Hestia Healthcare Limited

The Willows Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 26 April 2017 and was unannounced.

The Willows is a residential care home providing a service for up to 32 adults, who may have a range of care needs, including dementia and physical disabilities. There were 29 people living at the service on the day of the inspection, and two people were in hospital.

A registered manager was in post. 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:

There were sufficient numbers of suitable staff to keep people safe and meet their needs; however, people told us they were sometimes left waiting when they called for assistance. The registered manager had already made changes to the way staff were deployed in the home and new staff had been employed. It was therefore hoped that this would improve as the new staff gained confidence and experience. Further action was taken by the provider after the inspection to enable the management team to monitor staff response times in future, to ensure people's needs were met in a timely manner.

The provider carried out checks on new staff to make sure they were suitable and safe to work at the service. The majority of the required checks were in place however, we found some checks had not been carried out for all staff, such as obtaining a full employment history. The registered manager confirmed after the inspection that changes would be made to the existing recruitment process, to ensure all required checks were obtained in future.

Systems were in place to ensure people's daily medicines were managed in a safe way, but these had not been followed consistently on the day of the inspection. Although no one experienced any adverse effects, the registered manager again took swift action to address our findings and confirmed that changes had been made to minimise the risk of medication errors. He also advised that a new electronic medication system was being introduced, which would improve the safe management of medicines in the future.

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 were supported safely and did not have their freedom unnecessarily restricted.

Staff received the right training to ensure they had the necessary skills and knowledge to meet people's needs.

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. Further improvements were planned in this area with the appointment of a new head chef.

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. Personalised care plans had been developed to record how people wanted to receive their care and support, and they were supported to have choice and control of their lives as far as possible. Further improvements were planned in this area with the introduction of a new electronic care planning system.

People were given opportunities to participate in meaningful activities and further improvements were planned in this area with the appointment of a second activity coordinator, to support the provision of activities over seven days a week.

Arrangements were in place for people to raise any concerns or complaints they might have about the service. These were used by the service as an opportunity for learning and improvement. We saw that people were given regular opportunities to express their views on the service they received and to be actively involved in making decisions about their care and support.

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

Systems were in place to monitor the quality of the service provided and drive continuous improvement.

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 however; improvements were required to ensure all legally required checks were carried out.

Systems were in place to ensure people's daily medicines were managed in a safe way, but these were not always followed consistently.

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.

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?

Good

The service was responsive

People received 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?

Good

The service was well led

The service promoted a positive culture that was inclusive and empowering.

A registered manager was in post who provided effective leadership.

There were systems in place to support the service to deliver good quality care.

The Willows Residential and 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.

The inspection was unannounced and was carried out on 26 April 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 and clinical commissioning group; who both have 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 eight 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 medicines were being administered. We also spoke with the registered manager, the peripatetic nursing manager, the service quality manager, the head of care, one nurse, one senior care staff, three care staff, the housekeeper and one relative.

We then looked at care records for three 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 provided mixed feedback about whether there were enough staff to keep them safe and meet their needs. Some people told us they were often left waiting for help when they called for assistance. For example, one person told us: "You don't wait too long for them to come and speak to you, but then they go again and it can be a long time before they do what you wanted them for." In contrast, another person said: "They (the staff) are all very busy all the time but I think there seems enough of them. In the lounge [there] always seems to be two about nowadays." A relative also told us they there always seemed to be enough staff to manage people's care when they visited.

Staff confirmed there were times when they had left people waiting for support because they were busy. One staff member told us: "We do go and see them and ask what they want, reassure them and say we will be back, but sometimes it can be a little while." The registered manager told us there had been a period of time when staff recruitment and retention had been an issue, but they had since recruited new staff. He also told us that changes had taken place to ensure staff were deployed in the most efficient way. He explained that he tried to limit the amount of cover provided by agency staff, but where agency staff were used, they focused more on providing care for specific people. This allowed the more experienced staff members time to provide care to the remaining people, in order to promote consistency of care for them.

Staff confirmed these approaches were in place. They acknowledged that the turnover in staff had been challenging, but felt that things were improving. One staff member said: "It's not that we are short of staff now, it's that the staff we have are very new. Some are new to caring and some new to here, so although they are really in the numbers on shift, in reality they are still shadowing. This makes it really hard especially in the mornings."

