Four Seasons (No 9) Limited

Midfield Lodge

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

Midfield Lodge provides accommodation and personal and nursing care for up to 60 people, some of whom were living with dementia. There are external and internal communal areas for people and their visitors to use.

During this unannounced inspection on 12 July 2016 there were 44 people receiving care from the service. The manager confirmed that the regulated activity, diagnostics and screening, was not provided at this service. We have therefore not assessed this during this occasion.

The last registered manager left in May 2016 when the current manager took up post. A registered manager is a person who has registered with the Care Quality Commission (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. The manager had applied to register with the CQC and their application was being processed.

Medicines were stored securely and people were supported to take oral medicines appropriately. However, this was not the case for administering and recording topical medicines and medicines prescribed to be given 'when required'.

Although the service looked cleaned there were malodours in some areas of the service.

There were sufficient staff to meet people's needs safely. However, people sometimes had to wait for their care to be provided. Staff were only employed after satisfactory pre-employment checks had been obtained. Staff knew the people they cared for well and understood, and met, their needs. Staff were trained, and well supported, by their managers. Systems were in place to ensure people's safety was effectively managed. Staff were aware of the procedures for reporting concerns and of how to protect people from harm.

People's health, care and nutritional needs were effectively met. People were provided with a balanced diet and staff were aware of people's dietary needs.

There were formal systems in place to assess people's capacity for decision making and applications had been made to the authorising agencies for people who needed these safeguards. Staff respected people choices and staff were aware of the key legal requirements of the MCA and DoLS. People were involved in every day decisions about their care.

People received care and support from staff who were kind, caring, friendly and respectful to the people they were caring for. Staff treated people with dignity and respect. There were limited opportunities for social engagement and occupation. However, the manager had taken action to improve this.

Care records provided staff with sufficient guidance to provide consistent care to each person. Changes to

people's care was kept under review to ensure the change was effective.

The manager was supported by a staff team that including registered nurses, care workers, and ancillary staff. The service was well run and staff, including the manager, were approachable. People and relatives were encouraged to provide feedback on the service in various ways both formally and informally. Concerns were thoroughly investigated and plans were actioned to bring about improvement in the service. The manager had clear plans for involving people, visitors, staff and the local community in developing and improving the service to benefit those receiving it.

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.

People were supported to manage their prescribed oral medicines safely. However, this was not the case for administering and recording topical medicines and medicines to be given 'when required'.

Although the service looked cleaned there were malodours in some areas of the service.

There were sufficient staff to ensure people's needs were met safely.
Staff were only employed after satisfactory pre-employment checks had been obtained.

There were systems in place to ensure people's safety was managed effectively. Staff were aware of the actions to take to report their concerns.

Is the service effective?

Good

The service was effective.

Trained and well supported knew the people they cared for well and understood, and met, their needs.

People's rights to make decisions about their care were respected.

People's health and nutritional needs were effectively met and monitored.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were kind, caring, friendly and helpful.

People were involved in every day decisions about their care.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

There were limited opportunities for social engagement and occupation. However, the manager had taken action to improve this.

People's care records provided staff with sufficient guidance to ensure consistent care to each person.

People had access to information on how to make a complaint. Complaints were thoroughly investigated.

Is the service well-led?

Good

The service was well led.

The manager was experienced and staff were managed to provide people with safe and appropriate care.

People were encouraged to provide feedback on the service in various ways.

The service had an effective quality assurance system that was used to drive improvement.

Midfield Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 12 July 2016. It was undertaken by one inspector, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to our inspection we looked at all the information we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about.

We asked for feedback from the commissioners of people's care and Healthwatch Cambridge.

During our inspection we spoke with 11 people and seven relatives. We also spoke with the regional director, the manager, the deputy manager, a care home assistant practitioner, one team leader and one care worker. Throughout the inspection we observed how the staff interacted with people who lived in the service.

We looked at five people's care records, staff training records and other records relating to the management of the service. These included audits, staff rosters, meeting minutes and records of compliments and complaints.

Following our inspection we received feedback from four visiting healthcare professionals. These included two specialist nurses and two GPs.

Requires Improvement

Is the service safe?

