

St. Martin's Care Limited

Woodside Grange Care 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?

Good ●

Summary of findings

Overall summary

We inspected Woodside Grange Care Home on 21 December 2016 and 11 January 2017. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

We completed a full inspection of the home in August 2015 and found that that action was needed to ensure the systems for overseeing the service were effective and identified risks. Following a number of concerns being raised we conducted a focused inspection on 14 and 28 April 2016. We rated Woodside Grange Care Home as requires improvement because action was needed to ensure sufficient staff were deployed and governance arrangements were improved.

Woodside Grange Care Home is a purpose built care home for up to 121 people, which provides nursing and personal care for both older people with dementia and younger people with mental health needs. There are three floors to the building, each connected by two vertical passenger lifts. All bedrooms are lockable, there are spacious single rooms, with en-suite facilities. The building is surrounded with private grounds and has on site car parking facilities.

The home has had a registered manager in since 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.

At previous inspections we found that albeit the provider had systems for monitoring and assessing the service, these had failed to identify that staff were working in silos so not using the resources effectively. It was unclear as to what systematic oversight was given to the nursing service. At the inspection in April 2016 we found that staffing levels had been reduced during then night and for 96 people who used the service up until 9pm there were 12 staff members on duty and overnight there were 11 staff members. We found these staffing levels did not meet the needs of the people.

At this inspection we found action had been taken to ensure staffing levels were now sufficient to meet people needs of the 87 people who used the service and significant improvements had been made to the way the home was run.

People told us that since the change of directors, the manager and deputy manager they were happy with the service. They felt the new team had made a lot of improvements to the home and felt the staff did a good job. We heard how people felt the home was well-run and that the registered manager was extremely effective.

We found that a range of stimulating and engaging activities were provided. There were enough staff to support people to undertake activities in the home and community. We saw people went on trips to local tourist attractions and events.

People's care plans were detailed and tailored for them as individuals. People were cared for by staff that knew them really well and understood how to support them. We observed that staff had developed very positive relationships with the people who used the service. The interactions between people and staff were jovial and supportive. Staff were kind and respectful.

Staff were supported and had the benefit of a programme of training that enabled them to ensure they could provide the best possible care and support. Staff were all clear that they worked as a team and for the benefit of the people living at Woodside Grange Care Home.

The registered manager understood the complaints process and detailed how they would investigate any concerns. We heard that since they had come into post work had been completed to review all of the previous complaints to ensure appropriate action had been taken to resolve these concerns. We heard how the director of operations and registered manager were actively seeking people's views and suggestions were acted upon. They had also promoted a reflective learning culture in the home, which allowed staff to look at even the smallest of incidents to determine what lessons could be learnt.

The registered manager and staff had a clear understanding of safeguarding. The registered manager acted as a champion for people and would raise complaints and safeguarding matters when this was needed.

Where people had difficulty making decisions we saw that staff worked with them to work out what they felt was best. Staff understood the requirements of the Mental Capacity Act 2005 and had appropriately requested Deprivation of Liberty Safeguard (DoLS) authorisations.

We reviewed the systems for the management of medicines and found that overall people received their medicines safely.

People told us they were offered plenty to eat and we observed staff assisted individuals to have sufficient healthy food and drinks to ensure that their nutritional needs were met. The cook provided a home cooked healthy diet and provided a range of fortified meals for people who needed extra calories to ensure they maintained their weight. People were supported to manage their weight and nutritional needs.

People were supported to ensure their health and well-being were promoted. The staff had formed good links with the Consultants, GPs, dieticians, speech and language therapists, tissue viability nurses, community nurses and the falls team.

Effective recruitment and selection procedures were in place and we saw that appropriate checks had been undertaken before staff began work. The checks included obtaining references from previous employers to show staff employed were safe to work with vulnerable people. The staff team was stable and a number of the staff had worked at the home for over four years.

