Care Quality Commission

C.T.C.H. Limited

# Parton House

## 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

Parton House 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. Parton House provides accommodation and personal care. The care home accommodates 36 people in one adapted building. At the time of the inspection 22 people were living there, of whom 11 people were living with dementia.

Parton House is being refurbished. It provides spacious communal areas including three lounges, a reception room, a dining room, a cinema, seating areas on each floor and accessible gardens. People's rooms are individualised and some have en suite facilities. They also have access to shared toilets, showers and bathrooms.

This inspection took place on 20 and 21 February 2018. At the last comprehensive inspection in December 2016 the service was rated as Requires Improvement overall.

At this inspection we found the service had improved to Good overall.

There was a registered manager in place who had recently transferred from another of the provider's homes. 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 were benefiting from sustained improvements to the service they received. Their care and support was individualised reflecting their preferences, routines and lifestyle choices. Staff understood people well anticipating their emotions, helping them to stay calm. People's health and wellbeing were promoted. They had access to a range of healthcare professionals. Their medicines were safely administered at times to suit them. People's dietary needs were considered when offering them a choice of meals, snacks and drinks. Fortified foods and drinks were provided to those at risk of malnutrition. People at risk of developing pressure ulcers were provided with equipment to protect their skin and staff followed strategies to prevent deterioration in their skin. People had discussed their end of life wishes which were respected. A relative said, "You all went the extra mile for her in her last few days, and [Name] and I are extremely grateful for your dedication."

People's care records were kept up to date with their changing needs. They and their relatives were involved in developing their care and support. Information was shared with other agencies and organisations, when needed, to ensure a smooth transition between services. People were kept safe from the risk of abuse. Staff had a good understanding of safeguarding procedures and were confident management would take the appropriate action. 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 had access to a range of meaningful activities which included visits by people and children living in their local community. Visitors were made to feel welcome and arrangements could be made for private dining.

People were supported by staff who had been through a robust recruitment process before starting work. Staff had access to a range of training to equip them with the skills and knowledge they needed to meet people's needs. Staff were supported to develop in their roles. Disciplinary procedures were in place should they be needed. The registered manager was open and accessible and understood the challenges of introducing change management. There were plans to recognise best practice and to introduce staff champions in key areas.

People, their relatives and staff had a variety of ways to express their views about the service. Their feedback was used to drive through improvements. Quality assurance processes were in place to monitor the standard of the service provided. Accidents, incidents and complaints were monitored. Lessons were learnt when things went wrong and action taken to prevent issues reoccurring. A relative commented, "I would not hesitate to recommend your services for your professionalism and compassion."

## 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's safety was promoted. Safeguarding concerns were followed up and systems reinforced to keep them safe. Any risks were assessed to reduce the risk of harm or injury. Lessons were learnt from accidents and incidents and improvements made to reduce the risk of these happening again.

People were supported by enough staff to meet their needs. Staff had been through a robust recruitment process before they started work.

People's medicines were safely managed and administered.

People were protected against the risks of infections.

### Is the service effective?

Good

The service was effective. People's needs were assessed to make sure a service could be provided.

People were supported by staff who had been subject to a robust recruitment process and had the opportunity to acquire the skills and knowledge to meet their needs.

People's health and wellbeing was promoted through access to a range of healthcare professionals. Their dietary and nutritional needs were considered.

People lived in a home which was undergoing major refurbishments.

People's capacity to make decisions was considered in line with the Mental Capacity Act 2005. When people were deprived of their liberty to keep them safe the appropriate authorisations were in place.

### Is the service caring?

Good

The service was caring. People were treated with kindness and care. Staff respected their dignity and their human rights.

People were involved in the planning of their care. Staff understood them well and promoted their independence.

## Is the service responsive?

Good

The service was responsive. People received individualised care and support which reflected their changing needs.

People had access to a range of meaningful activities and were encouraged to be as independent as possible.