We discussed with the management team that there was currently no way for them to monitor how long staff took to respond when people called for assistance. The peripatetic nursing manager told us this had already been identified internally as an area for improvement. Shortly after the inspection, the registered manager provided evidence that the provider had authorised an upgrade to the call bell system, to enable the management team to monitor staff response times in future and ensure people's needs were met in a timely way.

We observed staffing levels during the inspection and found that people's needs were met in a timely way. Staff provided a constant presence in the communal areas of the home, and we heard call bells being answered quickly in other areas of the building. Where people were not able to use a call bell to summon assistance, we saw that staff had been deployed close by, so they would be able to hear someone calling out for help.

The registered manager described the processes in place to ensure that safe recruitment practices were being followed and 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 the

majority of legally required checks were being carried out, although there were some gaps in employment histories for two staff members. The provider had also not checked why another staff member had left a previous position working with vulnerable adults. This had the potential to place people living at this service at risk of harm. After the inspection the registered manager provided evidence that they had made further checks in these areas, and no concerns had been identified. He also advised that they would be reviewing the existing recruitment process to ensure all legal requirements were fully met in future.

Systems were in place to ensure people received their medicines in a safe way. Without exception, everyone told us that they got their medicines when they needed them. We observed medicines being administered to people at lunch time. People were not rushed and the staff member administering understood the purpose of the medicines they were giving to people and how best to take it. They also checked with people to see if they needed 'as required' (PRN) medicine, such as pain relief. They staff member confirmed they had received training to be able to administer medicines and demonstrated a good awareness of safe processes in terms of medicine storage and administration. We saw that medicines were stored securely, with appropriate systems and facilities in place for temperature sensitive medicine.

However, we did find some anomalies regarding medication administration records (MAR). For example, we found that the reason for PRN medicine being given was not always recorded. Although there was no indication that this had not been given as prescribed, this meant that records did not provide full information about the use of such medicine. In addition, due to sickness, there was a change in the member of staff administering medicines during the morning shift, covering breakfast and lunch. At lunch time, we found that one person had not received their morning medicines because they had been asleep, and the staff member giving out the lunch time medicines confirmed that this had not been handed over to them to enable them to reattempt administration when the person woke up.

Although, the person did not experience any adverse effects on this occasion, the registered manager acknowledged our concerns. He told us it was normal practice for clear handovers to be shared between the nursing staff responsible for administering medicines on each shift. However, due to illness this had not carried out on this occasion. He told us that a meeting had been organised for all the nurses to reflect on this shortfall. He advised that with immediate effect, nursing staff would go through MAR sheets with the nurse responsible for administering medicines on the following shift, before leaving the building. The management team also advised that there were plans to introduce an electronic medication system to the home, which would automatically alert the nursing staff and the registered manager if someone had not received their medicines on time.

Everyone we spoke with confirmed that they felt safe living at the service. One person said: "I came out of hospital about three weeks ago and I feel a lot safer here." Another person told us: "I do feel safe here. I do because someone is always around - they are never too far away." Staff told us they had been trained to recognise signs of potential abuse, and understood their responsibilities in regards to keeping people safe. They confirmed that they had received recent safeguarding training and were clear about the various forms that abuse may take, and the potential impact on people living at the service. They all told us that if they ever suspected abuse, they would report their concerns to a senior member of staff straightaway. One staff member told us they would: "Write down what you see or heard and talk to the manager about it."

We saw that information was shared with staff and visitors about safeguarding procedures, 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 service followed locally agreed safeguarding protocols.

Staff spoke to us about how risks to people were assessed to ensure their safety and protect them from

harm. They described the processes used to manage identifiable risks to individuals such as not eating or drinking enough, falls and pressure damage to the skin. One staff member told us: "We write risk assessments and hand over the information to carers (staff) in the communication book and verbally at handover." Another staff member added: "[We] make sure there are no trip hazards, and don't do things on your own if you need two people. Use pressure mats or cushions as you need to." We observed staff taking positive action to minimise the risk of negative interactions between people. For example, when one person moved close to another person living in the home, a member of staff carefully guided them away and then continued to walk around with the person until they were happy to stop. We noted that the member of staff rightly prioritised the need and safety of the people involved over an administrative task that they were in the process of completing.

Risk management plans were in place to promote and protect people's safety, and separate daily observational charts recorded the care provided by staff in order to mitigate identified risks. For example, these recorded how often someone cared for in bed had been supported to turn or received food and fluids in order to reduce the risk of pressure damage to the skin. It was evident that people's personal preferences and choices were respected in terms of how staff managed identified risks; minimising potential restrictions on their freedom, choice and control.

