HC-One Oval Limited

Waterside Care Home

Inspection report

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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 28 March 2018 and was unannounced. This was the first rating inspection of this service under the new provider, HC-One Oval Limited.

Waterside is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Waterside Care Home accommodates 60 people in three separate units across one adapted building. One of the units provides care and support for up to 12 people who require intermediate care following discharge from hospital and prior to returning home.

There was a manager in post who was not registered with the Commission, but had submitted their application. 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.

People felt safe and were supported by staff who were aware of the risks to them and their responsibilities to report any concerns they may have. Where safeguarding concerns were raised they were acted on and reported appropriately. Where accidents and incidents took place they were investigated and lessons were learned and appropriate actions taken. Safe systems of recruitment were in place. Systems were in place to ensure people received their medicines as prescribed by their GP and staff competencies in this area were checked.

Staff were provided with an induction and training to ensure they were skilled and competent in their role. Staff felt supported, well trained and were confident in approaching the manager or deputy for advice, guidance and support. People were supported to make choices at mealtimes and drinks and snacks were available throughout the day to help people maintain a healthy weight. People were supported to access a variety of healthcare services in order to maintain good health.

Staff obtained people's consent prior to offering support. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received support from staff who they described as kind and caring. Staff treated people with dignity and respect and ensured people were involved in making decisions regarding how they spent their day. Staff treated people with kindness and responded to their needs. Information was available in people's care records to assist staff to communicate effectively with them.

People were involved in the planning of their care. Staff were aware of peoples needs and preferences and what was important to them. People were supported to maintain relationships and friendship groups. Staff respected people's choices and supported people to take part in a variety of activities they enjoyed. People had no complaints but were confident that if they raised concerns they would be responded to appropriately.

The transfer of ownership had created some uncertainty amongst some of the staff group, but arrangements had been put in place to reassure staff and answer any questions they may have. The return of the manager was welcomed by all at the home. Audits in place and the provider's own inspection of the service, had supported the manager to identify areas for improvement which were immediately acted upon.

The provider had notified us about events that they were required to by law and had on display the previous Care Quality Commission rating 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 supported by staff who had received training in how to safeguarding people from abuse were aware of the risks to them. People were supported by sufficient numbers of staff who had been safely recruited. Systems were in place to ensure people received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Pre-assessment processes in place provided staff with the information required to meet people's needs effectively. Staff felt supported and received training which provided them with the skills for the job. People were supported to maintain a healthy diet and good health. Staff routinely obtained people's consent prior to offering support.

Is the service caring?

Good

The service was caring.

People were supported by staff who they described as kind and caring. Staff treated people with dignity and respect. People were supported to express their views and make choices regarding their daily living.

Is the service responsive?

Good

The service was responsive.

Staff were aware of people's health and social care needs as well as their personal preferences with regard to how they wished to spend their time. There were a variety of activities for people to take part in. People were confident that if they raised a complaint they would be listened to.

Is the service well-led?

Good

The service was well led.

Changes in provider and management had taken place and people were positive about this process and considered the service to be well led. People were complimentary of the manager and staff group and felt well cared for and listened to. A variety of audits were in place to assess the quality of the care provided and where areas of concern were identified they were acted upon.

Waterside Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. The information shared with CQC about the incident indicated potential concerns about the management of risk of falls at the home. At the time of the inspection, we were assured from evidence seen, that the provider had mitigated the risks appropriately.

This inspection took place on 28 March 2018 and was unannounced. The inspection was carried out by two inspectors, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, this included information received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commission services to gather their feedback.

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 to us.

We spoke with the registered manager, the deputy manager, the regional quality director, four members of care staff, three nurses, activities co-ordinator, the chef, the administrator, one housekeeper and two visiting dieticians. We also spoke with ten people living at the service and five visitors.

We reviewed a range of documents and records including the care records of three people using the service, four medication administration records, three staff files, training records, accidents and incidents, complaints systems, minutes of meetings, activity records, surveys and audits.

Good

Is the service safe?

