Lillibet Healthcare Limited

Lillibet Lodge

Inspection report

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Bedfordshire
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Date of inspection visit:
14 February 2017

Date of publication:
19 April 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 14 February 2017 and was unannounced.

Lillibet Lodge is a residential care home providing a service for up to 25 adults, who may have a range of care needs, including physical disabilities, mental health, dementia and sensory impairments. There were 24 people living at the service on the day of the inspection.

A new manager was in post who had applied to register with us, the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found some areas that required improvement:

Staff had the right skills and knowledge to meet people's needs. However, people told us they were often left waiting for help when they called for assistance, and records we looked at supported this.

Care plans had been developed to record how people wanted to receive their care and support. However, these sometimes lacked important information about the person involved, or they were not followed consistently.

People were given opportunities to participate in meaningful activities when staffing levels allowed for this. This meant that there wasn't a regular programme of activities, particularly for those people who were not able to, or chose not to, leave their rooms.

Systems were in place to monitor the quality of the service provided and drive continuous improvement. However, these were not always effective because we found that concerns identified during this inspection had not always been picked up within audits that had been carried out.

The manager and provider acknowledged our findings and following the inspection, provided an action plan and clear assurances that all these areas would be addressed.

We also identified many areas during the inspection where the service was doing well:

Staff had been trained to recognise signs of potential abuse and keep people safe. People felt safe living at the service and staff were confident about reporting any concerns they might have.

Processes were in place to manage identifiable risks within the service to ensure people did not have their freedom unnecessarily restricted.

The provider had carried out appropriate checks on new staff to make sure they were suitable to work at the service.

Systems were in place to ensure people's daily medicines were managed in a safe way.

Staff had received training to carry out their roles, including support to complete nationally recognised induction and health and social care qualifications.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

Systems were in place to ensure the service worked to the Mental Capacity Act 2005 key principles, which state that a person's capacity should always be assumed, and assessments of capacity must be undertaken where it is believed that a person cannot make decisions about their own care and support.

People had a choice of food, and had enough to eat and drink. Assistance was provided to those who needed help with eating and drinking, in a discreet and helpful manner.

The service worked with external healthcare professionals, to ensure effective arrangements were in place to meet people's healthcare needs.

Staff provided care and support in a caring and meaningful way. They treated people with kindness and compassion and respected their privacy and dignity at all times.

We saw that people were given opportunities to express their views on the service they received and to be actively involved in making decisions about their care and support.

A complaints procedure had been developed to let people know how to raise concerns about the service if they needed to. People were confident in raising concerns if they needed to do so.

The new manager provided effective leadership at the service, and promoted a positive culture that was open and transparent. Everyone felt she was approachable and fair.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

There were sufficient numbers of suitable staff to keep people safe and meet their needs; however, people were sometimes left waiting for assistance.

The provider carried out checks on new staff to make sure they were suitable to work at the service.

Staff understood how to protect people from avoidable harm and abuse.

Risks were managed so that people's freedom, choice and control was not restricted more than necessary.

Systems were in place to ensure people's daily medicines were managed in a safe way.

Is the service effective?

Good

The service was effective

We found that people received care from staff who had the right skills and knowledge to carry out their roles and responsibilities.

Systems were in place to ensure the service acted in line with legislation and guidance in terms of seeking people's consent and assessing their capacity to make decisions about their care and support.

People were supported to have sufficient to eat, drink and maintain a balanced diet.

People were also supported to maintain good health and have access to relevant healthcare services.

Is the service caring?

Good

The service was caring

Staff treated people with kindness and compassion.

Staff listened to people and supported them to make their own decisions as far as possible.

People's privacy and dignity was respected and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive

People did not always receive personalised care that was appropriate for them.

Systems were in place to enable people to raise concerns or make a complaint, if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well led

There were systems in place to support the service to deliver good quality care however, these were not always effective.

A new manager had been appointed who had applied to register with the Care Quality Commission.

There was effective leadership in place and we found that the service promoted a positive culture that was inclusive and empowering.

Lillibet Lodge

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 was unannounced and was carried out on 14 February 2017 by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we checked the information we held about the service and the provider, such as notifications. A notification is information about important events which the provider is required to send us by law.

The provider completed 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.

In addition, we asked for feedback from the local authority; who has a quality monitoring and commissioning role with the service.