The registered 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 also in place for the service; to support staff in the event of an emergency.

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, although they recognised that some of the staff were new and were still learning. Staff talked to us about the training and support they received to help them in their roles. They told us they received the right training to do their jobs. One staff member told us about their induction training and said: "I was set up with a senior carer, shown where the fire exits were, where all other things were, signs and signals of each individual. I was introduced to all the residents and briefed on their care plans. I was told about the routine for the day for the residents."

The registered manager talked to us about the home's approach to staff training. A training matrix had been developed which enabled him to review all staff training and see when updates or 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 area care, nutrition and hydration, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw evidence on display of further training being booked too.

Staff told us that meetings were held to enable the registered 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 staffing, call bells and communication had been discussed. Records also showed that staff had received individual supervision; providing them with additional support in carrying out their roles and responsibilities. Staff confirmed these took place on a regular basis. One staff member said: "I had my supervision about a month ago and my appraisal will be soon."

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 to make decisions about their care and appropriate DoLS applications had been completed by the registered manager.

Staff were seen supporting people 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 and we observed this in practice. For example, when someone made it clear they were not ready to take their medicines, the member of staff administering arranged to come back later. Someone else living at the service confirmed this approach by telling us: "They (the staff) will go away if you want a lie in."

Where DNARCPR (Do Not Attempt Cardiopulmonary Resuscitation) arrangements were in place, there was evidence that these had been discussed with people and their involvement recorded. One person had not agreed to one being in place and this had also been clearly stated in their records, meaning that staff would know how best to respect their wishes in the event of them becoming unwell.

People told us they had enough to eat and drink. They told us that if something was not to their taste, they could request something different. One person told us: "It's alright. Something's are not to my taste but the girls look after me and he [the chef] comes out of the kitchen to see me. They know what I do and don't like." We saw there was a menu on display in the dining room, which offered a choice of meals three times a day.

We observed that a variety of food and drink was freely available throughout the day, and meals we saw looked and smelt appetising. Dining tables were arranged in a way that provided a visual clue for people living with dementia that it was time to eat, and assistance was provided, where needed, in a discreet and helpful manner. We noted that staff in a variety of roles supported people requiring assistance at meal times, which helped the kitchen staff to get meals out to people in a timely way. People were seen enjoying their meals and ate well as a result.

Staff demonstrated a good awareness of people's individual dietary requirements and confirmed that that they monitored people's food and fluid intake to help with identifying people at risk. One staff member told us: "We give some people those shake drinks. Some do have a fortified diet. We keep fluid charts and the nurses monitor them." Records we looked at supported this. In addition, we saw a certificate that 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. Care records showed that people's weight was being monitored, to support staff in identifying any potential healthcare concerns. These had been reviewed regularly and showed that people's weight had remained stable as a result of the care and support being provided.

People confirmed they were supported to maintain good health and have access to relevant healthcare services. One person told us: "A few days ago I didn't feel very well so the doctor came out to see me; they (the staff) were on to it straight away." A relative echoed this comment by telling us about an occasion involving someone living at the service. They said: "She had a fall. They called the ambulance and the doctor and they phoned me later to tell me. They do seem to be on top of all that."

Staff were clear about the importance of monitoring people's health needs and seeking additional support and advice as required. A member of staff told us they would: "Tell the Nurse" in the first instance; recognising that the service employed qualified nursing staff who monitored the health of people living at the service, to ensure they received the proper care. They also told us they felt well supported by external healthcare professionals, who they called upon when they required more specialist support, such as the local Complex Care Team. Records showed that people were seen by relevant healthcare professionals, such as the GP when they needed to, and clear records were maintained from the outcome of these appointments in terms of instructions for staff on how to manage any changes in people's health needs.

Good

Is the service caring?

Our findings

People told us that staff treated them with kindness and compassion. We saw some recent written feedback from relatives that echoed this feedback. One relative had written: 'The staff are very caring and attentive', and 'Since [name of person] came to The Willows, he has had very good care and I have had a lot of kindness and love shown to me by the staff'. Another relative had praised members of staff for their 'Can do attitudes', whilst a visiting GP had commented in writing about the friendly staff team, who we also noted to be friendly and welcoming on our arrival.

