Highfields Limited

Highfields Nursing Home

Inspection report

330 Highbury Road
Bulwell
Nottingham
Nottinghamshire
NG6 9AF

Tel: 01159278847

Date of inspection visit:
27 April 2017

Date of publication:
08 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 27 April 2017. Highfields Nursing Home provides accommodation for a maximum of 42 people who require nursing or personal care. On the day of our inspection 31 people were using the service.

A manager was present during the inspection however they were not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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. Our systems showed an application to become registered had been received and we will continue to monitor its progress.

During our previous inspection on 11 August 2016, we identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the safe management of people's medicines.

During this inspection we checked to see whether improvements had been made. We found some improvements had been made but further improvements were still required. People's medicines were stored and administered safely, however the recording of when people had taken their medicines was not always completed. We also found minor issues in the way medicines were handled when staff were carrying out their medicines round.

People were protected from the risk of harm because staff could identify the potential signs of abuse and knew who to report any concerns to. Assessments of the risks to people's safety were carried out, but some risks such as ensuring pressure relieving equipment was set at the correct level, were not always managed effectively. Where people had been involved in an accident or incident at the home the incident had been recorded and reported to the manager and was investigated. People were supported safely by staff but there were concerns with the number of staff available to support people on the first floor of the home.

People were supported by staff who had completed an induction and training programme, with the majority of this training being up to date. Staff received supervision of their work; however the frequency was not always consistent.

The principles of the Mental Capacity Act (2005) had not always been followed when decisions were made about people's care. Deprivation of Liberty Safeguards were in place and managed effectively. People spoke positively about the food provided at the home. We observed an organised lunchtime experience for people on the first floor, however people on the ground floor's experience was more disorganised. People had access to external healthcare professionals when they needed to.

Staff were kind, caring and compassionate and responded quickly to people when they showed signs of

distress or had become upset. Staff understood people's needs and listened to and acted upon their views. People's privacy was maintained although additional private space throughout the home was limited. People were treated with dignity and respect. People's diverse needs were respected. People were involved with decisions made about their care and were encouraged to lead as independent a life as possible. People were provided with information about how they could access independent advocates. People's friends and relatives were able to visit whenever they wanted to.
People were supported with activities when the activities coordinator was present at the home. Staff responded quickly to people when needed. People's care records were person centred, focusing on people's preferences. People felt able to make a complaint and were confident it would be dealt with appropriately.

The new manager led the service well and was respected and well-liked, by people, their relatives and the majority of staff. People were encouraged to provide feedback about the quality of the service and this information was used to make improvements. Quality assurance processes were in place or due to be implemented to ensure people and others were safe in the home. We were unable to judge whether these improvements were effective and sustainable due to the limited time they had been in place.

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 consistently safe.

Some improvements had been made in relation to people's medicines but further improvements were still required.

People were protected from the risk of harm because staff could identify the potential signs of abuse and knew who to report any concerns to.

Assessments of the risks to people's safety were carried out, but some risks were not always managed effectively.

People were supported safely by staff but there were concerns with the number of staff available to support people in certain parts of the home.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who had completed an induction and training programme, with the majority of this training being up to date.

Staff received supervision of their work; however the frequency was not always consistent.

The principles of the Mental Capacity Act (2005) had not always been followed when decisions were made about people's care. Deprivation of Liberty Safeguards were in place and managed effectively.

People spoke positively about the food provided at the home. We observed an organised lunchtime experience for people on the first floor, however people on the ground floor's experience was more disorganised.

People had access to external healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and compassionate and responded quickly to people when they showed signs of distress or had become upset. Staff understood people's needs and listened to and acted upon their views.

People's privacy was maintained although additional private space throughout the home was limited. People were treated with dignity and respect. People's diverse needs were respected.

People were involved with decisions made about their care and were encouraged to lead as independent a life as possible. People were provided with information about how they could access independent advocates.

People's friends and relatives were able to visit whenever they wanted to.

Is the service responsive?

Good

The service was responsive.

People were supported with activities when the activities coordinator was present at the home.

Staff responded quickly to people when needed.

People's care records were person centred, focusing on people's preferences.

