Care Worldwide (Nottingham) Limited

Beechdale Manor 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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 14 June 2017. Beechdale Manor provides accommodation, nursing and personal care for up to 65 older people, some of whom were living with dementia. There were 31 people living at the service at the time of our inspection.

At the time of our inspection there was no registered manager in post. The registered manager had left the service in September 2016. Interim management arrangements were in place. 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 our last comprehensive inspection in November and December 2016, we asked the provider to take action in relation to a number of breaches of regulations. During this inspection we found improvements had been made.

People received their medicines as prescribed and medicines were managed safely. People were kept safe by staff who understood their responsibility to protect people from avoidable harm and abuse. Measures to keep people safe, such as equipment and regular observation were in place and safety checks were carried out as required. People were supported by sufficient numbers of staff.

People were supported by staff who had received training and were supported by the management team. People were encouraged to make choices and decisions and had their rights protected under the Mental Capacity Act 2005. We observed that some people required further encouragement to eat but people were supported to drink enough. People were supported to maintain their health and people's health was monitored and any changes responded to.

People were cared for by staff who were kind and treated them with dignity and respect. People and their relatives were given opportunities to be involved in reviewing the care they received and people had access to advocacy services if they required this.

People told us they received care and support at the time they required it and in line with their preferences. Staff were provided with guidance about people's needs and preferences in care plans which had been regularly reviewed and updated when people's needs changed. People and their relatives felt able to approach the management team with any concerns and we saw that action had been taken to address concerns which had been raised.

Systems in place to monitor and improve the quality of the service were not always fully effective. People and their relatives told us the management team were approachable and responsive to concerns visible and staff felt supported and motivated. People and their relatives were kept informed of changes and given

opportunities to be involved in the development of the service.

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

People received their medicines as prescribed and medicines were managed safely.

People were kept safe by staff who understood their responsibility to protect people from avoidable harm and abuse.

Measures to keep people safe, such as equipment and regular observation were in place and safety checks were carried out as required.

People were supported by sufficient numbers of staff.

Is the service effective?

Good

People were supported by staff who had received training and were supported by the management team.

People were encouraged to make choices and decisions however and had their rights protected under the Mental Capacity Act 2005.

We observed that some people required further encouragement to eat but people were supported to drink enough.

People were supported to maintain their health and their health was appropriately monitored and any changes responded to.

Is the service caring?

Good

People were cared for by staff who were kind and treated them with dignity and respect.

People and their relatives were given opportunities to be involved in reviewing the care they received.

People had access to advocacy services where required.

Is the service responsive?

Good

People told us they received care and support at the time they

required it and in line with their preferences.

Staff were provided with guidance about people's needs and preferences in care plans which had been regularly reviewed and updated when people's needs changed.

People and their relatives felt able to approach the management team with any concerns and we saw that action had been taken to address concerns which had been raised.

Is the service well-led?

Requires Improvement

Systems to monitor and improve the quality of the service were not always fully effective.

People and their relatives told us that the management team were approachable and responsive to concerns visible and staff felt supported and motivated.

People and their relatives were kept informed of changes and given opportunities to be involved in the development of the service.

Beechdale Manor 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.

This inspection took place on 14 June 2017 and was unannounced. The inspection team consisted of one inspector, a specialist advisor who was a nurse 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, 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. We checked the information we held about the service such as the completed PIR, previous inspection reports and statutory notifications. A notification is information about important events, such as such as allegations of abuse and serious injuries, which the provider is required to send us by law. We also contacted the local authority and the clinical commissioning group who fund the care of some people at the service and asked them for their views. We used this information to help us to plan the inspection.

During our visit we spoke with four people who lived at the service and three relatives. We also spoke with one nurse, two care workers, the activities co-ordinator, the maintenance person, cook and the manager. We looked at the care records of seven people who lived at the service, the recruitment records of three members of staff, as well as a range of records relating to the running of the service, such as audits and complaints. As part of our inspection we observed care and support in communal areas during our visit.

Good

Is the service safe?

Our findings

At our focused inspection in November 2016, we asked the provider to take action to ensure people were given their medicines as prescribed and that these were managed safely. We identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found that improvements had been made and the provider was no longer in breach of regulation.