Staff demonstrated a person centred approach in the way they spoke about people and through their actions. For example one staff member told us: "I tell the new carers we do all that we can to make this their [the people living at the service] home." Another staff member added: "Service users come first." 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. 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. When one person indicated that they wanted to walk about, staff were attentive and supported them to do so. At no point did the staff member try to get the person to sit down or distract them from their purpose.

Staff were seen providing care and support in a gentle and reassuring manner, such as when they used a hoist to support someone to move position. We heard them talking to people throughout the process, explaining what they were doing, so the person knew what was happening. We saw that practical action was taken too, to relieve people's distress or discomfort. For example, we observed one person being given their lunch time medication first. The nurse administering explained that the person was distressed and that the medicine would help with this. When other people requested support to go to the toilet, this was provided in a timely manner. A relative confirmed this was normal practice by telling us: "I have no concerns at all about the care. I sometimes ask them (the staff) to take her to the toilet and they do it straight away."

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. We saw that hot and cold drinks were readily available for visitors to help themselves to, and to make them feel welcome.

Without exception, everyone told us that their privacy and dignity was respected and upheld. Staff talked to us about how they helped people to maintain their privacy and dignity. One staff member told us: "[We] shut the door and curtains, make sure that they could cover themselves with a towel as we are washing them and keep them covered as much as possible." We observed staff protecting people's dignity during the inspection. For example, when people were being hoisted, staff covered their legs and bottom half with a blanket. On another occasion, staff used a privacy screen to protect someone's dignity in a communal area of the home.

We also noted the building to be clean and well maintained. Redecoration had taken place in some areas, with further work planned. Efforts had also been made to provide an interesting and stimulating

environment for the people living there. This showed that the provider was committed to providing people with comfortable and dignified surroundings.

Good

Is the service responsive?

Our findings

People confirmed that they, or those acting on their behalf, were encouraged to contribute to the assessment and planning of their care. One relative told us that the registered manager and a member of the nursing team had visited them at home before their relative moved into the service, in order to discuss the person's needs prior to moving in. People were positive about the care they received and said were able to contribute their views and have these taken into account. One person gave us an example that they could ask for a bath when they liked. They said: "I ask and usually I can have one when I want. They like to keep an eye on me and then they help me get out and dried which is fine."

Staff confirmed that they supported people to have as much choice and control as possible. One member of staff told us: "We ask them if they want a shower, wash or bath or go to the toilet first, then we give them what they have asked for." Another staff member added: "[We] greet the service users and ask them if they are ready to get up yet or would they like me to come back. Then I would ask them if they would like a shower, bath or a bed wash. I would let them do what they can for themselves, like give them a cloth to wash their face and help where they need me to, then show and ask them what they want to wear today." We observed people being supported to maintain their independence as far as possible. For example, we saw that dining tables included condiments for people to use if they wished at meal times. We also saw that people were free to move about as they pleased, and that staff facilitated this, rather than restricting people's movements.

Staff told us that information gathered during the initial assessment process was used to develop care plans that reflected how people wanted to receive their care, treatment and support. We looked at care records for a sample of people and found they had been discussed with them or someone acting on their behalf, such as a relative. Care records contained 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 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.

We checked to see how people were supported to follow their interests and take part in social activities. On our arrival, we found staff sitting with people and some people were colouring. Another person had some colouring pencils and seemed to enjoy the feel and movement of the pencils in front of them. A relative confirmed that this was a regular occurrence by telling us: "Sometimes that activity lady will sit and colour with them." It was clear since our last inspection that some thought had gone into increasing activity provision at the service. A new activity board was on display with activities listed three times daily. In addition, the registered manager confirmed that although the service already employed an activity coordinator, they were in the process of recruiting a second person; to support the service in providing activities seven days a week. This showed that the service recognised that people who are engaged in some kind of meaningful activity enjoy a more fulfilled life, and that cognitive stimulation can help to preserve skills for those living with dementia.

Although this meant that a full activity programme was not yet in place, we noted that attempts had been made to make the environment stimulating through decoration, pictures and objects of interest. Photographs were also seen on display of people engaging in activities. We saw staff stopping to chat to people and taking the time to walk around with them, if they wished to do so. We also heard music people enjoyed being played in the different communal areas of the home and during the afternoon, some lively singing was heard from a visiting gospel choir group. In addition, the registered manager showed us that scrap books were being used to store individual people's activity work such as colouring, word searches and some photographs. The service quality manager explained that the scrap books often provided reassurance for relatives that people were being encouraged to take part in activities in order to avoid social isolation.

