Queensland Care Limited

Homecroft Residential Home

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?	Requires Improvement

Summary of findings

Overall summary

Homecroft Residential provides personal care for up to 26 older people. The home is situated in a quiet residential area within the town of Ilkley. The accommodation is provided in mostly single rooms with a small number of double rooms. Some rooms have ensuite facilities. The home has a range of communal areas including lounges, dining room and gardens. This was an unannounced inspection which took place on 15 November 2016. On the date of the inspection there
were 15 people living in the home.

A new registered manager had been appointed on 2 November 2016. 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.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate in any of the key questions. Therefore, this service is now out of Special Measures.

We found improvements had been made to the medicines management system. Medicines were safely managed and robust systems were in place to check medicines were given correctly.

People living at the home, relatives and staff told us they felt people were safe in the home. Staff understood how to recognise and report any allegations of abuse. Risks to people's health and safety were assessed and clear plans of care put in place to assist staff to keep people safe.

The premises were well maintained and suitable for its intended purpose. Regular checks were undertaken on equipment and fittings to ensure they were in a safe condition.

There were enough staff deployed to ensure people were provided with safe and timely care. People received prompt assistance when they needed it. Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people.

Staff were aware of the need to report incidents. Any incidents were logged, investigated and where appropriate actions put in place to prevent a re-occurrence.

Staff received regular training and support from the organisation. Staff had a good understanding of the people they were caring for. Use of agency staff had been reduced over recent months to help ensure consistency and continuity of care.

The service was acting with the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People's consent was gained before assisting with care and support.

The service ensured people had access to a range of health professionals to help ensure their healthcare needs were met.

People living at the home and relatives praised staff and said they were kind, caring and treated people with dignity and respect. Good, positive relationships had developed and staff knew people well.

The registered manager had put measures in place to ensure people felt listened to and had their views and opinions acted on. For example around food and activities.

Care plan documentation was much improved and demonstrated people's needs had been fully assessed. People and relatives told us that care needs were met by the service.

The registered manager had improved the range of activities and social opportunities available for people, whilst acknowledging further work was needed in this area to ensure a more varied and consistent activity regime was in place.

Since the last inspection, a new registered manager had been employed and their presence in the home meant that people and relatives now had a permanent contact to address any concerns or complaints to. People and relatives said they were satisfied with the care provided and the manager had dealt effectively with any minor concerns they had raised.

The service was now better organised with staff having clear roles and responsibilities. Staff morale had improved and relatives and staff remarked that the home had significant improved in recent months. We found a pleasant and inclusive atmosphere within the home.

Systems were in place to regularly assess, monitor and improve the service including regular audits and checks both internally and externally. The findings of these were used to inform a service improvement plan to further improve the service.

We could not be assured that the service was well led, because the provider would have to demonstrate that the improvements and stable leadership and management were sustained over time.

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.

Improvements had been made to the way medicines were managed. We found people were receiving their medicines as prescribed in a safe and proper way.

There were enough staff deployed to ensure safe and timely care.

People told us they felt safe. Risks to people's health and safety had been assessed and staff were provided with clear instructions on how to care for people safely.

Is the service effective?

Good

The service was effective.

People said staff were competent and skilled in their role. Staff received regular training updates and developmental opportunities.

People's consent was obtained before offering care and support. The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People told us the food was tasty and they had sufficient choice. Where people were nutritionally at risk, action was taken to control these risks.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were kind and treated people with dignity and respect. This was confirmed by our observations of care and support.

Staff knew people well and had obtained information on people's likes, dislikes, preferences and life histories to aid in the provision of person centred care.

People were listened to and their views recorded and acted on.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and appropriate plans of care put in place which were understood by staff.

Activities took place; the registered manager had taken steps to improve the provision of activities within the home.

A system was in place to listen to and respond to people's concerns or complaints. People and relatives told us they were satisfied with the service.

Is the service well-led?

Requires Improvement

We would need evidence that improvements were sustained over time before we could be assured that the service was well led.

Improved systems to assess and monitor the quality of the service had been put in place following the last inspection. A range of audits and checks were undertaken and used to drive improvement.

People's feedback was regularly sought, and their comments used to make further improvements to the service.