During the inspection we used different methods to help us understand the experiences of people using the service, because some people had complex needs which meant they were not able to talk to us about their experiences. We spoke with nine people living in the home and observed the care being provided to a number of other people during key points of the day, including breakfast, lunch time and when medication was being administered. We also spoke with the provider, the manager, two senior carers, two care staff, three relatives and a hairdresser - who visits the service on a weekly basis.

We then looked at care records for five people, as well as other records relating to the running of the service. These included staff records, medication records, audits and meeting minutes; so that we could corroborate our findings and ensure the care being provided to people was appropriate for them.

Requires Improvement

Is the service safe?

Our findings

People told us there were not always enough staff to keep them safe and meet their needs. They told us they were often left waiting for help when they called for assistance, particularly where two staff members were required together, for example, to support people to mobilise. One person told us: "At the weekend it can be bad. That is when they use more agency staff. That is when you have to wait and wait. I think the waiting is down to not enough staff." Another person added: "One can come soon enough - about 10 minutes, but you try and get two. They need two to hoist me, that's what takes the time. There is not enough of them." A third person told us they had been forced to wet their bed because it had taken too long for two staff to become available at the same time to support them. They told us they had needed to wait over 45 minutes on occasions. They added: "It's the waiting that is getting me down more than anything." We read some recent feedback from a relative which echoed these comments. They had written: 'Could be more staff around as there is not always enough on the floor in the lounges'.

Staff provided mixed feedback about staffing levels, but told us that the provider would arrange for agency cover if they were short staffed. One staff member told us: "At weekends we don't have enough staff and so we do use agency." The manager told us she had made changes to the way staff were deployed in the home to ensure two staff were available to assist people with their mobility and that people received the help they needed at meal times. She explained that one person also required one to one care to keep them safe. She told us that a minimum of five care staff were planned for each day time shift, and rotas we looked at confirmed this. Additional support was provided on the day of the inspection from the manager, two senior carers, a cook and two domestic staff. We noted from rotas that not all of this additional support was available at weekends. The manager told us she was in the process of recruiting new staff, to minimise the use of agency staff. She also told us that she hoped to enhance staffing levels at key times by recruiting additional staff to provide support with activities and cleaning; to ensure care staff were able to focus on care tasks and meeting people's needs.

We observed staffing levels during the inspection and found that people's needs were met. Call bells were answered in a timely manner, the person requiring one to one care received this in an effective and unobtrusive way. And at lunch time, meals were provided in two sittings, enabling staff to maximise their support to people requiring assistance with eating.

We then checked the call bell system, which provided an audit trail of the times people rang for assistance to when assistance was actually provided. The manager confirmed that staff were expected to respond to call bells within three minutes, with any urgent assistance being provided there and then. She added that a non-urgent request for assistance might take up to 20 minutes to be dealt with. We looked at the call bell response times for a sample of people over a weekend period. In general, we found that people had received assistance around five minutes after they had called for help. We did find lots of evidence however of call bells being reset by staff, before they returned to provide assistance. People told us this happened often, particularly if a staff member needed to find a second member of staff to help them. In a number of cases, we found that people had been left waiting longer than five minutes, with waiting times ranging from 12 minutes to 40 minutes.

Following the inspection the manager showed us a new call bell response protocol that was being issued to staff, which emphasised their responsibilities in meeting people's needs in a timely way. The protocol reminded staff that they faced possible disciplinary action if they did not provide care as expected. The manager also told us that regular spot checks and audits of the call bell system would take place. This showed that action had been taken by the manager to ensure people's requests for support are met promptly in future.

The manager described the processes in place to ensure that safe recruitment practices were being followed; to confirm new staff were suitable to work with people living in the home. We were told that new staff did not take up employment until the appropriate checks such as, proof of identity, references and a satisfactory Disclosure and Barring Service [DBS] certificate had been obtained. We found that legally required checks were being carried out.

Everyone we spoke with confirmed that they felt safe living at the service. One relative said: "Without a doubt he feels safe here, and I think he is safe here." Another relative added: "She is definitely safe here, I feel she is safe here." Staff told us they had been trained to recognise signs of potential abuse, and understood their responsibilities in regard to keeping people safe. One staff member talked to us about the different types of abuse that could occur, and explained how they checked for signs of these. They were very clear that they would report any concerns to a senior member of staff. We saw that information was shared with staff about whistleblowing procedures and safeguarding, including who to contact in the event of suspected abuse. Records we looked at confirmed that staff had received training in safeguarding and that the home followed locally agreed safeguarding protocols.

