The Koppers Care Limited

The Koppers Residential Home

Inspection report

The Street
Kilmington
Axminster
Devon
EX13 7RJ

Tel: 0129732427
Website: www.thekoppers.co.uk

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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 October 17 and 19, 2016 and was unannounced.

We last inspected the service in July 2014. At that inspection, we found the provider was meeting all of the regulations we inspected. There were no breaches of legal requirements at this previous inspection.

The Koppers is a residential care home for older people. It is registered to provide accommodation for up to 24 people who require help with personal care. There are 14 single rooms and five shared rooms. The service specialises in the care of older people but does not provide nursing care. At the time of the inspection there were 22 people living at the home.

There was a registered manager who was responsible for the service. She was registered on 19 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.

In December 2015 four new directors took over the service with a clear vision for how to improve the service. They have embarked on a programme of renovation of the building and a comprehensive review of existing systems, including quality assurance and training. The registered manager has the autonomy to plan, organise and manage training. A new staffing structure was put in place which created progression from care assistant to senior carer to deputy manager. There were now two deputy managers in addition to the registered manager. New shift patterns have been created in order to incorporate more flexible timings to start and end of shift. This enabled wider recruitment to take place. There was a positive culture of teamwork in the home, with directors and the registered manager being very "hands on".

People visiting the service commented on the significant improvements to training, staff morale, and fabric of the building. One person commented, "I would say this place is massively better since the new owners arrived."

Staff understood their responsibility for safeguarding and people living at the service said they felt safe. A programme of induction, training, supervision and appraisal was in place. Staff were able to describe what they had learned and how this had improved their practice. However, better staff awareness and understanding of the requirements of the Mental Capacity Act 2005 was needed.
The registered manager planned to seek additional specialist guidance and training in this area. By the time this report was written she had already implemented additional training for new staff.

People living at the service were cared for by cheerful staff who were sensitive to individual needs. An effective care planning system ensured that each person had the support they required. Staff were seen to work well together as a team, offering mutual support. The Koppers received universally positive comments

from family members. "I visited other homes before placing (name) in Koppers. None came close in terms of compassionate care as far as I could tell."

Two visitors commented on how much their relative's health had improved since moving to the service. Healthcare needs were closely monitored as part of their care.

Five bedrooms were shared and had the potential to compromise people's privacy and dignity and adverse comments were made about this by relatives. However, people had given their consent to sharing and screens were used to maintain privacy of individuals. Staff were aware of how to maintain people's privacy and dignity when providing support for them in shared rooms.

Whilst there was a range of generic activities organised to suit people in groups, some people were seen to spend most of their time alone. There was a programme of individual activities to stimulate and engage those with more advanced dementia to help avoid social isolation.

There was a sense of strong forward-looking leadership at all levels, with managers recognising the need for improvement, encouraging openness to change, questioning practice and listening to staff, residents and families. The culture is one of continuing to seek improvement. Quality assurance systems were robust and regularly reviewed.

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 safeguarded from the risk of abuse because staff knew how to recognise abuse, how to report concerns and what systems were in place to protect people.

People were protected against risks to their health and from risks in their environment. Care plans were updated to reflect changes to
people's needs.

People's medicines were managed safely.

There were enough staff to meet people's needs. There were safe and effective recruitment and selection processes in place to protect people.

Is the service effective?

Good

The service was effective.

Where people lacked capacity, their legal rights were fully protected in accordance with the requirements of the Mental Capacity Act (MCA) 2005. Some people were subject to restrictions on their liberty for their safety but the proper processes had been put in place.

People received care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

People had access to relevant healthcare professionals when required.

People were offered a varied diet and were supported to eat and drink to ensure they maintained good health.

Is the service caring?

Good

The service was caring.

People were treated with dignity, kindness and compassion.

People were consulted about their care and support and their wishes respected.

Is the service responsive?

Good

The service was responsive.

Care files were personalised to reflect people's individual needs and preferences.

Activities were provided for people both in groups and for individuals.

There were opportunities for people and their relatives to raise issues, concerns or give compliments.

Transition between services was managed well.

Is the service well-led?

Good

The service was well led.

There was a registered manager and a group of supportive, engaged providers.

The culture was open and promoted person centred values.

The home was well organised and people, relatives and staff expressed confidence in the registered manager.

The provider had systems in place to monitor the quality of care provided. They made changes and improvements in response to findings and had a vision for future improvements.

