C T C H Limited

Redlands Acre

Inspection report

35 Tewkesbury Road,
Gloucester, GL2 9BD
Tel: 01452 507248
Website: www.ctch.co.uk

Date of inspection visit: 21 October 2014
Date of publication: 16/12/2014

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 21 and 22 October 2014 and was unannounced.

Redlands Acre provides personal care and accommodation for 40 people some of whom were living with dementia. At the time of our visits there were 29 people living at the home two of whom were living with dementia. Redlands Acre provides accommodation on the ground and first floor of the home and in eight self contained bungalows. People living in the bungalows have the opportunity to be more independent whilst also receiving personal care from staff. There was a registered manager in post. 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 and associated Regulations about how the service is run.

Staff were kept busy meeting the individual needs of people as well as providing activities and preparing the evening meal. At times the care and support they provided focussed on the task in hand without having a meaningful interaction with people.

Summary of findings

People raised concerns with us about the attitude and behaviour of some staff. Despite this being raised previously with the registered manager in January 2014 and action taken with staff, some people still felt some staff were "rude and bad tempered."

People had limited opportunity for stimulation and occupation due to the poor and inconsistent provision of activities. People enjoyed music and movement sessions, the occasional film show or quiz however there was no programme in place for day to day activities. Staff met people's needs in a task centred way with little social engagement. When they had time to sit and chat with people the atmosphere was lifted and people could be heard laughing. People living with dementia did not receive a service which reflected their individual needs. For example there was inadequate signage to help them find their way around the home.

Quality assurance processes had identified where improvements to the service could be made such as reviewing the provision of activities and staffing levels. The experience of people living in the home had not improved by the provider as a result of this feedback. However some minor improvements had been made in response to comments from people and their relatives. People and their relatives said the registered manager was approachable and accessible and concerns would be dealt with promptly.

People could see a range of health care professionals to maintain their health and wellbeing. People were supported by staff who had the experience to meet their individual needs. Staff said they were supported and were able to update their skills and knowledge. Staff conduct was monitored and when needed action had been taken to address poor performance. The registered manager had worked with external agencies to keep people safe when dealing with safeguarding concerns. People were supported to take risks to maintain their independence as safely as possible. Some people managed their own medicines. Effective systems were in place to manage people's medicines.

People were supported to make choices and decisions about their day to day lives. People said they enjoyed their meals and were offered choices about what to eat and drink. Where people had specific dietary needs these were catered for. Staff supported people with kindness, patience and sensitivity.

We made three recommendations for the provider to consider how improvements can be made to the service people receive. **We recommend that the service explores the relevant guidance on how to make the service provided to people living with dementia more dementia friendly. We recommend that the service considers how people can live well in a setting which promotes their mental health, wellbeing and their interests. We recommend that the service considers the relevant guidance about monitoring quality and how to listen, improve and respond to people's views.**

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. Staff were busy at times but people understood the reasons for this. Staff time was put under pressure by having to deliver activities, prepare and serve supper and carry out health and safety checks. Recruitment and selection checks were completed prior to new staff starting work.

People told us they felt safe and knew who to raise concerns with if they needed to.

People were supported to take risks to maintain their independence. Hazards were reduced to keep them as safe as possible.

The administration of medicines was managed safely. People were supported to manage their own medicines.

Is the service effective?

Good

The service was effective. People were supported and cared for by staff who had the skills, knowledge and experience to meet their needs.

Staff understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People's capacity to consent to their care and treatment was assessed. People were encouraged to make decisions and choices about their care.

People made choices about their diet and had sufficient to eat and drink. Their individual requirements were assessed and nutritional supplements provided to maintain or increase their weight.

People's health was monitored and they were supported to see health care professionals when their health or wellbeing changed.

Is the service caring?

Requires Improvement

The service was not caring. Two people complained about the behaviour and attitude of some staff. We had received similar concerns in January 2014. These had been addressed at the time and we were satisfied that the necessary action had been taken by the provider.

People were observed being treated sensitively, patiently and with kindness by staff.

People and their relatives had the opportunity to express their views about the care and support provided. People made choices and decisions about their care.

People were treated with dignity and respect. Their individual preferences were promoted and they were encouraged to maintain their independence.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not responsive. People had few opportunities to participate in social activities both inside and outside of the home. At times staff focussed solely on the task and did not interact with people in a meaningful way.

