Four Seasons (No 7) Limited

Charlton Park Care Home

Inspection report

21 Cemetery Lane
Charlton
London
SE7 8DZ

Tel: 02083164400
Website: www.fshc.co.uk

Date of inspection visit:
25 April 2018
26 April 2018

Date of publication:
19 June 2018

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 25 and 26 April 2018 and was unannounced.

Charlton Park Care Home is a 'care home' providing residential care for older people with dementia. 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. Charlton Park Care Home accommodates up to 66 people, there were 62 people using the service at the time of our inspection.

At the last inspection on 14 and 15 March 2017 we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found there was no clear guidance for staff when a person was assessed as being at-risk of choking, to make a Speech and Language Therapist (SALT) referral. The provider failed to notify the Care Quality Commission (CQC) as required, of the authorisations of Deprivation of Liberty Safeguards (DoLS). Following that inspection, the provider sent us an action plan showing how they planned to make improvements. At this inspection we found improvements had been made. There was clear guidance for staff when a person was assessed as being at risk of choking, to make a SALT referral. The provider had notified DoLS authorisations to CQC in a timely manner.

The service did not have a registered manager in post. The previous registered manager left the service in March 2018. The provider had appointed a new manager in March 2018 to run the home. The new manager's application to the CQC to become the registered manager was being processed. 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.

Staff knew how to keep people safe. The service had clear procedures to support staff to recognise and respond to abuse. The new manager and staff completed safeguarding training. Staff completed risk assessments for every person and they were up to date with detailed guidance for staff to reduce risks.

The service had an effective system to manage accidents and incidents, and to prevent them happening again. The provider recognised people's need for stimulation and social interaction and provided activities to meet their needs. People had end-of-life care plans in place to ensure their preferences at the end of their lives were met. Staff completed daily care records to show what support and care they provided to each person.

The provider carried out comprehensive background checks of staff before they started working and there were enough staff to provide support to people. Medicines were managed appropriately and people were receiving their medicines as prescribed. Staff received medicines management training and their competency was checked. All medicines were stored safely. The service had arrangements to deal with

emergencies and staff were aware of the provider's infection control procedures and they maintained the premises safely.

The provider trained staff to support people and meet their needs. People and their relatives told us that staff were knowledgeable about their roles and that they were satisfied with the way staff looked after them. The provider supported staff through regular supervision and yearly appraisal.

The new manager and staff understood their roles and responsibilities under the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS). 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 support this practice. People consented to their care before they were delivered.

Staff assessed people's nutritional needs and supported them to maintain a balanced diet. Staff supported people to access the healthcare services they required, and monitored their healthcare appointments. The new manager and staff liaised with external health and social care professionals to meet people's needs.

People or their relatives, where appropriate, were involved in the assessment, planning and review of their care. Staff considered people's choices, health and social care needs, and their general wellbeing.

Staff supported people in a way which was kind, caring, and respectful. Staff protected people's privacy and dignity.

The service had a clear policy and procedure about managing complaints. People knew how to complain and told us they would do so if necessary.

The provider sought the views of people, their relatives, and visiting professionals to improve the service. Staff felt supported by the new manager. The provider had effective systems and processes to assess and monitor the quality of the care people received which helped drive service improvements. The service worked effectively with health and social care professionals, and commissioners.

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 kept safe from the risk of abuse.

Staff completed risk assessments for every person and they were up to date with guidance for staff to reduce risks. The service had a system to manage accidents and incidents to reduce reoccurrence.

The service had enough staff to support people and carried out satisfactory background checks on them before they started work.

Staff were aware of the provider's infection control procedures and they maintained the premises safely. They administered medicines to people safely and stored them securely. The service had arrangements to deal with emergencies.

Is the service effective?

Good

The service was effective.

People and their relatives commented positively about staff and told us they were satisfied with the way they looked after them. The provider supported staff through training, supervision and an annual appraisal.

Staff assessed people's needs and completed care plans for every person, which were all up to date. Staff completed daily care records to show what support and care they provided to each person.

Staff assessed people's nutritional needs and supported them to have a balanced diet.

People consented to the care staff provided them. The new manager and staff knew the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and acted according to this legislation.