The Koppers Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 took place on 17 and 19 October 2016. The first day of inspection was unannounced. The inspection team consisted of one adult social care inspector.

Prior to the inspection, we looked at the information we held about the service. This information included the statutory notifications that the provider had sent to the Care Quality Commission (CQC) and the Provider Information Record (PIR). A notification is information about important events which the service is required to send us by law. The PIR is requested by us and asks the provider for key information about the service, tells us what the service does well and the improvements they plan to make. We also reviewed information from the previous inspection report and by checking the provider website.

We spent time talking with to three people using the service, seven relatives and friends of people using the service, and 11 members of staff. This included the registered manager, one of the cooks, the cleaner and six care staff. We looked closely at the care plans for three people, cross-referencing with other records such as weight charts. We observed activities on the premises, including medicines administration, mealtimes, a singing session and a staff handover meeting. We also reviewed records. Records we reviewed included staff duty rosters, three people's care files, medicine administration records (MAR) and MAR chart audit, staff training matrix, three staff recruitment files, the accident and incident record book and auditing form and a variety of policy documents. These included the medicines and safeguarding policies.

Contact was made with five health and social care professionals who worked with the service, asking them for feedback on the quality of care provided in relation to the five key domains. Responses were received

from three.

Good

Is the service safe?

Our findings

People said they felt safe living at the service. One person said, "I feel completely safe here… You can just ask anyone for help. I have never been unhappy here. You couldn't get a better home than this one." Another person said, "I feel pretty confident that I'm safe here. The staff are very kind to me."
Relatives confirmed that they also felt their family member was safe. Comments included "I feel she is very safe here… I think she's being looked after very well." and "we feel that Mum is in a safe environment where she appears to be content and calm."

Staff had received safeguarding training to help them recognise potential abuse or neglect. The registered manager and senior staff had had additional training in safeguarding for managers. However, whilst the majority of staff had an understanding of safeguarding and awareness of different types of abuse, two were unclear about this. The same applied for whistleblowing. Whistleblowing is when a worker reports suspected wrongdoing by someone else at work. The service had policies and procedures in place to follow if they witnessed or suspected abuse. The small minority of staff who were unsure about the principles and practice of both safeguarding and whistleblowing said they knew where to look for information should a concern arise.

However, the registered manager had implemented a new system to refresh people's knowledge. She selected one key policy per month and organised refresher training in this. The topic for the month of the inspection was safeguarding. Staff who were not able to explain what they would do said they would seek help from colleagues. So this risk was mitigated by the fact that the majority of staff, including those supervising others, knew how to put the principles of safeguarding into practice.

One safeguarding allegation had been reported to us by the provider in the past year. This incident was investigated by the local authority and the concern was proven unfounded.

The safety of premises was maintained by a comprehensive programme of risk assessment of premises and servicing of equipment. The risk assessment folder contained assessments of 26 different areas. Other servicing was carried out by an external health and safety contractor. They undertook inspections such as electrical portable appliance testing (PAT) on an annual basis, and included environmental risks, such as water safety. A certificate for Legionella testing was on display in the entrance hall. One of the directors maintained the spreadsheet which gave dates for these tests to be organised. This ensured that servicing was done regularly thereby minimising the risk to residents' safety.

Accidents and incidents were reported appropriately. An analysis was then carried out in order to identify any trends or changes to implement in order to reduce the risk of possible harm. For example, one person was noted to have had nine falls in one month. The GP was asked to review the person's medication. In following months, following a change in medication, the number of falls experienced by that person was reduced to zero. This showed a proactive and effective approach to managing risks and incidents.

The service had created a folder containing a personal emergency evacuation plan (PEEPs) for each person

living at the service. These were clearly written with a photograph and kept accessible in the fire panel cupboard in the hallway. Fire checks and drills were carried out regularly. The most recent fire drill was on September 11, 2016.

Staff expressed a variety of opinions about current staffing levels. The majority felt that staffing levels should be increased. The registered manager had calculated that they needed 4 to 5 staff on in the morning shift. This was the number on the rota and present on the morning shift during inspection. However, a member of staff said, "I sometimes feel there could be more staff on in the morning." Another one said, "there are normally 4 or 5 in the mornings. It depends on how the residents are. Sometimes it's not enough." A third staff member said, "it's not too bad… We do have some live-in staff who are flexible if we are stuck." Other staff confirmed that both the registered manager and on occasions, one of the directors who has a nursing qualification, had helped during times of staff shortage caused by unexpected absences. "They are both very hands-on".