The service had a strong leadership presence with a director of operation, a director of care and registered manager who had a clear vision about the direction of the service. They were committed and passionate about the people they supported and were constantly looking for ways to improve. Thorough and frequent quality assurance processes and audits ensured that all care and support was delivered in the safest and most effective way possible.

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.

Staff were knowledgeable in recognising signs of potential abuse and reported any concerns to senior staff.

There were sufficient skilled and experienced staff on duty to meet people's needs. Robust recruitment procedures were in place. Appropriate checks were undertaken before staff started work.

People's risks were monitored and managed appropriately with the least restrictive option always considered

People lived in a clean and well maintained home with environmental risks managed appropriately.

People's medicines were on the whole managed safely and audited regularly

Is the service effective?

Good ●

The service was effective.

Staff had the knowledge and skills to support people who used the service. They were able to update their skills through regular training.

Staff felt supported by their colleagues and the registered manager and staff worked as a team.

People's consent was sought at all times. Staff followed the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguard authorisations.

People were provided with a choice of nutritious food.

People's on-going healthcare needs were managed and monitored effectively, working with healthcare professionals in the community.

Is the service caring?

Good ●

The service was caring.

Staff knew people really well and used this knowledge to care for them and support them in achieving their goals.

Staff were considerate of people's feelings at all times and always treated them with the greatest respect and dignity.

Is the service responsive?

Good ●

The service was responsive.

People's needs were assessed and care plans were produced identifying how to meet them.. These plans were tailored to meet each person's individual requirements and reviewed on a regular basis.

We saw people were encouraged and supported to take part in a wide range of activities.

The people we spoke with were aware of how to make a complaint or raise a concern. They told us they had no concerns but were confident if they did these would be looked into and reviewed in a timely way.

Is the service well-led?

Good ●

The service was well-led.

People benefitted from a service which had a strong management team. The registered manager was always looking for ways to improve.

The values of the registered manager were consistently demonstrated by the staff in their interactions with people and with each other.

People's views were sought and acted upon. Relatives' views were sought.

Robust and frequent quality assurance processes ensured the safety, high quality and effectiveness of the service.

Woodside Grange Care 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 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.

The inspection took place on 21 December 2016 and 11 January 2017. The visit commenced at 6am so we could meet the night staff and look at nightshift practices. At the time of our inspection 87 people were using the service.

The inspection team consisted of four adult social care inspectors and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the registered provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

We contacted external healthcare professionals to gain their views of the service provided at the service. We spoke with relatives who had contacted us previously about the operation of the home.

During the inspection we spoke with 14 people who lived at the service and five relatives. We spoke with 15 members of staff, including the Director and the Director of Care, the registered manager, the deputy manager, unit leaders, nurses, senior carers, care staff, the head of housekeeping, the activity coordinator, the cook, kitchen assistants and the handyman. We looked at ten care records, and Medicine Administration Records (MARs), six staff files, including recruitment records, as well as records relating to the management of the service.

We looked around the service and went into some people's bedrooms, all of the bathrooms and the communal areas. We observed how staff engaged with people during activities.

Is the service safe?

Our findings

At the last two inspections we found the dependency tool to determine how staffing levels were calculated was extremely complicated and difficult to use. The staff could not explain how they used the tool to calculate the number of staff needed for the whole home or each unit. We found that the staff did not work as a team and told us they did not contact staff on different floors or units if they needed support. We found this pattern of working in isolation meant there was insufficient staff on the ground floor residential unit to meet the individual's needs.

In August 2015 we saw that 65 people used the service. At the time overnight there were 12 staff members on duty. In April 2016 we saw that 96 people used the service up. At that time there were 12 staff members on duty until 9pm and overnight there were 11 staff members. Although we asked for information about the guidance staff followed for calculating the staffing levels this was not provided. We could not determine why there were less staff on duty overnight although more people lived at the home. We found the tool was not fit for purpose and this had led to insufficient numbers of staff being deployed at the home.

Following the inspection in April 2016 the registered provider sent us an action plan detailing how the breach of regulations in respect of staffing would be addressed.