Although the needs of people living with dementia had been recognised and minor changes made to adapt to their needs there was room for improvement to make the service dementia friendly.

People's needs had been assessed and their care plans reflected their individual needs and preferences for how their care should be delivered. For most people the care they received was personalised and focussed on their needs as identified in their care plans.

People's concerns were dealt with as they arose and complaints were investigated with action being taken to address the issues raised.

Is the service well-led?

Requires Improvement

The service was not well led. Quality assurance systems whilst identifying areas for improvement did not always result in a better experience for people.

People found the registered manager to be open and approachable. People and their relatives were asked for their views about the service they received. The registered manager kept up to date with current best practice. Staff felt supported and would raise concerns with the registered manager. Staff knew and understood their roles and responsibilities.

Weekly and monthly audits were completed to check on the quality of service provided.

Redlands Acre

Detailed findings

Background to this inspection

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

This inspection took place on 21 and 22 October 2014 and was unannounced. One adult social care inspector and an expert-by-experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information we had received about the service such as notifications. Notifications are sent by the provider when they need to tell the Care Quality Commission(CQC) about important events relating to that service.

As part of this inspection we spoke with 12 people who use the service, seven relatives, the registered manager, a representative of the provider, nine care staff, a housekeeper and the cook. We reviewed three people's care records and their daily care and medicines records. We also looked at recruitment records for three staff, training records and quality assurance systems. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Following our visit we spoke with two health care professionals.

Requires Improvement

Is the service safe?

Our findings

At the time of our inspection there were 29 people living in the home. The staffing levels had not been reduced to reflect the vacancies although staff reported being very busy. Although people's individual needs had been assessed there was no evidence of how these related to current staffing levels. Rotas confirmed there were a minimum of five staff each morning and four staff each afternoon. At peak times during the morning and at lunchtime the call bells rang one after the other. We observed staff responding to them as quickly as they could. People told us, "Sometimes the staff are very busy and take a while to get to us", "They appear to have a skeleton staff on at weekends" and "When I need help they come. Sometimes they can take a while but I am happy with this because I know that I am not the only one who needs help". A relative commented, "I would look for another home but I don't think mum would cope. Staff are very task orientated." Whilst one person said, "The home is ok but it could be better if there were more staff around to help you and talk to you." It was the responsibility of staff to deliver social activities in between their other roles and responsibilities. Staff told us they had also been given additional duties such as completing weekly and monthly audits and this had also impacted on their ability to provide activities. We observed that staff were very busy at supper time when they had responsibility for preparing and serving the food. People complained about having to wait for their meals and their drinks. The registered manager had recognised this and had requested a kitchen assistant to help out at supper time but the provider had not agreed to an additional post due to the vacancies in the home. We noticed during the afternoon staff had time to sit and chat with people or carry out a quiz.

We looked at the staff rotas for September 2014 and October 2014 which confirmed shifts had been covered to maintain staffing levels. Agency staff were used to help out when needed. Agency staff told us, "I am not asked to do any tasks unsupported" and "I am always given a handover and information about people's needs". The registered manager said they used the same agency staff to provide continuity.

People told us, "I like living here and feel safe because people are there for me", "I feel quite safe, everybody is very kind" and "I have no concerns about my safety". A relative said, "Mum has only been here for a few weeks but I know that she is safe when I leave her." We observed staff discreetly watching people as they moved around the home offering support when needed to keep them safe. A member of staff was observed sensitively going to the aid of a person who became breathless and unsteady on their feet.

Staff explained the key elements of the safeguarding adults policy and procedure. They had completed safeguarding training and were aware of the signs to look for and their responsibility to record and report any concerns they may have. Staff told us they knew how to support people living with dementia when they became anxious or upset. They were aware of how people's behaviour could impact on other people living in the home. We observed staff reassuring a person when they were becoming agitated. They offered this person a drink which calmed them and helped them to focus on the task in hand.

The provider had notified us about allegations of theft. An investigation had been completed and the appropriate disciplinary action had been taken. As a result the registered manager had discussed with people and their relatives the importance of keeping money and their valuables safe. Each person had a drawer in their room which could be locked and they could also use a safe in the main office. One person told us they had a key to their room but they chose not to use it. We observed another person locking their room to keep their belongings safe.