The registered manager explained that she was very aware of this issue and had talked to staff "about five weeks ago" and had increased staffing levels at that point. This was just immediately prior to our inspection. She believed, therefore, that staff might very well have been referring to their experience before the recent changes in their comments to us.She explained the new shift patterns.

Staffing levels were being matched to busy times. New shift patterns had been created in order to incorporate more flexible timings to start and end of shift. An extra member of staff had been put in place in the mornings. Start and finish times were changed so that there were now five people on in the morning working the following flexible shifts: 7am. to 12 noon, 7am. to 2.30pm, 7am. to 3pm, 8am.to 4pm. and 8.30am to 3pm.

The evening shift had been extended. An increasing restlessness in the evening was noted. Whereas previously one member of staff would leave the shift at 8pm, now all stayed until 9pm. This meant more staff were available to provide support when people became restless.

The registered manager explained that she was constantly monitoring the situation. "We are making changes all the time and doing it in full consultation with all the staff." For example, this was adjusted slightly last week by moving one senior carer from administrative tasks to help with breakfast period.

The registered manager had insisted that there was always someone present in the lounge/dining area. Staff confirmed that someone was always present there. Our observations confirmed that people were not being left alone in that main social area. The registered manager was currently in the process of recruiting more staff with a view to increasing staffing levels. One visitor confirmed they had seen a recent advert for care staff. They said it had been "impressively worded… presenting a dynamic opportunity for a caring person to work and receive training."

People visiting the service felt that staffing levels were adequate. One person said, "the staff respond quickly to residents… There's always someone around". Another visitor said "there's always somebody in the lounge/dining room… They are never short of staff." And a third person said "I never see anyone taking any shortcuts. For example, they always use the hoist." No concerns were expressed about staffing levels in the afternoon/evening shift from 1pm to 9pm where the aim was to have three staff on duty.

During our visit, the atmosphere in the home was calm, people looked well cared for and staff did not appear to be rushed. The fact that cooks and a cleaner were employed meant that staff did not have to do these duties.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Recruitment files contained disclosure and barring service (DBS) checks, references and brief employment history

There were safe medication administration systems in place and people received their medicines when required. Staff responsible for the administration of medicines had received training in how to ensure safe practice. Shortcomings in medicine records had been identified during regular medicine audits carried out by an external pharmacy and remedied immediately. For example, one bottle of eye drops had been found to lack an opening and expiry date. The pharmacist allowed this to be rectified immediately as it was discovered by the auditing check within one week of the prescription having been written. This demonstrates a safe system. We observed staff assisting people in a sensitive way to take their medicines. One person was receiving medicines covertly. This had been assessed by a GP with consideration given to their capacity to make this decision and records kept in the care plan so that staff knew about this.

Good

Is the service effective?

Our findings

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff and visitors both described an improvement in training since the new directors and registered manager took over. One member of staff said, "We get a lot of training now… We are always kept up-to-date with things."

One visitor commented as follows, "It just has the feel of a much more dynamic home now… The staff certainly seem much more motivated. Training was needed and now they are getting it."
A training programme was now in place, which covered approximately 50 different topics. New staff were supported to complete an induction programme before working on their own. This induction was modelled on the content of the Care Certificate from Skills for Care. This is a national programme to help new staff fully understand their caring role. Essential training included moving and handling, risk assessment and safeguarding. The manager reviewed the training matrix "at least monthly". This ensured that staff had their knowledge updated as new training was developed.

Staff had support and guidance to ensure they could fulfil their role effectively. The manager told us she undertook regular supervision "about every eight weeks" but also on an ad hoc basis as required. This was now being shared with the two deputy managers. An example was given of having observed a member of staff trying to lift someone using an underarm position. The supervisor had immediately intervened and demonstrated how to use a hoist to lift the person safely.

Staff told us they felt well supported, both by the registered manager and by other members of the staff team: "When I need help I ask and they help me." Staff were being given an annual appraisal.
Staff were able to describe what they had learned from training. One said, "I've learned a lot about the different types of dementia… The fear they must go through when all that is happening to them. I try and stay in their world and reassure them… let them tell you, then you go along with it."
Another said, "I'm getting loads of qualifications on courses through Social Care TV. I've been on an amazing dementia experiential course. We can now deliver much better person centred care because we know how it feels for them" (people living with dementia).

