OakRay Care Ltd

Trent House

Inspection report

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31 May 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 27 and 31 May 2016 and was unannounced. The home provides accommodation for up to 17 people, including some people living with dementia care needs. There were 17 people living at the home when we visited. The home was based on two floors connected by a passenger lift; there was a lounge and a dining room where people were able to socialise.

There had been no registered manager in place since May 2015. 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. A manager had been appointed who was going through the process of registering with the Care Quality Commission (CQC).

Providers are required to notify CQC of significant events, so we can monitor occurrences and prioritise our work. Two occurrences had not been notified to CQC as required, but the manager had introduced a clear process to help ensure this did not happen again.

Some parts of the environment did not support the needs of people living at the home. Signage was limited, bedroom doors were not personalised and the garden was overgrown and inaccessible. The manager told us of plans to improve the environment, which included the installation of a new passenger lift as the current one had become unreliable.

People felt safe at Trent House. Care staff knew how to prevent, identify and report abuse. Risks to people were managed appropriately and there was a system in place to analyse and learn lessons from accidents and incidents that occurred.

Appropriate arrangements were in place for obtaining, storing, administering and disposing of medicines. People received their medicines when needed from staff who were suitably trained.

There were enough staff to meet people's needs. Effective recruitment processes were in place and staff knew how to keep people safe in an emergency.

People liked the food, had enough to eat and drink and received appropriate support to eat when needed. They were supported to access healthcare services, including doctors, nurses and specialists.

People had confidence in the knowledge and the ability of staff to provide effective care; staff were suitably trained and supported in their work.

Staff followed the principles of legislation designed to protect people's rights and freedom. They sought consent from people before providing care and support.

People were cared for with kindness and compassion. Staff took particular pride in the way they cared for people at the end of their lives. Interactions between people and staff were positive and staff clearly knew people well.

People's privacy and dignity were protected at all times. They were involved in planning the care and support they received and staff supported them to follow their faith.

People received personalised care and support that met their needs. Staff demonstrated a good awareness of people's individual support needs and responded promptly when their needs changed. Care plans provided sufficient information to enable staff to provide care in a consistent way.

People were encouraged to make choices about every aspect of their lives. They were able to take part in a wide range of activities suited to their interests. People knew how to raise concerns and the provider acted on feedback from people.

People were happy living at Trent House and told us it was run well. Staff enjoyed their work, were motivated and felt supported by the manager. The manager was held in high regard by staff and received appropriate support from the provider.

The manager promoted an open and transparent culture. Visitors were welcomed at any time and links had been developed with the community to the benefit of people and their families.

There was an effective quality assurance system in place, together with a development to further improve the quality and safety of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse; staff knew how to identify, prevent and report abuse.

Individual risks to people were managed effectively and people were supported to take risks that helped them retain their independence.

Medicines were managed safely. There were enough staff deployed to meet people's needs.

Appropriate recruitment practices were in place and arrangements. Staff understood how to keep people safe in an emergency.

Is the service effective?

Requires Improvement

The service was not always effective.

The environment was not supportive of people living with dementia and the garden was not accessible to most people.

People received a varied and nutritious diet; they were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

Staff followed legislation designed to protect people's rights and freedoms. People were supported to access healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to build friendships.

People's privacy and dignity were protected at all times.

Staff took pride in the way they cared for people at the end of their lives and the support they gave to relatives.

People were supported to follow their faith and were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

Most people received personalised care and support. Staff demonstrated a good awareness of people's individual needs and responded effectively when their needs changed.

People were encouraged to make choices about every aspect of their lives. They had access to a wide range of meaningful activities tailored to their individual interests.

The provider sought and acted on feedback from people. There was a complaints policy in place and people knew how to raise concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not ensured a registered manager was appointed and had not notified CQC of all significant events.

People and their families felt the home was well organised. Staff understood their roles, were motivated, worked well as a team and felt valued by the manager.

The service had an open and transparent culture; visitors were welcomed and links had been developed with the community.

A suitable quality assurance process was in place, including audits and spot checks.