People felt able to make a complaint and were confident it would be dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance processes were in place or due to be implemented to ensure people and others were safe in the home. We were unable to judge whether these improvements were effective and sustainable due to the limited time they had been in place.

The new manager led the service well and was respected and well-liked, by people, their relatives and the majority of staff.

People were encouraged to provide feedback about the quality of the service and this information was used to make

improvements.

Highfields Nursing 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 27 April 2017 and was unannounced.

The inspection team consisted of one inspector, a specialist nursing advisor 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 our inspection, we reviewed information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We contacted local authority commissioners of adult social care services, the local clinical commissioning group (CCG) and Healthwatch and asked them for their views of the service provided.

We spoke with six people who used the service, six relatives, four members of the care staff, the, a nurse, the assistant cook and the deputy manager, home manager and area manager. We also spoke with a health care professional during the inspection.

We looked at all or parts of the care records and other relevant records of nine people who used the service, along with all people's medicine administration records. We also looked at a range of records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection on 11 August 2016 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the management of people's medicines. After our inspection the provider forwarded us an action plan which advised how they would make the required improvements in this area.

During our inspection on 27 April 2017 we checked to see whether improvements had been made. We found some improvements had been made, but we identified some areas where further progress was needed.

People told us they were happy with the way their medicines were managed at the home. One person said, "We never run out and it's on time." A relative said, "No [my family member's] medicine has never been missed."

We observed a member of staff administer medicines to people and they did so safely. However, we did note on one occasion a medicine had been left unattended by the portable medicine cabinet. Whilst we saw people were not near the medicine and were unlikely to access it, it could have placed people's safety at risk. The staff member apologised and told us this had never happened before and assured us it would not happen again.

People's medicine administration records [MAR] contained photographs of each person to aid identification and to reduce the risk of misadministration, details of people's allergies and their preferences for how they liked to take their medicine. MARs are used to record when a person has taken or refused their medicine. We checked all 31 people's MAR. Whilst we found the majority of these had been completed, we also found gaps in four with no recorded explanation. We checked the stock levels of the medicines which indicated the medicines most likely had been given but not always accurately recorded. We raised this with the manager, they showed us a new medicines auditing process they had just introduced and assured us these errors would be picked up and acted on in future.

Processes were in place for the timely ordering and supply of medicines and we did not see any evidence of medicines not being administered due to a lack of availability. Stocks checks were carried out by a member of staff each week. Medicines were stored safely within a locked room in the manager's office. We did note that within this locked room the fridge used to store some medicines was unlocked. This was rectified immediately during the inspection.

Processes were in place to ensure medicines that were administered covertly were done so safely. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the person is unknowingly taking medication. We did note for one person guidance and authorisation had been requested from the person's GP but not a pharmacist. Guidance from a pharmacist is recommended to ensure the covert medicine is administered in a way that does not affect its effectiveness.

When medicines were prescribed in the form of skin patches, the site of application of the patch was rotated in line with good practice. Protocols were mostly in place to provide additional information about how medicines should be given when they were prescribed to be given only as required. 'As required' medicines are not given at set times of the day and are only administered if a person is showing signs that the medicines are needed, such as an increase in pain or agitation.

The manager since they arrived at the home in November 2016, told us they had identified medicines as an area where improvement was required. They invited a healthcare professional from the local Clinical Commissioning Group [CCG] to address staff during their staff meeting on safe medicines management. We spoke with this person during the inspection. They told us they felt the management of the medicines at Highfields had improved and they were confident the manager understood how to ensure medicines were handled and managed safely.

People and their relatives told us they or their family members felt safe at the home. One person said, "I feel safe here I'm happy here I've got everything I need, if I want anything I just ask." A relative said, "I feel [my family member] is safe because of the way they are looked after here." Another relative said, "We're generally happy [our family member] is safe now, safer than where they were before."

Processes were in place to reduce the risk of people experiencing avoidable harm. A safeguarding policy was in place. Staff had received appropriate safeguarding of adults training and the staff we spoke with understood who to report concerns to both internally and externally to agencies such as the CQC or local safeguarding teams. One member of staff told us they had confidence in the manager and gave an example of how they had taken immediate action when a concern had been reported to them.