The registered manager had a level three "Train the Trainers" qualification and was now completing on the next level, which is for teaching adults. This will enable her to deliver more training directly to staff which should make it more responsive. This also demonstrated a commitment by the manager to continuing her own learning.

The registered manager, provider, senior staff and most of the care staff were able to demonstrate by discussion their knowledge and understanding of the Mental Capacity Act (2005) and the Deprivation of Liberties Safeguards (DoLS) and implications for their practice.
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.

One or two newer members of staff were not able to explain fully what this meant. The registered manager responded promptly to this finding by including these staff in best interest decision meetings so that they could learn of the implications for practice. These staff were always with a more experienced worker and so there was no risk.

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 application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).The registered manager had identified a number of people who they believed lacked capacity as a result of living with dementia. The service had made two successful applications for DoLS authorisations and was in the process of applying for eight more. Best interest meetings had been held which included family members, friends, staff and independent professionals, including a social worker and an independent mental capacity assessor (IMCA). In each case the 'best interests' decisions were made in relation to a specific issue.

For example, one person was confused about where they were living and wanted to go home. The decision was made that the doors would be kept locked with a keypad and that whenever the person expressed a desire to leave, staff offered to take her for a walk or to sit in the garden. This was seen to be the least restrictive option and also offered choice to the person. All staff and the person's relative had access to the key code so that they could assist her in leaving whenever she wanted. The registered manager estimated that people who lacked the capacity to leave the home unaided were being taken regularly on outings, either to local shops, to a cafe or to the seaside and that this occurred anything from two to five times per week.

Another person lacked mobility and became particularly unsteady on their feet when suffering from a urinary tract infection (UTI). A 'best interests' meeting had been held with the person's daughter and staff from the home to ascertain the least restrictive option for that person. In order to prevent a fall on the stairs, a curtain had been placed across the bottom of the main staircase at waist height. It was held in place with a butterfly clip. Staff said, "It's meant to be used as a deterrent, to stop people going upstairs… It stops them from falling on the stairs". Whenever the person wished to go upstairs to their room they were assisted to do so, either by walking aided by staff or using the chairlift.
Another person was not able to make a decision that they needed to stay permanently in care. The IMCA and two friends were involved in a "best interest" decision meeting. All agreed that it was in the person's best interest to stay at the service. Friends helped them choose furniture and pictures to put in their room, which again preserved their choice. All of the above examples show that the service understood the difference between lawful and unlawful practices and that they were acting in line with legislation.

People's dietary needs were met. The staff were all aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also recorded in their care plans. People were supported to have a meal of their choice by attentive staff. We saw staff trying different approaches in order to assist a person to eat a meal independently whilst retaining their dignity. A board in the dining room displayed a picture of the meal for the day. We saw people enjoying their food, asking for second helpings and being given more food. One relative said "the food is good, (name) has put weight back on since she's been here."

People's care records showed relevant health and social care professionals were involved with people's care. Care plans clearly documented how staff should support people to maintain good health, and were

regularly reviewed. Relatives confirmed that people had timely access to appropriate health care. One person praised the staff for taking someone to hospital so that she did not miss a podiatrist appointment. Health care professionals were observed visiting the service at the request of the registered manager to assist in monitoring changes to people's health. On the second day of the inspection, the health of one person suddenly deteriorated and the GP was called promptly.

We contacted other healthcare professionals by e-mail. Comments we received included the following "They seem really proactive now, it's (healthcare) certainly improved." and "The pressure care here is generally pretty good now." And " I've got nothing but positives to say about them."
"They are seen to be very supportive of people".

The service had followed best practice in giving people individual painted doors which looked like the front door to their original home. They noticed that use of wheelchairs and hoists was causing damage to the paint. They decided to cover the bottom area of the door with the Perspex sheet in order to protect it from further damage. There was an ongoing programme of renovation in place throughout the building. Visiting relatives commented on improvements as follows "Since the new owners came there have been notable and marked improvements… the decoration is now lovely." We saw several bedrooms with completely new carpets and furniture. The entire ground floor had recently been re-carpeted. The quiet sitting room had had a complete makeover. This created a brighter, cleaner and safer environment for people living in the service.

Good

Is the service caring?

Our findings

The service had five bedrooms which were shared. Staff explained how they tried to maintain privacy and dignity by the use of screens. However, family members expressed concern at the potential lack of privacy in having a shared room. One said: "My only concern is that (name) currently shares a room. It would be lovely for (name) to have their own room, particularly as their health deteriorates… to enable us to sit with (name) privately." Other family members said they had only accepted a shared room on the basis that they would be able to move to a single room as soon as one became available. People had consented to sharing a room. People were moved in accordance with their needs for example if someone needed enhanced privacy.