Our findings

People were satisfied with the way staff supported them to take their prescribed medicines. There were appropriate systems in place to ensure people received their oral medicines safely. Staff told us that their competency for administering medicines was checked regularly. We found that medicines were stored securely and at the correct temperatures. Oral medicines were administered in line with the prescriber's instructions. Appropriate arrangements were in place for the recording of oral medicines received and administered. However, we found that staff were not always recording when they had administered topical medicines. We also found there was insufficient guidance for staff where medicines were prescribed to be administered 'when required'. The manager told us these issues had been identified and assured us plans were in place to bring about improvement.

Prior to our inspection concerns had been raised about the cleanliness of the service. The provider's representative investigated this and found that standards had recently dropped within the home due to staff leaving and the cleaning tasks not being addressed. They acknowledged that 15% of relatives who had responded to the provider's questions had said the service was not cleaned to the highest standard and 13% said there was an odour in the service. The provider's representative told us they had recently engaged a part time domestic and an agency domestic. They had also installed air fresheners in some areas of the service and were encouraged people to leave their rooms so they could be deep cleaned.

People said that there rooms were cleaned regularly. One person said their "room is always clean." Another person commented, "My room is very pleasant." A relative told us their family member's room was, "always clean." During our inspection the service looked clean. However, there were malodours in several areas of the service throughout the day. The manager told us she was aware of this and was continuing to address the issue.

Prior to our inspection, concerns had been raised that there was insufficient staff to provide people with the care they needed. The provider's representative investigated this. They told us they used a recognised tool to assess people's needs and determine the number of staff required. As a result of their investigation they said that staffing levels had been increased during the day in the week prior to our inspection. They also acknowledged that there had been occasions that, due to short notice of staff absence, the staffing levels had not been met. This led to some people not receiving their care as quickly as they would have liked.

We were given various examples where people and staff had concerns about the number of staff on duty. These included one person saying, "You can ring your bell and ring and ring it and [staff] don't bother to come." Another person said, "I know [staff] are busy and understaffed , but often it takes them a long time when you press the button and sometimes they don't come at all." Some relatives felt there were sufficient staff, but one commented, "The staff are very good [but they] are overworked." A staff member told us, "This is a very busy home. I feel sorry for the nurses." Another staff member said, "Staffing levels are a bit of a problem. I don't think staffing levels are great." All the staff we spoke with assured us people's care needs were met safely. However, for some people this meant they did not receive their personal care and were not able to get up at the times they preferred. In addition, there were insufficient staff to provide one to one

engagement with people who may have benefitted from this.

Healthcare professionals told us they felt staff, and nurses in particular, were very busy. One told us, "Staff are extremely busy, very rushed. However, they try their absolute hardest to be as efficient as possible and do their best." Another healthcare professional told us that they had observed nurses finding it difficult to cope with the workload when there was only one nurse on duty. None of the healthcare professionals had seen anyone's safety compromised and one commented that they felt the staffing situation had "improved recently."

The provider had also created a new role called care homes assistant practitioners (CHAPs). These were care workers were trained to take of some of the responsibilities of the nurses. One CHAP said, "I feel I can take some weight off the nurse's shoulders." They also explained that the deputy manager assisted with nursing and care tasks. They said, "We see him on the floor quite a bit." This helped to reduce the pressure on the nursing staff.

The manager told us they were continuing to recruit new staff and increase the number of permanent staff employed. In the interim agency staff were used when permanent staff were unavailable. Whenever possible the agency staff had worked at the home before and understood people's needs. However, agencies were not always able to supply staff to cover short notice absence.

During our inspection we found that although staff were busy, there were sufficient staff to meet people's assessed needs. However, although we found that the staffing levels outlined by the provider's representative were met on the day of our inspection, we were told this was not always the case. Records showed the staffing levels had not been met on several occasions, including the day prior to our inspection. This was due to short notice staff absence. We saw that efforts had been made to cover these absences, but they were unsuccessful.

People receiving the service said they felt safe. One person told us, "I feel safe here." Another person said, "I've never felt unsafe when staff have been helping me."

Staff told us they had received training to safeguard people from harm or poor care. They showed they had understood and had knowledge of how to recognise, report and escalate any concerns to protect people from harm. Staff told us they felt senior staff were approachable and were confident that their manager's would act on any concerns they raised. We saw that where concerns had been raised, these had been referred to the appropriate organisations, including the local authority and the Care Quality Commission (CQC).

Staff understood the support people needed to keep them safe, during periods of distress and behaviour that was challenging to themselves and others. Two members of staff explained to us how they tried to understand the causes of distress in order to avoid these and minimise the impact both for the person and others around them.