Our findings

Prior to the inspection we were made aware of two separate incidents where people had fallen and sustained fractures. We found that appropriate actions had taken place to reduce the risk of these people falling and staff had supported people appropriately. The manager had notified us of the incidents and kept us informed of events. We looked at the information regarding the management of falls at the service and found that the appropriate risk assessment paperwork was in place. Where falls did take place, they were recorded and analysed for any lessons learnt. The manager had completed an audit regarding falls management and as a result of this had introduced additional training for staff and had identified six staff to be 'falls champions' to help reduce the number of falls occurring in the home.

People were supported by staff who were aware of the risks to them and how to manage those risks. One member of staff described how one person was a risk of falling and what was put in place to manage this risk. They told us, "[Person] has alarms under their chair and mattress [to alert staff to when they get up]; you've always got your eyes on them". We saw another person who was at risk of choking ask for more porridge at breakfast, this was provided, but staff were mindful of the importance of the consistency of the porridge, thus complying with the persons wishes but keeping them safe at the same time.

People told us they felt safe living at the home, one person said, "Yes, [I feel safe], there's always someone about" and another said, "Yes, at home I had some falls, I've only had one small one here and I didn't hurt myself". A relative told us, "[Person] is safe and secure and no matter how distressed they are, they have never said they feel unsafe. That is important to me". People were supported by staff who had received training in how to recognise signs of abuse and were aware of their responsibilities to report any concerns immediately. One member of staff told us, "I would inform the nurse, document [the concerns] and speak to the manager as well". We saw where safeguarding concerns had been raised, they were responded to appropriately.

We received mixed responses about staff responses to call bells. Some people told us they didn't really need to use a call bell as there was always someone about and staff regularly checked on them through the night. Others commented how busy staff were and felt there could be more staff. From our observations, we noted people were generally responded to in a timely manner. We did not hear call bells ringing and if someone decided to call out to staff, we saw staff respond. One person told us, "I've only used it [call bell] once. It was at night and I was cold. They put a blanket on" and another person said, "They do come quickly when you ring the bell". Another person commented, "Not enough staff, I try not to use the call button too much". A relative said, "They [staff] do come if she or we call them and they will pop in".

We discussed staffing levels with the manager. We saw there was a dependency tool in place to assess staffing levels. The manager told us, "I'm a big believer in staff working a dedicated floor; they need to know if people don't look right." The manager went on to describe work that was going on in respect of staff rotas and allocations in order to ensure people were supported by a group of staff who knew them well. We saw additional care and nurse hours were in place to assist staff to complete their roles.

Systems were in place to ensure people were supported by staff who had been safely recruited. Staff told us that prior to commencing in post, they were required to submit references and a Disclosure and Barring [DBS] check; this check would show if a prospective member of staff had a criminal record or had been barred from working with adults. This would decrease the risk of unsuitable staff being employed. We looked at the personnel files of three members of staff and found this to be the case.

We saw that people were supported to safely take their medication and that medication was stored and secured safely. One person told us, "The nurse gives it [medication] to me and she stays until I've taken it". We observed medication being administered effectively, with nurses treating people with respect and only signing Medication Administration Records [MARs] charts once medication had been taken. We looked at the medication administration records across all three units in the home. We saw that the amount of medication given tallied with what was in stock. Medicines were being signed for and the appropriate codes were used on MARs when they weren't administered. We saw that medicines were kept securely and at the correct temperature. Staff were knowledgeable about the people they were looking after and when to administer 'as required' medicines.

People commented positively on the cleanliness of the environment. One person said, "Yes, they are cleaning all the time". We observed people were protected from the spread of infection and staff wore gloves and aprons when providing personal care. Staff advised that PPE was available for them to use and we observed the home to be clean and odour free. Cleaning schedules and rotas were in place and the home was supported by a team of housekeeping staff.

We saw where accidents and incidents took place they were reported and recorded and acted on appropriately. One member of staff described actions they would take following an incident, "I would complete an incident form. The HC-One forms are more detailed, they are better and then I'd hand it over the nurse". In response to the two separate incidents where people had sustained fractures following a fall, the manager told us, "We are setting up a falls team and falls prevention board. We will meet every quarter to look at equipment. We've introduced 24 hour observations following falls, sensor mats where appropriate".