People told us they received their medicines in a way and at the time they required them. One person told us, "They (staff) sort my tablets. They do it morning and night," whilst a person's relative commented, "I can't recall any issues with medicines, they (staff) keep me informed if there's been a change in medication."

Information was available to aid the safe administration of medicines. People's medicines administration records were completed consistently and we did not identify any gaps to indicate medicines had been missed.

Medicines were stored in locked trolleys and cupboards within a locked room and records showed they were kept at an appropriate temperature. However, we observed that one member of staff left the medicine trolley unlocked and open when they were administering medicines in a communal area of the service. This meant there was a risk of unauthorised access to medicines which could place people at risk of harm. People received their medicines from staff who had received training and had their competency assessed. Following our feedback to the manager about the above issues, they confirmed that staff competency would be reassessed to ensure that issue above was addressed with staff.

At our last comprehensive inspection in November and December 2016, we asked the provider to take action to ensure that people were cared for in a way that protected them from risk of harm. This was because risks to people were not always managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found that the required improvements had been made.

People were kept safe by staff who responded appropriately to potential risks. One person told us, "There's always someone around and if there isn't you press the buzzer and they come quick," whilst another person commented, "They (staff) watch all the time, make sure we're alright." People's relatives also felt that risks were managed and described the measures staff put into place if required to ensure people's safety.

People's risks had been assessed and regularly reviewed. Management plans were in place for staff to follow to ensure people were supported safely. Staff we spoke with were able to tell us about people's risks and how they needed to support them to mitigate potential risks to their safety. For example, staff told us about people who were at risk of falls and how they completed regular observations of them. They were able to tell us about people who had specific equipment in place to reduce the risk of harm, such as fall sensors. Records we looked at confirmed that staff were carrying out care in a way that reduced people's risks. For example, where people were at risk of pressure injuries records showed people were being supported to

change their position in line with their care plan. This meant that action was taken to protect people from risks associated with their care and support.

People could be assured that equipment used to support them was safe and used appropriately. Records showed that required safety checks in relation to the environment and use of equipment were carried out on a regular basis. We observed that staff followed safe practices when supporting people with their mobility. Equipment required to assist people with their mobility was available although we did observe two people waiting for a short period of time when they required support to move. This was because there was only one hoist of the type required and it was being used on a different floor. We discussed the problems which may arise if the specific hoist needed repair. The manager told us they would consider contingency plans or ordering an additional hoist.

At our last comprehensive inspection in November and December 2016, we asked the provider to take action to ensure that safe recruitment practices were followed. This was because not all staff had been recruited safely. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found that most of the required improvements had been made.

People were supported by staff who had been through the necessary recruitment checks. For example, checks had been carried out through the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work vulnerable adults. However, the provider had not always followed their action plan and completed a risk assessment which considered that a positive DBS check had been returned. However, we found that measures to mitigate the risks to people were in place and the risk to people was low. This meant that the necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

People told us there were enough staff to respond to their needs. People's relatives told us in the past the service had used a lot of agency staff who did not know their relations but this was no longer the case. One person's relative told us, "There is (enough staff) now," whilst another relative commented, "Most of the time there's enough (staff) on and they're good."

Staff told us there were enough staff on duty to meet the needs of people who lived at the service. They told us that staffing levels were generally maintained and short notice sickness or staff absence was normally covered by other staff members or agency. We looked at staffing rotas. These showed that people were supported by a sufficient number of care staff each day. During our inspection, we observed there were a sufficient amount of staff to respond to people's needs in a timely manner.

People told us they felt able to approach staff with any concerns they had about their safety. One person told us about feeling threatened by another person who lived at the service and that the staff were "soon there" and ensured they were safe. The relatives we spoke with told us they would report any concerns they had about people's safety and were confident staff would take the appropriate action to safeguard their relation.

Systems were in place to minimise the risk of abuse. The staff we spoke with told us they had received training in safeguarding adults, were aware of the signs of abuse and would report concerns to the manager. They told us they were confident the manager would take action in response to any concerns raised. Some of the staff we spoke with were not sure of the immediate action they would take in the absence of the manager. However, the manager told us that they have an on call system and all staff should be confident to use this if they have any concerns and records showed that safeguarding referrals had been made to the

local authority when required.