Staff told us that the required checks were carried out before they started working with people. These included written references, proof of recent photographic identity as well as their employment history and a criminal records check. This showed that there was a system in place to make sure that staff were only employed once the provider was satisfied they were safe and suitable to work with people who used the service.

Systems were in place to identify and reduce the risks of harm occurring to people who used the service. We

saw generic risk assessments had been completed where staff had taken into consideration risks that may affect everyone who received the service. For example, the action to take if a heat wave occurred. People also had individual risk assessments and care plans which had been reviewed and updated. Risks identified had been assessed for those people at an increased risk of choking, falls, poor skin integrity and who needed assistance to move safely. Appropriate measures were in place to support people with these risks. For example soft food or pureed diet as well as guidance on safe moving and handling techniques. Staff were aware of people's risk assessments and the actions to be taken to ensure that the risks to people were minimised.

Staff were aware of the provider's reporting procedures in relation to accidents and incidents. Accidents and incidents were recorded and acted upon. For example, where any untoward event had occurred, measures had been put in place to monitor people more frequently or check on their wellbeing more often. We saw that the potential for future recurrences had been minimised. Accident and incident forms were monitored by the manager and the provider's head office. This ensured actions were taken and identify any themes that may have occurred.

Good

Is the service effective?

Our findings

People and relatives said that they thought that staff were adequately trained for the jobs they had to do. One person told us, "[The staff] are good and some of [them] are very good." A healthcare professional told us they felt the deputy manager "leads the nursing team well" and felt staff were competent.

Staff spoke enthusiastically about their jobs. One staff member told us, "[Working here has been] one of the most enriching experiences of my life. It's a great responsibility. It's been very rewarding."

Staff told us they were trained in the subjects deemed mandatory by the provider such as moving and handling, fire safety and safeguarding people from harm. Staff had also had the opportunity to receive training in other areas relevant to the needs of the people they were supporting. For example, some staff told us their training included dementia awareness and pressure ulcer prevention and care.

One staff member told us, they did a lot of training within their first three months at the service. They said, "You get a lot of information. It can be so daunting." The manager and deputy manager recognised the need for this initial e-learning to be consolidated. They told us they planned to supplement this training with face-to-face learning in topics such as the Mental Capacity Act (MCA), Deprivation of Liberty Safeguarding (DoLS) and safeguarding people from harm as well as refresher training in basic care needs.

Two staff had recently completed a 'train the trainer' course which enabled them to train other staff to safely assist people to move. This meant that new staff would receive this training quickly and enable to assist more people with their care.

We spoke with a member of staff who had completed the care homes assistant practitioners (CHAPs) training. This enabled them to take on some of the responsibilities from the nurse. They told us the training had been very thorough and had included their competency being checked. For example in administering medicines and changing dressings.

The manager told us of their plans to increase the training available to staff and further develop their confidence and skills. For example, they were planning to offer additional training in palliative care, prevention of pressure ulcers and the use of specialist equipment, for example syringe drivers. Following our inspection a health care professional told us that nurses had received the training in the use of the syringe drivers. This would help improve the pain management for people on end of life care.

Staff members told us they felt well supported by their managers. Staff received formal supervision regularly, although there had been a slight break due to the change of management. We saw that formal supervisions were programmed in for July 2016 and bi-monthly thereafter. One staff member told us the manager and deputy manager were supportive. They said, "I feel treated as an individual and respected. I feel they listen to me. I feel supported." They went on to tell us a team leader "has a lot of experience and is an excellent example [to us]." Another staff member told us, "I do feel well supported by [the deputy manager] and [manager. The deputy manager] doesn't stand any nonsense. He addresses issues. [Some

staff were not doing people's] personal care. [The deputy manager] addressed it and it's improved."

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 found the service was working within the principles of the MCA. We saw that assessments and decisions to restrict people's liberty had been properly taken and the appropriate applications were in the process of being made to the relevant authority for authorisation. This showed that consideration had been taken to ensure the service provided was in people's best interest and was provided in the least restrictive manner.

Staff were trained and knowledgeable in relation to the application of the MCA. A healthcare professional told us that the staff have always shown great respect for patients' wishes. Where people had been assessed as not having the mental capacity to make specific decisions, we saw that decisions were made in their best interest. The staff we spoke with had an understanding and were able to demonstrate that they knew about the principles of the MCA and DoLS. They confirmed that any decisions made on behalf of people who lacked capacity, were made in their best interests. One member of staff told us, "I can't force [people to do anything]. I can't be overpowering. It wouldn't be ethical. [Each person has an] individual line were we don't push or encourage any more. I respect that."

