G & A Investments Projects Limited

Oakwood Residential Home

Inspection report

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Tel: 02380466143

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 21 January 2016 and was unannounced. The home provides accommodation and personal care for up to 28 people, including people living with dementia or other mental health needs. There were 22 people living at the home when we visited.

The home is based on two floors with an interconnecting stair lift. Some bedrooms have en-suite facilities and there is a separate bathroom and shower room. There is a large lounge, where activities are held and a dining room where most people eat their meals.

There was a registered manager 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 of the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our previous inspection, on 24 and 27 March 2015, we identified that infection control risks were not being managed safely. We issued a requirement notice and the provider sent us an action plan detailing how they would meet the regulation. At this inspection we found action had been taken and improvements had been made.

The laundry room had been extended and a clear process was in place to reduce the risk of cross contamination. The home was clean and staff followed appropriate infection control practices.

People told us they felt safe at the home. Staff knew how to identify, prevent and report abuse, and the provider responded appropriately to allegations of abuse. Clear systems were in place for managing medicines and people received their medicines when they needed them.

Most risks to people were managed safely, although the risks of one person smoking had not been documented. People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions.

The process used to recruit staff helped make sure that only suitable staff were employed. There were enough staff to meet people's needs at all times. Staff were suitably trained, were supported appropriately in their work and felt valued.

Staff followed legislation designed to protect people's rights and liberties. They sought verbal consent from people before providing care and acted in their best interests.

People liked the food and were able to make choices about what they ate. They received appropriate support to eat and drink enough. Appropriate action was taken if people started to lose weight and they were able to access healthcare services when needed.

People were cared for with kindness and consideration. Staff knew people well and build positive relationships with them. People's privacy and dignity were protected at all times and they were involved in planning their care.

Staff encouraged people to remain as independent as possible and empowered them to make choices about all aspects of their lives. Care plans provided detailed information about how people wished to receive care and support. Staff were responsive to changes in people's needs and this was reflected in people's care plans. A range of activities was provided based on people's individual interests.

The registered manager sought and acted on feedback from people and their families. A suitable complaint procedure was in place and complaints were dealt with promptly.

There was a clear management structure in place and management were supportive of staff. Staff enjoyed working at the home and worked well as a team. There was an open and transparent culture. Staff welcomed visitors and had formed good working relationships with external professionals.

Key aspects of the service were audited regularly to help ensure the service ran well. Where improvements were identified, these were implemented promptly. An effective system was in place to analyse incidents and accidents and learn lessons from them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff followed safe infection control practices. Medicines were managed safely and people received their medicines as prescribed.

People felt safe and staff had received training in safeguarding adults. Risks to people were managed appropriately.

There were enough staff to meet people's needs and recruitment practices helped ensure only suitable staff were employed.

Is the service effective?

Good

The service was effective.

Improvements had been made to the environment to make it more suitable for people.

Staff were suitably trained, skilled and knowledgeable about people's needs and received support through supervision. Staff followed relevant legislation to protect people's rights and ensured decisions were made in their best interests.

People were given a choice of nutritious food and drink and received appropriate support. They had prompt access to healthcare services when needed.

Is the service caring?

Good

The service was caring.

Interactions between people and staff were positive. Staff spoke fondly of the people they cared for and treated them with kindness and compassion.

People's privacy and dignity were respected and confidential information was kept securely.

People were involved in assessing, planning and agreeing the care and support they received. Where people did not have

family or friends to support them, lay advocates had been appointed to help ensure their voices were heard.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to meet their individual needs. They were supported to make choices and retain their independence.

Staff were responsive to people's needs. Care plans were comprehensive and reviewed regularly to help ensure they reflected people's needs.

People knew how to make complaints and they were dealt with promptly in accordance with the provider's policy. The registered manager sought and acted on feedback from people.

Is the service well-led?

Good

The service was well-led.

There was a clear management structure in place. All staff were committed to providing high quality care and worked well as a team.

The service had an open, transparent culture. Visitors were welcomed and there were appropriate links to the community

Quality assurance systems were effective. A suitable system was in place to analyse incidents and accidents and learn lessons from them.

Oakwood Residential 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 21 January 2016 and was unannounced. It was conducted by an inspector and an expert by experience in the care of older people. 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 reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with six people living at the home, two friends or family members and a visiting community nurse. We also spoke with the registered manager, the deputy manager, five care staff, the cook and the housekeeper. We received feedback from the local authority Quality and Safeguarding Team. We looked at care plans and associated records for five people, staff duty records, three recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

At our previous inspection, on 24 and 27 March 2015, we identified that infection control risks were not being managed safely. At this inspection we found effective action had been taken and improvements had been made.