Good

Is the service effective?

Our findings

We found that people's needs had been assessed prior to moving into the home. We saw people's care records and noted that initial assessments gathered information regarding peoples' personal care needs, medical history, dietary requirements, family history and personal preferences including whether they wished to be supported by male or female carers and if they had any religious or cultural needs. Staff spoken with were aware of these preferences.

A relative told us, "[Person] has been here five weeks and yes, I think they are well looked after" and another relative said, "My mum has excellent care here". People told us they felt staff were well qualified to do their job. One person commented, "They seem to know what they are doing" and a relative said, "The staff seem good and I can only judge what I see at weekends".

People were supported by staff who considered themselves to be well trained. A number of care staff had worked at the service for many years but told us their induction had provided them with the information they required to meet people's needs. They told us they felt valued and supported. One member of staff described recent training they had attended on the subject of dementia. They told us, "I did enjoy it, it opens your eyes a bit. [Manager's name] finds additional training for us to attend". Another member of staff described recent courses they had attended with regard to manual handling and dehydration and told us, "I get regular training". They were aware of a programme the new provider had in place for senior care staff to train to become nursing assistants. This was something they were keen to do and had already spoken to the manager regarding this who was looking into it on their behalf. This meant that staff were provided with the opportunity to enhance their learning and develop existing skills.

We saw people were supported to maintain a healthy diet and efforts were made to ensure people had enough to eat and drink. A relative told us, "There's always a jug of water and [person] has their squash". We saw that drinks were readily available throughout the day. We observed lunchtime and saw the food looked and smelt appetising. Each meal was served up in accordance with people's individual preferences, although gravy was automatically added without asking people first. We raised this with the manager who confirmed this had been raised at a meeting the week prior to the inspection and orders were in place to provide equipment that would allow people to choose a variety of condiments at mealtimes. People told us they enjoyed their food and were offered choices at mealtimes. One person told us, "You can have a cooked breakfast if you want it, whatever you want, it's lovely" and another person said, "You get to choose and if I want something else I can have it. You get enough you don't need seconds". We saw two options were made available at mealtimes plus a vegetarian option. We saw that if people did not like what was on offer, an alternative meal of their liking was provided. Snacks were made available during the day and we observed people enjoying fresh fruit which they helped themselves too from a platter. One person told us, "Yes, they [staff] do come round [with fresh fruit]" and showed us a plate which held a variety of fruit segments which they had chosen including strawberry, grapes and orange segments.

The home was decorated with Easter decorations throughout, creating a bright and welcoming atmosphere. Efforts had been made to create a homely environment. There were plants on windowsills, flowers on tables

to match the spring theme and newspapers available for people to read. Clocks and calendars were on walls helping people to orientate to date and time and there was plenty of information on display for people and visitors alike. One person told us, "It's lovely [here], look at the scenery". The person had a crocheted blanket on their knees, a side table next to them with family photos and a vase of flowers; everything was in easy reach.

We saw people were supported to maintain good health. One person told us, "The doctor comes in on a Monday, though they would call him anytime if I needed". Relatives told us they were confident that their loved one's health care needs were met. One relative, whose loved one had particular healthcare needs told us, "They know the first sign of anything and they get the doctor out and contact the family". We saw one person was admitted to the home with pressure sores. We noted staff followed the guidance and recommendations of the visiting Tissue Viability Nurse in response to the care of this person resulting in their sores healing. Care records containing people's health care needs were regularly reviewed and updated. One person had a catheter in situ and a comprehensive care plan was in place. We spoke with a visiting dietician who told us they had no concerns regarding the service and that the staff worked alongside them to maintain people's dietary needs. For example, one person had lost weight over a short period of time, but with the input and guidance from dieticians, the person had gained weight. We saw in January and February this year 16 people had been noted as losing weight. In March that figure had reversed and 26 people had put on weight. We asked how this change had been achieved. The manager told us, "The kitchen [staff] are more aware; we have changed what we are doing. At 11.00 am fruit on a platter is offered [we observed this] or milkshakes and jelly, which also aid hydration. We introduced a night snack box on each unit and at last week's residents meeting they confirmed they were using it. The suggestion was made by a family member; they said people should have to ask for snacks, you should make it a bit more visible, so we have".