Homecroft Residential Home

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 look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also checked to see whether improvements had been made to the home following our previous inspection in April 2016 where breaches of regulation were identified.

The inspection took place on 15 November 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

We used a number of different methods to help us understand the experiences of people who used the service. 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.

We spoke with five people who used the service, three relatives, five care workers, the cook, the domestic, an external activities co-ordinator and the registered manager. We also spoke with two health professionals who have experience of the service.

Prior to the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned to us in a prompt manner. We reviewed all information we held about the provider and contacted the local authority to get their views on the service.

Good

Is the service safe?

Our findings

At the last inspection in April 2016 we found medicines were not safely managed. People were not receiving their medicines as prescribed and we were unable to account for all medicines. At this inspection we found improvements had been made.

Arrangements were in place to ensure people received medicines when they needed them, for example some medicines were prescribed to be given before food and staff took measures to ensure these medicines were given before breakfast. We saw one person took their medicines with a spoonful of honey and appropriate documentation was in place demonstrating the appropriateness of this had been checked and the person's rights protected.

We looked at a sample of Medicine Administration Records (MAR) and found them to be well completed, indicating people received their medicines as prescribed. A new stock balance sheet had been put in place for medicines which were not included in a dosette box and we found that overall this had been effective in providing a greater accountability for medicines. We undertook a random check of medicines and found the number in stock matched what should be present if people had received their medicines as records stated.

During the inspection, we identified a medicine error which had been made by an agency care worker the night previously. We found the registered manager took immediate and appropriate action to resolve this, putting in place an enhanced monitoring regime to reduce the likelihood of a reoccurrence.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given. This helped ensure they were given in a consistent manner.

We looked at records for the administration of topical creams and found them to be well completed demonstrating these were applied appropriately. Information was provided to staff on how often to apply creams and to which areas of the body.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled drugs. We found these medicines were managed safely and robustly accounted for. We found medicines were stored securely and appropriately. Drug refrigerator and storage temperatures were checked and recorded daily to ensure medicines were being stored at the required temperatures. Where medicines were no longer required a system existed to record and dispose of the medicines safely

Staff received training in the management of medicines and had their competency to safely administer checked. Regular checks and audits were undertaken on the medicine management system by the registered manager, which gave us assurance that any errors would be promptly identified and action taken to prevent a re-occurrence.

Safe staffing levels were maintained to help ensure safe and timely care. People, relatives and staff told us there were enough staff deployed. We spoke with a member of staff who told us, "Staffing's better. Have enough staff." Another member of staff told us, "We have an extra staff member in the mornings; this has helped." A relative told us "There always seems to be enough staff around." We observed care and support and saw people received prompt attention when they needed it. A dependency tool was used by the registered manager to assess staffing levels. With present occupancy, one senior and two care workers were present during the day, and one senior and one care worker worked overnight. In addition, a new morning shift had been created between 7am and 11am which the registered manager told us was now a permanent feature to provide additional support to staff early in the day. A staff member we spoke with told us this extra staff member had been needed and hoped it would now be a consistent feature. In addition, the new registered manager also worked supernumerary five days a week but helped out where required. Ancillary staff such as domestics and kitchen staff were also in place. Whilst at the last inspection, the service had been using a high number of agency staff, this had been steadily reducing. The registered manager told us two new senior care workers were currently going through the recruitment process which they hoped would eradicate agency use.

Safe recruitment procedures were in place to help ensure staff were of suitable character to work with vulnerable people. We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references were requested and checks performed with the Disclosure and Barring Service (DBS) to establish whether potential applicants had any criminal convictions before they were offered the job. Staff identity and previous qualifications was checked as part of the application process and work history was explored.

People and relatives told us people were safe living in the home. Staff we spoke with understood how to identify and report any allegations of abuse. Staff had received training in safeguarding vulnerable adults. A safeguarding log was in place and we saw evidence the registered manager had made appropriate referral to the local authority and notification to the Care Quality Commission (CQC). Following safeguarding incidents, we saw risk assessments were updated and where appropriate health professional advice was sought.

We saw appropriate risk assessments were in place where risks to people had been identified, such as falls risk assessments, nutritional assessments and assessments around people's skin integrity. These were subject to regular review and updated if the person's needs changed.

