West Berkshire Council

Willows Edge

Inspection report

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Ratings

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

Overall summary

The inspection took place on 28 and 29 April 2015 and was unannounced. The service is registered to provide personal care support for up to 39 older people. At the time of the inspection care was being provided to 37 people all of whom were living with varying degrees of dementia. The home provided care over three floors, each with communal facilities available.

The service was required to have a registered manager. A manager was in place who had applied for registration. 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 service had been through a period without a permanent manager and where staff turnover had been high. This had resulted in training and staff support having fallen behind and reduced levels of activities at a time when dependency levels had increased.

Summary of findings

The new manager was acting to address these issues and had sought additional care and activities staffing to do so. At the time of inspection staff levels were not sufficient to meet people's needs at all times, which potentially placed them at risk of harm. Following the inspection plans were made to address this pending the recruitment of additional permanent staff.

People were supported with food and fluid intake and received their medicines correctly. Appropriate support was sought from external health professionals and others to support individuals and the development of the service.

Staff supported people in a caring way, involving them where possible and took account of their wishes. People's rights and dignity were respected by the staff in the way their worked.

The operation of the service was monitored effectively by the manager and provider. Actions taken to address any issues were monitored.

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 always safe because there were not always sufficient staff available to meet people's needs. The manager had begun to address this and progress will be monitored.

The provider's medicines procedure did not provide guidance to staff on the circumstances when medicines may be given covertly. However, individual guidelines were provided in one case where this might be necessary and appropriate best interests agreements had been obtained.

The service had responded appropriately to safeguard people where they had been at risk of harm.

Is the service effective?

Good

The service was effective in meeting people's support needs. People received the support they needed with their personal care.

Staff were provided with an appropriate induction and previous training gaps were being addressed to ensure staff were aware of current best practice. Staff were supported to perform their role.

People's rights were protected. They received appropriate health care and their needs around food and drinks were met to help them remain well.

Is the service caring?

Good

The service was caring. Staff worked with people in a caring way and involved them in their care where possible.

People's dignity and privacy were provided for by staff.

Information about people's history, background and interests was sought to help staff engage effectively with them.

Is the service responsive?

Good

The service was responsive and people were provided with care according to their needs and their care plan.

The provider's survey system did not provide service specific information to assist development. However, people and relatives felt they were listened to and any issues they raised were dealt with.

Where staff were available, they responded promptly to people's needs and supported them to make day-to-day choices about their life.

Summary of findings

Is the service well-led?

Good

The service was well led. The manager and provider had a system of regular audits in place. The new manager was working to address the issues identified such as the backlog in staff training and supervision.

The staff consultation system did not provide service specific information to inform management of any local issues, although a sample of staff views was sought during monitoring visits.

The advice of appropriate external professionals was sought in developing the service.

Willows Edge

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 28 and 29 April 2015 and was unannounced. The inspection was carried out by one inspector.

Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

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 looked at the information provided in the PIR and used this to help us plan the inspection.

We contacted six health professionals, four local authority care commissioners and received feedback from some of them about the service.

During the inspection we spoke with four staff, the registered manager, deputy manager and the operations manager. We also spoke with three people using the service and four relatives.

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. We reviewed the care plans and associated records for five people, including risk assessments and reviews, and

related this to the care observed. We examined a sample of other records to do with the home's operation including staff records, complaints, surveys and various monitoring and audit tools. We looked at the recruitment records for four recently appointed staff.

Requires improvement

Is the service safe?

Our findings

People and their relatives felt people were safe in the service. One person told us: "Oh yes, they are all kind, I feel safe here". Another person said: "Staff look after me well and I'm safe". A relative told us they had: "Not seen anything of concern". Another said: "I feel he is safe". Some people and relatives told us there were not always enough staff. One person said the service was: "Sometimes a bit short-staffed, you can wait to get up sometimes". Another person told us there were: "Sometimes enough staff, sometimes not".

External health professionals were happy the service kept people safe. One told us: "I feel the environment is safe in that these are very vulnerable patients and the staff appear to respond appropriately to safeguarding issues."

During the lunchtime staffing levels were sufficient to ensure that people's support needs were met. Lunch service had recently been divided into two sittings to help ensure this. At other times there were insufficient staff available to ensure the effective supervision and safety of people. For example at one point during the morning for a period of seventeen minutes no staff were present in one of the lounges to address people's needs. The staff were busy supporting people with personal care elsewhere in the building. During that time one person was becoming agitated by two of the other people wandering, which could have escalated. Had staff been present they could have intervened to defuse the situation.

The service did not use a dependency tool to assess required staffing levels. The regular assigned staffing level was two care staff per floor for between 11 and 13 people, with one senior staff member on duty leading the shift. It had been agreed recently to provide additional support on the first floor by the addition of one care staff. This was due to some people having been reviewed as becoming in need of nursing care who were awaiting transfer to a service able to meet this need. An additional staff member had been allocated to provide one-to-one support for one person on the second floor. Rotas had also been reworked to include two part time shifts covering the mid-morning to mid-afternoon period to encourage and support people's food and fluid intake. However, levels of staffing had not been increased sufficiently to account for the increased level of dependency now that the service was specialising in supporting people living with dementia.