People's care records contained assessments of the risks to their health and safety which they could experience whilst living at the home. This included the risk of falls, developing pressure ulcers, nutritional risk and choking. When bed rails were used to prevent people from falling out of bed, risk assessments had been completed. Records showed when a person had fallen, a safeguarding referral had been made and the person was referred initially to a physiotherapist for an assessment, to identify additional interventions which were needed to reduce the risk of them falling again. Recommendations made had been followed by the staff.

The manager carried out regular reviews of the accidents and incidents that occurred at the home. These reviews enabled the registered manager to identify any themes or trends which would enable them to put preventative measures in place to reduce the risk of reoccurrence.

Relatives told us they did not feel unnecessary restrictions were placed on their family members. We observed people being assisted to move around the home independently of staff, with some using walking aids for support. We also saw staff were attentive to the risks of people mobilising independently, with a staff member reminding a person to use their walking aid, which the person had appeared to have forgotten to do.

Where people were at risk of developing pressure ulcers, care plans were in place to provide staff with the guidance needed to reduce this risk. We noted some people had pressure relieving equipment such as mattresses in their bedrooms available for them. We did note that three of these mattresses were not always set to the required setting. We raised this with the manager who told us this would be addressed immediately. They also showed us a new bedroom auditing process that was being introduced which included the review of all pressure relieving equipment. They told us they felt pressure care management was good at the home, with no-one currently experiencing a pressure sore, but agreed that more needed to

be done to reduce this risk.

Regular assessments of the environment people lived in were conducted to ensure that people were safe. Regular servicing of equipment such as hoists, walking aids, gas installations, fire safety and prevention equipment were carried out. We observed staff supporting people with moving around the home. The equipment they used to do so was used safely. People had individualised personal emergency evacuation plans (PEEP) in place that enabled staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner.

People and their relatives felt there were sufficient numbers of staff at the home to keep them or their family member. One relative said, "Since [my family member] has been receiving one to one care all the time, they are protected from danger." However some concerns were raised in relation to the number of staff present on the first floor. One relative felt extra staff were needed due to the needs of the people living on that floor.

We carried out observations on the first floor to assess whether sufficient staff were in place. We noted key pad locking systems were in place to ensure people could not access stairways and a key mechanism was also in place if people wished to use the lift. These measures assisted staff in keeping people safe.

We noted the staff managed to support people safely and people's requests for assistance were responded to in good time. We did observe some short periods of the day where the lounge was left unattended due to staff supporting other people, which could place the safety of others at risk.

Staff gave mixed feedback in relation to staffing numbers throughout the home. Some felt there were enough staff in place, whilst others felt more, especially on the first floor were required. We raised this with the manager and the area manager. We saw dependency assessments had been completed to assist them in identifying the number of staff needed to support all people safely. However, they did acknowledge that one person's needs had recently changed and that an extra member of staff to provide additional support may be beneficial. They assured us they would review this immediately.

Safe recruitment processes were in place to reduce the risk of unsuitable staff members working at the home. These processes included criminal record checks. Other checks were conducted such as ensuring people had a sufficient number of references and proof of identity.

Requires Improvement

Is the service effective?

Our findings

People and their relative told us they felt able to give their views on the care provided for them or their relatives and that staff requested their consent where appropriate. One person said, "I'm pleased with the care here because everything is going how I want it to be." A relative told us they were always kept up to date on their family member's care and their views were requested.

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. We checked whether the service was working within the principles of the MCA.

In all of the care records that we looked at we found MCA assessments had been carried out in a number of areas. These included; management of medicines, personal care and maintaining a safe environment. However, we did note that documentation to show how a decision had been agreed in the person's best interest was not always recorded on people's care records. We saw detailed care plans were in place following the assessments but there was limited recorded evidence of who had been involved in the process. The manager told us this had formed part of their current review of all care records and they had identified this as an area that needed improving. Records viewed confirmed this. They told us they would ensure that where these assessments were in place the appropriate documentation would be in place to support it.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Records showed that DoLS applications had been made for people whose safety would be at risk if they were out in the community on their own. We looked at the paperwork for three of these people and saw the staff adhered to the terms recorded. Staff told us they requested people's consent before providing them with care and support. We observed this happening throughout the inspection.