People's rooms and communal areas of the home were clean. One person told us "[Staff] are always cleaning; they keep it spotless." Staff had received training in infection control and followed safe working practices to prevent the spread of infection. The laundry room had been extended and a clear process was in place to reduce the risk of cross contamination. The hand washing sink in the laundry was accessible and a good supply of personal protective equipment (PPE) was available to protect staff and their clothing. A staff member told us "The laundry is a big improvement and makes it easier for us to cope with."

The registered manager had completed an annual statement of infection control and the provider's infection control policy was appropriate and up to date. It was supported by infection control risk assessments and cleaning schedules which detailed how all areas of the home should be cleaned. Check sheets confirmed cleaning had been completed as planned. Clinical waste was stored safely and disposed of by an approved contractor.

People felt safe at the home. One person said, "I feel safer here than I ever have before." Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. They had received appropriate training and were aware of people who were at particular risk of abuse. For example, staff accompanied one person when they went to buy a new car; the person told us "One of the girls came with me as I think they thought I might be pressurised by the salesman." This protected the person from the risk of financial abuse.

The registered manager responded appropriately to any allegation of abuse by conducting thorough investigations and liaising with the local safeguarding team. Following concerns of potential abuse by one person towards another, practical steps were taken to reduce the likelihood of them being able to spend time together unsupervised. Staff had also worked closely with partner agencies to protect a person from potential abuse by a family member. At lunchtime, when two people became involved in a verbal altercation, a staff member tactfully placed themselves between the two people concerned; they distracted them by engaging each of them in conversation and this defused the situation simply and effectively.

People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, staff encouraged people to mobilise using their walking frames; they remained close by, in case the person needed additional support, but allowed them to travel at their own speed and retain their independence. The person who bought a car told us "[The registered manager] was worried about me driving as I hadn't driven for a while, so we agreed I'd have a couple of lessons and they were fine. It's good to be able to get out now."

Most other risks were also managed effectively. These included the risk of people falling or developing

pressure injuries. Fall saving equipment was in people's reach at all times and staff encouraged people to use it correctly. Where people had fallen, additional measures were put in place to protect them, such as reviewing their medicines or changing the layout of their rooms to remove hazards. Pressure relieving cushions and mattresses were in place for people at risk of developing injuries. Two people smoked cigarettes and were aware that they could only smoke outside of the building. One person had been assessed as safe to look after their own cigarettes and lighter. Staff told us it was not safe for the other person to keep these items, so looked after them for the person. However, the need for this restriction had not been documented, so there was a risk this safety measure would not be implemented consistently by all staff.

One person was at risk of choking on their food. Staff had referred the person to a specialist and were awaiting an assessment. In the meanwhile, the person was receiving a soft diet and staff were supporting the person to eat their meals in case they got into difficulties.

Risks posed by the environment had been assessed and were being managed appropriately. Additional handrails had been installed to support people in the corridors. Equipment, such as hoists and lifts were serviced and checked regularly. Upstairs windows had restrictors in place to prevent falls and fire exit doors were alarmed so staff would be aware if anyone had left the building unsupervised.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. Staffing levels were determined by the number of people using the service and their needs. The registered manager told us they had identified that a number of incidents had occurred in the morning and in the evenings and some newer people to the home were choosing to stay up later. Therefore, they were introducing additional staff at these times to support people more effectively.

The process used to recruit staff was safe and helped ensure staff were suitable for their role. The provider carried out relevant checks to make sure staff were of good character with the relevant skills and experience needed to support people effectively. Staff confirmed this process was followed before they started working at the home.

There were appropriate arrangements in place for the safe handling, storage and disposal of medicines. Medication administration records (MAR) confirmed that people received their medicines as prescribed. One person told us "[Staff] are very organised with the medicines." An additional medicines round had been introduced at 07:00am for people who needed to receive certain medicines before food. Some people were living with dementia and were unable to communicate when they were in pain. A pain assessment tool had been introduced to help staff assess when people needed pain relief and to check that it had been effective.

Staff were suitably trained to administer medicines and knew how people liked to take them. They had a good working relationship with the community pharmacy and were able to resolve any issues or concerns effectively; for example, if they thought the wrong medicines had been delivered or alternative forms of medicine needed to be considered for someone. A community nurse told us "[Staff] took an awful lot of care sorting out the drugs for [a person with very complex needs]." A recent audit conducted by an external pharmacist confirmed that medicines were being managed safely.