Trent House

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 was unannounced and took place on 27 and 31 May 2016. It was conducted by one inspector.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous inspection reports and notifications we had been sent by the provider. 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, three visiting relatives and a community nurse. We also spoke with the manager, the deputy manager, the head of care, four care workers, the cook and the activities coordinator.

We looked at care plans and associated records for six people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records. We also observed care and support being delivered in communal areas.

The home had not been inspected since October 2014 when it was taken over by a new provider.

Good

Is the service safe?

Our findings

People told us they felt safe at Trent House. One person said, "I feel quite safe; most staff are pretty good." Another person told us, "The safest place to be is in this room. Nothing can happen here without staff knowing about it." Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. Staff were aware of two people who had recently had a physical altercation. They knew what had triggered the incident and the action they needed to take to prevent a recurrence; however, the risks had not been documented in the care plans of those involved. We brought this to the attention of the manager who arranged to update the relevant care records accordingly.

Investigations into other safeguarding incidents were thorough and where necessary, appropriate steps had been taken to protect people. For example, when a person behaved inappropriately in another person's room, staff requested support from mental health services and the person was transferred to a setting more suited to their needs.

Risk assessments had been conducted and measures had been put in place to reduce the likelihood of people developing pressure injuries. These included encouraging people to eat well and mobilise as often as possible. Staff were aware of people who needed to use special cushions or mattresses and we saw these being used consistently. However, one mattress was not set correctly for the person's weight and there was no process in place to ensure the correct settings of other mattresses were maintained. We drew this to the attention of the registered manager who arranged for the mattress to be adjusted and the settings monitored more effectively.

The risks of people falling were managed effectively. Staff knew the support each person needed when mobilising around the home and provided it whenever needed. When people fell, their risk assessments were reviewed and additional measures put in place where needed. For example, one person had fallen from bed, so staff had obtained a hospital bed with bedrails to prevent this from happening again. The person told us, "The rails stop me falling out; they are essential and have solved the problem." Another person said they liked a staff member to walk with them because "they give me confidence." A family member told us staff had "experimented" with their relative's bed by "lowering it to the floor" at night, which had prevented falls and kept them safe.

People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, some people chose to smoke and had been provided with an outdoor area to do this. Risk assessments had been completed for each person, which safeguarded the person as well as other people living at the home. One person was at risk of choking and had been assessed by a speech and language therapist (SaLT). They recommended the person received a soft diet to reduce the risk, but the person had chosen to eat a normal diet. Other ways of reducing the risk, such as supervising the person while they ate, or giving them a hand-held call bell to summon assistance if they got into difficulties, had been declined by the person. Staff respected the person's wishes but monitoring them discretely from a distance. The manager told us they were continually reviewing the situation to help ensure the person did

not come to harm while eating.

An appropriate system was in place to assess and analyse accidents and incidents across the home and lessons were learnt from them. For example, when a person fell while re-arranging the furniture in their room, staff took time to support the person to do this safely. Another person fell in one of the bathrooms and the provider installed a handrail to reduce the risk of them falling again.

Suitable arrangements were in place for obtaining, storing, administering and disposing of medicines. Staff administering medicines had received appropriate training and had their competency assessed. They were knowledgeable and were able to explain what each medicine was for and how it should be given. We observed staff administering medicines to people and saw they followed best practice guidance by administering and recording them individually. Clear guidance had been developed to help staff know when to administer 'as required' medicines, such as pain relief and medicines to help reduce people's anxiety. Medication administration records (MAR) contained no gaps and confirmed people had received their medicines as prescribed. An appropriate system was also in place to help ensure topical creams were applied when needed and not used beyond their safe 'use-by' date.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. One person told us, "There are enough staff; there are times when they're rushed off their feet, but it's not caused me any problems." A family member told us there were "enough staff" and that staff always found time "to stop and help, even when they're busy". Staffing levels were based on people's needs. The manager provided examples of when additional staff had been brought in to support people when they were particularly poorly, needed end of life care, or had complex needs. This was usually achieved by asking part-time staff to work extra hours, as they knew the person they would be supporting.