Good

Is the service effective?

Our findings

People told us they felt staff displayed appropriate knowledge in meeting their needs. One person told us, "Oh yes no problem at all (with staff competency). They're all up to speed now." A person's relative said, "The management team seem committed to developing skills. They all seem to have the skill set to manage the residents. If a member of staff thinks they're not sure they will ask a member of staff who is more experienced."

Staff told us they had received an induction when they commenced working at the service which involved shadowing another member of staff. Records showed the vast majority of staff had completed the required training and yearly reviews of knowledge were scheduled so that staff could remain up to date with skills and knowledge. Staff gave examples of the training they had received and how they used this to support people. They told us they also received regular supervision every two to three months during which they could discuss any training needs they had. They gave the example of new paperwork being introduced and this being talked about as part of group supervision. This meant that staff received training and support to enable them to care for people effectively.

People told us they were involved in daily decisions about their care. One person told us, "Yes, they (staff) ask me about things, what I want to eat and if I want to join in with stuff." People's relatives told us they were consulted about decisions that needed to be made in the event their relation was unable to make decisions for themselves. One person's relative told us, "[Relative] can't really make the choice. They (staff) sometimes ask me."

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. Staff told us they had received training in the MCA and records showed this to be the case. The staff we spoke with displayed an understanding of the principles of the MCA and described how they supported people to make their own decisions where able. For example, one staff member spoke about the importance of offering people choices, respecting people's preferences and acting in a way which was least restrictive of their rights.

Records showed that people's agreement and consent to general aspects of care and record was sought. In some instances a relative had signed the form on behalf of the person and it was not clear whether they had the legal authority to provide consent on behalf of the person. The manager confirmed following our visit this information had been checked and added to people's care plans. When specific decisions were required in relation to certain aspects of care a mental capacity assessment had been carried out if the person's capacity was in doubt. These were documented to show how capacity had been assessed and how a best interest's decision had been made. This meant that people's rights under the MCA were respected.

People can only be deprived of their liberty so that they can 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. DoLS applications had been made for a number of people who used the service. We checked the records of a person who had a DoLS authorisation in place and saw that they were receiving care in line with the authorisation.
People who sometimes communicated through their behaviour were supported by staff who recognised how to support the person and how to respond in a positive way. There were care plans in place informing staff of how best to support the person in a way which was least restrictive of their rights and freedom.

Most of the people we spoke with told us they liked the food and confirmed they were given choices of what to eat. One person told us, "They come in the day before and say, 'What do you want for dinner?' We have two or three choices but even if you want something else they'll do it." A person's relative commented, "The food is fine, they (people) do get a choice." We observed that people's choice of food was provided during our visit.

People were supported to maintain adequate levels of hydration. All of the people we spoke with told us they were provided with plenty of drinks throughout the day. We carried out our visit on a warm day and observed that people were routinely supplied with drinks. Some people had their fluid intake monitored and records confirmed that people were provided with sufficient fluids on a daily basis.

The support that people received to eat their meals was variable and we observed some staff offer more support and engagement during the mealtime than others. When this was provided it had a positive effect on people. For example, we observed one person was not eating and received little encouragement to eat for thirty minutes until a member of staff noticed their food was cold, provided a fresh meal and talked to them gently, offering encouragement. The person then began to eat. We discussed this with the manager who confirmed that supervisions would be carried out with staff to discuss the need for prompting and encouragement and the importance of offering alternatives if people were not eating.

People's needs in relation to their nutrition had been assessed and care plans were in place and regularly reviewed. A diet notification record was available for staff which identified any specific dietary requirements and people's preferences. Records showed that people were weighed weekly or monthly according to their level of risk. The people whose care we reviewed were maintaining or gaining weight.

People told us they had access to healthcare professionals and were supported to maintain their health. One person told us, "A member of staff takes me to the eye people and to the hospital, they're very good." People's relatives told us that staff monitored people's health and liaised with external professionals as required. One person's relative said, "The chiropodist comes in. I think [relative] may well have seen the optician. A GP and practice nurse visit." Another person's relative told us, "Earlier on [relative's] behaviour was a bit erratic. [Relative] wasn't as responsive as normal so they dipped [relative's] urine and called in the doctor because [they] had a UTI."