There were plans in place to deal with foreseeable emergencies. The provider had a sister home nearby, and arrangements had been made to share resources if the need arose. An emergency bag and file had been prepared containing contact details for staff and management out of hours, together with personal evacuation plans for people. These included details of the support they would need if they had to be evacuated, which were linked to a system of symbols on people's doors for easy reference in an emergency.

Staff were aware of the action to take in the event of a fire. Fire safety equipment was maintained and tested regularly.

Good

Is the service effective?

Our findings

People were cared for by staff who were motivated to work to a high standard and received appropriate training. One person told us "Staff are excellent and look after me well." Staff had completed a wide range of training relevant to their roles and responsibilities. They praised the quality of the training and told us they were supported to complete any additional training they requested. New staff completed a comprehensive induction programme before working on their own. Arrangements were in place for staff new to care to complete the Care Certificate while being supported by an experienced staff member acting as their mentor. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. Following this, staff told us they were supported to study for nationally recognised qualifications in health and social care or other courses relevant to people living in the home, such as diabetes management and mental health.

Staff were skilled and knowledgeable about the needs of people living with dementia and how to care for them effectively. For example, a family member told us "[Staff] got [my relative] to bathe; at home she did not look after herself." When it was difficult to understand what people were saying, staff used facial expressions, body language and appropriate touching to aid communication, reassure people and make them feel listened to.

Staff told us, they were supported appropriately in their role by the registered manager and said they felt valued. They received regular supervisions and yearly appraisals. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. One staff member said, "[Supervisions] have been useful; we discussed my goals, for example to complete my level three [diploma in health and social care] and I've just done it. I'm now waiting for dates to do my level three [diploma] in management." Group supervisions were also held with staff to help them understand certain aspects of their role better. For example, a group session had been held to discuss the purpose of social activities for people and to explore ways that this could be improved. The registered manager was in the process of completing annual appraisals for staff who had worked at the home for more than a year. Other senior staff were being trained to complete appraisals to enable this process to be completed more quickly.

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 had received training in the MCA and demonstrated a clear understanding of the legislation in relation to people living with dementia. Before providing care, they sought consent from people using simple questions and gave them time to respond. A staff member told us "Most people can make choices about what to wear, what to eat, whether to have a bath or a shower; but we don't give them too many choices at once as it could confuse them."

People who had capacity had signed their care plans to indicate their agreement to the care planned. Where

people lacked capacity, best interest decisions had been made and documented in most cases, following consultation with family members and other professionals. However, we identified one person for whom best interest decisions had not been made in respect of their medicines. We drew this to the attention of the registered manager who took immediate steps to address this. Staff were not clear whether one person was able to make a particular decision and were working closely with healthcare professionals to enable them to assess the person's capacity accurately.

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). The provider had appropriate policies in place in relation to DoLS. Authorisations were in place for six people and staff were aware of the support these people needed to keep them safe and protect their rights.

People told us they liked the food and were able to make choices about what they ate. One person said, "The food is very good. I had a hankering for blueberries and salmon, and [the chef] got them for me." A family member told us, "My [relative] and I are happy with the food at the home. There is always choice. My [relative] likes hot-cross buns, so they brought them in for her".

The chef involved people in developing the menus and adapted them as new people arrived at the home. They told us "Some of the newer people weren't keen on the chicken curry, so we substituted this for chicken casserole for them." Menus were appropriate to the seasons, varied and nutritious. Alternatives to the main meal of the day were offered, including low-fat alternatives for people who wished to manage their weight. People received meals in varying portion sizes, based on their appetite and preferences. When people did not eat their meal, staff tempted them with alternatives, such as sandwiches or soup. We observed the lunchtime meal and saw staff created a calm, relaxed, atmosphere that encouraged people to eat and drink well.

The chef was aware of people's likes and dislikes, including those who required special diets and accommodated these at all times. A staff member had recently returned from a course about diabetes and we heard them using their new knowledge to discuss strategies with the chef that might support a person whose diabetes was unstable. One person was at risk of not drinking enough; staff encouraged them to drink often, and when they returned to their room after lunch, staff carried the person's drink through to their room for them.