Clear recruitment procedures were in place to help ensure staff were suitable to work at Trent House. These included reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home. The manager told us they sometimes obtained telephone references from previous employers when written references were not forthcoming, but did not always record the content of these calls. Following discussions, they introduced a system to record any telephone references they obtained in future.

There were arrangements in place to keep people safe in an emergency, such as in the event of a fire. Staff understood these and took part in regular fire drills; the provider had plans in place to upgrade their fire safety system to make it easier to detect the source of a fire. Personal evacuation plans were available for people; they included details of the support each person would need if they had to be evacuated and were kept in an accessible place. Arrangements were in place with a nearby business which could be used to shelter people in an emergency and staff had been trained to administer first aid.

Requires Improvement

Is the service effective?

Our findings

Some parts of the environment did not support people living with dementia or those with limited mobility or visual perception difficulties. Signage to help people navigate round the building was limited and not prominent. Bedroom doors were all painted the same colour and were not personalised to help people find their own rooms. The garden was overgrown and was inaccessible to people with limited mobility. One person told us, "I don't get out in the garden. We were supposed to have a bench, but it's not gone up yet." We discussed this with the manager, who outlined plans to improve the environment, including alarming a door that led to a steep flight of steps down to the garden. Some preparatory work was done to the garden between the first and second days of the inspection, in preparation for an open day, but the garden was still not accessible to most of the people living at the home. Other plans for the home included the replacement of the passenger lift, which had become unreliable and was scheduled for July 2016. A positive feature of the environment was handrails along the main corridors that had been painted bright red. They stood out against the cream walls, making them easy for people with poor eye sight to spot and use. The lounge had been redecorated since our last inspection and there was an on-going programme to redecorate bedrooms as they became available.

People liked the food and said they were able to make choices about what they ate. They received a varied and nutritious diet including fresh fruit and vegetables. One person said, "[Staff] keep us well fortified and we get plenty to drink." Another person told us "The food is fine and if you can't eat it they give you something else." A family member said, "When [my relative] came out of hospital they had lost a huge amount of weight and couldn't eat or drink. Bit by bit, [the staff] have managed to turn things around. They love the food, are starting to gain weight and no longer need help to eat." Staff were aware of people who needed special diets or had particular food preferences and we saw these were provided. For example, one person preferred smaller portions and received these; another person was not able to drink certain fruit juices that could affect their medicines, so were not given them.

Some people needed to be encouraged to eat and this was done in a discrete and supportive way. To encourage people to drink more, 'happy hour non-alcoholic cocktails' had been introduced once a week and we saw people enjoying these. Staff monitored the amount people ate and drank using food and fluid charts. One person had been identified as at high risk of dehydration. Staff told us they "pushed fluids" as often as possible and the person had been given a straw to make it easier for them to drink. However, no guidance was available to inform staff how much the person should be encouraged to drink and staff did not total the amount people had drunk each day to assess whether this had been sufficient. We discussed this with the manager who agreed this was an area for improvement.

People had confidence in the knowledge and the ability of staff to provide effective care. One person said, "We get well cared for here." Another person outlined all the support they needed and said it "all comes together in this room. We get all the help we need in here." Staff demonstrated a good understanding of the needs of the people they cared for and how to communicate with them effectively. For example, care plans advised staff to give people time to process information and we saw staff doing this when speaking with people and supporting them to make choices. A staff member told us "[One person] can make decisions

some days, but not others; but we are always led by them. We explain what's going to happen, reassure them, and repeat slowly if needed."

New staff received induction training, which followed the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. They worked alongside a more experienced member of staff until they had been assessed as competent to work unsupervised. Training for experienced staff was refreshed regularly and we saw training dates had been set for the coming year. Most staff had also obtained vocational qualifications relevant to their role or were working towards these. A senior staff member said, "The training is fantastic for knowledge, but staff also have lots of experience, so we use that to make sure we haven't missed anything. [Staff] who have known the person for a long time can recognise signs and advise how best to respond." An experienced staff member later gave an example of this. They told us, "[One person] can't tell you what's wrong, but when [they are in pain] this shortens his mood and he starts asking for more cigarettes. We then know to treat [the source of their pain] and give paracetamol."