Following the inspection the service planned to cease using the second floor lounge to try to free up an additional care staff to cover on the other floors. Whilst this may assist with staffing, it does reduce the choice of communal areas available to people. The manager planned to review the current rotas to ensure they made the best use of available staff. Night care staffing and domestic staffing was maintained at the planned levels. The manager told us they were considering the introduction of 'housekeeper' posts to provide a mixture of supervision and basic care support within lounges, while care staff were engaged elsewhere supporting people with personal care.

Staffing issues had been identified by management, within monthly audit reports. The home had significant vacancy levels including over 150 care assistant hours and 74 care officer hours, and was using a number of agency staff to cover these. For example for the week commencing 21 April the service used 238.5 hours of agency staff of which 175 were to support one person to manage their behaviour. Other additional hours were covered by existing permanent staff or by the provider's casual staff 'bank'.

Staff also felt there were insufficient staff available to meet people's needs. They told us staff were working a lot of long days to provide cover and were aware of the increased levels of dependency. They felt the new manager was beginning to address this issue. One staff member told us: "Staffing is being tackled, but it's slow". Staff were concerned about the impact of the high use of agency care staff on consistency of care. One staff member said that staffing levels were particularly an issue at weekends when there wasn't any management cover. The manager told us staff retention was generally good and where staff had left recently this was for reasons other than dissatisfaction or issues with the service.

The service had a standing advertisement for care staff but the cost of living and competition from other employers in the area meant the recruitment rate was slow. In order to maximise consistency and continuity of care the service were seeking to cover four part-time vacancies with short term contracted agency staff in the interim.

The available activities coordinator hours of two part time posts covering two days each, were inadequate for a service of its size and physical layout, given the level of

Requires improvement

Is the service safe?

people's needs. The manager told us there were plans to increase activities worker hours to cover the additional weekday and further discussion planned regarding the provision of weekend activities cover.

During the inspection a whistle-blower contacted the Care Quality Commission (CQC) to raise some concerns about the way one person was supported to manage their behaviour. They felt the level of support was insufficient and left other people at potential risk. A review of this person's care had taken place recently and the process to find a more appropriate placement to meet the person's needs had begun. Additional staffing had been provided in the interim to support them. The service had kept family informed of incidents and had notified the safeguarding team and CQC about the issue. Support had also been sought from the community psychiatric team.

The recruitment records were mainly held centrally at the provider's headquarters, with copies of some documents held within the service. The records showed that a robust recruitment process was completed to check that potential staff were of suitable character to work with vulnerable people. One person's employment history did not fully address all gaps in employment but this was being followed up and was addressed during the inspection.

The provider had an appropriate medicines policy and procedure. However, it did not address the circumstances and procedure where it had been agreed that medicines should be given covertly in a person's best interests. The operations manager agreed to request a review of the procedure to include covert administration. In one instance where covert administration had been agreed, appropriate steps had been taken to protect the persons' rights. A 'best interests' decision had been made and appropriate guidelines provided to staff for when covert administration was appropriate.

The medicines administration process ensured that people received the correct medicine in the correct dosage at the appropriate time. Records provided the necessary audit trail for medicines and any refusals were recorded. None of the people could manage their own medicines. The staff member administering medicines wore a tabard indicating that they were administering medicines and were not to be disturbed. People were offered their medicines and we heard staff explaining what the medicine was for where the person would understand this. Medicines were stored appropriately in locked medicine trolleys.

Staff had been trained and understood their role in reporting any safeguarding concerns and were familiar with the different types of potential abuse. They told us their priority was to ensure the person was safe and then record and report their concerns.

Where safeguarding issues had arisen the service had reported these appropriately to CQC and the local authority safeguarding team. They had been investigated and where identified as appropriate, action was taken to reduce the risk of recurrence. A recent medicines issue led to improved communication with the GP and the supplying pharmacy to speed up the response to any supply issues. Another recent safeguarding issue led to appropriate retraining for staff.

People's care files contained a risk assessment overview which identified areas of risk requiring individual detailed risk assessments. Risk assessments were reviewed and updated where necessary. Accidents and incidents were appropriately recorded and reported where necessary. They were monitored to identify any themes that required changes to care provision. We saw that if people had sustained bruising this was recorded and followed up to try to establish the cause.

Good

Is the service effective?

Our findings

The training matrix showed that some training had been provided regularly in accordance with the provider's expectations. For example most staff had attended training on safeguarding, dementia and health and safety training as prescribed. Other staff were booked to attend although the date was not specified. Other training, essential to equip staff with the current skills and knowledge for their role had fallen behind due to staff turnover and shortages of permanent staff. For example food hygiene training was only current for six of 35 care staff. This training had been booked for 22 other staff and was overdue for seven others. People were potentially at risk of not receiving care in accordance with current best practice.