Staff spoke to us about how risks associated with people's care were managed; to ensure their safety and protect them. They described the processes used to manage identifiable risks to individuals. For example, one staff member told us: "At handover, seniors tell us about new concerns regarding safety. We have to ensure that if we are walking the way is clear of equipment and furniture. We try to keep people safe from falls at all times." Another staff member talked us about the systems in place to minimise the risk of people developing pressure ulcers. They said: "We have body maps on doors in bedrooms. They tell us where to cream each person." We saw that people had appropriate equipment in place, where required, such as mattresses and cushions designed to minimise the risk of developing a pressure ulcer. We looked at care records and read some recent notes written by a member of the external district nursing team, who confirmed staff supported people correctly when they were at risk of developing pressure ulcers; in terms of risk management plans, equipment and the care provided.

The manager described the systems in place to ensure the premises and equipment was managed in a way that ensured the safety of people, staff and visitors. We saw that checks of the building were carried out routinely, and servicing of equipment and utilities had also taken place on a regular basis. A business continuity plan was in place for the service; to support staff in the event of an emergency. The plan contained some useful information, however, we noted that it had not been reviewed recently and subsequently contained some out of date information such as contact details for the previous manager and provider.

Systems were in place to ensure people received their medication in a safe way. Staff showed us that they used an electronic system to manage people's medication and ensure they were given the right medication at the right time. We saw that the system would alert staff if they tried to give someone their medication too soon after the previous dose; minimising the risk of people being given too much medication. Staff confirmed that a backup paper system was ready to use if the electronic system were to fail for any reason.

We observed medication being administered to people at lunch time. People were not rushed and the staff member administering took the time to explain the purpose of the medication they were administering to people and how best to take it. They also checked with people to see if they needed 'as required' (PRN) medication, such as pain relief. We saw that this was only given as requested with clear reasons for doing so being documented. Staff took their time to check medication against records, to ensure they were giving people the right medication. They confirmed they had received training to be able to administer medication and demonstrated a good awareness of safe processes in terms of medication storage and administration. We saw that medication was stored securely, with appropriate systems and facilities in place for controlled drugs and temperature sensitive medication.

Good

Is the service effective?

Our findings

Without exception, people told us they were supported to have their assessed needs met by staff with the necessary skills and knowledge. One person told us: "They keep going on training, they tell me they will see me later because they are going on training now, so it must be regular. I have no complaints about that."

Staff talked to us about the training and support they received to help them in their roles, and to meet people's assessed needs, preferences and choices. They told us they received the right training to do their jobs. One staff member said: "They are very good with our training here, we regularly update our safeguarding, moving and handling and food hygiene training." Other staff talked to us about their induction training. One staff member told us: "It was to work out any issues here, about the work, how you can talk with people, and if something is not right, take it to a senior."

The manager talked to us about the home's approach to staff training. She told us new staff completed the Care Certificate (a nationally recognised induction programme). Records we looked supported this. A training matrix had been developed which enabled the manager to review all staff training and see when updates / refresher training was due. This confirmed that staff had received training that was relevant to their roles such as safeguarding, dementia awareness, manual handling, pressure awareness, nutrition, falls, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff told us that staff meetings were held to enable the manager to meet with them as a group, and to discuss good practice and potential areas for staff development. Recent minutes showed areas such as keyworkers, training, infection control and meal routines had been discussed. Records also showed that staff had received individual supervision; providing them with additional support in carrying out their roles and responsibilities. One staff member said: "It's every 14 weeks, very regular. They do tell us if anything needs to change, any complaints any moving and handling issues." Another staff member added: "Yes it is very regular, I can talk in it no problems."

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 that systems were in place to assess peoples' capacity and appropriate DoLS applications had been completed by the manager.

Staff were seen interacting with people in a way that supported them to make their own decisions. They were very clear when we spoke with them that if someone refused care from them, they would respect this. We observed that where people refused care from one member of staff, that another member of staff would

be asked to provide the care instead. In this way, staff demonstrated a positive approach in terms of dealing with potentially difficult situations, whilst ensuring people's rights were protected.