Whilst carrying out observations, we witnessed a person fall in the lounge area. We saw staff response was immediate with three staff members coming to their assistance, speaking with the person calmly, ascertaining any injuries and assisting appropriately. We saw the staff members reassured the person constantly and helped them remain calm throughout. After the incident, we saw staff requested a GP check the person and assess if any further action was required. An accident form was also completed which we reviewed and found to be completed appropriately. We examined the system in place to record, investigate and learn from any adverse incidents that occurred in the home and found it to be appropriate. The registered manager understood the importance of reporting incidents and accidents and it was clear that a culture to report all incidents had been instilled throughout the staff team. Following falls a period of post-accident observation was conducted to check people's condition had not deteriorated. We saw any concerns or incidents were discussed during staff handovers to help further reduce the risk to people.

Personal emergency evacuation plans were in place in people's care records and these had been updated if a change in their mobility had occurred. Staff were able to tell us what they would do if an emergency such as a fire occurred.

People and relatives spoke positively about the environment and said it was a pleasant home, kept sufficiently warm and in a good state of repair. One relative said "His room is smashing." We looked around the premises and found it was managed in a safe way. Window restrictors were in place to reduce the risk of falls and radiators were guarded to reduce the risk of burns. The home was pleasantly decorated and well maintained with rooms personalised, although the homes' environment could have been made more dementia friendly. Communal space was available including a lounge, dining area and quieter area where people could spend time or talk with their families. A large garden area was present which the registered manager told us they had a long term plan to develop to make it safer and more accessible for the people who lived in the home. Maintenance checks were undertaken on the building including to the fire, water, gas, electric systems. We found maintenance of equipment and fittings was up-to-date.

People and relatives told us the home was always kept clean and odour free. This was confirmed by our observations of the home environment which we found to be clean and hygienic. Cleaning schedules were in place and infection control audits took place to ensure a pleasant and hygienic environment.

Good

Is the service effective?

Our findings

People and relatives we spoke with said staff had the right skills and knowledge to care for them. Staff we spoke with demonstrated a good knowledge of the topics and people we asked them about which helped provide assurance staff were appropriately skilled. New staff undertook a six day comprehensive induction training at the provider's head office covering key topic areas as well as completing a period of shadowing. New staff without previous care experience completed the Care Certificate. The Care Certificate is a nationally recognised study plan for people new to care to ensure they receive a broad range of training and support. Regular training updates were given to staff which consisted of a mixture of face to face and computer based training. Topics included first aid, dignity, infection control, fire safety, moving and handling, safeguarding and medicines for senior staff. We looked at training records which showed us that most staff training was either up-to-date or staff were booked onto the next available session.

Staff generally told us the training they had received was appropriate, although one staff member told us they thought some elements of the face to face training could be improved. The registered manager and compliance manager were currently making changes to training provision through making use of an additional training provider to improve the overall package of training. Work was being undertaken to enrol staff on national qualifications in health and social care. The service was in the process of identifying and training champions in key areas such as dignity and dementia care. This would provide these staff with enhanced skills in these areas to share with others within the team.

Staff told us they felt well supported. They told us they received regular supervision and annual appraisal which was confirmed by the records we reviewed.

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. In the case of a residential home a Deprivation of Liberty Safeguards (DoLS) must be in place. We found the service was working within the principles of the MCA and the registered manager had an understanding of how these principals applied to their role and the care the service provided.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. Two DoLS authorisation were in place and nine applications had been made. We saw that these were in line with the assessment of people's needs.

We reviewed the care records for people who had been assessed as lacking capacity and found these

contained assessments of the person's capacity to make decisions. We saw records confirming discussions had taken place with people's families, external health and social work professionals and senior staff members and best interest decisions made as a result. We saw evidence of best interest meetings in people's care records regarding areas such as their care and support.

During our inspection we witnessed consent being sought from people and saw examples of this in resident's meetings minutes and people's care records, such as signed consent for photographs and administration of medicines. Staff we spoke with had received MCA training and had an understanding of the application of the Act.