At this inspection we found that new senior management such as directors of operations and care had been appointed plus the management team within the home were new. The director of operations explained that the previous home management team had not been working collaboratively and this had led to no action being taken to ensure sufficient staff were on duty. Since the changes had been made the team had a clearer understanding of people's dependency levels and demands of the home; this had enabled the registered provider to review staffing levels with the staff and ensure they were appropriate.

At the time of the inspection 87 people used the service and overnight one nurse, two senior carers and ten care staff were on duty. During the day a nurse, six senior care and 11 care staff were on duty. On the Chestnut suite (the unit for people with a learning disability) day staff worked to 10pm. The deputy managers, catering staff and domestic staff worked seven days a week. Alongside this the registered manager, clinical lead and administrator worked during the week. We found that staff now worked as a team across the whole home, which led to each unit being able to readily get additional support when it was needed.

The director of operations told us that they were currently reviewing the staffing levels within the Chestnut suite to ensure more one-to-one hours were provided.

We found that there were now sufficient staff deployed at the home to meet people's needs.

During our inspection, we looked at the arrangements for the management of medicines.

We looked at the medication administration records (MAR) for 39 people. We found on the nursing unit the morning medicine administration round, that the MAR often stated the person was asleep therefore no medicine was administered. However there had been no attempt to administer the medicine once the

person had woken up. We saw one person had only received their tea time dose twice in five days because they had been asleep. No attempt had been made to see if the dosage times could be changed for people who like to sleep in or like to have a sleep at tea time.

We found that where medicines were prescribed to be given 'only when needed', the guidance to inform staff about when these medicines should and should not be given, was not always available.

The service used homely remedies, medicines such as Paracetamol or cough mixture bought over the counter. No protocols were in place for the homely remedies, no permission sought from the GP to say who could use them and no stock checks. Whilst staff were able to tell us how the medicines were given, this information was not recorded in detail or specific to individual people. This information would help to ensure that people were given their medicines in an appropriate way.

When medicines were carried forward from the previous month this was not always recorded on the new MARs. Accurate records of medication available in the home are needed to ensure care staff can see when further medication would need to be ordered.

Daily checks were not carried out on the temperature of all the rooms storing medicines and refrigerators that stored items of medication.

Staff knew the required procedures for managing controlled drugs. We saw that controlled drugs were appropriately stored and signed for when they were administered.

We noted that up until recent weeks a high volume of agency nurses were working at the home and this had appeared to impact the medicine administration practice on the nursing units. Since the director of operations and registered manager had come into post the use of agency staff had reduced. On 9 January 2017 a clinical lead had commenced working in the home and they outlined to us the review of medication practices they had completed. We found they had identified the same issues as we did and they discussed with us the action already underway to improve the administration of medication on the nursing units. The nurse on duty confirmed the actions that had already been commenced.

We discussed our findings with the registered manager and two directors. They explained that following an internal review completed in December 2016 they had identified issues with the way medicines were managed and had commenced rectifying the issues. We saw that positive action had already been taken to improve the administration of medication on the residential units.

People told us they were very pleased to be living at the home and that the level of care had exceeded their expectations. Relatives told us that they found staff effectively cared for the people who used the service and were very kind. They told us that they thought the staff provided care that met people's needs and kept individuals safe.

People said "I can't fault one of them." And, "They are all very nice." And, "I'm happy here."

Relatives said, "I'm very pleased we found this home. My relative has done really well since coming here and we could not be happier." And, "I don't know why the home is only rated as a 3 star by environmental health as every time I come it is very clean." And, "The staff are very helpful."

People who were identified to be at risk had appropriate plans of care in place such as plans for ensuring action was taken to manage pressure area care. Charts were used to document change of position and food and hydration were clearly and accurately maintained. The records reflected the care we observed being

given. This meant people were protected against the risk of harm because the registered provider had suitable arrangements in place. The risk assessments and care plans for people we looked at had been reviewed and updated on a monthly basis.