People knew how to make a complaint. Their concerns were listened to and in response the appropriate action was taken to address them.

People's end of life wishes were respected. Support was provided to them and their relatives, with sensitivity and compassion.

## Is the service well-led?

Good

The service was well led. There was a clear vision to drive through improvements to promote individualised care and support.

Quality assurance processes were in place to learn from mistakes and manage risks to provide as safe a service as possible.

People, their relatives and staff were encouraged to give feedback about their views to help develop the service.

The registered manager was open and accessible, working with other organisations and agencies for the benefit of people living in the home.

Care Quality Commission

# Parton House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 20 and 21 February 2018 and was unannounced. One inspector carried out this inspection.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make. We contacted the commissioners of the service to obtain their views about the care provided to people.

During our inspection we spoke with six people and two relatives. We spoke with the registered manager, a representative of the provider, the deputy manager, an activities co-ordinator, four housekeepers, two domestic staff and five members of care staff. We joined staff at a handover meeting between shifts. We looked at the care records for three people, including their medicines records. We looked at the recruitment records for three new members of staff, training records and quality assurance systems. We have also used feedback given to the provider as part of their quality assurance processes. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We contacted three social and healthcare professionals for their views of the service.

Good

# Is the service safe?

## Our findings

People's rights were upheld. Their needs relating to their protected characteristics under the Equality Act, for example, age, disability, race or religion were considered and they were supported to maintain respectful relationships with each other. One person told us, "I came here so I could feel safe." Relatives confirmed they had no concerns about the care provided by staff. People and staff were provided with easy to read information about abuse and contact details of who to contact. Staff understood how to keep people safe from harm. They knew what to do should they have concerns about a person's safety. They were confident if they raised concerns under the organisation's whistle blowing procedure that the appropriate action would be taken by managers. Whistle blowing legally protects staff who report any issues of wrongdoing. When there were safeguarding concerns policies and procedures were followed to maintain records to evidence the suspected abuse and to contact the relevant agencies such as the Police, the local safeguarding team, the local authority and the Care Quality Commission. We had been notified about safeguarding concerns and any subsequent investigations. The appropriate action had been taken in response to these to keep people safe.

People were protected against the risk of harm or injury. Any risks had been assessed and people's care records described the strategies in place to minimise these. People's independence, choice and freedom of movement were promoted. For example, people liked to go out for walks and staff accompanied them providing support and encouragement. Risk assessments were reviewed each month to make sure any changes had been identified and the appropriate action taken. Accident and incident records were kept and monitored closely to assess if any trends had developed which needed to be addressed. For example, after increasing falls people were referred to their GP, the occupational therapist and/or physiotherapist to reassess their physical health and mobility. Action had been taken and monitored to make sure risks had been managed and people were safe. Where necessary people were supplied with equipment to help them stay safe such as walking aids, high/low beds with mattresses on the floor and sensor alarms to alert staff if people had moved or fallen.

People had access to a safe environment. There was a long term maintenance plan for the refurbishment of the home. Work had started at the time of our inspection. Health and safety checks were completed to make sure a safe environment was maintained. These included testing and servicing of fire systems, portable appliance checks, room checks and the servicing and checking of individual equipment. Each person had an individual personal evacuation plan should they need to leave the building in an emergency. Emergency information for fire services was kept securely near the entrance. A business continuity plan provided information for staff about utilities, bad weather strategies and emergency contacts.

People who at times became distressed or anxious were helped by staff to manage their emotions. Their care records described what might upset them and the action staff should take. Staff had received guidance and training, in line with current best practice, from health care professionals to understand people's mental health wellbeing and how best to support them. Staff understood people well and envisaged what might upset them. A healthcare professional confirmed this, "Staff are doing some good anticipatory work managing behaviour. They know when to offer personal care before she becomes anxious."