People were supported to take risks to maintain their independence. Risks were assessed and strategies put in place to minimise any hazards to keep people as safe as possible. We observed risks being managed subtly. For example, people with restricted mobility had been provided with the appropriate equipment and when staff were in the vicinity they kept an eye on them. A person told us, "I go out with my friend here most days. We walk for about an hour. We let people know we are going out and we need to sign out and sign when we come in."

When people had accidents or incidents these were recorded. Staff monitored people's wellbeing after an hour, then 12 hourly and after 24 hours. Where people had a number of accidents or incidents these had been identified. The action taken in response to these incidents

Requires Improvement

Is the service safe?

were recorded such as calling the GP, referral to the falls clinic or emergency services. Action had been taken to follow up accidents and incidents to prevent them happening again.

Plans to respond to emergencies such as fire, flood, shortages of staff or power failure were in place. The registered manager said staff had recently taken part in an evacuation of the home after staff had said they did not feel confident in the correct procedure. Each person had a personal evacuation plan should they need to leave the home in an emergency. Out of hours emergency support was in place and staff were aware of this.

A new member of staff had been appointed in September 2014. Recruitment and selection checks had been completed prior to employment to verify their character and ability to work in the home. Gaps in their employment record had been checked to provide a full employment history. They had started an induction programme which followed the Skills for Care - Common Induction Standards. These are nationally agreed minimum training standards new staff.

We saw people being given their medicines safely. Staff sought people's permission before giving them their medicines. Staff explained what medicines they were giving to people and made sure they had a drink of their choice. They waited patiently whilst people took their medicines.

People were not rushed and were offered reassurance if needed. Staff then signed the medicines administration record (MAR). If people wished to manage their own medicines they were supported to do this. The provider information return stated three people had responsibility for their own medicines. Protocols were in place for the use of medicines which could be taken when necessary (PRN). This included medicines bought over the counter. The use of these medicines had been authorised by the GP. When this medicine was administered a record was made on the MAR with the reason why the medicine was given. For instance if a person had been given medicines for pain relief. Medicine audits monitored the use of PRN medicines to check that it was being given appropriately. Medicines were stored securely and checks completed to maintain the temperature levels in cabinets to prevent medicines becoming spoiled. Stock records were kept for all medicines and audited each month. A record was kept for all returns to the pharmacy. The home had no controlled drugs but secure cabinets and records were in place should they be prescribed. Staff had completed medicines training and the registered manager said their competency was checked annually. They also had access to the provider's policy and procedure based on guidance from the Royal Pharmaceutical Society on the safe administration of medicines.

Good

Is the service effective?

Our findings

A person said, “I am alright, staff look after me ok, the food is fine.” A relative told us, “Before mum came in here I was worried to death. Now I know that she is in safe hands and looked after by people who know what they are doing.” Staff spoke with knowledge and confidence about people’s needs and how they wished to be supported. Staff had a good understanding of how they should support people living with dementia and memory impairment. Staff were observed providing support which reflected people’s assessed needs. For example, a person at risk of developing pressure ulcers was supported to change their position in bed every two hours to prevent skin damage.

People were supported by staff who had access to a training programme to develop and maintain their skills and knowledge. Their training needs had been recorded on a training log and they were reminded when refresher training was due. Refresher training was provided to maintain and develop their knowledge. Staff confirmed they were aware of their training needs and it was their responsibility to make sure they had updated these. The registered manager monitored this and prompted staff if they had not completed the training on time. Due to the increased risks to some people of falling, we observed training in falls prevention being delivered to staff. Staff had also completed training specific to the needs of people living in the home such as dementia awareness and end of life planning. The provider information return stated all staff had either completed or were working towards a diploma in health and social care. Staff practice was observed by the management team to make sure the care and support people received reflected their learning. Where concerns were raised about their practice this was dealt with through one to one meetings with staff. Staff had received an annual appraisal and one to one meetings every two months to discuss their performance and training needs. This provided the opportunity to reflect on how people were supported by staff and whether the skills and knowledge of staff continued to match their identified needs.

People benefited from a registered manager who had links with local organisations such as the care providers association, an activities network and the dementia training and education strategy for Gloucestershire. These provided guidance and training opportunities for staff to keep up to date with current best practice. For example, staff had been supported to develop advanced care plans with people to reflect their wishes about support at the end of their lives.