Overall people and relatives provided positive feedback about the food. One person said "food is alright". A relative told us "The meals are tasty, she never leaves any food. " Another relative said "Food is excellent he devours everything." People were encouraged to eat a good diet and keep sufficiently hydrated. We saw jugs of juice and beakers had been placed on a table in the lounge and staff used these to encourage people to drink during the day. People were offered hot drinks mid-morning and mid-afternoon, as well as a variety of cakes and biscuits. People were offered a choice of foods for instance; we saw people offered cereal or a cooked breakfast and a choice of main meals at lunchtime. The food looked nutritious, was home cooked and people appeared to enjoy their choices. A choice of juice was offered during the lunchtime meal and we observed staff encouraging people to drink plenty and offering more fluids wherever possible. Mealtimes were unhurried and relaxed, with staff spending time talking with people and encouraging them with their food. The menu for the day was written clearly on a board hanging on the wall outside the dining room and was up to date.

We spoke with the cook who explained how they and the chef had recently devised a new monthly rolling menu, using fresh ingredients where possible. They told us they had discussed the new menu at the recent resident/relatives meeting and had devised this after listening to people's suggestions, likes and dislikes. The cook demonstrated their desire to create tasty food, telling us how they prepared various foods, as well as what they used to fortify the food they prepared, for instance using full fat milk, butter, cream and powdered milk. They were able to explain which people had specialised diets and how they were able to accommodate this in their menu choices. We saw people's dietary requirements were written on a chart in the kitchen. Where people were required to have a soft diet, we saw this was provided. The cook told us they were introducing 'shape cutters' for pureed diets, such as the shape of a fish if that was the meal that day, in order to make the dish look more appetising and recognisable.

However, we saw one person who was supposed to avoid certain foods and drinks due to a health condition but had been given these foods by staff over recent days. We raised this with the manager who said they would immediately investigate particularly as this person had been assessed as lacking capacity to make decisions for themselves.

Where people were nutritionally at risk, we saw food/fluid charts were in place and staff noted accurately what was consumed. People at nutritional risk were weighed weekly and others monthly with appropriate referrals made to the dietician if concerns were raised about people's weight loss.

A relative told us how they were very impressed how the service was vigilant over their relatives' healthcare needs and liaised effectively with the district nurses when required. It was evident through speaking with staff, observing handover and reviewing records that staff regularly liaised with health professionals if they were unsure about people's healthcare needs. We saw records which showed people had regular health checks and were accompanied by staff to hospital appointments. We saw evidence of visits from a range of health care professionals including GPs, district nurses, chiropodists and dietician. A health care

professional we spoke with told us the service contacted them appropriately with any concerns about peoples' health and welfare.

The home was signed up to a Telemedicine scheme run by a local acute NHS trust. Telemedicine provides remote video consultations between healthcare professionals and patients in care and nursing homes. It aims to reduce patients' lengths of stay in hospital and also supports care outside hospital, including early discharge, or avoids unnecessary visits and admissions to hospital. Although some staff had received training in use of the system, due to an influx of new care staff further training was required. The registered manager told us they had organised for this training to be provided in the near future. This would help improve staff use of the system.

Good

Is the service caring?

Our findings

People and relatives told us that staff were kind and treated them with dignity and respect. One person said "Staff are friendly and kind to me." A relative told us "Staff are marvellous" and another relative told us "Staff always seem friendly and pleasant and my relative seems settled and very happy."

During the course of the inspection we observed staff and people who lived at the service interacting in a friendly and relaxed manner and the atmosphere was calm. Staff were kind and caring in their manner and spoke to people with respect. For instance, we saw one member of staff addressing a person formally rather than use their first name since this was the way they preferred to be spoken to. One person told us, "[Staff name] is very polite. Beautiful." Staff spent time with people chatting and comforting them where required. We observed people's dignity and privacy was generally well respected, with staff knocking before entering people's bedrooms or to assist them in the toilet. We saw a member of staff kneeling down to speak with one person quietly about a concern they had which showed respect for their privacy and dignity. However, whilst sitting in the lounge area we were able to clearly hear details of the staff handover being held in the dining room which included references to people's names.

Staff interacted with people using a variety of communication. For instance, a staff member spent time sitting with someone who was unable to communicate verbally, simply holding their hand, smiling and speaking with them gently. We could see this person enjoyed this interaction through the expression on their face. We observed staff were happy to hug people and hold their hand, exchanging stories or jokes with some people and talking sympathetically with others.