People were supported by enough staff to meet their needs. Staff confirmed staffing levels had improved and they were better able to cope and had more time to offer person centred care. Staff told us, "Rotas are well organised" and "We use fewer agency staff." Some staff had trained in dual roles and were able to help out with personal care tasks if needed. The representative of the provider said they promoted a "whole home approach" whereby all staff could help each other out when needed. Recruitment procedures were managed robustly and staff were appointed after all the necessary records had been received and checks had been completed. There was evidence gaps in employment history were verified and people's character and competency were checked through references and a Disclosure and Barring Service (DBS) check. DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable staff from working with vulnerable groups of people. New staff completed a newly devised induction programme which included health and safety and safeguarding training.

People's medicines were administered and managed satisfactorily. Staff had completed training in the safe management of medicines and a new competency assessment had been introduced which included observations of them administering medicines. Medicines audits were completed each week and monthly. Any issues were identified and discussed with staff. Gaps in the medicines administration record (MAR) were checked straight away to make sure medicines had been given. People had their medicines at times to suit them and staff were observed making sure they had been given within the correct time frames. For example, staff explained how they managed the medicines round to ensure people had their medicines before meals if this is how they had been prescribed. Medicines which needed additional security were managed appropriately and were administered by two members of staff. People were supported to manage their own medicines if they wished. They had secure facilities in their rooms. Staff were observed discreetly and sensitively discussing with people their medicines and staying with them until they had taken them. Staff were observed reviewing people's medicines and contacting health care professionals for prescriptions and advice. Staff were kept up to date about any changes at the handover between shifts. People had a transition record which kept up to date information about their medicines which could be shared with other organisations if needed.

People were protected against the risk of infection. Measures were in place to prevent and control the risk of infection. An annual report had been produced in line with the code of practice in the prevention and control of infections. Staff had completed the relevant training and had been provided with personal protective equipment. Records confirmed water systems and legionella checks were monitored in line with current guidance and legislation. Staff had completed food hygiene training and the catering facilities had been awarded the top score of five stars by the food standards agency. Infection control procedures were monitored by the provider.

Action had been taken in response to safeguarding concerns and the security of people's personal possessions. People were offered secure facilities in their rooms and in the office. The representative of the provider shared learning from incidents at other homes in the group. They made sure changes to minimise risks were implemented in Parton House. For example, reviewing the duties of night care staff and the records they used.

Good

# Is the service effective?

## Our findings

People's physical, mental and social needs were assessed. People had been assessed prior to being admitted to the home. The management team visited people in their homes or hospital and liaised with relatives and social or health care professionals to decide whether they were able to meet their needs. Throughout their stay at the home people's needs continued to be assessed and reviewed in line with evidence based guidance to ensure their care was being delivered effectively. Nationally recognised tools were used to assess areas such as people's activities of daily living, risks to their nutrition and diet and risks to the integrity of their skin.

People's protected characteristics under the Equality Act were promoted. Staff had access to training in Equality and Diversity. People's spiritual, religious, sexual and cultural needs had been identified as part of their initial assessment of need. Each person had a document entitled "This is Me" which reflected their protected characteristics and provided background information about them. People's diverse needs were considered and whether any adjustments needed to be made to the delivery of their care. For example, people living with dementia were provided with specialist crockery to encourage them to eat. Signage around the home helped them to find their way around.

People benefited from the use of technology and equipment to ensure their care was effective and promoted their independence. The management team were using an application on their smart phones to share information with each other, which could then be immediately shared with staff. An electronic touch screen tablet had been set up in the reception area inviting people and their relatives to provide instant feedback to the provider. A television screen in the reception area was also being used to share information and photographs with people. People's independence was promoted through equipment which made use of electronic sensors for example, mats which alerted staff if they had moved and required support. People had access to call-bells in their rooms to request staff to visit them.