Staff supported people to access the healthcare services they

needed. The new manager and staff liaised with external health and social care professionals to meet people's needs.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind and treated them with respect.

People and their relatives were involved in making decisions about their care and support.

Staff respected people's choices, preferences, privacy, dignity, and showed an understanding of equality and diversity.

Is the service responsive?

Good

The service was responsive.

Staff recognised people's need for stimulation and social interaction and supported them appropriately.

Staff involved people or their relatives in the assessment, planning and review of their care.

Staff prepared, reviewed, and updated care plans for every person. Care plans were person centred and reflected people's current needs.

People had end-of-life care plans in place to ensure their preferences at the end of their lives were met.

People knew how to complain and would do so if necessary. The service had a clear policy and procedure for managing complaints.

Is the service well-led?

Good

The service was well-led.

People and their relatives commented positively about the new manager and staff.

The service had a positive culture, where people, relatives and visiting professionals felt the service cared about their opinions and acted on their feedback to make improvements to the service.

Information about the management of the service was shared with staff through regular meetings to ensure they understood the responsibilities of their roles.

The service had an effective system and process to assess and monitor the quality of the care people received.

The service worked effectively in partnership with health and social care professionals and commissioners.

Charlton Park Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 April 2018 and was unannounced. A specialist nurse advisor, one inspector and an expert by experience inspected on 25 April 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspector returned to the service on 26 April 2018 to complete the inspection.

Before the inspection we looked at all the information we held about the service. This information included the statutory notifications that the service sent to the Care Quality Commission. A notification is information about important events that the service is required to send us by law. The provider had 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 contacted health and social care professionals involved in people's support, and the local authority safeguarding team for their feedback about the service. We used this information to help inform our inspection planning.

During the inspection we spoke with seven people, eight relatives, 10 members of staff, the deputy manager, the new manager, and the regional manager. We also spent time observing the support provided to people in communal areas, during meal times, and medication round.

We looked at 14 people's care records and 10 staff records. We also looked at records related to the management of the service such as the quality audits, administration of medicines, accidents and incidents reports, Deprivation of Liberty Safeguards (DoLS) authorisations, health and safety records, and the provider's policies and procedures.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe and that staff and the new manager treated them well. One person told us, "Yes, it feels good here." One relative said, "Yes, my [loved one] feels safe." Another relative commented, "My [loved one's] never shown any signs of anxiety." We observed staff kept a close, but discreet, eye on individual people who posed risks to themselves as they moved around the home.

At the last inspection in March 2017, we found there was no clear guidance for staff when a person was assessed and identified as being at risk of choking, to make a Speech and Language Therapist (SALT) referral. At this inspection we found the service had made improvements.

Risks to people were assessed and managed to help keep people safe. There was clear guidance for staff when a person was assessed and identified as being at 'medium' risk for choking, to make prompt referrals to Speech and Language Therapists (SALT). We saw that staff had followed this guidance where people had been identified as being at risk of choking and had sought advice from the SALT team. A risk management plan had been put in place which identified the type of food and the level of support people needed to reduce the level of risk. We observed during the lunch time that people were getting the correct type of diet suitable to reduce risk of choking. Records further confirmed that staff followed the prescribed guidance provided by the SALT team.

Staff completed risk assessments for every person. These included manual handling, falls, eating and drinking, pressure sore prevention and wound care. The risk assessments were up to date with detailed guidance for staff to reduce identified risks. For example, where the risk of pressure sores was identified, the risk management plan addressed the use of correct equipment such as air mattress and support needed for preventing pressure ulcers. Records confirmed that staff followed this guidance to prevent or minimise the risk of pressure sores. In another example, where a person was identified with a risk of falls, a risk management plan and correct equipment was put in place.

People were kept safe from the risk of abuse. The service had a policy and procedure for safeguarding adults from abuse. The new manager and staff understood what abuse was, the types of abuse, and the signs to look for. Staff knew what to do if they suspected abuse. This included reporting their concerns to the new manager, the local authority safeguarding team, and the Care Quality Commission (CQC) where necessary. Staff we spoke with told us they completed safeguarding training and training records we looked at confirmed this. Staff knew the procedure for whistle-blowing procedure and said they would use it if they needed to. The service maintained records of safeguarding alerts and monitored their progress to enable learning from the outcomes when known. The new manager implemented performance improvement plans for staff to make sure they used safeguarding incidents as an opportunity for learning. The service worked in cooperation with the local authority, in relation to safeguarding investigations and they notified the CQC of these as they were required to do. The local authority safeguarding team confirmed that the provider cooperated with them in the safeguarding investigations and took appropriate follow-up action were required.