We saw the welfare of the people living at the service was important to the staff. For example, one member of staff was introducing themselves to the inspection team and broke off suddenly to check the welfare of someone who had started coughing, making sure they had a drink and were settled before returning to the conversation. This demonstrated a caring attitude among the staff working at the service.

We observed people were encouraged to be as independent as possible, such as choosing their own clothes to wear in the morning and staff encouraging people's mobility.

A person centred approach to care and support existed within the home with people exercising control over their daily regimes. One relative told us how they were impressed their relative was able to keep to their previous regime of getting up later and staff always accommodated their breakfast when they awoke. We saw the medicines administration round was flexible and adapted to people's routines. Staff we spoke with demonstrated a good understanding of the people they were caring for. Care records contained detailed information about people's likes, dislikes and preferences as well as information about their life histories. This information helped staff to understand the people they were caring for.

Religion or belief is one of the protected characteristics set out in the Equalities Act 2010. Other protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity status and race. We saw no evidence to suggest that anyone that used the service was discriminated

against and no one told us anything to contradict this.

During observations of care and support, we saw staff took the time to listen to people, their requests or any concerns they had. The registered manager had put in place several mechanisms to ensure people's views were listened to and acted on since taking on the role in July 2016. They had introduced themselves to people and relatives and offered to meet them to discuss any concerns following the previous inspection in April 2016. Regular resident and relative meetings were now held and people's views were also sought through surveys and review meetings.

We saw care records indicated people's end of life wishes or where they had declined to discuss these.

Good

Is the service responsive?

Our findings

People and relatives told us they were all happy with the quality of care provided at the home and that care needs were met by the service. For example one relative said "Very happy, she is clean and tidy and is putting on weight." Relatives told us that the quality of care had improved following the appointment of the registered manager. Staff we spoke with demonstrated a good understanding of the people we asked them about, which provided us with further assurance that people's care needs were being met.

Since our last inspection we saw the layout and information contained in people's care records had improved. Records demonstrated a thorough assessment of people's needs. We saw preadmission assessments had been completed with the person and/or their family and plans of care then formulated to reflect the required needs and support. They contained sections on various aspects of the person's care, including sections on communication, hygiene and personal appearance, skin integrity, mobility and food and nutrition. We saw people's records contained detailed information about their life history, likes and dislikes and the amount of support they required with specific tasks such as washing, dressing and choosing their clothes. The registered manager told us this was an area they had worked hard to improve. We saw plans of care were person specific and detailed and included information about what could trigger different behaviours in people.

Care plans were reviewed regularly and care record amendments completed if people's needs changed. However, some care record amendments we reviewed indicated the care plan itself needed altering. We brought this to the attention of the registered manager who agreed these needed to be amended. From our discussion with the registered manager we felt confident these amendments would occur.

Daily handovers were in place where staff passed key information on people's health and wellbeing and the details of any incidents to the next staff shift. We observed the morning handover and found it to be detailed and a good mechanism to help ensure responsive care.

Although the service did not currently employ an activities co-ordinator, steps were being taken to improve the programme of activities offered. Some relatives we spoke with said they would like more structured activities and trips out for people The registered manager had also identified through resident meetings, surveys and reviews that activities was an area for improvement and had asked the provider for a part-time person to be employed in this role. In the meantime, we saw measures had been taken to improve activity provision. People's preferences had been sought and this was being used to plan appropriate activities We saw some activities planned over the next few weeks which included regular fortnightly sessions from outside exercise and activity companies and period entertainment such as an organist and musical activities. We saw the service had started a monthly coffee morning with proceeds going towards residents' funds. The registered manager told us of their plans to encourage people who were interested in gardening to help in the garden by creating an enclosed rear garden with raised flower and vegetable beds. During the inspection we witnessed an external activities person provided people with some activities and care staff also engaged people in games such as domino's and general chat.

The registered manager had recruited two volunteers from a local school who visited the home weekly and undertook one to one activities and interaction with people. This was a useful mechanism to provide people with enhanced social interaction.