Staff had completed training on the Mental Capacity Act 2005 (MCA) and understood the need to assess people’s capacity to make decisions. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Each person’s mental capacity to consent to aspects of their care and support had been assessed and recorded with each care plan. Where decisions had been taken in people’s best interests the people involved in the decision making process were recorded. A decision or action taken on a person's behalf must be made in their best interests where a person had been assessed as lacking capacity to make a decision. People had given their consent to the use of restrictions such as bed rails or lap belts which were being used to keep them safe. The registered manager discussed with us how they had consulted with health care professionals about the least restrictive practices to keep people safe in bed. For example, instead of using bed rails for one person they had ordered a bed which could be lowered to the floor with the additional safeguard of a mattress on the floor should they slip out of bed.

We observed staff seeking people’s consent before helping them or supporting them with their care. If a person did not want help staff withdrew but came back later to offer support again. A person told us, “The staff always help me. I am never made to do anything that I don’t want to do. I don’t like going to bed early, about 10.30pm to 11pm, so when I tell them that I am ready they take me up to my room.”

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. Staff had been trained to understand when and how an application to deprive someone of their liberty should be made. The registered manager was aware of recent developments around changes to DoLS and assessing which people would need an authorisations for the deprivation of their liberty.

People told us, “The food is good and I really like salads so they get me one if I ask” and “Great food - a good mixture

Good

Is the service effective?

and variety. Very good sweets I really enjoy them". We observed people helping themselves to biscuits, savoury snacks and fruit which were available in the lounges. One person told us, "I don't sleep very well and even at 2am the carers will make me a cup of tea." We observed people having lunch and supper. People chose where to have their meals and what they would like to eat. At times the atmosphere in the dining rooms was jovial and light hearted. A number of people told us that lunch was a real social occasion and provided an opportunity to have a good chat. People with specific dietary requirements were provided with a range of appropriate meals. These included mashed/pureed food and a specific diet of soup and ice-cream for one resident. The cook had completed training in the dietary needs of older people. They said they added cream, butter or sugar to the food for people at risk of weight loss. Food supplements were available in the form of nutritional drinks. We observed a person being offered an alternative to their hot meal which they did not wish to eat. They chose sandwiches but decided they did not want to eat these either. They were then offered a nutritional drink and a pudding which they ate. At staff handover this was mentioned and staff were told additional puddings were available and to offer these again later to the person.

People's weights had been monitored and strategies were put in place when they were at risk of weight loss. This included involving a dietician. When people were at risk of choking a speech and language therapist had been asked for advice. One person had been advised to use a thickener in their drinks but chose not to use it. The risks to them had been explained so they agreed to use the thickener in cold drinks.

People's health needs were detailed in their care records. People could see their GP who visited the home every two weeks. A person confirmed, "I know what my treatment is and I see my doctor every two weeks." Appointments were made with other health care professionals such as a dentist, optician and podiatrist. Whenever people had an appointment with a health care professional a record was kept detailing the outcome and any future appointments. The provider's information return stated advice was sought from other professionals and people were referred quickly when their needs changed. People's care records confirmed when their needs changed they had been referred to the relevant health services. For instance, community nurses had provided treatment when the condition of a person's skin started to deteriorate. They told us they had been called promptly by staff whenever they had any concerns about people's health or wellbeing.

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback and mixed observations about the care being provided to people. People told us, "If you know anyone who needs care then tell them to come here. It is very good" and "Everybody is very kind." During the inspection a relative raised concerns with us about the attitude of one or two staff. They said they had observed them being rude and harsh with people. A person told us, "Some staff are lovely and kind, others not so." This issue had been raised with us previously and the registered manager had taken action to address the concerns. We discussed these new concerns with the registered manager who logged them and said they would be investigated. The registered manager said they had planned to work with staff to reflect on how they interacted with people to promote positive communication. However feedback from community nurses was positive, they told us they had observed staff trying to do the best they could. They said they were friendly and caring.

At times during the day we observed staff focussing on the care they provided to people and responding promptly to their needs. Occasionally they exchanged pleasantries and shared jokes or laughed with people. At meal times whilst staff waited to serve people they did not engage in conversation with people. Once the meals were served there was no further interaction between staff and people until the next course was served. On both afternoons when we visited, staff had time to sit with people and chat with them. There were times when people had meaningful conversations with staff which people responded to with enthusiasm. Staff were observed treating people respectfully and politely. They understood people's likes and dislikes and how they wished to be supported.