People received appropriate support to eat and drink enough. This included cutting up people's meals when requested and prompting them to eat when needed. Staff did this in a supportive way that helped people retain their independence. For example, a staff member cut up a person's food and prompted them to eat. The person started to eat independently, so the staff member left them. Later, when it became clear the person needed more support, the staff member returned and sat with the person to support them to eat the remainder of their meal. People were not rushed; they were given time to eat at their own pace and desserts were not offered until people had finished with their main course. Some people were given their meals on brightly coloured plates; this is known to assist people with visual perception difficulties as it makes the food more visible and encourages them to eat more. The amount people ate was monitored and appropriate action taken if people started to lose weight. This included referrals to the GP or other specialists.

People were able to access healthcare services to stay healthy. For example, a family member told us they were pleased that staff had contacted a doctor quickly when their relative developed an eye infection. Staff also had arranged for people to receive monthly health monitoring checks. The community nursing team

had trained senior staff to give insulin to a person with diabetes. Staff were aware of the signs the person displayed when their blood sugar levels dropped suddenly and knew what action to take to support them to recover when this happened. Staff enjoyed good working relations with the community nursing team. A staff member told us, "[The community nursing team] have been a great support; we can phone them any time for advice." A visiting nurse confirmed this and said, "It's a sign of confidence [in the staff] that we trained them to give insulin. They keep us informed if there are any problems and follow any advice we give."

The building was suitable for the people living in the home. There was a choice of suitable communal areas available for people to spend their time. Chairs were placed in clusters to promote conversation. From our observations, it was clear that this was effective as people readily engaged with each other and with staff. A stair lift connected the ground floor to the first floor of the building and people were supported to use this safely. Corridors were wide, kept free of obstructions and had had handrails installed since our last inspection. However, there was a lack of colour contrast between the walls and the handrails, which would make it difficult for people with impaired vision to see them clearly. We discussed this with the registered manager who told us of plans to repaint the handrails and introduce more signage to help people mobilise and navigate their way around the building.
A maintenance person was employed to attend to all minor repairs and maintain the building in a suitable state of repair. A staff member told us, "The new maintenance man is great. Anything that needs fixing is just done. We told him [a person] needed a new curtain rail and he is returning today to do it." The floor covering in some bedrooms and communal areas had been replaced which made it easier to keep the home clean and had removed potential trip hazards. The communal areas of the home were bright, with pictures and photographs on the walls that were appropriate and relevant to the people living there. Colourful notices about events and information for people and their families were also displayed prominently.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. One person said of the staff, "They're very kind to me; they're very good people." Without exception, all interactions we observed between people and staff were positive, showing that staff understood people's needs and knew them well. People and staff freely shared stories about their lives including holidays, their families and family events. Conversations were inclusive and helped build relationships, many of which were clearly close and long-standing. Two people had formed a friendship and staff promoted this by supporting them to sit together and keeping each of them informed about what the other was doing. Staff relationships with relatives continued after people had left the service. A staff member told us, "[One person] needed nursing care, so we had to let them go. It was very upsetting, but the [relative] still visits weekly as they used to. We've told him he's more than welcome."

Staff spoke fondly of the people they cared for and described them as "a family". Regardless of their role, they expressed a shared view that they were responsible for meeting people's needs and making life as pleasant and comfortable for people as possible. One staff member said, "I love treating people like I would want a loved one treated. They aren't just people; they are someone's mum or nan." Another told us, "I love spending a bit of time with [people], getting to know them as people. Information about their personal history, their jobs, their children and their families is in the care plans and it's really useful." We heard conversations between staff and people, which showed they knew people and their backgrounds well. Care and non-care staff supported people to access the community, for example to go shopping or for a walk. When a person went outside for a cigarette, a staff member joined them and had a cigarette, a coffee and a chat with them.

Staff treated people with dignity at all times. Information about the 'common core principles of dignity' was posted on the home's notice board and a staff member had been appointed as a 'dignity champion' to promote its importance. Staff were familiar with the dignity principles and worked to them every day in the way they treated and supported people. When they met in passing around the home, staff always acknowledged people and made friendly comments.

After lunch, one person's hands were dirty from food. Two staff members encouraged the person to clean their hands but the person was reluctant to do this. Sensing that the person was becoming upset by the request, one of the staff members said, "I will leave now because I think this is getting too much for her." The remaining staff member gave the person some time, and then warmed some hand wipes so they would not be cold to the touch. They offered them to the person, which they accepted readily.

We observed a person fell asleep in a chair while holding a cup of tea. The tea spilt on a blanket covering their legs and the person woke with a start. A staff member attended to the person immediately mopped up the spillage and replaced the person's blanket without fuss. They explained what had happened and reassured the person effectively. Another person was also offered a fresh cup of tea as the one they had had gone cold. Communication with the person was not easy, but the staff member focused on the person's face and made eye contact with them. The person responded with a big smile.