People were supported by staff who the skills, knowledge and experience to deliver their care. People commented, "Staff are all excellent" and "They are all just the best." Staff confirmed they had access to a range of training to keep their knowledge up to date. The training needs of staff were closely monitored by the provider's training lead who produced a monthly spread sheet and sent individual prompts to staff about when refresher training was due. This record indicated a number of staff had training to complete. The registered manager had discussed this with them during a staff meeting and discussed strategies they could put in place to make sure this was completed. Staff had access to open learning, training delivered by internal trainers and also external courses. Staff had completed training in subjects considered mandatory by the provider such as first aid, fire, moving and handling and food hygiene. In addition they completed training in dementia, end of life care and mental health. The registered manager was carrying out workshops with staff to reflect about ways they worked with people. These included person centred care and end of life care. New staff completed the care certificate and could progress to the diploma in health and social care. A schedule was in place for individual support meetings with staff held every other month. Annual appraisals had been completed to review the performance of staff and their professional development. Staff were also observed carrying out their duties to ensure they had the skills to match their

knowledge base.

People had a healthy and nutritious diet. Meals were provided by an external contractor and people said they were happy with the food provided. One person commented, "I enjoy the food, I never leave anything." People and their relatives had recently been invited to a taster session to trial new meals. The chef had up to date information about people's dietary needs. They confirmed they were able to provide soft, mashed or fortified diets. They were aware of any allergies and information about allergens was displayed in the dining room. The chef had introduced cooked breakfasts and a range of different snacks throughout the day to encourage people to eat. They said home baked cakes were also provided. People were supported to eat and drink if needed. They were shown a sample of the main meals and offered side dishes at the table which enabled them to decide how much or little they wished to eat. Specialist crockery was provided including brightly coloured cups and plates to encourage people living with dementia to eat and drink. A private dining area was available for people and their relatives and visitors.

People had their weight monitored and a Malnutrition Universal Screening Tool (MUST) was used to identify people who were malnourished, at risk of malnutrition or obese. They were aware of who was at risk of malnutrition and provided fortified milkshakes in addition to meals. Staff had raised concerns about the ongoing weight loss of one person and had been advised to seek advice about fortified supplements from their GP. People's risks of developing pressure ulcers had been considered and where necessary they had been provided with air mattresses and cushions, cream was applied to their skin or if in bed they were turned at regular intervals. People at risk of choking had been assessed and risk assessments described the support they needed to reduce these risks. For example, providing soft or pureed food and ensuring good posture when eating.

People's health and wellbeing was promoted. Relatives told us how a person had thrived since moving into the home. People benefited from the enhanced services provided by a local surgery, whereby one GP was responsible for visiting each week; this meant that people saw a doctor when they needed to and their medication was reviewed regularly. They had access to a range of health care professionals when needed. An optician and chiropodist visited the home. Staff worked closely with social and health care professionals to co-ordinate their care and support. Records were kept of any communication and shared with the staff team. Managers described how they liaised with social and health care professionals to ensure people received effective care and support as they moved between services. For example, when being discharged from hospital for a period of short term care at the home.

People had access to an environment which was gradually being fully refurbished. Some individual rooms had been upgraded and offered en suite facilities. Communal areas and hallways were being redecorated. There were plans to replace all carpets with washable floors. The registered manager spoke about plans to make the gardens a safer environment for people to enjoy without staff supervision. Consideration had been given to how to adapt the environment to promote the wellbeing of people living with dementia. Improved signage aided people to find their own rooms, bathrooms and lounges. Hallways had lighting which provided well-lit walkways without casting shadows.

People's capacity to make decisions about all aspects of their day to day care had been considered in line with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People's care records highlighted where they had capacity to make decisions about their care and support and when decisions would need to be made in their best interests.

There was evidence who had been involved in making decisions in people's best interests for example their relatives and health care professionals. People were observed being given choices about their day to day lives, what to eat and drink, where to spend their time and with whom and what activities to be involved in.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been made on behalf of people who were being deprived of their liberty or who had restrictions in place. People's liberty was restricted at times to keep them safe. The registered manager confirmed requests had been submitted and reviewed when needed. There were no conditions attached to those DoLS which had been approved.