Everyone spoke highly of the food provided and told us they had enough to eat and drink. One person told us: "The food is excellent, there is no other way you can describe it. It is well cooked homemade food. Lots of veg – great." People told us there was a choice of two main meals at lunch and tea time, and that drinks and snacks were provided in between meals. We observed people being offered tea or coffee before lunch, and a choice of biscuit was also offered.

Food and drink was available throughout the day and meals we saw looked and smelt appetising. We observed that people were supported in an appropriate manner, with staff sitting by their side and engaging meaningfully, where help was needed to eat.

Staff demonstrated a good awareness of people's individual dietary requirements. One staff member talked to us about people who were at risk of malnutrition. They said: "We document drinks, we do prompt them to drink and we offer them something else to eat if they are not eating after we have prompted them. Sometimes we make them toast or give them a jacket potato. We do the same with puddings." Written information about people's dietary needs was available for staff working in the kitchen, to support them in providing appropriate food and drink according to people's individual preferences and assessed needs. Food and fluid charts were also being maintained, to monitor those most at risk of malnutrition. Other records showed that people's weight was being monitored, to support staff in identifying any potential healthcare concerns. These were being reviewed regularly. We saw a certificate had been awarded to the service by the local Food First Team, who work with care homes to promote the detection of, and provide support in managing, those at risk of malnutrition using everyday foods.

People were supported to maintain good health and have access to relevant healthcare services. We read some recent positive feedback from someone using the service about the way they were cared for. They had written: 'The doctors are called quickly if required'. Other people confirmed they were supported to maintain contact with their own GP, who would come out to visit them if necessary. One person was concerned about their medication, and reported this to a staff member. We heard the staff member contact the person's GP for advice and then providing appropriate reassurance to the person afterwards. The person was seen to respond well to this.

Staff we spoke with were very clear about the importance of monitoring people's health needs and seeking additional support and advice from relevant external professionals as required. They told us they felt well supported by external healthcare professionals, who they called upon when they required more specialist support. Records showed that people were seen by relevant healthcare professionals, such as the District Nursing team and GP when they needed to.

Good

Is the service caring?

Our findings

People told us that staff treated them with kindness and compassion. Without exception people felt that the staff all knew them well. One person told us: "No complaints at all about the care. I can't stand you see, I am totally in their hands and they are good and kind to me." Another person added: "They are kind and patient with me and every one. There is no rushing me. They let me do what I can and help me when I need it." We saw some recent written feedback from relatives that echoed these comments. One relative had written: 'Thank you for all the kindness and support you give'.

The manager showed us a quiz that she used to test staff knowledge from time to time regarding people's care needs; to ensure they knew about the people they were caring for. We observed positive interactions between staff and people, and all of the staff demonstrated a good understanding of the needs of the people they were supporting. Their approach was meaningful and personalised. For example, staff were seen offering people choices, and trying to involve them in making decisions about their care as far as possible, such as where they wanted to sit and what they wanted to eat or drink.

Staff were patient and took the time to explain what they were doing before carrying out care tasks. They were also seen taking practical action to relieve people's distress or discomfort. One person reported that they were cold, and staff acted quickly to ensure their heating was working correctly. The person was also anxious about some medication they thought they had missed. A staff member was then heard ringing the person's GP and relaying information back to them, which immediately reassured the person that they had been taking their medication as prescribed. They told the staff member: "Thank you for telling me. Thank you."

People were supported to maintain important relationships with those close to them. Everyone we spoke with confirmed that friends and family could visit at any time. A relative told us: "They always give me a cup of tea. The manager has (also) asked if I would like to come for lunch with my wife." We saw evidence of positive written communication between the manager and relatives, including the sharing of photographs and video footage of people engaging in activities; to enable relatives to see their loved ones being happy and involved. The manager told us that Wi-Fi (wireless networking technology) was available to use. She explained that this would enable people to access the Internet and social media; to support them to avoid social isolation and maintain relationships with people that matter.

Everyone told us that their privacy and dignity was respected and upheld. People told us curtains and doors were always closed and that staff ensured they were appropriately covered when providing personal care. Staff talked to us about how they ensured people's privacy and dignity. One staff member told us: "We ask the people first of all… We have to cover them before we give them personal care."