Staff were able to clearly outline the steps they would take if they witnessed abuse and we found these were in line with expected practice. We asked staff to tell us about their understanding of the safeguarding process. Staff gave us appropriate responses and told us they would report any incident to senior managers and they knew how to take it further if need be. Staff we spoke with were able to describe how they ensured the welfare of vulnerable people was protected through the organisation's whistle blowing and safeguarding procedures. Staff said, "I would not hesitate to report any incidents and know the manager would ensure this was thoroughly investigated."

The registered provider had given care staff access to a training programme that gave them the clinical skills needed to take blood and provide wound care

We looked at the recruitment records for four staff members. We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. We saw evidence to show prospective staff had attended interview and the registered manager had obtained information from referees. A Disclosure and Barring Service (DBS) check had been completed before they started work in the home. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people working with vulnerable adults.

We saw that staff had received a range of training designed to equip them with the skills to deal with all types of incidents, including medical emergencies. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. Staff could clearly articulate what they needed to do in the event of a fire or medical emergency. Staff were also able to explain how they would record incidents and accidents.

Accidents and incidents were managed appropriately. The registered manager discussed how they analysed incidents to determine trends. They outlined how they had used this to assist them to look at staff deployment and additional measures such as pressure mats that could be put in place, which had led to a reduction in accidents. We saw that where accidents had occurred they had been fully recorded and appropriate remedial action taken.

All areas we observed were very clean and had a pleasant odour. The registered provider's infection control lead had recently completed their review of the service compliance with infection control requirements and scored the home at 100% for compliance with the standards.

We saw that personal protective equipment (PPE) was available around the home and staff could explain to us when they needed to use protective equipment. Ample stocks of cleaning materials were available. We saw that the domestic staff had access to all the necessary control of substances hazardous to health (COSHH) information. COSHH details what is contained in cleaning products and how to use them safely.

We saw evidence of Personal Emergency Evacuation Plans (PEEPs) for all of the people living at the service. The purpose of PEEPs is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. We also found that fire drills were completed every six months for day staff and every three months for night staff and refresher training was undertaken annually.

We saw records to confirm that regular checks of the fire alarm were carried out to ensure that it was in safe working order. We saw that the water temperature of showers, baths and hand wash basins in communal areas records showed the hot water was kept within safe limits. We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the gas boiler, fire extinguishers and the portable appliance testing (PAT) were scheduled to be tested. The registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

Is the service effective?

Our findings

The people, who were able to comment and the relative we spoke with told us they thought the staff were good and had the ability to provide a service which met individuals' needs. All of the people we spoke with told us they believed that the home delivered a good service.

People said, "The staff are kind and caring, they always are at hand." And "Since the new manager came there are always enough staff." And, "I can't thank the staff enough for what they do."

Relatives said, "Since September we have seen a lot of improvements. The director of operations is easy to speak with and they come in to have meetings with us. Both the director and manager take the time to listen to us and let us know what is going on. The staff go out of their way to make sure everyone is happy." We saw that some people are provided one-to-one support and the placing authority arranges this via an agency. We discussed the arrangements with staff and they all found it worked well and the agency staff told us they were treated as a part of the team.

An agency staff member said, "This is the best home I come to, as the staff are really friendly and genuinely put the people first. They are always quick to make sure the people have everything they need and are so attentive."

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We 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.

We found these assessments were only completed when evidence suggested a person might lack capacity, which is in line with the MCA code of practice. Care records also described all of the efforts that had been made to establish whether people could make decisions. The staff went to see the person on average three times during a day, in order to see if the individual was more able to make decisions at a different time. This approach also adopted trying all means to support the person formulate their decision and is the abiding principle of the MCA.

When people had been assessed as being unable to make complex decisions there were records to confirm discussions had taken place with the person's family, external health and social work professionals and

senior members of staff. This showed any decisions made on the person's behalf were done after consideration of what they would have wished and this was used to form a best interest decision. Best interest decisions were clearly recorded in relation to various aspects of care, including treatment plans, supporting individuals to safely engage in activities, finance and administering medicines amongst others. We found that the staff had a good understanding of the Mental Capacity Act 2005 (MCA) and what actions they would need to take to ensure the home adhered to the code of practice.