People were cared for by staff who were appropriately supported in their work. Staff received a range of supervisions with the manager or a senior member of staff. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. In addition, plans were in place to complete yearly appraisals of staff. Each staff member had signed a 'supervision agreement' in which they agreed to take responsibility for attending supervisions and for their personal development. Staff told us supervisions were beneficial; for example, they said they had requested additional training and this had been arranged.

Staff followed the principles of the Mental Capacity Act (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Some people had a cognitive impairment and assessments showed they were not able to make certain decisions. These included decisions around the delivery of personal care and the administration of medicines. Staff had documented decisions they had made on behalf of people, after consulting family members and doctors where appropriate. In addition, staff sought verbal consent from people before providing care and support by checking they were ready and willing to receive it. Records confirmed that staff complied with people's wishes; for example, one person had repeatedly refused to be weighed and their wish had been respected. The manager told us, "My 'go to' person for any decisions is the person themselves."

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). 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 the provider was following the necessary requirements. One DoLS authorisation had been arranged prior to the person moving to Trent House, as the manager had anticipated the need for it in advance. This demonstrated a good understanding of the legislation and the process. Staff understood their responsibilities and knew how to keep the person safe in the least restrictive way.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. One person said of the staff, "They're good; they arrange anything you need. I've had an optician in and got new glasses." A family member told us, "[Staff] called me one night when [my relative] was unwell and called the GP out. Another time, they also noticed

[discolouration] on her feet, so called the GP to check as [my relative] has diabetes." A visiting community nurse told us "Staff have really stepped up their game. They do blood sugar [tests] daily for two people. They call us when needed and follow our advice. This is shown by the fact that [pressure injuries] for two people are now healing. I have no concerns." Another person needed support with their continence and we saw they had been referred to the continence service for professional assessment.

Good

Is the service caring?

Our findings

People were cared for with kindness and compassion. One person said of the staff, "I like their company." Another person told us staff were "great" and "friendly"; they added, "We get on with them, they understand us." A family member described staff as "really nice" and said they enjoyed the "positive vibe" of the home, which staff had created. Feedback from another family member, whose relative had received end of life care, included the comment: "You loved my gramp like he was your own." and "You never left our side the whole time, making us laugh and cry. I have never met such beautiful, kind hearted girls in all my life. I feel overwhelmingly privileged to have had you in our life."

Staff told us they took pride in the care they provided to people at the end of their lives and the support they gave to relatives at these times. They talked affectionately about the arrangements that were made; things they had done to mark the death which the person would have appreciated; and examples of how relatives remained at the home for many hours afterwards to grieve in the company of staff. The manager told us, "[A staff member] even came to work for us having seen the way we handled the death of [a close relative]."

Without exception, all the interactions we observed between people and staff were positive and staff clearly knew people very well. For example, when medicines were being given, staff checked people were happy to receive them and explained what they were for. One person's television had broken and been replaced with a new one. From time to time they became anxious about this and asked for their old television back. Knowing this was a pattern, staff had retained the old television which they were then able to return to the person and demonstrate that it was not working. This calmed the person and alleviated their anxiety.

We heard good-natured banter between people and staff, for example about the clothes they were wearing and how smart they looked. People were clearly relaxed and comfortable in the company of staff. Staff spoke warmly about people and knew how to relate to them in a positive way. For example, a family member told us they had been impressed by the skilled way staff dealt with a situation when a person interrupted a private discussion they were having about their relative. They said, "[The staff members involved] immediately engaged with [the person] and led him to want to move out of the room. There was an immediate empathy."

Staff supported people to build and maintain friendships. Two people got on particularly well together and staff enabled them to sit together at meal times. We heard them engaging in verbal banter and clearly enjoying one another's company. A staff member told us, "To see [people] enjoying life again is wonderful. Life hasn't ended just because you're in a residential home." Another staff member said, "We are like a big family. I phone up to see how residents are on my day off and come in early to spend time with them. It's lovely." This was confirmed by people and family members.