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 MCA 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions to authorisations to deprive a person of their liberty were being met. We found that they were.

The manager had told us when they arrived in post, one of the areas for improvement they had noted was to ensure applications for DoLS were in place for those people who needed them. The manager told us, "We have found who we need to focus on". Staff spoken with were aware of who had a DoLs in place and those people who needed an application made on their behalf. One member of staff told us, "There is one lady downstairs with a DoLS in place and some others who are in the process of having them put in place". Staff were aware of the need to obtain people's consent prior to supporting them and we observed this. One member of staff told us, "You must make sure you ask people if they want to go the toilet or what they want to wear. The same goes for food and drink. You still have to ask people even if you know their preferences".

Good

Is the service caring?

Our findings

People were complimentary of the care provided and described the staff as kind and caring. We received the following comments from people, "You're not lonely here, it's very good", "Yes they [care staff] are kind, they help me get up", "They are kind on the whole, it's taken a lot of getting used to. I've gotten used to it" and "Care is 'out of this world'". We saw that staff took their time to support people and observed a number of caring interactions between staff and people living at the home. For example, we noted one person sitting in a chair in the lounge and as the afternoon passed, the sun came over her. Immediately a member of staff went over and offered to close the curtain for them. We saw that people's relationships with staff were positive, people told us they felt cared for and staff spoke warmly of people. We noted in one person's care record a member of staff had written, '[Person] is such a loveable lady, it's a pleasure to just sit with her'.

Care plans included information on how to communicate with people and for those who may not be able to communicate verbally information was available to support staff. For example we saw one person use a whiteboard and their care plan provided staff with the following information; '[Person] is able to use hand gestures and facial expressions and point to words and write on whiteboard'. We saw pre-printed words and pictures were available to assist people to express choices.

We saw people were involved in the planning of their care and were supported to make choices as to what they did and how they wished to spend their time. A person told us, "I choose what I wear; they ask me each morning. They ask what I want for lunch". People told us they could get up when they wanted and we observed this. On arrival, a number of people were up and about, but others were asleep in bed. One person told us, "I go to bed when I want, I just tell them and mornings I get up when I wake". Another person told us, "They [care staff] give you a wash every day. They don't do your legs or feet though. There hasn't been a lot of baths/showers, there has been with a problem with the boiler". We raised this with the manager who confirmed there had been a problem with the boiler but it had been fixed quickly .They told us people were supported to take baths and showers and would look into these specific concerns.

We saw that where possible, people were supported to maintain their independence. A person told us, "They [staff] are encouraging" and another said, "I do what I want and they help me do the rest". We saw that people were treated with dignity and respect and observed staff to be polite and respectful when speaking to people. One person said, "Staff are always polite" and another added, "If the door's shut they knock". A relative told us, "One by one the girls [staff] have told me how fond they are of my mom but they didn't have to tell me I can see it. Mom is very tactile and they respond, for example, with a touch on the arm, it's done with dignity, I could see it, it's very important". Relatives told us they felt welcome when they visited the home. One relative said, "All family who visit say how friend staff are and they are very comfortable visiting".

We saw for those people who required the support of an advocate, arrangements would be made to access these services. An advocate can be used when people have difficulty making decisions and require this support to voice their views and wishes.

Good

Is the service responsive?

Our findings

We saw that prior to moving into the home, people's care needs were assessed to ensure the provider was able to meet their needs. We looked at people's care records and saw that they and or their relatives had been involved in this process. One relative told us how supportive the staff group were during the process of their relative settling in and now considered some of the staff to be friends. Relatives told us they were kept up to date with changes in their loved ones' needs and staff kept them informed of any changes. One relative said, "I have regular meetings with [manager's name] and feel up to date with everything". Another relative described how their loved one was moved to another room when it became available, in a bid to encourage them to spend less time in their room where it was felt they were isolated, and to mix with other residents and join in activities. They told us, "It was the best decision for her".