Some people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) documentation in place. These had been completed by the person's GP or other appropriate professional person. This meant that the decision for CPR to not be carried out had been taken, if it may have a detrimental effect on the person's on-going health.

People's relatives spoke positively about the way staff supported them or their family members. One relative said, "We think they do their best." Another relative said, "Yes they know what they're doing, I've seen them helping people to walk with hands on their backs and guiding them." Another relative said, "The staff look after [my family member's health]. The nurse is on to it straightaway."

Staff received an induction when they first came to the home and regular training thereafter, to provide

them with the skills needed to support people effectively. Records viewed confirmed this. The majority of staff training was up to date. The staff we spoke with felt well trained. One staff member described a recent training course they had been on as "brilliant" and felt this had given the skills they needed in this particular area. Staff felt supported by the management team and they received supervision of their work. Records showed some of staff received supervision less frequently than they should have. The manager told us this would be rectified by their new supervision process where heads of department would carry out supervisions for their teams, consequently freeing up the management team to focus on areas of management at the home.

Staff were encouraged to undertake external professionally recognised qualifications such as diplomas (previously NVQs) in adult social care. The continued development of staff ensured the care they provided people with was effective and in line with current best practice guidelines.

People's care records contained detailed guidance for staff to enable them to communicate effectively with people. Due to the wide ranging needs of the people living at the home, with many people living with dementia, staff were required to use a variety of different methods to communicate and engage with people. Throughout the inspection we saw staff doing so effectively. This included a patient approach when helping people to transfer around the home, supporting people with their lunch or engaging in general conversation. Guidance was also in place for staff to support people who may present behaviours that may challenge others. Staff told us they felt they would benefit from more training in this area however, we saw people respond positively to the way staff supported them throughout the inspection.

We observed the lunchtime experience in the two dining rooms. We asked one person if they enjoyed their lunch and they said they did. Another person told us they enjoyed the food that was served in the home and a relative told us food "looked nice".

However, we did note that the serving of the lunchtime meal was unorganised on the ground floor with some people having to wait longer than others for their meals with little explanation. Some people on the ground floor received support from staff, although others would also have benefited from additional support. We heard some people comment that they did not know what was for lunch and when asked a staff member struggled to answer. As there were no menus available for people, people were unsure what they were going to receive. On the first floor, we found things improved. People received their meals quicker, staff supported all people that needed it and where people required a soft diet, due to the risk of them choking on their food, this was provided.

The assistant cook, along with other staff, had undertaken a nationally recognised qualification in catering and food hygiene and had detailed information about people's allergies and food preferences. We saw this information included people who required a diabetic, high protein or soft textured diet. The assistant cook told us they ensured people received a varied diet, with a four week revolving menu in place. We noted the cupboards, fridges and freezers were well stocked with food and drink specifically requested by people also in place. Regular temperature checks of the fridges and freezers were carried out to ensure food was stored safely.

Nutritional risk screening was completed and reviewed monthly and eating and drinking care plans were in place. These identified people's support needs and dietary requirements (such as thickened fluids, or a soft diet) in addition to their personal preferences. We noted one person received their food via percutaneous endoscopic gastrostomy (PEG). This is a medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. The support for this person was carried out effectively. Their records did note they had lost weight

during a short period and the home could have been quicker in referring this to a dietician for expert guidance, but once they did, the person's weight started to increase.

Relatives told us they felt their family member's day to day health was managed effectively by the nurses and the care staff. One relative said, "Yes the staff look after [my family member's] health. The nurse is on to it straightaway." Another relative told us the staff listened to them when they had concerns about their family member's health and acted on it. They told us, "I asked the nurse to get the doctor to give [my family member] a blood test to make sure their medication was doing its job. They contacted the doctor."