However we were told that three people received their medicines covertly. This is when medicines are given in food or drink to people unable to give their consent or refuse treatment. We saw that for one person their covert care plan had been written in April 2015 by their previous care home. The list of medicines allowed to be administered covertly did not match this person's current medicine. Another person receiving medicines covertly had nothing written about this in their care plan. There was no evidence that staff had sought advice from the pharmacist to make sure that the medicines were safe to administer in this way. This information is necessary to ensure people were given their medicines safely when they are unable to give consent. We made the registered manager aware of this discrepancy and they undertook to take action immediately to ensure these plans were updated.

At the time of the inspection, we found that where appropriate people were subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. Staff had a good understanding of DoLS and why they needed to seek these authorisations. We found that they had recognised that people may have disabilities but were able to retain the capacity to make decisions about their care. The registered manager also kept a record of when the DoLS expired and were aware they may need to do further assessments and re-apply for another authorisation. The registered manager was aware of the person's right to contest the DoLS and apply to the Court of Protection for a review of this order.

All the staff we spoke with told us that they were supported in accessing a variety of training and learning opportunities. Staff were able to list a variety of training that they had received over the last year such as moving and handling, infection control, meeting people's nutritional needs and safeguarding, amongst others. They also discussed the training they had recently completed and felt the training sessions were extremely beneficial. The registered manager told us they had been using a new training provider who they found offered a wide range of courses, provided both internal and external training and would facilitate any additional training.

We confirmed from our review of staff records and discussions that the staff were suitably qualified and experienced to fulfil the requirements of their posts. We confirmed that all of the staff had also completed refresher training.

When new staff commenced work at the home they had obtained access to the Care Certificate induction. The Care Certificate sets out learning outcomes, competences and standards of care that are expected. The registered provider had ensured the Care Certificate formed the basis for a comprehensive induction and this format when new starters commenced work.

Staff we spoke with during the inspection told us they had regularly received supervision sessions and had an annual appraisal. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. We were told that an annual appraisal was carried out with all staff. We saw records to confirm that supervision and appraisal had taken place. The registered manager ensured that staff received supervision at least every two months and also routinely completed competency checks.

The written records of the people using the service reflected that the staff had a good knowledge and

understanding of people's care needs. We saw that the assessment forms were completed for people and these provided a comprehensive range of information about individual's needs.

People were seen by GPs when concerns arose and attended regular healthcare appointments. We found that the staff had formed a close working relationship with the attending GPs, community nurses and hospital consultants, which had led to them being able to raise any slight concerns and seek advice in a timely manner. We saw records to confirm that people had regular health checks and were accompanied by staff to hospital appointments. This meant that people who used the service were supported to obtain the appropriate health and social care that they needed.

People received appropriate assistance to eat in both the dining room and in their own rooms. The tables in the dining room were set out well and consideration was given as to where people preferred to sit. People were offered choices in the meal and staff knew people's personal likes and dislikes. People also had the opportunity to eat at other times.

The cook told us that the registered provider gave them an ample budget. They explained that the registered manager expected food to be of a high quality. The cook told us their expenditure was never questioned and this freedom had allowed them to ensure the food was made using fresh products and home-cooked. Staff told us that there was a range of options at each meal-time and the cook confirmed that they would cook alternatives if people did not want what was on offer.

We saw that Malnutrition universal screening tool (MUST) tools, which are used to monitor whether people's weight were within healthy ranges were being accurately completed. We found that the majority of people had gained weight whilst at the home, including those individuals who had physical conditions which caused weight loss.

People said "The food is always really tasty and I can have as much as want."

Is the service caring?

Our findings

The people we spoke with said they were happy with the care provided at the home. They told us that staff respected them and were considerate. People told us all of the staff were kind. Relatives told us they thought the care had improved significantly and was now good.