Records showed that people had access to health care services as required and that information provided by external professionals was incorporated into care plans. For example, one person's care plan reflected the advice a tissue viability nurse had provided in relation to treatment of a person's wound and records showed that staff were following this advice. Advice was sought from external health professionals when people's needs changed and we saw that people had been referred as appropriate to a dietician, speech and language therapist, specialist nurse and occupational therapist. Records evidenced that people also had access to dentistry, chiropody and an optician.

Good

Is the service caring?

Our findings

The vast majority of people we spoke with told us that all of the staff were kind and caring. One person told us, "They're (the staff) very good. They wait on you hand and foot." Another person said, "Oh yes they're (staff) all caring. There are five or six that are really caring. They all know what they're doing." Only one person felt that some members of staff could be more caring. They told us, "They are very good, some are but a couple aren't, they're not so good. They don't seem to get things done so I just ask someone else. But the rest can do anything you need."

All of the relatives we spoke with were very complimentary of the caring attitude of the staff. One person's relative commented, "They're a very caring and very patient staff team, it's the general care, it's not like finding one case. They are all very, very good." Another person's relative told us, "I'm never edgy about leaving [relative]. I know they'll look after him." We observed that staff had a good rapport with people and greeted people warmly and spent time engaging people in friendly conversation.

We witnessed some thoughtful interactions between staff and people who lived at the service and several occasions of staff providing support in an attentive and caring way. For example, we observed one person being supported with their mobility. Staff members engaged with the person throughout the task, adjusted their clothing to preserve their dignity and ensured they were comfortable before leaving them. On another occasion a staff member noticed a person's clothing tags were sticking out and asked if they could tuck them in for them. During our visit, several people who lived at the service were sat outside in the sunshine and staff ensured they were kept comfortable by applying sun cream and ensuring they had plenty to drink.

Some people who lived at the service had dementia and could be anxious and distressed at times. We observed staff responding to people's distress or anxiety and saw that staff sought to provide people with reassurance and comfort. We saw that swift action was taken by staff in response to someone who had drink spilt on them to ensure they were comfortable and clean.

People and their relatives confirmed that people were given information, choices and asked their preferences before care was provided. One person told us, "The chef knows me, knows what I like and I asked them not to give me a dinner plate full so they don't." One person's relative told us, "They (staff) try to communicate with [relative]. My [relative] can sometimes be a bit difficult at times but they try to engage with [relative] to get [relative] to make the choice they're comfortable with." We observed staff asking people about their preferences; for example, when a person requested a hot drink a member of staff asked how they would like it. People's independence was also promoted by staff. Another person's relative said, "They (staff) move [relative] in a chair and transfer [relative] but if [relative's] in a good mood they encourage them to use the Zimmer (frame)."

The majority of staff we spoke with were knowledgeable about people, including their preferences such as whether they preferred to be supported by male or female staff and the food they liked or disliked. When a person had difficulties in communicating verbally, communication care plans were in place and provided information for staff on strategies to facilitate conversation and support people to make choices and

express their preferences. Care plans contained information about people in the form of a 'life story' which included important information about the person including significant events and people in their lives.

People and their relatives told us that they had the opportunity to review care plans and were asked if they felt any changes or additions were required. One person's relative told us, "I have reviewed [care plan] recently with one of the senior carers. If they're any changes they'll incorporate it." The manager described sitting down with two people and going through their care plans. Records confirmed that people and their relatives had the opportunity to comment on the care they were receiving and whether it was meeting their needs.

People had access to advocacy services. Details of an advocacy service were available with the home and records showed that an advocate had been involved in the review of a person's care plan. Advocates are trained professionals who support, enable and empower people to speak up. An advocate had visited the home to hold group sessions to help identify and concerns that people may have.

People and their relatives told us that people were treated with dignity by staff and raised no concerns about the attitude of staff towards them. One person's relative told us, "Definitely (treated with dignity). They (staff) close the curtains and shut the door when they give [relative] a wash or change her. They tell [relative] what they are going to do."