People's records showed staff referred people to external healthcare professionals when needed. These referrals included; speech and language therapists, physiotherapists, the dementia outreach team, opticians and chiropodists. Staff also told us a local GP visited fortnightly to review their patients and most people at the home were registered with that GP practice. They told us they were able to contact the GP and arrange additional visits if a person was unwell.

Good

Is the service caring?

Our findings

People told us they felt the staff were kind and caring and they enjoyed living at the home. One person said, "Yes the staff are kind, we have a laugh, if they did me any harm I'd tell my family." Another person said, "I have no problems with the place or the staff." A third person said, "The staff are kind and caring we're like a big family. I've got no concerns." Relatives also spoke positively about the staff. One relative said, "Yes they're caring, and kind." A second relative said, "We've got no concerns, the care is very good [our family member] is waited on hand and foot."

Staff interacted with people in a kind, compassionate and caring way. We saw warm and friendly interactions between people and staff. We saw staff speaking cheerfully with people and it was clear they knew them well. We also saw staff respond quickly and effectively to people who were living with dementia and showed signs of distress and had become upset. The staff were caring in their approach and showed an understanding of their anxiety. By talking quietly with people, they became calmer and more settled.

People were supported by staff who had a good understanding of what was important to them. Information such as people's life history and likes and dislikes were recorded in people's care records. This information was referred to and used by staff when talking with people. Staff gave us some examples of how they felt they had made a difference to the lives of the people they cared for. It was clear the staff and people living at the home got on well together.

People's care records showed their religious and cultural needs had been discussed with them and support was in place from staff if they wished to incorporate these into their life.

People were encouraged to make decisions about their care and support needs and were regularly asked for their views in case they wanted to make changes. Documentation within the care records indicated people or their relatives had been involved in reviewing their care plans. A relative told us they had been involved in planning their family member's care and they were happy with the service provided.

Information was available for people about how they could access and receive support from an independent advocate to make decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

We saw people were supported to be as independent as they wanted to be and were encouraged by staff to do as much for themselves as possible. One person explained their daily routine which the staff supported them with if they needed it. They said, "I shave myself in the morning, I get my
razor out every evening ready for the morning. At 7.30pm I have a strip wash; yes they ask permission before they [staff] do anything."

People and their relatives told us they felt staff treated them or their family members with dignity and respect. A relative said, "Yes they [staff] respect their dignity. The carers tell you about showering; they

struggle with washing [my family member's] hair. They asked us if we would mind them getting it cut as it was knotting and we said 'go ahead'." Another relative said, "Yes the staff are kind and respectful to [my family member]. They have never complained to me about the staff." A person living at the home told us the staff were respectful when helping them with bathing.

Staff were attentive to people's needs, ensuring people were well presented. We saw one example where a person had not noticed they had food on their mouth, the staff member quickly asked them if they would like their mouth wiping and the person responded positively to this. We also observed staff speak respectfully about people and when people's personal care needs were being discussed, this was done with discretion to protect the person's dignity.

People's privacy was respected within the home. Staff told us they knocked on people's doors before entering. They closed the door and curtains when providing personal care and kept the person covered as much as possible. We observed this taking place throughout the inspection. We did note there was limited private space available, other than people's own bedrooms, if they wished to be alone or to sit privately with their family or friends. We raised this with the manager and area managers who told us they would discuss this with the provider to consider making more space available within the home.

People's care records were handled respectfully. People's personal records were not left in communal areas, which ensured their privacy and dignity was maintained.

The registered manager told us that people's relatives and friends were able to visit them without any unnecessary restriction. We observed and spoke with relatives visiting during the inspection who confirmed this.

Good

Is the service responsive?

Our findings

We were informed by the manager that an activities coordinator was in place at the home, however during they inspection they were off on leave. We did see some interaction between staff and people in terms of activities, but the manager told us much more took place when the activities coordinator was there. People's care records supported this. We saw people were encouraged to follow their interests where possible with staff assisting people to access some activities outside of the home. Staff told us they had supported some people with going out for afternoon tea and others with visiting a local attraction to see some animals, although the majority of activities took place within the home. Some of the people we spoke with told us they were occasionally able to go out on group outings.