Good

# Is the service caring?

## Our findings

People were treated kindness and care. Staff were observed spending time with people, chatting with them, reminiscing and laughing. People had positive relationships with staff. They told us, "They're lovely to me", "Carers are wonderful" and "I can't fault them." Relatives reflected, "Staff are amazing" and "They are very good, nothing is too much." Healthcare professionals said they had no concerns about the care provided. Staff had been issued with new contracts of employment which prompted them to be person centred and to focus on people's wellbeing. Daily records also included a section about people's wellbeing and staff were commenting about how people were during the day rather than focussing on the tasks carried out.

People's culture, disabilities and backgrounds were considered to ensure information was accessible and easily understood. The management team were considering how they could promote accessible information around the home. People's communication needs were highlighted in their care records which guided staff about how to communicate with them, such as giving them reassurance and taking time to listen to them. Staff were observed at times diverting conversations so that people would not become distressed.

People's human rights were respected. People's protected characteristics were identified in their care records such as their sexuality, religion and disability and their care records prompted staff that they had the "right to participate fully and to have the same relationships as everyone else". Staff respected people's right to family life. Staff gave consideration to their relationships with others and respected their right to privacy. People's preferences for the gender of staff providing their person care had been discussed with them and were respected. People's spiritual and cultural preferences had been discussed and if people could not attend a local place of worship they were able to attend a service held within the home.

People were supported to express their views about their care and support. The Provider Information Record stated, "People are encouraged to play an active part in planning, decision making and offering their views and opinions." Each person met formally every month with a named member of staff (key worker) to talk through their care needs. A record evidenced if any changes were made to their care and support. Relatives confirmed their involvement and said they were kept involved and informed. Where a lasting power of attorney (LPA) had been appointed they had the authority to make specific best interests' decisions on behalf of that person, if they were unable to make the decisions for themselves. There was evidence that LPA's had been included in the decision making process. Information about access to advocates was provided. Advocates help people to express their views, so they can be heard. They can be lay advocates or statutory advocates such as Independent Mental Capacity Advocates (IMCAs).

People benefited from staff who had the time to provide the support and care people needed in a person centred manner rather than focussing on tasks. Staff told us, "We have time to sit with people", "There are more staff and we feel happier being able to spend time with people." We observed staff being with people in the lounges and dining room as well as in their rooms. Staff interactions were friendly and polite. People were treated with dignity and respect. A person told us, "Staff treat me well." Personal care when being offered was done discreetly. People were encouraged to be independent. Their care records clearly stated

what they were able to do for themselves and what they needed help with.

People's relatives and friends were able to visit whenever they wished. Facilities were provided in the dining room for visitors to make drinks and sit with their relatives in private. Relatives told us how the staff had helped them to hold a birthday celebration in a private dining room. They said the family were able to relax and enjoy the sandwiches and cake provided, knowing their relative could come and go as they wished and staff were around providing support if needed. Plans for the refurbishment included providing a guest suite for relatives. Relatives commented about, "the loving quality of care", "compassion and consideration shown to her in her day to day care" and "loving care".

Good

# Is the service responsive?

## Our findings

People's care records reflected their aspirations, routines and their changing needs. These were discussed with them and their relatives. Each month people talked with a named member of staff (key worker) about their care and support. Their care records clearly detailed what they could do for themselves and what they needed help with. People's independence was promoted for example encouraging them to do as much of their personal care and dressing as they could. People, their relatives and social and healthcare professionals were involved in planned reviews of their care or sooner if their needs changed. For instance, a social care professional had reassessed a person's needs to determine whether or not Parton House could continue to provide their care and support. As people's needs changed their care records were updated to reflect these. Relatives told us they were kept informed. They said, "They are all so proactive" and "Nothing is too much, their consistency has really helped."