Incidents and accidents were recorded and analysed to reduce the risk of harm to people. The service had a system to manage accidents and incidents to reduce them happening again. Staff completed accidents and incidents records. These included actions staff took to respond and minimise future risks, and who they notified, such as a relative or healthcare professional. The new manager saw each incident record and monitored them. Records we looked at showed examples of changes made after incidents occurred. For example, following an incident of a fall an incident record, body map with photographs were completed. The person was referred to the falls clinic and was placed on 30 minutes observations. In another example, one person had suffered weight loss following a hospital admission, their weight was regularly reviewed and a referral was made to the community dietician. We noted that their care plan had subsequently been updated to include further guidance for staff on how best to support them, and records showed that this had been discussed with staff during staff meeting. The service had a process for analysing accidents and incidents and identifying if there were any trends. This was tracked and managed by reviewing risk assessments and management plans, and having the relevant equipment for people.

Staff administered prescribed medicine to people safely and in a timely manner. One person told us, "Yes, I get them from the nurses' station." One relative said, "Yes, it [medicines] arrives on time. They [staff] are also continuing to monitor and reassessing my [loved one] due to their health condition. We are also in touch with the resident GP." Another relative commented, "Yes and the nurses are good at doing that."

Staff checked medicines against the Medicines Administration Record (MAR) sheet, ensured that people were positioned correctly and comfortably before giving them medicines. The provider trained and assessed the competency of staff authorised to administer medicines. The MARs were up to date and the medicine administered was clearly recorded. The service had PRN (as required) medicine protocols in place for any medicines that people had been prescribed. The protocols gave information about when the medicines should be given. The medicines including controlled drugs were securely stored. Staff monitored fridge and room temperatures to ensure that medicines were stored within the safe temperature range. The provider carried out regular medicines audit and shared any learning outcomes with staff to ensure people received their medicine safely.

The provider carried out comprehensive background checks of staff before they started work. These checks included details about applicants' qualifications and experience, their employment history and reasons for any gaps in employment, references, a criminal records check, health declaration, proof of identification, and registration for qualified nurses with their professional bodies. This ensured staff who worked with people were suitable to do so.

There were enough staff on duty to help support people safely. The new manager carried out a regular review of people's needs to determine staffing levels which met people's needs. Records showed that staffing levels were consistently maintained to meet the assessed needs of the people. The new manager told us if they needed extra support to help people, they arranged additional staff cover. Staff rotas we saw confirmed this. The service had a call bell system for people to use when they required support and we saw staff responded to requests in timely manner. People told us that staff were quick to respond to their room call-buttons. One person said, "I have only used it once and the response was pretty quick." One relative told us, "It [call bell] is always on her bed." Records also showed that staff carried out checks for people who could not use the call bell, to ensure their needs were met.

The service had arrangements to deal with emergencies. They carried out regular fire drills and records we saw confirmed this. Staff completed personal emergency evacuation plans (PEEP) for every person. These included contact numbers for emergency services and provided advice for staff on what to do in a range of possible emergency situations. Staff received first aid and fire awareness training so that they could support

people safely in an emergency. Staff and external agencies, where necessary, carried out safety checks for environmental and equipment hazards such as hoists, and safety of gas appliances.

Staff kept the premises clean and safe. They were aware of the provider's infection control procedures. Bedrooms and communal areas were kept clean and tidy. Staff told us they washed their hands before and after any procedure and used protective materials like gloves and aprons when necessary, and did not use them across the rooms or from one person to another, to prevent transferring infection. We observed staff using personal protective equipment such as gloves, and aprons to prevent the spread of infection. Staff and external agencies, where necessary, carried out safety checks for environmental and equipment hazards such as hoists, and safety of gas appliances.

Good

Is the service effective?

