ordinator who organised one to one and group activities, outings and social events. The activities co-ordinator explained people living at the service were encouraged to participate in meaningful activities they enjoyed. For example, one person had been allocated an area of garden to grow vegetables and flowers. People participated in baking, art, music sessions, singing and dancing if they wished. Staff also volunteered to come in when off duty to lead activities during the weekend. One member of staff said, "I enjoy it that's why I volunteer." Records and photographs displayed at the service showed activities that had taken place.

Staff at the service initiated activity sessions on a one to one basis with people. We observed a member of staff supporting and speaking with one person as they sorted through items in one of the rummage boxes. Another member of staff stopped what they were doing when a person using the service brought a sensory toy to them. We observed them talking about the toy and allowing the person to interact with them and to touch their face with the toy. We looked at activity plans for one person who was nursed in bed. This included bringing sensory items and coloured lamps into their room. The registered manager was qualified in dementia care, coached staff and worked with a dementia specialist to purchase suitable items that could be used during activities to promote recalling memories and stimulate the senses. The service had a visiting pet as part of pet therapy. Staff told us this was enjoyed by people using the service and some people found it very relaxing to spend time with the pet.

The service had a car in the garden without an engine. People using the service were able to sit in the car when they wished. One person often sat in the car when they wanted some quiet time. Another person living at the service used to work as a car mechanic and often spoke to staff about the car and its

maintenance. During our inspection the person told us about the car and said he had been to check it over that morning.

The service had a large mural of a London bus and street scene in one unit complete with a bus stop. Some people living at the service used this as a point of reference when moving around the home. We saw two people talking about the mural as they walked past it. The service had a mobile sweet shop which staff had made and was taken to each unit two or three times a week. People were able to request what they wanted from the shop and staff kept a log of people's choices so they could monitor sugar intake for people who had specific dietary needs. During our visit we saw people selecting sweets and chatting with staff about the different types of sweets they liked when they were children.

During our inspection some people at the service went to the cinema and when they returned told us they had enjoyed the film. People were encouraged to move around the service and garden. There were coat stands by the garden door to remind people to wear a coat when going outside. We saw staff prompting people and supporting them to go for a walk in the fresh air. This meant people living at Cherry Orchard were able to participate in meaningful activities that stimulated memories and encouraged independence.

People using the service were encouraged to give their views about the service. For example, people were asked for their suggestions for activities and the décor within the home. The service produced a newsletter for people using the service and their relatives. We looked at the most recent issue which included updates on events that had taken place at the service, dates of meetings and outings, new staff joining the service and birthday celebrations.

Relatives meetings took place at the service. The registered manager told us although these were well advertised they were not always well attended. We saw dates of future meetings scheduled at different times and days of the week including weekends to make it more convenient for relatives to attend. One relative we spoke with told us they were informed of meetings but found they didn't have to wait for meetings to speak with the registered manager and staff about the service.

People had access to health care services. People told us they were able to see a doctor if they needed to. Staff told us and we saw records of the weekly GP visits to people living at the service. The GP could be contacted for visits at other times if people became unwell. We saw records of visits to the service from various health care professionals. There were records of visits from the chiropodist, psychiatrist and dietician. People's care records contained information relating to various appointment letters following up from referrals. A number of people had been supported with visits to hospital and clinics.

The service had a complaints policy and procedure. The registered manager and staff were able to explain how they would deal with a complaint. Since our last inspection the service had received one complaint which had been responded to and resolved in line with the providers' complaints procedure.

Is the service well-led?

Our findings

At our last inspection of this service in November 2014 we found the service did not inform the Care Quality Commission (CQC) of important events at the service in a timely manner. This meant the CQC were unable to monitor that appropriate action had been taken. During this inspection we found these issues had been addressed.

The service had a registered manager who had been working for nine months at the time of our visit. 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.

Staff told us they enjoyed working at the service and found the management team supportive. Staff said management of the service had improved and there had been a lot of positive change. One staff member said, "There been loads of changes but it was really necessary." Another staff member said, "I've worked here for years and seen management change and new rules and ways of working but this time it's for the better."

Staff told us they found the management team knowledgeable and approachable. One staff member said, "The manager and deputy work well together. You know where you are with them." Staff members' described the registered manager as "Firm but fair" and "Easy to talk to."

Nurses we spoke with told us they felt supported in their role and felt they had good clinical leadership from the deputy manager. One nurse told us, "We discuss clinical practice and how to give the best nursing care."

Staff said they found the culture in the service open and supportive. They said they could discuss any concerns about clinical or care practices and ask if they were unsure about any aspect of their work. They felt listened to and valued in their role. One staff member said, "This is a caring organisation. Change is for the better." Another staff member said, "You get a thank you at the end of your shift and told when you do a good job and when you have made a poor decision, you get told so you can learn."

The management team told us they felt supported by senior management. They said they had regular visits and audits carried out to improve the service. The focus had been on improving the quality of the service for people and staff at the service. The senior manager we spoke with told us they felt the management team and staff at the service had worked hard and there was a culture of team work and enthusiasm to improve the service.

The management team and staff told us and records showed monthly team meetings had taken place. Staff said they found the meetings useful and were kept up to date with changes to work practice and people's needs. Clinical review meetings took place weekly and included updates on peoples nursing and care needs. For example, records showed medicines, wound care, falls monitoring and nutritional needs assessments were discussed. Daily meetings took place to share information and changes across all units and were

attended by care and nursing staff who were available.

The service worked in partnership with other agencies and health professionals. One health professional told us they found the service easy to work with and had noticed an improvement in communication and documentation in the nursing records.

Quality monitoring systems were in place and records were accessible and up to date. The deputy manager and registered manager had responsibility for competing audits. We looked at records of up to date weekly and monthly audits carried out. These included care planning, risk assessment, nutritional needs, wound care, infection control, falls monitoring and medicines management. As part of the quality monitoring there was a 'Resident of the day'. This person was had their care file including care plans and risk assessments reviewed, maintenance checks completed in their room, a special meal and activity of their choice. This meant that each person's care file was reviewed and updated every 40 days.

The provider notified CQC of important events at the service in a timely manner. The provider had a service improvement action plan which they used to improve quality of service delivery. We saw the action plan was updated monthly and covered the area of concern's we had raised at our inspection in November 2014. Staff we spoke with were aware of the action plan and changes that had been made to improve practice at the service. We looked at records of the most recent six monthly governance audit carried out by the provider on 25 September 2015. We noted they had identified and addressed areas highlighted for improvement. For example, incomplete monitoring charts, recording and progress reporting on wound care and review of care records. We saw that all of these actions for improvement had been completed in a timely manner.

We saw systems in place for the maintenance of the building and equipment to monitor the safety of the service. This included monthly audits of the environmental health and safety. There were systems and daily checks in place to ensure peoples safety.