People's human rights and their protected characteristics under the Equality Act, such as age, disability, religion and marriage, were understood by staff. A new lifestyle profile had been put in place which described these as well as including information about their backgrounds and lifestyle preferences. Consideration had been given to whether any adjustments needed to be made to their care and support in light of their cultural, spiritual and sexual needs and their disabilities. People were supported with personal relationships and staff recognised their need for privacy and personal space. People attended local churches as well as attending a service held within the home. People living with dementia had access to crockery to encourage them to eat, as well as finger food and signage to guide them around the home. They were also provided with items, such as soft toys (to keep their hands busy and providing comfort), which they could interact with.

People were encouraged to join in with a range of activities. An activity co-ordinator helped out each week and staff also took the lead when they were able. Staff had attended a workshop to reflect about what activities they could offer to promote people's wellbeing. These included using a large crossword with a group. Activities included fitness sessions, watching films in the home's cinema, quizzes, a sing-a-long and walks around the garden. The activities co-ordinator encouraged people to join in with a game of darts as well as spending individual time with people offering nail care. People who chose to stay in their rooms were visited by staff for chats. School children from a local school had visited people and on a return visit had written a song for one of the residents. School children had been paired with people living in the home as part of a pen-friend scheme to exchange letters. There were plans to create a kitchenette where people could make themselves snacks and drinks.

People's sensory needs were considered. Staff checked to make sure hearing aids were in working order and people had access to their glasses. Documents were displayed in easy to read formats enabling people to easily access information about their home, how to recognise abuse, how to make a complaint and activities. Large pictures of the meals provided were used to help people make an informed choice about what to eat. Staff were looking at ways of using these photographs to produce a menu for each day. People had access to telephones to keep in touch with their family and friends. Each person had a call bell in their room should they need to see staff. Staff were observed monitoring and responding to call bells during our

inspection. Electronic touch screens had been installed in the reception area to give feedback and another screen showed photographs of the home. A new application had been installed onto mobile telephones enabling the provider and management to keep in touch to promote responsive care and support to people.

People knew how to make a complaint. They said they did not have any but would talk to staff or the managers. Relatives told us, "The staff have time for us and if we need to talk with someone there is always someone around." They said they talked through any issues as they arose with staff and found them and managers open and approachable. Concerns were recorded with evidence of any action taken so that any themes could be monitored. For example, a person going to bed early or a call bell being out of reach. These were addressed with staff individually and had not reoccurred. One complaint was being dealt with and there was evidence this was being thoroughly investigated. Face to face meetings had been held with the complainant. The Provider Information Return stated, "The service has a culture of openness and transparency where apologies are made when things go wrong."

People's end of life wishes had been discussed with them and their relatives. Each person had an end of life plan in place, if this is what they wished. These provided details about how they would like to be supported, such as whether they would wish to remain at Parton House and whether they had a preferred funeral director and service. Feedback to the provider about end of life care included the following statements: you made sure "The family were present and gave him a last drink of whisky through a syringe before he passed", "You all went the extra mile for her in her last few days, and [Name] and I are extremely grateful for your dedication" and "The last day, I sat with her, your attention to her and myself was above and beyond, in my eyes." Another resident wanted their favourite rag doll with them when the time neared and this was respected. The registered manager confirmed they worked closely with healthcare professionals at this time to ensure people had the care and support they needed and anticipatory medicines were available if needed.

Good

# Is the service well-led?

## Our findings

People benefited from a provider who had a clear vision to improve the quality of care and support provided. The aim of the organisation, as described on their website, was quoted as "to make sure you enjoy the best time possible, and make new memories for you and everyone". A relative commented, "I would not hesitate to recommend your services for your professionalism and compassion." The registered manager said they worked alongside staff, leading by example and monitoring the quality of care and support provided first hand. Staff said they were open and approachable and were confident she would take the appropriate action in response to any concerns they might raise. The Provider Information Return (PIR) confirmed, "Management provide visible management within the home and are actively involved with the service users and their care."