Our findings

People and their relatives told us they were satisfied with the way staff looked after them, and that staff were knowledgeable about their roles. One person told us, "Yes, they [staff] are all pretty good." One relative told us, "They [staff] are very impressive in supporting my [loved one] to adjust to being here, and they are very good at reassuring my [loved one]." Another relative said, "My [loved one] has been here for three years now. They [staff] all look after my [loved one] well."

People received care and support from staff who were trained and competent in their roles. The provider trained staff to support people and meet their needs. Staff told us they completed induction training, when they started work and mandatory training identified by the provider. The mandatory training covered areas from basic life support, food safety, health and safety, infection control, safeguarding vulnerable adults to moving and handling and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The home had recently been accredited to the Dementia Care Framework. Staff told us the training programmes enabled them to deliver the care and support people needed. The service provided refresher training to staff as and when needed and all staff training was up to date.

Records showed the provider supported staff through regular supervision and yearly appraisal. They included discussions about staff members' wellbeing and sickness absence, their roles and responsibilities, and their training and development needs. Staff told us they felt supported and could approach the new manager, at any time for support.

Staff carried out a pre-admission assessment of needs for each person to ensure they could be met. The assessment considered the level of support they required, their choices and preferences, day-to-day needs and any identified areas in which they needed support. The assessments covered medical conditions, physical and mental health; personal care, mobility, nutrition and skin care needs. This information was used as the basis for developing personalised care plans to meet their individual needs.

The Mental Capacity Act 2005 (MCA) provides legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The new manager knew the conditions under which an authorisation may be required to deprive a person of their liberty in their best interests under DoLS. Records showed that appropriate applications had been made, and authorisations granted by the relevant 'Supervisory Body' to ensure people's freedoms were not unduly restricted.

People's mental capacity had been assessed where staff suspected they may not have capacity to make a decision about a specific aspect of their care for themselves. Records showed that assessments had been completed in accordance with the requirements of MCA. Where people had been assessed as lacking capacity we saw that the relevant decision had been made in their best interests, with the involvement of staff, relatives and healthcare professionals, where appropriate. For example, when people were having their medicines administered covertly, we found mental capacity assessments were carried out and in their best interests the service had sought advice from healthcare professionals and agreed on how to administer the medicine covertly.

Staff asked for people's consent, where they had the capacity to consent to their care. One person told us, "Yes, they [staff] normally do." One relative said, "Yes, they [staff] talk to my [loved one] about what they are going to do." Records were clear on people's choices and preferences about their care provision and how staff sought their consent before giving them care in relation to giving them a wash, shower or personal care. Staff we spoke with understood the importance of gaining people's consent before they supported them.

People were supported to eat and drink sufficient amounts for their wellbeing. Staff assessed people's nutritional needs and supported them to have a balanced diet. People and their relatives told us they had enough to eat and drink. One person told us, "On the whole it is good. I can have choices. If I want they [staff] will even do a rasher of bacon in a sandwich, if I want it." Another person said, "The food is very good." Staff recorded people's dietary needs in their care plan and shared this information with kitchen staff to ensure people received the right kind of diet in line with their preferences and needs. For example, we saw information available to kitchen staff on which people needed soft or fortified diets, and meals to meet their specific nutritional needs.

The service protected people from the risk of malnutrition and dehydration. Staff completed nutritional assessments for each person and monitored their weights as required. We saw action had been taken where risks associated with nutrition had been identified. For example, where people were at risk of malnutrition, records showed that staff sought advice from a dietician and completed food and fluid charts to monitor people's intake. We saw during the inspection that staff ensured people were kept hydrated. Drinks and snacks were available and offered to people throughout the day. People received appropriate support to eat and drink. Interactions between people and staff during a lunchtime meal were positive and the atmosphere was relaxed and not rushed. We observed staff providing support to people who needed help to eat and drink and encouraged them to finish their meal.

People were supported to have access to healthcare services where required. The service had strong links and worked across with local healthcare professionals including a GP surgery, Speech and Language Team (SALT) and dietician. We saw the contact details of external healthcare professionals in every person's care record. Staff completed health action plans for everyone who used the service and monitored their healthcare appointments. The staff attended healthcare appointments with people to support them where needed.