People's privacy was protected at all times. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. Confidential care records were kept securely and only accessed by staff authorised to view them. A married couple shared a room and said they did not see the need to use privacy screens when staff attended to each of them. However, the need to

consider each other's privacy was documented in their care plans, and staff said they always offered to use screens when delivering personal care.

Staff treated people with dignity and respect. For example, they described practical steps they took to preserve people's dignity when providing personal care. People said they could choose the gender of the staff member, or request particular staff members, to support them with personal care. One person said, "[The manager] talked to us about it, but I'm not bothered either way."

The majority of people living at Trent House had a particular faith and staff supported them to follow it. Monthly services were held, which most people attended. One person told us, "We had a church service in the lounge. The vicar came with wine; it was just like in church." A large print version of the service had been produced to enable people to follow it and other members of the local church also attended to help maintain community links.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. The manager told us, "When we create the care plan, we sit with the person and write the words they say about how we can support them to get the best out of life." A family member told us, "[Staff] checked with me if the plan was OK and I agreed." Comments in care plans showed this process was on-going and family members told us they were kept up to date with any changes to the health of their relatives.

Good

Is the service responsive?

Our findings

Most people received personalised care and support that met their needs. One person said, "I don't need much support, but I enjoy having someone to talk to." Another person said of the staff, "They do everything I'd want them to do." A family member described the care people received as "spot on". One person told us they were "generally satisfied" with the support they received but had not had a bath since arriving at the home a few weeks previously. We brought this to the attention of the manager and by the end of the inspection they had received a bath.

When we spoke with staff, they demonstrated a good awareness of people's individual support needs and how each person preferred to receive care and support. For example, they knew which people needed to be encouraged to drink; the support each person needed with their continence; and when people liked to get up and go to bed. They recognised that some people's mobility varied considerably from day to day and were able to assess and accommodate the level of support they needed at a particular time. A staff member told us, "[One person] has good days and bad days. Sometimes they need two [care staff to support them], other days they can manage with one. Their continence is generally good in the day, but we have to check them regularly in the night."

Care plans provided sufficient information to enable staff to provide appropriate care in a consistent way. Staff were in the process of updating care plans into a new format to make them more personalised and comprehensive. We viewed some care plans in the new format and saw they were centred on the person and clearly detailed the way they wished to be supported.

Records of care provided confirmed that people received appropriate care and staff responded effectively when their needs changed. For example, one person identified as needing a hospital bed and staff had arranged for one to be provided. The person's relative told us, "It was difficult to get, but staff managed it in the end." A family member told us that when their relative came out of hospital they were out of routine, awake all night and asleep all day. They said "It was causing problems for [them] and for other people. [Staff] took some advice and discussed their medicines with the GP. We agreed a plan and since then their sleeping pattern has changed and they are much brighter during the day."

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed; and how and where they spent their day. One person said, "I used to go to bed early, but I like to stay up later now." People could also choose to take part in a wide range of meaningful activities. These included art work, music, cooking and discussion groups. One person told us, "I do knitting and will have a go at [artwork] too." Another person said, "There's lots to do; I've taken part in discussions and I love the guitarist." One person enjoyed walking to the local shops each day and another person had been supported to visit a local stately home on their birthday.

The activity coordinator was skilled at supporting people with their social and activity needs. They told us they tried to develop ideas into themes rather than one-off events. For example, the week of our visit coincided with a well-known flower show. People who were interested in watching it had been tasked with

finding out the times it was to be shown on the television. An existing contact at a local supermarket was approached and offered to donate flowers which people then used for a session of flower arranging. Following a presentation about a local wildlife reserve, people made bird cake to encourage wild birds to visit the home's garden and then took part in bird watching sessions to try and identify them.

The provider sought and acted on feedback from people. One person told us they had experienced clothes going missing from the home's laundry and had raised this with management. In response, they had been given labels with their name on that they were in the process of attaching to each item of clothing. Other people had expressed a wish to have take away fish and chips one day a week. Staff had purchased these from a local shop, but people found them too greasy. Therefore, they had produced their own fish and chips and presented them in take away containers, which had satisfied most people.