Before people came to stay at the home a detailed pre-admission assessment was carried out to ensure people could receive the support they needed. Care plans were then formed for each person which detailed how they liked to receive care and support from staff. We saw the majority of these care plans contained sufficient detail for staff to enable them to provide safe and effective care for people in the way they wanted. A regular review process was in place to ensure they met people's current needs and we saw the majority of these care plans were regularly reviewed. A small number of these care plans did require updating to ensure they met people's current needs.

People's care records were person centred with information provided for staff on people's daily routines, how they liked to be supported by staff and whether they preferred male or female care staff to support them with personal care. One person explained their daily routine to us and told us staff respected their wishes. They said, "I like to go to bed early. They [staff] come about 6.00pm to get everyone ready for bed. Bedtime is 7ish. I watched a film at 11.30pm last night 'Vin Diesel, I also like watching the snooker." A relative said, "We prefer female to male carers for [our family member] and they [staff] respect that." Another relative told us they had asked for specific care to be provided for their family member and the staff responded to this and put the measures in place.

Adaptation to the building had been made in response to people's changing care and support needs. For example a rail had been added to a person's bathroom to enable them to have more stability when using their shower.

People's relatives told us they felt any concerns they had raised about their family member's care and support needs were dealt with quickly. One relative told us they were pleased their family member was now supervised more closely and another relative told us the home had provided a new chair for their family member which they were grateful for. Staff could explain what they would do if a person made a complaint to them.

People were provided with a complaints policy which was also displayed within the home. The policy contained details of who people could make a complaint to, both internally and externally to agencies. We did note that the policy, covering five pages and printed in small font, may prove difficult for some people to use and in some cases understand. The manager agreed to review this and would ensure a more 'user

friendly' version was provided for people.

We saw processes were in place to manage and respond to people's complaints within a timely manner ensuring people's complaints were treated equally.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection on 11 August 2016 a new management team has been appointed to oversee improvements at the home. The manager, in place since November 2016, had applied to become registered with the CQC. They were supported by a deputy manager and an area manager. During the inspection the new manager and area manager described and showed us a number of new quality monitoring processes that had either recently been introduced or were in the process of being so. These included, more detailed information within people's bedrooms to ensure staff had all the information they need when supporting people in their rooms. Additionally, detailed infection control and medicine audits and a more robust process for ensuring staff received meaningful and regular supervision of their work were also in or about to be put in place.

Whilst we saw some of these processes, and others, were in place, we were not yet able to judge whether they were effective and sustainable. There has been some improvement from the last inspection; however, more sustained improvement was needed to ensure that all people received safe and effective care and support. The manager and area manager agreed. They told us they were confident that the new systems that were, or soon will be in place, will further improve the service. The area manager told us the manager provided a monthly update on the service to them. This update included the number of accidents, incidents and safeguarding referrals that had occurred along with other data such as staff numbers and improvements to the environment. We saw action plans were developed to assist the manager and her team to make improvements within the home. Again, sufficient time had not yet passed to enable us to judge whether these were effective, however if these new processes continue to be implemented and used effectively then improvements should be made.

People, relatives and the majority of the staff spoke highly of the new manager. One person said, "We see the manager most days, she pops in, she's nice." A relative said, "She has helped me loads with my family member's care." A staff member said, "She is lovely. She praises you and makes you feel as though you are doing a good job." Another person said the manager was approachable and they felt she acted on issues when they were identified.

People, their relatives and staff were able to give their feedback during regular meetings and action plans were developed to act on the feedback. The manager told us they also held head of departments meetings to ensure senior members of staff were aware of what was expected of them and their respective departments. We were also told plans were in place to delegate some managerial responsibilities to more senior staff, giving the manager more time to plan the continued development and improvement of the home.

People were supported by staff who had an understanding of the whistleblowing process and there was a whistleblowing policy in place. Whistleblowers are employees, who become aware of inappropriate activities taking place in a business either through witnessing the behaviour or being told about it.

The manager had a clear understanding of their role and responsibilities. They had the processes in place to

meet the requirements of a registered manager with the CQC and other agencies, such as the local authority safeguarding team. The manager had also ensured that the CQC were notified of any issues that could affect the running of the service or people who used the service.