People's religious and cultural beliefs were respected. People had access to holy communion either together or privately if they wished. If people had preferences for the gender of care staff providing their personal care this was recorded in their care plan. Daily records confirmed this was happening. Accommodation could be provided for couples if they wished to live together.

People were involved in expressing their views about the support they received. Their feedback and thoughts were recorded in the monthly review of their care. Not all relatives felt included in this process. A relative told us, "I'm not seeing care plans but I know that if there is anything serious to report then I will be contacted." Although one relative said they were kept informed of any changes another relative said they had not been given any information about the care provided. The registered manager said they tried to keep in contact with people's relatives and people had provided the details of their main contact with whom information could be shared. Records confirmed when there was contact between staff and relatives and the information passed on. We observed relatives and people living in the home dropping in to speak with the registered manager. This exchange of information kept people and most of their relatives involved in making decisions about their care and support. People's personal information was kept safe and secure. Staff had been reminded during a staff meeting to keep information about people confidential.

People were helped to maintain their independence around their environment. We observed staff supporting them to be independent in their day to day lives and respecting their wishes to remain mobile, to prepare snacks or to go out unaccompanied by staff. We observed people choosing where to be with their visitors either in the ample shared areas around the home or in privacy.

Requires Improvement

Is the service responsive?

Our findings

People gave us mixed feedback about the social activities available to them. They told us, "I wish that I could get out and that the staff had time to take us out and about", "We have music and movement but otherwise there are no other activities" and "There is not much going on". People also said they had joined in a film night, bingo and had been out shopping. A diary had been kept logging any activities provided and this confirmed there were one or two activities arranged each week. However there was no set activity programme offering stimulation or supporting people to follow their interests. We observed staff arranging a quiz but a person said, "This is a one off." There was no activities co-ordinator so care staff had to find time to provide activities along with their other responsibilities. A person told us they had discussed at a house meeting about what activities they would like. We observed a group of people spending a lot of time during their day in a lounge with the television switched on. No one took any interest in the television. For people unable to occupy themselves there was little to do. In another lounge music was playing which a person sang along to. Another person had classical music playing in their room. Staff said they really liked this. People who were independent were able to go out locally to the park or pub and said they enjoyed this. Relatives and friends were seen visiting people throughout our inspection. The provider information return stated an activity meeting was held by the provider every two months to share good practice ideas. The registered manager said they were aware that the provision of activities needed to be improved. The registered manager had made a request to the provider for an activities co-ordinator to help alleviate the demands of staff delivering personal care. The provider had not agreed to this additional post whilst there were fewer people living in the home.

People's needs had been assessed when they moved into the home and these were reviewed each month or sooner if their needs changed. From these assessments people's care plans were developed to reflect their individual needs. For people with physical or sensory needs adaptations were made to their environment. Their needs had been assessed and they were supplied with equipment to maintain their independence. Where people were at risk of malnutrition or their skin breaking down their care plans provided guidance for staff. For example, applying creams or re-positioning people at two hourly intervals when they were in bed. Daily records and monitoring records had been completed by staff to confirm people had received the care and treatment as detailed in their care plans and risk assessments. We observed staff tenderly supporting a person unable to get out of bed encouraging them to eat and then moving them to make sure they relieved pressure on their skin. The environment did not always support people living with dementia to be independent. For example signs were not used to help them find their way around the home and use was not made of objects or pictures to make them feel at home. All walls and doors were painted the same colour which could confuse people. The provider information return stated they recognised there was limited signage around the home which might help people living with dementia to find their way around. One person had a personal photograph on the door of their room so they could recognise their bedroom.

People's care plans provided a personalised account of how they wished to be supported, their preferences, wishes and routines important to them. Each person had discussed with staff their life history which had been recorded to help staff understand people and their personal interests. Staff knew people well and one member of staff said they recognised the importance of individualised care plans as a starting point to deliver personalised care. We observed staff meeting between shifts where they discussed the needs of each person living in the home. A member of staff said this meeting was important to ensure continuity of care for people.

People and their relatives told us they would talk to staff or the registered manager if they had any concerns. They said their concerns would get dealt with quickly. A person told us, "I don't have any complaints" and a relative said, "I would complain if I thought there was a real problem, but so far, only little things, which have been sorted out quickly." Two relatives said they would not raise their concerns directly with the registered manager but would speak with staff. The registered manager said they had a number of concerns raised on behalf of one person which they decided to deal with as a complaint. They had arranged a meeting with the provider and the family of the person to address the concerns. No other complaints had been received. We saw a copy of the complaints procedure was displayed in the reception area but this was partially hidden from view. Each person had been given a personal copy of the complaints procedure to keep in their room.