People were treated with kindness and compassion in their day-to-day care. We saw staff sitting and spending individual time in conversation with people who appeared isolated or withdrawn. This resulted in an immediate improvement in mood. People were given clear explanations and information about their care, such as what was on the lunchtime menu. This led to people feeling and looking more relaxed. Comments included the following:
"There is wonderful care here, people are so kind, they show them real affection."
"All the staff work to a very high standard of care and Mum is treated with respect and dignity."
"They sit with people and talk to people and hold their hands."
"I do find them caring here... I can't praise all the staff enough."
"They're very caring. I would have no problem in bringing my own mum here."

People's records included information about their personal circumstances and how they wish to be supported. Family members were a constant presence in the home during the inspection. One of the deputy managers noted: "We are very family-oriented here… people come and go all day." We saw that some family members took their relative out for the day, whilst others enjoyed sharing lunch with their relative. There was a clear positive change in demeanour as a result of these visits. People living at the service said they felt happy and were well supported. One person said:" they're friendly, it's like a family, they're easy-going… it's a fabulous place. It's the atmosphere- people are so friendly here, I can't honestly say there is anything I dislike."

Staff were particularly praised for maintaining a happy cheerful atmosphere in the home. One visitor said, "the staff are always happy and cheerful… They answer all your questions." The second person said, "it doesn't matter when you come over, everybody is always cheerful."
Another person said that the staff were "very responsive and very helpful. I can't complain anyway about the staff here." One person living at the service said, "the staff are kind to me. Everything is all right here. We all speak the same language. I'm feeling part of the community."

The service was working towards accreditation of the Gold Standard Framework for end of life care. They implemented a colour coding system to identify people at different stages as they approach the end of their life. This information was updated monthly and sent to each person's GP. Palliative care specialists from the local hospice had been called to give pain and anxiety relief and support the district nurses for one person

who had reached the end of her life.This meant that people nearing the end of their life received appropriate care and treatment in a timely fashion. We saw this approach in practice during the inspection where healthcare professionals and relatives were alerted in good time to deterioration in the condition of person, thus enabling them to receive high-quality support at the end of their life. The registered manager told us that a submission for accreditation to the award will be made at the next opportunity which happens twice per year.

Relatives were universally positive about the care provided when people were at the end of their lives. They confirmed that people had been treated with dignity and respect. One visitor said "The care, support and treatment (name of relative) received was absolutely first-class. Nothing was too much trouble and the staff treated (name) with respect and dignity at all times."
Another person said, "in (their) last few weeks (name of person) was treated with love, care, attention and dignity."

Good

Is the service responsive?

Our findings

People received care and support which was personalised for them. Care plans were personalised and each file contained information about the person's likes, dislikes and people important to them. Files were well organised and clearly written with clearly labelled sections, in sturdy ring binders. People or their relatives were involved in developing their care, support and treatment plans. We saw their signatures in files confirming they had been consulted. One family member said "Her plan? Yes we did go through that when she first came here." A member of staff said I think it's really important that we understand how residents feel. We read the care plans. They give examples of things that happened to people (mentions specific operation) to help me know how it feels to them."

Staff were able to explain the purpose of all the different sections in the care plans. Staff confirmed that the registered manager has been given more autonomy and as a result was now focusing much more on individualised care plans. "(Name of manager) is allowed to do what she thinks is best now… (since new directors came) she really knows the residents, she makes an effort to do that. More is being done for each individual person."

People's health needs were reviewed regularly and as required. Where necessary, health and social care professionals were involved. An example of this was someone having regular treatment for leg ulcers and other people having regular blood tests to ensure their diabetes was maintained or that other medicines that needed regular monitoring were at a safe level. Two visitors to the service confirmed that significant improvements had been achieved in their relative's health since moving into the service. One of them said, "He used to use a wheelchair and a hoist, but now they're getting him to stand up. That's wonderful, that's real progress."

Handover meetings between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. We observed one handover meeting where senior care staff informed care assistants of all changes in people living at the service and described their mood and general needs for that next shift. This ensured continuity of care for people.