From our conversations with staff, it was clear they knew people well. They were able to describe people's preferences, what was important to them and how they wished to spend their day. For example, one member of staff said, "[Person] prefers to eat their breakfast in their armchair, they like to sit in their room until lunchtime, they need to be encouraged to take part in activities". They went on to describe how the person was encouraged, with the help of a relative to take part in a particular activity which they enjoyed. We observed people were supported to socialise and sit in friendship groups. A person told us, "There's another lady I usually sit by and we chat. We're making cakes today".

People were supported to take part in a variety of activities that were of interest to them. On the day of the inspection we observed people were involved in baking and icing cakes. Incubators had been placed in both lounges with eggs and people watched them hatch. There was a buzz of excitement in the home regarding these new arrivals and they were a talking point for people, staff and visitors alike. The activities co-ordinator told us that when new people arrived at the home information was collected from them regarding their history and likes and dislikes and memory boxes were created containing items that were important to them. We observed the activities co-ordinator and a visiting volunteer sit together with four people to decorate cakes with an Easter theme. There was a good atmosphere and a person who had earlier had a visitor, was encouraged to join in the decorating when their visitor left. One person told us, "We are baking today". People were aware of the activities that were taking place that day and some chose to join in and others preferred to watch.

Staff were complimentary of the activities co-ordinator and their role in the home. One member of staff said, "[Activities co-ordinator's name] does really well, she does loads of stuff, people are always doing arts and crafts, have been supported to vote, been to the café at the Black Country Museum and planting in the garden; any excuse to go out". Newsletters provided people with information regarding events that had taken place and events that were planned. We saw opportunities were taken to celebrate a variety of events, including saints days, birthdays and holidays. On international women's day, a group of people sat together to talk about the women who had had an impact on their lives. We saw the chef held a weekly session which encouraged people to get involved in baking their favourite recipes. The chef asked people what they wanted to bake and each week a different person's idea was taken on board and people were supported to join in. Everyone in the home was offered a piece of cake at tea time. People clearly enjoyed this activity and

we saw requests had been made to make jam roly poly and apple pie.

We saw that newspapers, books and magazines were available for people to look at in lounges. One person was waiting for the WIFI to be connected. We discussed this with the manager. We were told WIFI was available throughout most of the building but arrangements were in place to ensure the whole building was connected so that the person could use their tablet and keep in touch with their family via skype.

People told us they had no complaints, but if they did raise concerns they were confident they would be dealt with and listened to. One person told us, "I haven't made any [complaints] but I would approach [manager's name] if I had one". A relative told us, "If ever I've had any problem, I just talk to them, they are very open, approachable. I'm like a dog with a bone". We saw where complaints had been received, they were investigated and responded to appropriately.

We saw systems were in place to support and record people's choices with regard to their end of life care.

Good

Is the service well-led?

Our findings

In December 2017 the service transferred ownership to the new provider. The manager had previously been registered manager at the service for two years but had left last year. They had recently returned to the service in December 2017 and had submitted their application to become registered manager. They told us, "Things were very different when I got back, staff weren't coming to me [about issues]. I have an open management style. I am having to build staff and relatives confidences again". She told us of the concerns she had identified and how she was working to change things, such as introduction of newsletters, pictures of people living at the service on display, developing activities and amending staff rotas to ensure staffing levels met people's needs.

A relative confirmed there had been two meetings with the manager since their return and they felt well informed and reassured about the changes that were taking place. Staff also told us that they had been kept well informed of the changes. One member of staff told us, "Any issues and I would speak to [manager's name]. I spoke to her and she gave me a sample of the new documentation [care plan] which was useful". We saw daily meetings taking place and plans to transfer care plan paperwork over to the new provider's paperwork. A transition plan was in place for this and staff identified to lead on this subject. The service had received an internal inspection from their own quality team which also highlighted the same areas for improvement as the new manager, for example, staff supervisions and applications for Deprivation of Liberty Safeguards. The manager told us, "It was fair" and had taken on board the findings and put actions in place.