We saw that the service had marked 'Dignity Action Day' on 1 February 2017, with a 'dignity tree' on display in the lounge. Each leaf recorded what dignity meant to individual people using the service. We also noted the building to be clean and well maintained. Redecoration was taking place in some parts, and the manager advised that new curtains were also on order. This showed that the provider was committed to

providing people with comfortable and dignified surroundings.

Requires Improvement

Is the service responsive?

Our findings

The manager told us that people, or where appropriate, those acting on their behalf, were encouraged to contribute to the assessment and planning of people's care. She added that relatives were always contacted if there were any concerns or issues. Everyone we spoke with told us they had a relative or good friend who could speak for them, and relatives confirmed that meetings were held to discuss people's individual needs. One relative told us about a recent meeting and explained how staff tried to ensure the involvement of the person concerned. They said: "They did keep speaking with [the person] to try to find out what she thought and felt." The manager showed us evidence of a new family liaison role, linked to the service's keyworker system, that she was in the process of introducing, to enhance communication links between relatives and the service. She explained that this would provide relatives with a named member of staff for them to discuss any issues or concerns they might have in the first instance.

The manager told us that people's feedback was used to develop care plans that reflected how they wanted to receive their care, treatment and support. The service used an electronic care planning and recording system, which provided prompts to staff to remind them what to record and when. The provider showed us that he was able to monitor the care planning system when off site, to ensure people's needs were being met as agreed. We looked at care plans for a sample of people and found they contained some useful and personalised information; to support care staff in providing the care and support needed to meet individual people's needs. Additional records and monitoring charts were being maintained to demonstrate the care provided to people on a daily basis. We also found that people's needs were routinely reviewed; to ensure the care and support being provided was still appropriate for them and that their needs had not changed.

Despite this, we noted a number of areas for improvement where care plans lacked important detail, contained out of date information or were not being followed consistently. For example, one person's care plan stated that they needed assistance to go to the toilet using a commode. However, their daily records contained a recent entry where a staff member had used an alternative method referred to as the 'roll method.' We spoke with the person in question and they explained that this method caused them discomfort. They said: "If I tell them I want to go to the toilet they don't bother to get a hoist most of the time, they make me lean over and push the sharp potty up from the commode under me." The manager confirmed that the 'roll method' was not included in the person's toileting care plan and therefore should not have been used by staff. She told us that she would address this with the staff members concerned. The manager also told us that all care plans were being reviewed and updated as required. She showed us one that had been written more recently, as an example of how she wanted care plans to be written in the future. We noted that this plan contained clearer detail, in terms of making sure the person received care in a more person centred way.

We spoke with people about their social interests and how they were supported to take part in social activities. No one was aware of daily activities that took place at the service, but they did say that a musician came in on a monthly basis. Some people also told us that they enjoyed reading a newspaper or watching television. The manager confirmed that the service did not yet employ an activity coordinator, but said this was something she hoped to change in the near future in consultation with the provider. She told us that in

the interim, activities were arranged by care staff. Staff we spoke with confirmed this, but told us they were often busy providing care, so activities were not always a priority for them. One staff member told us: "We don't have an activities coordinator and we are all very busy." Another staff member added: "We try to take them all downstairs as far as possible for interaction with others." During the afternoon we heard lots of laughter as a group of people were supported by staff to participate in a romantic song and discussion activity for Valentine's Day. Other people were supported to look and feel their best through having their nails painted or an appointment with a visiting hairdresser, who was on site during the day. After the inspection, the manager confirmed that action would be taken to improve activity provision and reduce the risk of social isolation. She said this would include daily one to one time for anyone unable to, or not wishing to leave their room.

We saw that information had been developed for people outlining the process they should follow if they had any concerns with the service provided. People we spoke with were aware of the complaints procedure and who they could raise concerns with, although no one had felt it necessary to do so. Staff were clear that if a concern was reported to them, they would pass this onto a senior staff member immediately.

The manager showed us that a record of concerns, complaints and compliments was being maintained. We noted from this that feedback was taken seriously, and updated to record any actions taken in response. This showed that people were listened to and lessons learnt from their experiences, concerns and complaints; in order to improve the service.

Requires Improvement

Is the service well-led?

Our findings

The manager talked to us about the quality monitoring systems in place to check the quality of service provided. She showed us that satisfaction surveys were sent out to people, relatives and staff; to gain their feedback on how well the service was doing, and to see if there were areas that could be improved. Internal audits were also taking place on a regular basis covering areas such as medication, care records, accidents and the premises. We also saw evidence that the manager had developed further comprehensive quality monitoring tools, to assist her in carrying out spot checks on areas such as the kitchen, moving and handling techniques, personal care and assistance with meals. She told us she planned to introduce these within the next month.