The registered manager reflected how they supported staff following accidents and incidents, giving them the opportunity to debrief and reflect about what had happened and whether anything needed to change to prevent it reoccurring. This learning was shared with the staff team and wider organisation as appropriate. For example, after medicines errors and reflection by staff, improvements were made and shared in the administration of medicines. The registered manager and representative of the provider were aware of their duty of candour to acknowledge when mistakes had occurred and to take preventative action. They said, "Families are given emotional support and we set professional boundaries" and "We arrange face to face meetings and are transparent with relatives."

The registered manager and representative of the provider acknowledged the challenges of change management. They were supporting staff to embrace new ways of working, providing more person centred care and empowering them in their roles. Staff commented, "It's improved" "There are more staff – we feel happier." Staff were encouraged to be part of the decision making process of the home. They had been asked for feedback about new job descriptions and their comments had resulted in changes. The representative of the provider said they were reviewing how they valued and showed their appreciation to staff. Long term service awards were already in place and staff had been offered a financial incentive to introduce new staff to the service. In addition a reward scheme was being looked at to recognise best practice and champions were being trained in key areas within the staff team. The registered manager reflected that staff "were transitioning well" and activities were improving with staff spending quality time with people.

The registered manager had the support of the representative of the provider to carry out their role and responsibilities. They had individual meetings with them to monitor and evaluate the quality of service provided. Action plans were developed and monitored to make sure any improvements or changes had been implemented. For example, appointing moving and handling champions and clearing the cinema of spare equipment, so that it could be used again for screening films. The registered manager understood her responsibilities to meet the Care Quality Commission's (CQC) requirements and to adhere to health and safety legislation and keep up to date with changes in legislation and best practice. They had displayed the rating from their last inspection in the home and on their website. People's personal information was kept confidentially and securely in line with national guidance. Disciplinary procedures were in place which

would be used if concerns were raised about the professional conduct of staff. Staff had been issued with new job descriptions which focused on person centred care and the wellbeing of people. A team meeting had been held to discuss these with them.

People, their relatives and staff had a range of ways to give their views about the service. For example through residents' and relatives' meetings, staff meetings, annual surveys, complaints and compliments and external websites. A new residents' council had been set up and the first meeting had been held. The PIR stated this would "provide a further voice for the service users who we recognise as stakeholders". The registered manager said there were plans to introduce a staff council, to "encourage staff to be part of the decision making process". Relatives and visitors had improved access to give their feedback. A touchscreen electronic device had been installed which allowed them to give feedback directly to the provider and to a national website.

Quality assurance processes were completed by staff, the registered manager and the representative of the provider. Health and safety systems, care planning, staff support and the environment were all regularly monitored. Any actions identified were checked each month to make sure they had been implemented to drive through improvements. For example, removing protected meal times to improve visiting times, starting with the refurbishment of the home and increasing the range of activities provided.

The registered manager and staff worked in partnership with other organisations and agencies. They kept in close contact with social and health care professionals ensuring smooth transitions between services whether people were moving into or out of the home. They sought advice from commissioners and the local authority when needed. The representative of the provider described how the management team would be working towards an admission process which could be offered seven days a week in light of recent requests from commissioners. They were taking part in a county wide project to improve activities for people in care homes.

The representative of the provider said, "Our vision is to provide a social, thriving environment for the residents who live there and for the local community." The registered manager was establishing contacts within their local community to encourage those living locally to participate in the day to day life of the home. A person who attended the local church visited people. Children from a nearby school had become involved and students also completed work practice. The provider received appreciation about "the time and effort given to our students to help them develop their confidence, work and work readiness."

The registered manager attended a local care home providers' association and the representative of the provider had a place on the board. The management team continued to work with local commissioners and other agencies to drive through improvements. They worked closely with a local authority initiative to improve care to people which also provided training for staff. Staff were involved with a learning exchange network, dementia and activity forums to ensure their knowledge and skills reflected current best practice.