Requires Improvement

Is the service responsive?

People had said they were unsure of who they should make a complaint to if they were unhappy with the response or action taken by the registered manager. This information was included in the complaints procedure.

We recommend that the service explores the relevant guidance on how to make the service provided to people living with dementia more dementia friendly.

We recommend that the service considers how people can live well in a setting which promotes their mental health, wellbeing and their interests.

Requires Improvement

Is the service well-led?

Our findings

People had access to information about the service and quality assurance systems in the reception area. This included the statement; "All residents have the right to expect a high standard of care, delivered by safe, competent team members. All staff accept that, in achieving the aim of enabling residents to lead as full a life as possible, there may be some element of risk involved for the resident." Whilst the registered manager and staff recognised these were their goals, they were also aware of the limitations placed on them by a lack of resources including the impact of staffing levels and staff roles and responsibilities on the service they provided. They were not always able to offer people a full range of activities or to enable them to lead active lifestyles.

People, their relatives and staff had the opportunity to be involved in a review of the service each year. We saw copies of questionnaires they had returned in September 2014. A response and action plan had been put together as a result of the completed questionnaires. These included comments about the lack of activities, staff being busy and people not being aware of their care plans. The registered manager said they had reminded staff to talk with people each month when reviewing their care. The registered manager had requested additional staff so that improvements could be made to the provision of activities. The provider information return stated an activity meeting was held by the provider every two months to share good practice ideas between their homes. There was little evidence of how these meetings had improved the experience of people living in the home as the shortfalls raised were also identified at this inspection. There was no evidence that the drive to improve the quality of the service was being encouraged by the provider.

The registered manager was supported by a deputy manager. They were aware of their roles and responsibilities. They had notified the Care Quality Commission (CQC) about accidents and incidents and other enquiries. They had also informed the police and safeguarding team about safeguarding alerts. People, relatives and staff said they were accessible and approachable. They all said the registered manager would listen to them and address any concerns or issues quickly. We observed the registered manager interacting positively with people and visitors. A relative told us, "I know that the manager will deal with any concerns." People and staff were able to give feedback about the service at staff and residents' meetings. Issues raised at residents' meetings were discussed at staff meetings. For example, staff not answering call bells instantly or agency staff introducing themselves to people. People had also commented about not knowing who their key worker was. As a result photographs had been produced as visual prompts for people so they could recognise their key worker.

Staff were aware of the whistleblowing policy and procedure and said they would feel confident to raise concerns to the registered manager or to CQC. Whistleblowing is where a member of staff raises a concern about the organisation. Whistleblowers are protected to encourage people to speak out. The registered manager discussed with us how they had dealt with poor practice after an incident and had followed the provider's disciplinary procedure. Staff had one to one meetings to monitor their performance and to assess whether they were competent to meet people's needs. Support was provided when needed to effect positive change for instance through additional training.

The provider information return stated the registered manager took part in monthly management meetings held by the provider to exchange ideas and good practice within the organisation. Audits had been completed each month by a representative of the provider. Where any issues had been highlighted the registered manager had been requested to put an action plan in place. This was then monitored at the next visit to make sure improvements had been made. For example concerns had been raised by people about the position of the television in the front lounge. This had been moved. Staff completed additional audits and checks for instance monitoring care plans, health and safety systems and medicines.

Professionals from other agencies said the registered manager worked with them to make improvements to the care received by people and had worked co-operatively with them. The provider information return stated they worked closely with health professionals to improve the experience of people living in the home. The registered manager was a member of a learning exchange network and attended meetings with other external organisations to promote best practice in care homes. Staff had been appointed as a dignity champion and end of life champion and also attended local dementia link meetings. The

Requires Improvement

Is the service well-led?

registered manager said involvement with these stakeholders provided the opportunity to review the quality of care and make improvements. These included reviewing the provision of activities. The registered manager said they planned to hold a day in 2015 for all homes owned by the provider. External organisations would be invited to participate to promote positive caring for older people. They had also arranged for the local Alzheimer's Society to deliver dementia friends training to relatives and staff.

We recommend that the service considers the relevant guidance about monitoring quality and how to listen, improve and respond to people's views.