Records showed that appropriate people's views were taken into consideration when staff made best interest decisions. These included people who knew the person well or the person's legal representative.

People said they liked the food and the choices that were available. One person said, "The food is lovely and you get lots of it." Another person told us, "The food is lovely. You couldn't get better food." A third person said, "The food is quite good generally."

People were offered a choice of what they would like to eat and drink in a way they could understand. Menus showed two choices available at mealtimes. In addition staff told us people could request other options. People were supported to eat their meals where they chose. Some people ate in the dining room. Tables were nicely laid with printed menus, tablecloths, cutlery and napkins. Other people chose to eat in their bedrooms and staff took their meals to them on trays. Staff discreetly offered people help with their meals and drinks, if they needed assistance. We saw that staff gave each person the time they needed and did not try to rush them. There were good interactions between staff and people using the service at lunchtime in order to make it a social occasion.

People's nutritional needs were assessed and appropriate referrals were made when appropriate to dieticians and speech and language therapists. People were supported to have enough to eat and drink. Appropriate diets, such as soft food, were provided for people who required them and people were referred to a dietician when needed. Although staff were confident people were being receiving sufficient food and fluids, we noted that where people's intake of food or fluid was being monitored, the records were not always completed demonstrating this. In addition to meals, we saw that a range of drinks and snacks were available throughout the day and night. Staff knew people's likes and dislikes and this was recorded in their

care plans.

Records showed that timely advice was sought from healthcare professionals. The healthcare professionals we spoke with all told us that staff made appropriate referrals to them. One told us, "They have a quite good referrals system." They went on to tell us that staff always contacted them as soon as a person's health changed. Another told us that staff "often speak to me directly" for advice when people are admitted to the service.

Three healthcare professionals were confident that staff followed their guidance. One told us, "I've asked [staff] to call me next week [to provide an update on a person's condition]. They've got a good system that works and I know I'll get the call." However, another healthcare professional told us this had not always been the case. They told us that a person had been admitted to hospital although it had been agreed the person would be cared for at the service. Records showed that systems were in place so that people were offered regular health checks, such as visits from an optician and chiropodist. This meant that people were supported to maintain their health and well-being.

Good

Is the service caring?

Our findings

People and their relatives were complimentary about the staff. One person said, "Everybody is so friendly and helpful here"; the staff all talk to you and I've made friends here." Another person described staff as, "They're very kind and caring." A relative told us, "The staff seem very kind and caring."

A healthcare professional described staff as, "Very kind and compassionate." Another said, "[Staff] treat people with respect and tell them what they are doing. They're brilliant…they are kind and friendly, with patients being cared for very well." A third healthcare professional said, "Some [of the staff] have just got caring in their blood. There's not one [member of staff] who's not caring." This extended to the way staff spoke with relatives. A healthcare professional told us staff made "great efforts" to have good relationships with people and their families. Another healthcare professional said they sometimes heard staff speaking with relatives and had observed this was always done, "In a sensitive way."

Throughout our inspection staff maintained a caring attitude towards people. We saw staff interacting with people in a respectful and empathetic manner. They reassured people who became distressed. For example, we saw a staff member comforting a person who was frustrated because they couldn't operate a door lock. Care plans provided guidance to staff on how to reduce people's anxiety. For example, one person's care plan said, 'I don't like loud music.' It told staff to 'talk slowly and clearly' and to limit the options presented at one time to the person. Staff were familiar with this information and told us how they applied it when caring for the person.

People were kept informed and involved with choices about their day-to-day care. For example, we heard staff asking a person if they were "ready for some lunch?" Staff offered the person choices about what they would have and where they would eat it. We heard a member of staff inform a person that a healthcare professional would be visiting them later in the day. The staff member said, "The doctor's coming to see you in a little while. How are you feeling now?" They asked the person, "How's the pain?" and told them, "The doctor will be here soon." We saw that where people wished, their family members were involved in their care planning and reviews of their care. The manager told us that planned to further develop people's involvement in the care planning process over the next 12 months. People's relatives said they were kept informed of any changes in their family member's condition and well-being. One relative told us, "[The staff] keep us in touch."