People said "The night staff are lovely and give me a hand no problem, they are all good." And, "I can't think of anything they could do to make the home any better." And, ""The carers are like my daughters, they shower me every day and put cream on."

Relatives said, "My relative is being well looked after here."

We found that every member of staff that we observed used a caring and compassionate approach when working with the people who used the service. The interactions staff had with people led to all of the individuals responding positively to staff. They also encouraged people to engage in conversation and express their opinion about what they wanted to do.

Staff described with great passion their desire to deliver high quality support for people, and were extremely empathetic. We found the staff were warm and friendly. The directors, registered manager and staff showed genuine concern for people's wellbeing. It was evident from discussion that all staff knew people very well, including their personal history, preferences, likes and dislikes and had used this knowledge to form very strong therapeutic relationships. We found that staff worked in a variety of ways to ensure people received care and support that suited their needs. People were encouraged to remain as independent as possible. Where needed staff ensured people had access to advocacy services.

The staff explained how they maintained the privacy and dignity of the people they cared for and told us that this was a fundamental part of their role. One care staff member said, "We want to make sure people get the best care possible." We saw that staff knocked on people's bedroom doors and waited to be invited in before opening the door.

People were seen to be given opportunities to make decisions and choices during the day, for example, what activities to join in. People's care plans also included information about personal choices such as whether someone preferred a shower or bath. The care staff told us they accessed the care plans to find information about each individual and always ensured they took the time to read the care plans of new people.

The environment was designed to support people's privacy and dignity. People's bedrooms had personal items within them. All the bedrooms we went into contained personal items that belonged to the person such as photographs.

The head housekeeper had reviewed the living environment and made significant changes to the use of space within the home. They had created areas on the corridors where people could quietly sit and enjoy

views from the windows. They had made sure communal areas were set up to encourage people to join in conversations. Also the registered provider had completed a refurbishment programme in the units for people living with dementia and employed artists to create murals of shops and other local amenities on the walls. We found this enhancement of the environment had a positive impact upon peoples' mood and behaviour.

Is the service responsive?

Our findings

We saw that people were provided with and engaged in a variety of activities. From our discussion with the activity coordinator we found that the activities were designed to be engaging. People discussed recent trips out, the activities that went on at the home and a Shetland pony was visiting. People appeared to derive a great deal of pleasure from seeing visiting pony and one person reminisced, when they saw the pony, "I was always asking my father for a pony."

People said, "There is always something going on." And. "They always come up with good ideas." And, "I really love it in here. I can go out when I want and I am well looked after."

The person who owned the pony said, "Out of all the homes we visit [the pony] seems to enjoy coming here the most."

People who used the Chestnut Suite went out each day and also at evenings. Staff told us they were looking to increase the activities people became involved with and since the last inspection staff worked until 10pm so people could lead ordinary lives. This meant people could go to the cinema, theatre, to local pubs and bowling on an evening as well as to groups specifically set up for people with a learning disability.

We saw that staff promptly responded to any indications that people were experiencing problems or their care needs had changed.

We found the care records were well-written. They clearly detailed each person's needs and were very informative. As people's needs changed their assessments were updated, as were the support plans and risk assessments. We found that care plans were up to date and written with each person in mind. Thus they reflected each individual's needs and wishes.

A relative said, "Can I just say that the new manager is very approachable. I complained several times about my mother's curtains not closing and also that the toilet was not flushing to the previous manager. Nothing happened until they and the director started working at the home. We just mentioned it to them and the curtains and toilet were fixed straight away."

Staff were able to explain what to do if they received a complaint. We looked at the complaints procedure and saw it informed people how and who to make a complaint to and gave people timescales for action.

Over the previous year we had been made aware that a number of people had made formal complaints. We found that it was unclear from the records as to whether the previous management team had thoroughly investigated these concerns. The directors and registered manager told us they would review the records to see if all had been documented as being received and check with people that their concerns had been addressed. During the inspection the relatives and people we spoke with told us that if they were unhappy they would now not hesitate in speaking with the registered manager. They felt any concern raised would now be addressed.