The service met people's needs by suitable adaptation and design of the premises. There were door guards on all the bedrooms which automatically released in the event of fire. People's bedrooms were personalised and were individual to them. Some people had bought personalised items from their previous home which had been used to make their rooms familiar and comfortable. We observed people moving freely about the home. Access to the building was controlled to help ensure people's safety.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were caring and treated them with respect. One person told us, "They [staff] are very kind." Another person said, "Yeah, yeah I do think they [staff] are kind." A relative commented "They [staff] have been kind, if not they would soon hear from me." Another relative said "From what I have seen, they [staff] are kind and caring."

People were cared for by staff who were kind and caring. We observed staff communicating with people in a caring and compassionate manner throughout the time of our inspection. For example, staff took time to talk to people on a one to one basis, talking softly and in a dignified manner. They pro-actively engaged with people, using touch as a form of reassurance, by holding people's hands, and by maintaining an eye contact with them, which was positively received.

People and their relatives were involved in the assessment, planning and review of their care. One person said, "Yes, I am involved in my care planning." One relative told us, "My brother and I continue to be involved in my [family member's] care planning." Staff respected people's choices and preferences. For example, staff respected people's decision around where to spend their time; in their own room, lounge, and walk about in the home. Relatives told us there were no restrictions on visiting times and that all were made welcome. We saw staff addressed visitors in a friendly manner, and they were made to feel welcome and comfortable.

People were supported to maintain their independence. One member of staff said, "Some residents can wash their face and their other parts I wash. I encourage them to choose their clothes." Another member of staff told us, "If they[people] can feed themselves we observe, if I find their hands are shaking, then I support them." Staff prompted people where necessary to wash, dress and undress, eat and drink, and brush their teeth.

People were treated with dignity, and their privacy was respected. One relative told us, "Yes, I see staff knocking on the door of the bathroom." Another relative said, "My [loved one] does not feel comfortable in general but here it is better." We saw staff knocked on people's bedrooms before entering people's rooms and they kept people's information confidential. We noticed people's bedroom doors were closed when staff delivered personal care. People were well presented and we saw examples of staff helping them to adjust clothing to maintain their dignity. Records showed staff received training in maintaining people's privacy and dignity.

Good

Is the service responsive?

Our findings

People received personalised care and support that met their needs. One person told us "We see [new manager] regularly and all [staff] others too. All are very receptive." Another person said, "They [staff] are trying to oblige every time."

Staff recognised people's need for stimulation and supported people to follow their interests, and take part in activities. One relative said, "On Monday they [The home] had a new man come in with a keyboard and my [loved one] actually started to sing. There was also a big cake made for St. George's day. They [Staff] are also planning to do a big event for the upcoming royal wedding too." The service employed an activities coordinator who arranged activities daily. Staff told us that they ask people what they would like to do and built programmes to suit them. Activities on offer included musical events, pampering sessions, quizzes, arts and crafts sessions and external entertainers. We observed that these activities had a positive effect on people's wellbeing.

Care plans were person centred. Staff had developed care plans for people based upon their assessed needs. These contained information about their likes, dislikes, personal life and social history, their health and social care needs, allergies, family and friends, and contact details of health and social care professionals. They also included dependency assessments which identified the level of support people needed in areas including identifying the things they could manage to do by themselves. Staff told us this background knowledge of the person was useful to them when interacting with people who used the service. Care plans were reviewed on a regular basis and reflective of people's current needs.

People's care plans included details about their ethnicity, preferred faith and culture. The service was non-discriminatory and staff supported people with any needs they had with regards to their disability, race, religion, sexual orientation or gender. Staff showed an understanding of equality and diversity and supported people with their spiritual needs where requested. For example, the provider arranged activities for people, to meet their spiritual needs.

Staff completed daily care records to show what support and care they provided to each person. They also completed a separate record which included the specific tasks for the day such as who required a weight check, fluid and food intake monitoring, repositioning of people in the bed and skin care management. The service used a communication log to record key events such as changes to health and healthcare appointments for people.

People received appropriate end-of-life support. Records showed people's end-of-life preferences had been discussed with them, and care plans developed to ensure their preferences in this area were met. The service worked with staff from the local hospice where appropriate to ensure people's end-of'-life needs were met. Staff had also completed end-of-life care training. People had valid Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms in place where this decision had been discussed with them and their relatives, where appropriate.