Staff explained what they were going to do before assisting people. For example, we heard a staff member ask a person, "Can I help you to sit up?" We heard staff chatting with people about things that interested them while providing care. They told us this helped to reduce people's anxiety and provided added interest.

Staff told us they would be happy with a family member receiving care from the service. One staff member told us this was because it "is such a friendly place."

People who required advocacy were supported in a way which best met their needs. For example, relatives and people who knew the person well were consulted about people's care and involved in best interest

decisions. Referrals had also been made for more formal advocacy. Advocates are people who are independent of the service and who support people to decide what they want and communicate their wishes.

People had their own bedrooms and staff had supported people to personalise their bedrooms with photographs and small items of furniture. This was to help people feel comfortable with familiar things that were important to them.

People told us that staff respected their privacy and dignity when supporting them. One person told us, "[Staff] always shut the door when they come in to help you with the toilet." Our observations throughout our inspection showed us that staff knocked on people's doors and waited for a response before entering. They also let people know who they were as they entered. This meant that staff respected and promoted people's privacy.

Good

Is the service responsive?

Our findings

People told us that there had been a reduction in organised activities and events in the service. One person said, "A year ago there were more activities than now, like music and an Elvis impersonator."

During our inspection most people chose to stay in their rooms, many watching television, rather than joining in the organised activities. One person said, "I'm happy to stay in my room." Another person said, "I'm not bothered about the activities." Several people commented that they appreciated being able to look out from their bedroom windows on to open gardens and watch rabbits, squirrels and other wild life.

During the morning of our inspection seven people took part in cards and word games led by an activities coordinator. In the afternoon a similar number of people took part in a ball game and bingo. The activities co-ordinator was enthusiastic and encouraged conversation and participation in group activities. However, there were insufficient staff available to provide one to one interaction with those people who may benefit from this.

The manager told us that they had recently filled vacancies for activities co-ordinators with one member of staff starting work at the service on the day of our inspection, and another due to start work once satisfactory checks had been received. The manager said that filling these posts meant that the service would have organised activities provided seven days a week and there would be more opportunity for one to one engagement. The manager also talked of plans to encourage visitors to the service. For example, developing links with Pets As Therapy (PAT), a local art and agricultural colleges. This would provide further stimulation for people receiving a service.

Staff understood and responded to people's needs and clearly knew people well. For example, we say three separate staff all approach a person on the same side when talking with them to accommodate the person's hearing loss in one ear. One person told us, "I'm happy with my care." Another said, "I'm happy here, everybody talks to you." A person's relatives told us, "We are happy with [my family member's] care here." Another relative said, "I think they're looking after [my family member] very well."

People's care needs were assessed prior to them moving to the service. This helped to ensure staff could meet people's needs. This included staff requesting information about people's life history, preferences, allergies, their hobbies and interests, and people who were important to them. This assessment formed the basis of people's care plans and was to help ensure that the care that was provided would effectively and consistently meet people's needs. For example, people's preferred names and how they liked to spend their time. One person was diagnosed with epilepsy. Although their records showed the person had not had a seizure for over a year, there were clear instructions as to how to care for the person is a seizure occurred and when to use emergency interventions.

People's care plans were reviewed regularly and reflected people's changing needs. Where people were at risk of developing pressure ulcers, we saw care plans had been developed to reduce this risk. We saw there was a clear record of when routine procedures such as wound dressings were changed. However, records

did not always show that people were assisted to reposition at the required frequency. We also noted that abbreviations were used with no explanation. Staff completed care notes each time they provided care. However, we found these were task orientated and contained very little information about how the person said they felt or about any non-task driven engagement. The manager told us they had identified this as an area for improvement.

Staff talked enthusiastically about the people they provided a service too. They had a good understanding of people's individual personalities and preferences. This included ancillary staff. For example, we heard a domestic training a new member of staff. The domestic explained the reasons there were particular pieces of equipment in the person's room, including a bed with adjustable height and a crash mat beside the bed. They said the person sometimes got upset with people in their room and said they would "see how we go," making it clear if the person became upset they would leave.

People said that staff listened to them and that they knew who to speak to if they had any concerns. Information about how people could complain, make suggestions or raise concerns was available throughout the service. Staff had a good working understanding of how to refer complaints to senior managers for them to address.

We found that complaints were investigated and dealt with appropriately and thoroughly within the timescales stated in the complaints procedure.