Throughout our visit we observed that staff treated people with dignity and respect. We observed staff ensuring that people were comfortable and clean. People's request for support to use the toilet was met in a timely and discreet way. The staff we spoke with were able to describe how they treated people with dignity and respect. One staff member described how they would support people to maintain their privacy and dignity by ensuring doors and curtains were closed before providing personal care, not discussing people's personal information where they could be overheard and checking the support people required with personal care.

Good

Is the service responsive?

Our findings

At our last comprehensive inspection in November and December 2016, we asked the provider to take action to ensure that people received care and support which was responsive to their needs. This was because people were at risk of receiving care which was not personalised to their individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we found that the required improvements had been made.

People told us that staff responded to their needs. One person told us, "I've got a buzzer and they (staff) come as quickly as they can." Another person's relative told us, "They (staff) check on [relative] regularly. I always check the sheet in [relatives] room, the fluid chart and the check and it's always signed." We observed regular checks on people who required these being carried out during our visit and that people's requests for support and call buzzers were responded to promptly. People told us that support was generally provided when they needed and wanted it. Although one person told us they altered the time they went to bed so they would not have to wait too long, the manager was aware of the person's concerns and told us they would speak to them to provide reassurance they could chose when they went to bed.

The provider told us in their PIR that, 'Before admitting a service user into home a full assessment of need is carried out, to ensure the individuals needs can be met safely, and that any equipment required is in place prior to them moving in to the home'. Records confirmed that a pre-admission assessment had been carried out and a summary of each person's care requirements was kept at the front for quick reference. A range of care plans had been developed which contained information about the person's requirements in relation to different care needs. We found these had been regularly reviewed and updated when people's needs had changed.

People's care plans contained sufficient detail to enable staff to provide personalised care. For example, a person's nutritional care plan identified the person required a diabetic diet and the range of blood sugar levels to be maintained for the person. Information about signs of a possible deterioration in their healthcare condition were provided to staff so they could recognise these and take action when necessary. Another person could display agitation when personal care was being provided. The care plan had been updated following the involvement of an external healthcare professional to include detailed information about how staff can best support the person to maintain their personal care which reduces their agitation.

The majority of staff we spoke with were knowledgeable about people's needs. During our last comprehensive inspection, staff had told us they did not have the time to read people's care plans. During this inspection one member of staff told us, "We (staff) are starting to read care plans so we know what to respond to." People's daily records showed that people were received care and support as specified in their care plans. For example, some people who lived at the service required regular observations to ensure their safety and we observed staff completed these as required. Other people required regular repositioning and records showed they were provided with this.

People described a range of activities which took place at the service and confirmed they were given the

opportunity to join in as they wished. One person commented, "There is a lot going on but I don't join in," whilst another person told us, "They have trips; they had one a week ago." People told us that church services were provided and they were supported to practice their faith if they wished to. We were also told that people were supported to go shopping to purchase items. One person told us, "I go down to the office if I wanted money. I have to go down when they take me shopping. I can't go without my money. Last time we went to Asda."

The service had a dedicated activities co-ordinator. They told us they planned these on a weekly basis and based activities on people's interests. When we asked how they ensured activities matched people's interests they told us, "We talk to them, do 'This is my life'. We've just found out that [Person's name] used to like knitting and so did a few others and so we're going to start up a knit and natter." They confirmed that trips to the community were arranged and that external entertainers visited three or four times a month. During our visit we observed people in the gardening listening to music and one person watered the plants. People were encouraged to join in activities such as a game of bingo, during which staff supported people to participate. In the afternoon an outside entertainer visited who sang and played instruments, people who attended were encouraged to participate in singing and playing tambourines. When asked about how people who preferred to stay in their rooms were supported they told us, "On Thursdays and Fridays I do one to one and room visits. I sometimes do sensory staff or hand massage because some of them can't engage with me."

People could be assured that complaints they made would be responded to appropriately. Information about how to complain was displayed within the service. People felt confident in approaching staff with any complaints or concerns and told us concerns they had raised had been responded to. One person's relative told us, "I spoke to someone when the heating went off for three days and they washed [relative] and I thought her room was too cold. So they brought some heaters in." The staff we spoke with were confident that any complaints raised with the management team would be responded to appropriately. One member of staff told us they felt comfortable to approach the manager with "anything and everything" and stated when they had raised issues with the manager these had been responded to in a confidential and professional manner.