Complaints were managed satisfactorily. People and their relatives told us they knew how to complain and would do so if necessary. They told us that they were confident any concerns would be taken seriously. One person told us "No, I have no issues and those that I did have were minor and dealt with very quickly." A relative said, "If I had a concern, I would go to [the new manager] in the first instance." The provider had a clear policy and procedure for managing complaints and we saw there was a copy of the provider's complaints policy in the front lobby, and notices about how to register concerns with local social services and the Care Quality Commission were made available to people. The service had maintained a complaints log, which showed when concerns had been raised senior staff had investigated and responded in a timely manner and where necessary meetings were held with the complainant to resolve the concerns. The log showed that complaints had been made about a staff issue and a financial matter. The new manager told us that there had been no reoccurrence of these issues following their timely resolution.

Good

Is the service well-led?

Our findings

People and their relatives commented positively about staff and the new manager. One person told us, "Yes, she [the new manager] is very easy to talk to, all the staff are approachable." One relative said, "The new manager cares and even helps making beds if required. They [the new manager and staff] are all working well together." Another relative commented, "For the mid-range prices that this care home sits in, it is good value for what it is."

At the last inspection in March 2017, we found the provider failed to notify the Care Quality Commission (CQC) as required, of the authorisations of Deprivation of Liberty Safeguards (DoLS).

At this inspection we found improvements had been made. The new manager understood their responsibilities to notify the CQC as required, of the DoLS authorisations because some people required continuous supervision by staff. The provider had notified CQC in a timely manner.

There were effective systems and processes to assess and monitor the quality of the care people received. This included audits covering areas such as accidents and incidents, medicines, health and safety checks, pressure care and wound management, house maintenance, care planning and risk assessments, food and nutrition, and infection control. As a result of these audits the provider made improvements, for example, care plans and risk management plans were up to date, staff refresher courses had been arranged, the premises had been redecorated where required and labels were put on hot water points, so that people received safe and effective service.

The service did not have a registered new manager in post. The previous registered manager left the service in March 2018. The provider had appointed a new manager in March 2018 to run the home. The new manager's application to the CQC to become the registered manager was being processed. 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.

The new manager had detailed knowledge about each person living at the home, and made sure they kept staff updated about any changes to people's needs. We saw the new manager interacted with staff in a positive and supportive manner. Staff described the leadership at the service positively. One member of staff told us, "The new manager is fair, good to talk to her. If there is a problem on the floor, she will come and sort it out." Another member of staff said, "The new manager is very professional, she is role model for me. She is very approachable, and I can trust her, she can resolve any issue."

There was a positive culture in the service, where people, their relatives and visiting professionals' opinion was sought to make service improvements. One relative told us, "I am very pleased, they [the home] is open to suggestions and is very caring at every level." People, relatives and visiting professionals completed satisfaction surveys about the quality of the service.

The results of these satisfaction survey carried out during April 2017 to March 2018, showed that the quality of service had improved from what it was during April 2016 and March 2017. For example, relatives felt their family member was safe within the home had improved from 99% to 100%. Similarly, people felt 'staff listen to them' had improved from 97% to 99%, and the visiting professionals were happy with the admission of their client and the care that they had received had improved from 92% to 96%.

The new manager encouraged and empowered people and their relatives to be involved in service improvements through periodic meetings. Areas discussed at these meeting included menus, activities, care plan reviews and redecoration of the premises. As a result of these meetings the provider made improvements like activities and redecoration of the premises. We observed that people, relatives and staff were comfortable approaching the new manager and their conversations were friendly and open.

The new manager held meetings with staff where staff shared learnings and good practice so they understood what was expected of them at all levels. Records of staff meetings showed that areas discussed had included details of any changes in people's needs, guidance to staff about the day to day management of the service, discussions about co-ordinating with health and social care professionals. Staff also discussed the changes to people's needs during the daily shift handover meeting to ensure continuity of care.

The provider had worked effectively in partnership with a range of professionals. For example, health and social care professionals, commissioners, dieticians, GPs, SALTs and hospital staff. Records we saw confirmed this. Their feedback also stated that the standards and quality of care delivered by the service to people had improved and that they were happy with the new manager and staff at the service.