The service organised a range of activities. A local reminiscence group visited weekly with memory boxes. Other activities included singing and dancing groups and religious observances. A relative said, "The music man came last week and they were up and dancing." We saw members of a local church lead a short service, including singing hymns. People confirmed they had enjoyed the music and dance activities. One person said, "I feel really stiff after larking about with the dancing." There was a range of photographs on the noticeboard in the hallway demonstrating the active involvement of residents in singing, dancing and reminiscence activities.

People living at the service were also taken on outings to the local teashop or to church activities. A variety of animals and children also visit the home to entertain people living there. One family member said, "They have lots of activities here. They have people coming to do music; they take them up to the farm shop."

Another relative said "I know they do activities because a member of staff got (name) interested in a word game which was quite an achievement, I can tell you. (Name) has certainly improved a lot since she's come here."
The registered manager explained that she had identified a need for different social activities to be organised for those residents with little or no mobility and/or communication.

An activities assistant was employed with the specific remit to work one to one with them. Activities particularly suitable for each person, such as hand massage, or playing classical music for those who had a background as professional musician, were offered. When the specialist was not available, care staff had been trained in how to offer occupation, such as doing puzzles or games. One said "I did some board games with them last week and they could all do it."

The service had compiled a separate 'Personal History Profile' folder for each resident. This gave detailed background information in a highly accessible format about previous lives, occupations, and family. We saw members of staff using this file to assist people living at the service to recall specific things, such as the name of their mother. Having that information helped the person living with dementia to regain a sense of confidence and control during a conversation with a care assistant.

People and families were aware there was a complaints system and were confident that any complaints and concerns would be taken seriously and used as an opportunity to improve the service. There had been one complaint since our last inspection. This had been dealt with by one of the directors who talked to the complainant and to the member of staff involved. It was resolved by offering more staff development.

A meeting for people living at the service was held in June 2016 to discuss how to improve activities and in September to discuss food. One of the new directors then reviewed menus, implemented some new dishes and received comments. New menu options were being planned as a result, which will give people living at the service a wider range of choice of food. There was a new post box style Suggestions box in the hallway for people to give anonymous feedback.

Good

Is the service well-led?

Our findings

People benefitted from a service which was well led. There was a change of management in December 2015 when four new directors took over the service. They communicated well with staff, people living at service and their relatives, reviewing systems and questioning quality of service. They demonstrated a clear vision and strong leadership by implementing a variety of improvements, many of which were based on feedback from people living in the service or their relatives.

For example, a new management structure now included two deputy managers. Other changes included a new senior carer meeting every fortnight. New more flexible shifts have been brought in. The impact was twofold. Firstly, it responded to the needs of people living at the service. Secondly, it enabled access to a wider pool for recruitment, for example, of people with caring responsibilities. Other changes included reorganising mealtimes so that people who needed support to eat their meal were served first, with the main lunchtime being moved to 1pm. This enabled staff to give more attention to those needing assistance. Other people living at the service who were able to eat independently appeared to be happy with the change.

The change of management resulted in a change of culture to focus more on the needs of people. This was noted both by staff and by visitors. One person said, "Nothing is a problem. You couldn't ask for more supportive people. The new directors are just amazing. They are all for the residents… It's an absolute delight… Everything is for the residents and for the home."

The directors were praised for being very accessible and friendly. One person said "They're very approachable, the new owners." One of the new directors was a qualified nurse. She was praised for being supportive and engaging actively in delivering care. A staff member said "She'll drop everything to help you if you're struggling" A director had undertaken phone calls to families to gain feedback about their views of care. Relatives confirmed that they appreciated the consultation. One said, "They talk to the residents and ask them what they'd like changed. They're really getting involved in things now."

The registered manager had a clear vision for the service. She said, ""My goal is to provide better care for the residents and for all staff to feel valued." She was considered to be very supportive by all staff. One said "she's really good… she listens and does her best to sort it out for you." In relation to flexibility with shifts, another said, "if we need to swap a shift (registered manager) is really good about it." She was also praised by family members for being accessible and supportive. One of them said, "The manager is always very willing to see me and talk." The service had been awarded a place in the list of Top 20 Care Homes in the South West in both 2014 and 2015. This was based on feedback from people using the service, family and friends to the website carehome.co.uk.

The registered manager had notified CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. Quality assurance systems were in place to monitor the quality of the service being delivered. These included some weekly checks, for example of medicines fridge and monthly checks of other systems, such as care plans and risk assessments. An

external consultancy undertook annual checks, for example of health and safety. Health and social care professionals who worked in partnership with the service described it as "all very positive".