One relative told us, "We looked at five care homes and as soon as we came through the door, we knew 'this is the one'. It just felt right. From that moment we felt mom would be looked after. [Manager's name] told us, we don't aim to replace your family we aim to become your extended family". Another relative said, "I would recommend the home, from what I've seen. There's a good atmosphere, everyone is always smiling and polite".

People told us they were happy with the service they received and considered it to be well led. People, staff and relatives all said how pleased they were that the manager had returned to work at the home. One relative told us, "Staff are lovely. The only time we were unsettled was when [manager's name] left; I've never been so glad to see someone come back in my life. She is calming and knows what she is doing" and another said, "I think the staff seem happy enough, best thing about here is they try and involve everyone in things".

Staff were complimentary of the manager and pleased that she had returned to the service and felt well supported. One member of staff told us, "We were willing [manager's name] to come back and were not happy when she left. She is a good leader, a very positive person and a people pleaser as well. Relatives have said they have seen a change in staff since her return and morale is good" and another said, "I'm glad she's back, I'm not gonna lie. You can talk to her, things are really good at the moment. Her people skills are really good. 99% of us get on really well. Staff have worked here a long time, we are one big dysfunctional family!" A new deputy manager had arrived at the home at the same time and staff were equally as positive

about how they had fitted in. One member of staff said, "[Deputy manager's name] is really approachable as well, if ever myself or someone needs to speak to management we would knock the door and have a word" and another said, "[Deputy manager's name] is getting her head round us, she is quite good and will act on any issues; she's on the ball".

We saw that despite being at the home a short space of time, the manager and the deputy worked well together. Both took responsibility for covering shifts when required, which provided them with the opportunity to get to know staff and people living at the service. The manager told us they conducted walk rounds twice a day and checked visually that staff were where they needed to be. The deputy took the role of clinical lead and also conducted daily walk rounds. Daily meetings were in place to discuss any accidents or incidents, appointments and the resident of the day. A member of staff said, "[Manager's name] gets involved with residents, speaks to them daily. It's nice to see her engaging with residents and relatives and she is one to help out as well".

People were supported by staff who were clear of the vision for the service. The manager was mindful of the impact of admitting people with complex needs and told us she was working closely with the Clinical Commissioning Group (CCG) regarding this. In response to her return to the service and the concerns identified through her own audits she had put an action plan in place. This home improvement plan was updated monthly and we saw evidence of this. We saw that she had identified staff supervisions needed improvement and some applications with regard to DoLs needed to be put in place. We saw that the manager had marked these issues as an area for priority and was working through the application process for a number of people living at the service. We also saw regular staff meetings were planned and arrangements were being made to ensure staff received formal supervision.

We observed all staff spoken with were helpful, polite, transparent and willing to discuss in depth their role and passion for their job. It was evident that the service benefitted from a team spirit which was embedded by having staff who had been in post for many years. Agency staff were not used and any absences were covered by the existing staff group. Staff were aware of the whistleblowing policy. One member of staff said, "I would contact the 'speak up line' if I had any concerns" [regarding poor practice]. I've known about a staff member raising concerns before and it's been dealt with".

People told us they felt listened to, one person told us, "They ask if I like things". We saw that people's views of the service were sought through meetings or the completion of surveys.
One person told us, "I go to the residents meetings though there hasn't been as many as usual due to the change over" and another said, "There are residents meetings sometimes and my daughter has filled in a survey".

We saw there were a variety of audits in place to assess the quality of the service provided. For example, medication, care plan, infection control and falls audits. Actions identified from the audits were added to the home improvement plan, a document which provided the manager with an overview of the service, areas for action and those responsible for those actions. Staff were provided with a copy of the plan and actions were delegated to staff members to ensure all staff were involved in improving the quality of the service provided.