Good

Is the service well-led?

Our findings

The staff had received several compliments from people who had received the service and relatives. For example, one person wrote, 'Thank you very much for the warm friendly welcome received at Midfield Lodge, the good food and the excellent care I received during my stay. You all do a good job.' A relative wrote, 'Thank you for the kindness, understanding and professionalism given to [my family member] during [their] recent stay.' Another relative wrote 'A big thank you for the devoted personal care and nursing my dear [family member] received during [their] stay at Midfield Lodge.'

The last registered manager left in May 2016 when the current manager took up post. A registered manager is a person who has registered with the Care Quality Commission (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. The current manager had applied to register with the CQC and their application was being processed.

Records we held about the service, records we looked at during our inspection and our discussions with the manager confirmed that notifications had been sent to the CQC as required. A notification is information about important events that the provider is required by law to notify us about. This showed us that the manager had an understanding of their role and responsibilities.

The manager was supported by a staff team that included registered nurses, care workers and ancillary staff. Staff were clear about the reporting structure in the service. From discussion and observations we found the manager and staff had a good knowledge and understanding of the care needs and preferences of the people receiving this service.

Staff told us they had been through an unsettling time in recent months due a number of staff leaving and changes in management of the service. They talked of the positive impact the manager and deputy manager had had on the service in the few weeks since they had taken up post. One staff member said, "The entrance's physical appearance has improved. It's more homely and warm. That's a big deal. I understand the importance of that." They went on to say, "I feel part of a team [now]. I stayed [working at Midfield Lodge] because I cared for people's wellbeing. In the small amount of time I do feel I have a management team I can approach. They've made that very clear. They have been tackling issues. I considered leaving before but I wouldn't leave now. Since the new managers have been here, they have started to make a difference to me and I feel good about myself." Another staff member told us, "I think [the manager] and [deputy manager] are on our wavelength. [The deputy manager] has been a nurse for over 20 years. He's seen all the different sides of care. [The manager], you can sit and talk to her. She says any worries come and see me. It's reassuring."

All the staff we spoke with were familiar with the procedures available to report any concerns within the organisation. They all told us that they felt confident about reporting any concerns or poor practice to more senior staff including the manager. We saw that following concerns having been raised, action plans had been developed to address the issues. These were being monitored by senior management to ensure

improvement in the service.

The provider's representative and manager sought feedback from people and staff in various ways. A console in reception enabled people, visitors and staff to comment on aspects of the service. This information went directly to the manager for action, if required, and was monitored by the provider's representative. Audits that the manager carried out, for example of care plans, were also monitored through this system.

The manager had held one care staff meeting and a nurses meeting. Second meetings were planned to take place shortly after our inspection. The minutes showed various topics were discussed included recruitment of staff, providing person centred care and improvements to the ways staff work, such as responding to call bells more quickly and encouraging and enabling more people to spend less time in bed. This showed the manager was involving staff in making improvements to people's care.

The manager had planned the first relatives meeting at which she would be present a few days after our inspection. She told us she planned to ask for their views and ideas to improve the service. Relatives were aware this meeting was planned.

The manager and deputy manager told us they both walked around the service at least twice each day, speaking with people, staff and visitors and monitoring the care being provided. Staff and people confirmed this was the case. The regional director conducted regular audits and agreed and monitored an action plan with the manager. This ensured any areas for improvement were addressed.

The quality of people's care and the service provided had been monitored in various ways. The manager and deputy manager stressed throughout our inspection the importance of spending time with the people who received the service and the staff. Staff told us that the deputy manager provided clinical and personal care and worked alongside staff on shifts. This helped the provider to ensure that staff were working to the expected standard as well as being able to mentor staff in their role.

The manager had plans for improving the service and was in the process of developing a formal plan once further discussions had been held with people and relatives. We saw that they had already instigated some improvements. For example in staffing levels, staff support and the environment. They told us they planned to develop community links and had already worked with a local supermarket who facilitated coffee mornings. They told us of their plans to extend this and invite local groups into the service to help improve the environment and encourage more use of the extensive gardens. They said this would help stimulate conversation and further interest for the people using the service.

Further plans included the development of a palliative care unit, together with appropriate staff training; training new staff in the Care Certificate; further training for staff in dementia care; developing closer links with specialist healthcare professionals. The manager told us, "I want this home to be as good as it can be."