The provider told us in their PIR that, 'All complaints are dealt with and responded to in a timely manner, following our internal complaints policy.' Records confirmed this to be the case. Two complaints had been received since January 2017 and these had been responded to in a timely manner with details of the action taken recorded.

Requires Improvement

Is the service well-led?

Our findings

Beechdale Manor has a history of non-compliance with the fundamental standards. At our last two comprehensive inspections in August 2016 and November and December 2016, we identified breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems in place to monitor the quality of the service were not effective which had resulted in breaches of regulations. During this inspection we found that the regulation had not been fully complied with and further improvements were required.

A range of audits designed to assess and improve the quality and safety of the service were carried out on a monthly basis. These were in relation to different aspects of care provision such as infection control, medicines management, catering and care plans. Scores from the latest audits in these areas were high and any actions identified had been included in a home development plan. We found that quality monitoring systems had not identified that all staff members with a positive DBS had a risk assessment in relation to this completed. This meant that the actions identified to address issues were not always fully implemented although in this case the risk to people living at the home was low as measures were in place to mitigate the risk.

Staff told us they received feedback about their performance and were able to discuss training and development needs. However, during our inspection we observed variability in staff knowledge and awareness of what was expected of them in their role. For example, some staff did not provide sufficient prompting and encouragement to people during mealtimes or did not know what immediate action they should take in the event of a safeguarding issue which arose when the manager was absent. We noted that in a recent review of a person's care a relative had raised issues of poor communication between staff, changes not being passed on and inconsistency of quality of care. We provided feedback to the manager about the variability we had found. The manager told us of measures in place to try and address these issues, such as regular supervision, handover sheets and daily morning meetings between representatives of each staff group on duty to discuss any issues. However the above information means that systems in place to communicate to staff about their role and responsibilities may not be fully effective.

At the time of our inspection there was not a registered manager in post. The registered manager had left the service in September 2016. A regional support manager was responsible for the day to day running of the service and was supported by representatives of the provider.

We found the management team were aware of their responsibility for reporting significant events to the Care Quality Commission (CQC). Our records showed we had been notified of incidents that had occurred within the service since our last inspection such as serious injuries and allegations of abuse. The manager told us that they were well supported in their role by representatives of the provider. Records showed that a representative of the provider visited and reviewed audits and actions on at least a weekly basis. This included speaking with staff, checking progress with training and supervision, monitoring staffing levels and discussing issues.

People and their relatives were aware of the role of the manager and the clinical lead in the service and reported them to be approachable and responsive. One person told us, "If I was worried I'd go to the manager and [manager] would come here." Another person's relative said, "The managers are [Managers name] and [Clinical leads name]. Manager is great, I asked a question when I came in and she'll find out the answer."

Staff told us they felt supported by the manager and the clinical lead at the service. They were positive about improvements which had been made. One staff member told us, "Paperwork was poor when I came here but is has improved now." They told us that care plans and the documentation of daily care had improved. We found this to be the case during our inspection. Staff described an improved working atmosphere and open culture in which they could approach the management team with any concerns or issues. We found staff were aware of the organisation's whistleblowing and complaints procedures and felt confident in initiating the procedures without fear of recrimination.

The views of people who lived at the service and their relatives were sought with a view to improving service delivery. People were invited to attend regular residents meetings during which different aspects of the service were discussed such as food, activities, housekeeping and laundry. People's relatives also had the opportunity to attend meetings and felt they were communicated with regarding any changes. One person's relative told us, "They do relatives meetings. I don't get to a lot because of the time they're held. I always ask for an update and I get it." People's relatives told us that changes were made in response to their concerns. One person's relative told us, "We were worried because of all the agency staff but now that's sorted." Another person's relative told us they had made suggestions about the security of the building, and the provider had taken these suggestions on board and acted upon them. All of the relatives we spoke with were aware of changes and developments within the service and felt they were kept well informed by the provider.