We found the registered manager was a strong advocate for people and critically reviewed the service to make sure staff followed best practice guidelines. They were committed to empowering people who used the service to live fulfilling lives and reach their potential.

Is the service well-led?

Our findings

At the August 2015 inspection we found that albeit the registered provider had systems for monitoring and assessing the service this failed to identify that staff were working in silos so not using the resources effectively. We found that the units in the nursing provisions were run as completely separate services and staff within the residential unit took no note of the service. We found that all of the information the management staff referred to such as staff rotas, staff training, safeguarding incidents, audits only dealt with what occurred in the residential service. Staff who worked in the nursing services could not produce information management documents for their service.

We also found that the systems had not assisted staff on the residential unit to critically review the service or care documents. We found for the residential unit there were gaps in the completion of generic care records so often saw staff had not filled in documents. We also saw that routine checks of the home were completed but this did not prevent staff from leaving combustible material in the electric cupboard or from leaving the domestic storage cupboards open.

Therefore it was unclear as to what systematic oversight was given to the operation of the home.

We also noted that no registered manager was in post at the time.

Following the inspection the registered provider sent us an action plan detailing how they would address these issues.

At this inspection we looked at the action that had been taken to improve the operation of the home. We found that the change of home and senior management had led to significant improvements made to the operation of the home.

The two directors we found provided strong, focused leadership. The registered manager was supported by an effective staff team. The registered manager and staff told us they were all comfortable about being able to challenge each other's practice as needed. A member of staff said "[The registered manager] is always looking for ways we can improve".

Staff told us they felt the new directors and registered manager truly valued them as well as the people using the service. They felt this made a significant difference to their morale, which in turn led to them delivering better care. Staff also told us that the director of operations and registered manager were approachable had supported them. All the staff found that they were respected and this made them eager to come to work and deliver a high standard of care.

We heard how staff had felt comfortable contacting the director of operations to raise concerns, which the director took on board and dealt with immediately. They also discussed how the director had helped with the day-to-day tasks in the home and made them drinks one night. The staff told us this was a completely new experience for them and previously they had felt unable to contact senior managers or even the

managers in post because any concerns were dismissed as irrelevant and some of the previous directors had made them feel intimidated.

The people and relatives we spoke with were complimentary about the home and how it was run. Relatives told us they now found the care to be good. People said, "I'm happy here." And, "You can't fault the staff." And, "I feel very safe and looked after and I'm very happy." Relatives said, "I think the new team are making a big difference to the home."

The registered manager held regular discussions with the people who used the service, relatives and staff, which provided a forum for people to share their views. As well as formal methods of feedback the registered manager encouraged informal feedback. They had an open door policy and encourage relatives to see them to discuss individuals care and how areas could be improved.

We heard how relatives had raised at a meeting in December 2016 the need to provide better car park markings and disabled parking spaces as the current arrangements were leading to space not being available. The directors told us that this had been made a priority and the work marking out spaces was to be completed by February 2017.

The quality, safety and effectiveness of the service was monitored by a wide variety of quality assurance processes and audits. The registered manager discussed the reflective process they used to assist them and staff learn from any incidents or accidents. The majority of staff we spoke with discussed how they used all incidents and near misses to assist them review the care. They felt this had helped them to reduce the likelihood of incidents re-occurring.

The registered manager audited all of the processes and records relating to the care and support of people within the home. This included health and safety, infection control, mealtime experience, medicine management and people's care plans. Action plans had been developed from the audits and the results had been used to drive improvements.

The director of operations and new director of care were completing weekly monitoring visits and using this to critically review the service. They then reported their findings to the registered provider. We saw their visits led to the development of comprehensive action plans, which the team regularly reviewed to make sure they were being implemented.

The staff we spoke with had a pride in the home. Staff said, "I always enjoyed supporting the people and wanted to do the best by them. Since the changes to the management team I really do love working here."