A system was in place to listen, record and respond to people's complaints. People and relatives we spoke with told us they had no cause to complain and were happy with the way the registered manager had improved the service. At the last inspection the lack of management presence in the home meant some people experienced difficulties raising complaints. The registered manager worked supernumerary five days a week which provided people with an avenue to directly raise complaints. We saw the number of complaints had reduced in the last year with none received in the last five months, indicative of an improved service. One relative said of the new registered manager "She will sort out any problems."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in April 2016, we found the service was disorganised and without a registered manager. This had a significant effect on the organisation and overall quality of the organisation with systems and processes to assess, monitor and improve the service not being operated effectively. At this inspection we found improvements had been made. However in order for the provider to demonstrate it was well led, we would need evidence of sustained improvement as well as stable leadership and management over time. Improvement at the home had been driven by a service improvement plan. The registered manager had only been in post for three months, and whilst it was evident that the service had improved significantly over the last few months, there were further ideas, initiatives and processes which they planned to embed in the coming months.

People and relatives told us they were satisfied with the overall quality of the service and that recent improvements had been made. One relative said "Great, couldn't be better." Another relative said "I have definitely seen the home improve under [registered manager]." Staff also shared this feeling, for example one staff member said it wasn't pleasant working under the old regime without a manager but that the new manager "has made things better." Another staff member told us "Things are looking up now, [registered manager] and [compliance manager] are really good." A third staff member told us, "I feel it has improved; a lot more organised." They also said, "Morale is a lot better with staff." A fourth staff member said, "It's much better with [registered manager's name]. It's definitely improved; more structure to the day. People (staff) know what they're doing; some do breakfasts, some help getting people up. Before, we were all trying to deal with things and things weren't getting done."

We found overall the service, staff and documentation was now much better organised. For example we observed the morning handover and saw each staff member was given clear instructions as to the tasks they were required to carry out that day. Staff praised this approach and said it had improved the organisation of the service and given people well defined roles and responsibilities.

We saw the registered manager had a visible presence in the home, chatting with people and assisting with care and support where required. Staff we spoke with told us the registered manager was approachable and would approach them if they had any concerns. A staff member commented, "We're getting support from [registered manager]. Getting appraisals and supervisions which we didn't do before."

At the last inspection, we had concerns over the use of agency staff by the service and the quality issues that this had led to. At this inspection we found new staff had been recruited and agency usage had decreased, although agency care workers were still being used to cover some senior care workers shifts whilst new staff went through the recruitment and induction process. We identified a medication error made by a senior care worker and also some allegations of agency worker conduct on night shift. Although we saw the registered manager was taking robust action to address, we concluded there was a risk that these quality issues would continue until a new stable senior care team was fully in place.

Following the last inspection, systems to assess and monitor the service had been improved. Audits were

now undertaken with greater consistency in areas such as weights, pressure sores, care plans and health and safety. We saw evidence audits were successful in identifying issues and taking action to address for example identifying issues with care plans and rectifying. Systems were in place to monitor staff compliance with training, supervision and ensure building checks were undertaken in a timely way.

Each week the registered manager completed a report on activity within the home. This included any accident, incident and an update on recruitment, supervision, and any audits undertaken. This helped the provider to monitor events occurring within the service. Audits were also undertaken by the regional and compliance manager and these in combination by external audits conducted by agencies such as the local pharmacy and local authority were used to inform the service improvement plan.

The registered manager held regular staff meetings and these were an opportunity to drive improvement with the home. Care plan workshops had also been held with staff in order to improve the quality of care plan documentation. The registered manager demonstrated a desire and commitment to continuously improving the home, for example they said of the inspection, "I want to know where I am so I know where I need to improve."

Incidents were subject to monthly analysis to look for any themes or trends. This included falls, safeguarding incidents and medicines errors. The registered manager told us they were in the process of improving the way any incidents were analysed with information being input onto a computer system to allow more in-depth analysis of factors such as time of falls.

Systems to seek and act on people's feedback had been put in place by the registered manager. Resident and relatives meetings were regularly held. We saw evidence these were an opportunity to keep people informed and involved with life in the home. For example activities and food were discussed and we saw people had been consulted over the implementation of a new 4 week menu.

Quality questionnaires had been sent to people and their relatives in September 2016. These had been returned and our review of these found most people were very happy with the care received. The registered manager told us they were planning on communicating what had been done following any negative comments received such as regarding activities. Staff and health professional feedback had also been sought through surveys, and the result of this were positive, consistent with an improved service.