People's privacy was protected by staff knocking and waiting for a response before entering people's rooms. When personal care was provided they ensured doors were closed and curtains pulled. People had been asked whether they had a preference for male or female care staff; their preferences were recorded, known to staff and respected. One person would only allow a particular staff member to help them with personal care. The staff member made it a priority to support this person whenever they worked, to ensure they received personal care as often as possible. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it. When staff discussed people's care and treatment they were discreet and ensured conversations could not be overheard.

People's bedrooms were personalised with items important to them, such as photographs and mementos. A staff member told us how they had changed the layout of some people's rooms (with their permission) to make the room more private, for example by moving the commode into a corner where it could not be seen from the door.

When people moved to the home, they, and their families where appropriate, were involved in planning and agreeing the care and support they received. A family member told us, "I have been asked about my [relative's] medical and personal history, which has been recorded. I am happy with the care; the staff are wonderful," Comments in care plans showed family members were kept up to date with any changes to their relative's needs. Some people did not have family members or friends to support them, so staff had secured the services of lay advocates to help communicate with these people and represent their interests. This helped ensure people's wishes were sought, heard and acted on. The registered manager was in the process of reviewing the process for making decisions about resuscitation. They were engaging with people, their families and medical professionals to help ensure that the issues were discussed and clear decisions put in place where appropriate. This would prevent unnecessary medical interventions being attempted when they were unlikely to succeed and could cause distress.

Good

Is the service responsive?

Our findings

People were empowered to make choices and have as much control and independence as possible. A family member told us, "My [relative] gets up and goes to bed at times of her choosing." Staff were clear that they were led by people's individual wishes and aimed to meet them wherever possible. One staff member told us, "It's about giving people all the normal choices we would expect; giving them the life they've always had, just with a bit of assistance." Another staff member said, "When you're giving personal care, you don't just do it; you always offer [people] the chance to do it themselves; it's not right to just assume they can't do it. Some people are slow eaters; we will offer to help, but leave it up to them to choose if they want it."

We observed people being given the time and space to mobilise independently whenever they could. Often, no more than a guiding hand or support to access a walking frame was needed to enable people to make the most of their physical abilities. Staff were clear about how to promote people's continence so they could remain independent. One staff member told us "[One person] doesn't like to use the loo if the seat is cold. I found that if you put paper down first, they will use it. It's better for [the person] if they can go on their own. I've made other [staff] aware and they do it too."

People had their needs assessed and spent time with staff at the home before they moved to it. The registered manager told us, "They come and spend the day with us and we collectively make a decision about whether we can meet their needs and whether they will fit in and be comfortable here." Information was then sought from the person, their relatives and other professionals involved in their care and this informed the plan of care that was developed.
Care plans provided detailed information about how people wished to receive care and support. For example, guidance for staff about the support people needed with personal care was clear and specified when people liked to get up and go to bed. Reviews of care were conducted regularly by senior staff in conjunction with people's key workers. The key workers were members of staff who were responsible for working with certain people, taking responsibility for making sure they had everything they needed in their rooms and their needs were met. People and their relatives were consulted as part of the review process, as were all other staff involved in the person's care.

When people's needs changed, staff responded appropriately and care plans were developed to ensure they reflected people's current needs. One person's mental health needs had changed and they had become more anxious. Staff had worked closely with the person's family, the community psychiatric nurse and the GP to identify the cause of the changes and the additional support they needed as a result. Another person had expressed a wish to return home and live independently. Staff had supported the person by working with them, their solicitor, an independent mental capacity advocate and a community psychiatric nurse to assess whether this was feasible. The person decided it wasn't and chose to remain at the home.

People had access to a range of activities which were adapted to meet their individual interests. We observed a reminiscence session where people were encouraged to talk about events from their lives using a series of old photos as a prompt. Staff interacted with people by comparing and contrasting people's accounts of the past with current events. Everyone was encouraged to join in, which created a positive social

experience for people. The home was also involved in an initiative to knit a woollen blanket from knitted squares. People, visitors and staff were encouraged to knit individual squares and this had given people a sense of purpose. People who chose not to engage in group activities told us staff spent time with them on a one-to-one basis. For example, one person told us staff had helped them arrange a holiday and given them the reassurance and confidence to go ahead with it.