We spoke with the provider who explained about some of the ways he checked the quality of service provision. He told us that he regularly visited the service on an announced basis and took time to speak with people, staff and families, as well as looking round the building, checking records and attending staff meetings. He added that he was in regular communication with the manager, and that they went through any issues identified together. This demonstrated that there were arrangements in place to monitor the quality of service provided to people, in order to drive continuous improvement.

However, the provider also talked to us about a new quality monitoring role that had been created at the service, to provide oversight and complete quality audits on his behalf. We had to request evidence of these audits, because there was no record of these at the service. Information we received after the inspection was brief, and did not demonstrate effective oversight of the service in terms of the regulations that registered care services are expected to comply with. Where improvements had been identified, we did not find a corresponding action plan or any obvious evidence regarding progress made from one month to the next. In addition, we were not assured about the effectiveness of these audits because they had failed to pick up some of the concerns we had identified during this inspection, in particular with the monitoring of call bell response times and the quality and content of care plans. The provider acknowledged our findings and confirmed that the lack of robust provider level quality monitoring records was down to the fact that some of this feedback was provided verbally, and as such a written record was not always maintained. He told us that he would develop and introduce a monthly provider review and actions template, which would be kept at the service, in order to evidence better oversight of the service at provider level in future.

People told us there were opportunities to be involved in developing the service, which included completing satisfaction surveys and attending meetings. All the relatives we spoke with said that staff were very approachable and they could get any information that they wanted. We saw minutes from a recent meeting for people using the service which showed that areas such as concerns, staff and activities were discussed. We saw that useful information had also been displayed around the building about safeguarding, nutrition and the procedure to follow in an emergency. Clear information had also been developed for prospective users of the service, setting out what they could expect from the service. Information was shared with staff through notices, training and meetings. This demonstrated an open and transparent approach in terms of how information was provided to and communicated with people. The manager told us she planned to introduce quarterly newsletters for relatives and to provide information for people, such as menus, in an

alternative format; to better support their inclusion and involvement with the service.

The service demonstrated good management and leadership. Since the last inspection, there had been a change of provider and manager. There was evidence that the outgoing provider and manager were still supporting the service as part of a planned handover; to aid a smooth transition for people using the service and the staff team. The new manager told us she had been in post from July 2016 and that she was in the process of applying to register with the Care Quality Commission. Our records supported this.

Everyone we spoke with knew who the manager was and said without exception that she was very approachable. One person told us: "She's always here and around and about. She pops in and chats to me when I am sitting here. She's a nice lady." We read some recent feedback provided by someone using the service about the way they were cared for. They had written: 'Very helpful and understanding management'.

Staff echoed this feedback and told us they felt well supported. One staff member said: "This is why I applied to work here, it's a friendly home and the manager is very good - very kind and approachable." Another staff member added: "The manager supports us well. If we have family problems or problems here, she listens to us and is good to us." A third member of staff told us that things had improved since the manager had started, and that she had: "Turned things around." They provided examples of improvements they felt she had made such as staff training, staff supervision, infection control and medication information. We observed the manager speaking with people. She knew people's names and interacted with them on a personal level, making them feel at ease. We noted that people recognised the manager, who took time to provide thoughtful touches, such as giving people individual gifts in recognition of it being Valentine's Day. People we saw were pleased to receive their gifts.

We noted that there was a relaxed, comfortable and happy atmosphere within the home. Staff we spoke with were clear about their roles and responsibilities across the service. They made positive comments about the open culture at the service and confirmed they were supported to question practice. They told us clearly that they knew how to whistle blow and raise concerns, if required.

We observed staff working cohesively together throughout the inspection and noted the way they communicated with one another to be respectful and friendly. We found the manager to be open and knowledgeable about the service. She responded positively to our findings and feedback, with a clear focus on finding solutions and promoting people's involvement and dignity; in order to improve the quality of service provided. The manager confirmed she felt well supported by the provider, and that appropriate resources were available to drive improvement at the service.

Systems were in place to ensure legally notifiable incidents were reported to us, the CQC in a timely way and records showed that this was happening as required.