People knew how to complain and there was a suitable complaints procedure in place. One person told us, "You can put forward concerns if you've any worries and they're sorted out. I'd talk to the senior [staff member]. There's a board telling you which one is on duty each day." Records showed complaints were responded to promptly and in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

The service is required to have a registered manager as a condition of their registration with CQC. The previous registered manager left the service in May 2015 and the provider had not taken all reasonable steps to register a new manager since then. The provider appointed the current manager in January 2016 and they were going through the process of registering with CQC.

Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory work. Whilst most significant events had been notified to CQC, the manager informed us of two deaths which had not been notified as required as they had been unaware of the need to do this until recently. Checks of CQC records showed all other incidents had been notified and the manager had introduced a clear process to help ensure CQC were notified of incidents promptly in the future.

Whilst the majority of people's care records were accurate and up to date, we noted that some parts of some records contained the wrong person's name. For example, guidance in one person's medicine records had another person's name on it. The manager explained that this had been caused by using common templates that had not been checked properly before being used. They undertook to amend the affected records immediately.

People were happy living at Trent House and told us it was run well. One person said, "It's run exceptionally well." A family member told us, "Everything was organised well for the admission [of my relative]. They arranged a hospital bed in advance and have looked after her well." Another family member described the home as "well organised" and said if anything needed doing, such as chasing prescriptions, the management were "right on it".

People benefitted from staff who understood their roles, were motivated, and worked well as a team. One staff member said, "Since [the manager] arrived, she's really pulled the team together. It's a really happy home and I work well with everyone." Another told us, "Gradually it's all come together and we're singing off the same hymn sheet."

Staff told us they often came in when they were off duty to catch up with people and sometimes brought family members with them. For example, one staff member was planning to visit with their daughter, to sow tomato seeds with people. Another told us, "This is my second home. It's so nice to pop in and sit and chat with people."

Staff felt supported by the manager and the manager was held in high regard by staff. Comments from staff included: "[The manager] is wonderful. She's always there for you"; "She is a breath of fresh air"; "She is so supportive. She listens, motivates and empowers. She is an all-round positive person"; and "[The manager] told me the other day, 'you are doing so well'; I nearly cried. She is the best manager I've ever had".

The manager told us the provider had supported them well since being appointed. They had agreed to fund

a consultant to guide and support the manager in their new role; four representatives of the provider visited regularly and contributed to the quality assurance processes; and the provider was funding the manager to obtain a level five qualification in health and social care.

The manager promoted an open and transparent culture. Communication between management and staff was relaxed; the manager had an open door policy and encouraged people and staff to discuss concerns. Relatives could visit at any time and were made welcome. There was a 'duty of candour' policy in place, which required staff to act in an open, honest way if anything went wrong. Links had been developed with the community through families, friends, faith organisations, voluntary groups and local businesses. For example, the manager told us they were working with a dementia charity to support family members to understand their relatives' condition better. This included a tea party to raise funds for the charity and promote their work further.

Audits of key aspects of the service, including care planning, medicines, infection control and the environment were conducted regularly to assess, monitor and improve the quality of service. When concerns were identified, changes were made to improve practice. For example, the care plan audit had identified omissions in some of the care plans and we saw these had been updated. An environmental audit had identified that new furnishings and decoration was needed in some rooms and these were planned. In addition, the manager from one of the provider's other homes visited Trent House to review aspects of the service and dip-sample a selection of care plans to assess their quality. Random spot checks were conducted by the manager, including at night, to assess and feedback on the quality of care being provided by staff out of hours.

There was a development plan in place to improve the quality and safety of the service. This included enhancing the environment; improving the content of care plans; and appointing lead staff members for medicines, infection control and promoting people's dignity. Detailed plans had been developed to support people while the new lift was being fitted. These include the provision of additional activities to distract people from the noise of the work and additional staff to help maintain the security of the building. The manager had also consulted the fire service about the fire safety arrangements they were putting in place for the duration of the work.