People knew how to complain or make comments about the service and the complaints procedure was prominently displayed. Records showed complaints were dealt with promptly and investigated in accordance with the provider's policy. Appropriate action had then been taken to prevent a recurrence of the issue. The registered manager also used meetings with people and their families to seek feedback about the service. Changes were then made to improve the service, for example by modifying the menu or changing the activities that were arranged.

The provider conducted surveys of people, their families and staff on a regular basis. The registered manager analysed these and developed an action plan of improvements. The last survey had identified the need for staff to receive more end of life training and for activities to be reviewed; we saw this was being addressed.

Good

Is the service well-led?

Our findings

People liked living at the home and felt it was well-led. One person said, "[The registered manager and the deputy manager] are excellent; they run the place very well." A community nurse told us, "We've really noticed a difference; the place has been completely turned around. [Staff] are a lot more on the ball, more helpful and better organised."

There was a clear management structure in place consisting of a registered manager, a deputy manager and senior care staff who had individual responsibilities. Staff enjoyed working at the home and told us they felt supported by management. Comments included: "Staff come to work with a smile on their face now and residents are much happier"; "I can't fault them. I can go to [the registered manager or the deputy manager] with any issue and we would sit and discuss it and there would be a quick outcome. I can speak in confidence if I need to off-load and know it won't go any further"; and "If someone's got something to say [at staff meetings] they just come out and say it so it's cleared up and makes a better atmosphere. If we have any ideas [for improvement] we can go straight to [the registered manager] to discuss them".

Staff worked well as a team and managers were keen to make use of the full range of staff skills for the benefit of people. One staff member had previously worked in a nursing home. The registered manager told us, "[The staff member] has got a good understanding of nursing care, so we use their knowledge to the full." A staff member said, "It's the best team of people I've ever worked with. They go out of their way to help people." Another told us "Team working is good. We have a list of jobs to do but help each other out; and we're happy to cover [shifts] for each other. The whole atmosphere is much nicer and calmer."

The registered manager and deputy manager told us they "wanted the home to succeed" and were committed to working tirelessly, often in their own time, to achieve positive outcomes for people. This vision was understood and shared by the staff, who were committed to delivering high quality care to people. Staff were encouraged to make suggestions to improve people's experience of care. A staff member said, "I can say if I have any ideas; like when people's needs change and they need more help with their continence or mobility or if they just don't look very well. You mention it and it's investigated." Minutes of the last staff meeting showed the needs of two people in particular were discussed and staff had made practical suggestions about how their needs could be met more effectively.

The registered manager told us they received appropriate support from the provider. They said, "[The chef] has a clear budget and buys whatever she needs within that. With other things, I just tell [the provider] what we need and he agrees. We don't have any problems with that; he's very supportive." The registered manager also received support from the Clinical Commissioning Group and the local authority and was attending as many of their courses as possible to keep up to date with best practice guidance.

There was an open and transparent culture within the home. The previous inspection report and rating was prominently displayed in reception. Visitors were welcomed, there were good working relationships with external professionals and the provider notified CQC of all significant events. There was a whistle blowing policy in place, which staff were aware of. Whistle blowing is where a member of staff can report concerns to

a senior manager in the organisation, or directly to external organisations. There were links to the community through two local churches, visitors and advocates. A local school was also working with the home on a project which brought people and children together. The home held an open day last year and were planning to hold another one this year as part of a 'National care homes open day' event. The registered manager told us, "The aim is to get our residents more involved in the community; they respond well to community-based events."

Auditing of key aspects of the service, such as care planning, the environment, medicines and infection control were effective. Where changes were needed, action plans were developed and changes made; the plans were then monitored to ensure they were completed promptly. For example, a recent environmental audit had identified the need for more fire safety training and this had been delivered. In addition the registered manager and the deputy manager spent time working with staff and observing care being delivered to help ensure staff worked effectively. The chef monitored people's nutritional intake by taking time out of the kitchen to observe how well people ate and adapted the menus accordingly.

The registered manager was aware of key strengths and areas for improvement at the home and there was a plan in place to manage these. This included enhancing the environment; providing a smoking shelter for people; further developing the staff team, improving activity provision; and building more links with the community.

An effective system was in place to analyse incidents and accidents and learn lessons from them. Accidents, such as falls, were reviewed monthly by the registered manager to identify any common themes or patterns. Action was then taken to minimise the risk of them reoccurring. In addition, staff made good use of a communications book to pass on information or concerns about people to their colleagues. This helped ensure all staff were aware of current risks to people.