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. One staff member told us: "I would go and talk to my senior or the nurse and I would write it down and give it to the manager." Other staff members told us they would: "Tell a nurse and go directly to the manager."

The registered manager showed us that a record of concerns, complaints and compliments was being maintained. We noted from this that feedback was taken seriously, and a clear audit trail maintained of any actions taken in response such as sharing feedback with staff during handovers and following up on agreed actions. This showed that people were listened to and lessons learnt from their experiences, concerns and complaints; in order to improve the service. All of the staff we spoke with confirmed that the registered manager talked to them when incidents happened, including complaints, so that they could be used as a learning tool. Records supported this, with one relative providing written feedback to confirm that a previous concern for them had now been rectified.

Good

Is the service well-led?

Our findings

The registered manager talked to us about how the service promoted a positive culture that was person centred, open, inclusive and empowering. He told us there were opportunities for people and relatives to be involved in developing the service, which included completing satisfaction surveys and attending meetings. We saw minutes from a recent meeting for people using the service and relatives which showed that areas such as staff recruitment and changes, choice for people living at the service and involvement in care planning were discussed. We saw that useful information had been displayed around the building too, including photographs of staff members and notices about safeguarding, advocacy support and how to make a complaint. Information had also been developed for prospective users of the service, setting out what they could expect from the service.

The management team advised us that a new electronic care planning and recording system was being introduced shortly after the inspection. The peripatetic nursing manager explained that the new system would allow people and relatives, where agreed, to access their care records at any time electronically; enabling them to monitor the care and support provided by the service on a daily basis. This change would increase opportunities for more accessible and inclusive ways for relatives to be involved, as well as the service demonstrating openness and transparency.

The registered manager explained that a lead person had been identified for different aspects of the service such as clinical care, catering, housekeeping and maintenance, and each lead had clearly defined responsibilities. Records showed that meetings were held with the various departments, to ensure responsibility and accountability was understood at all levels. There was a relaxed, comfortable and happy atmosphere within the home. Staff were observed working cohesively together and it was clear they understood their individual roles and responsibilities.

The service demonstrated good management and leadership. Since the last inspection, there had been a change of manager. The new registered manager confirmed he had been in post from September 2016. Everyone we spoke with knew who the registered manager was and many said that he was very approachable and friendly. One person told us: "He very often puts his head around the door and asks me if everything is alright. He seems a good guy." Other people confirmed that the registered manager was very visible and spoke with them as he walked round. We observed this happening during the inspection. A relative echoed this feedback by adding: "He (the registered manager) is very pleasant and always speaks to me when I am here."

Staff were in agreement, and told us things had improved in terms of stability and quality at the service since the new registered manager had come into post. One staff member told us: "The manager now is very good, you can phone or email him with any concerns, even when he is not here." We observed the registered manager to be very focused on the needs of people living at the service, prioritising their needs over the demands of the inspection. He spoke in positive terms about the staff team and how they were all working together to achieve the best outcomes for people. In addition, we read some recent feedback provided by an external healthcare professional who had written: 'The manager is easily accessible for communication

with external stakeholders'.

We found the registered manager to be open and knowledgeable about the service and the needs of the people living there. He responded positively to our findings and feedback, in order to improve the quality of service provided. The registered manager confirmed he felt well supported by the provider, and that appropriate resources were available to drive improvements 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.

The registered manager talked to us about the quality monitoring systems in place to check the quality of service provided. He 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. A tablet computer was available to encourage people to provide feedback whilst on site. We noted that the survey questions had been designed to answer the five questions that we, the Care Quality Commission, ask when we inspect a service: Is it safe, effective, caring, responsive and well led?

The registered manager showed us that he had developed a daily checklist for himself, which involved checking the building, care records and daily observation charts, safeguarding and incidents, falls, medication, staffing and infection control. More detailed audits were being carried out in these and other areas too such as moving and handling, tissue viability and people's meal time experience, on a regular basis. In addition, regular visits were undertaken by senior managers on behalf of the provider; to support the registered manager and to check the quality of the service provided. In all cases, each method used to assess the quality of service provision had resulted in an action plan, where areas for improvement had been identified. There was evidence that identified improvements were being made, and action plans updated accordingly. This demonstrated that there were arrangements in place to monitor the quality of service provided to people, in order to drive continuous improvement.