The manager told us what steps had been taken to address the training backlog. All staff whose manual handling training required updating would receive this by 11 May. Two staff were trained recently to enable them to train others in manual handling so the training could be provided when required. These staff would also undertake the manual handling competency assessments of staff as part of the 'competency framework' for the new care certificate. Where scheduled training updates in other core areas were not immediately due, funding had been agreed to buy in external training more quickly. The manager had sought competency assessment to deliver the mental Capacity Act training update herself. Action had been taken to improve the booking system for training and a training plan drawn up covering the next 16 months, with six-monthly review.

One staff member told us training was good when available. They said the deputy manager encouraged and put them forward for courses. Another staff member was doing a dementia course and hoped to do her care certificate. Nineteen staff had attained a National Vocational Qualification (NVQ) or equivalent in care and one staff member was working towards this.

The induction process for new staff had been revised in line with the new national competency framework and the new Care Certificate for staff. Induction now included observation of staff practice as part of defining competency.

Staff vacancies and shortages had affected the frequency of supervision meetings and staff appraisals since the last inspection. The stated frequency for supervision meetings was a minimum of six-weekly but the manager agreed they were not yet fully achieving this. The need to provide regular of supervision had been discussed in senior staff meetings. The new manager had put in place a schedule to book these throughout the year and enable their completion to be monitored. Supervision regularity had improved under the new manager. The supervision recording format included monitoring of training as well as other aspects of the employee's work. Staff were positive about the support they received through supervision which they felt was a positive process.

The building was not designed with dementia care in mind and had some issues which were not easily changed such as blind corridors rather than circular routes. An external health professional also expressed concern about the limitations of the building's design. Some adaptations had been made to make the environment more suitable such as the option of familiar pictures on people's bedroom doors and a sensory garden had been provided. However, signage for toilets and bathrooms was not suitable and there was no artwork to indicate the usage of particular rooms to assist people with orientation. Colour differentiation between corridors was also not provided.

The manager was aware of these issues and the support of the dementia care 'in-reach service' had been engaged to help develop the dementia care aspects. Plans had already been drawn up for improvements to bathroom facilities and to the conservatory. Visual menu boards were also in the process of development with the caterers.

People enjoyed their meals. One person told us: "It's alright here, I like the food". Another person said; "The food and drink's OK, I like it here, I've been happy". A relative told us their relative was unable to tell them what they had eaten but had put on a healthy amount of weight since admission, so they were happy with the care. Another relative said: "[name] had settled in really well and had gained a little bit of weight."

People received the help they needed to eat their meal from staff who generally sat with them, except when just cutting up their food for them. People were offered encouragement or prompted to eat where necessary. Drinks were encouraged and refills were offered to

maintain fluid intake. Cut up fresh fruit had recently been introduced and offered with morning drinks as this had been found to be more popular than offering the fruit without preparation.

Staff interacted with people while supporting them and offered praise and encouragement to encourage eating. The dining experience was calm and pleasant. People could eat at their own pace. People were not kept waiting and could leave the table when they had finished. Staff were available to support people in and out of the dining room. Other staff took meals to people who were eating elsewhere and one person was supported to eat their lunch in bed, by a relative. Lunchtime had been divided into two sitting to enable staff to spend more time responding to people's support needs. We saw this worked well and staff feedback confirmed this was working better and having a positive impact on people's eating.

The catering service was provided by an external catering company. Meals were freshly cooked and looked appetising. Where people required a soft diet or pureed food, meals were presented in an appetising way to maintain their appeal. Tables were laid with flowers, glasses and cruets to make the dining experience familiar and pleasant. Specialist cutlery and crockery were available if required, to help people remain as independent as possible. Records were kept and reviewed, where people had been assessed as at risk from malnutrition or dehydration. People were also weighed regularly to monitor wellbeing.

A relative told us they were happy with the healthcare provided. They said their relative had no health issues and had not had any falls since being admitted. Another relative said the staff had told them if their relative was unwell and kept them fully informed."

The service consulted appropriately with external health professionals for advice and guidance, including community psychiatric nurses, physiotherapists GP's and district nurses. One external health professional told us: "The relationship with GP practices has dramatically improved. They have come a long way considering the complexity and challenges the resident group present." The 'Speech and Language Therapy' team had advised about a person's increased swallowing difficulties.

The service managed people's skin care effectively and pressure damage was rare. Where skin breakdown had occured this was well managed and advice had been sought from the district nurses and the 'dementia in-reach team'. Two staff had completed a specialist "Skintelligence" course and were now passing on this training to others. Where people required hoisting to transfer between bed and chair they were individually assessed and had their own hoist slings to ensure they were suitable and reduce the risk of cross infection. Three hoists were available with disposable slings for use in emergency for people who did not use a hoist regularly.

Communication between staff was positive and effective. For example when the senior was leaving the dining room she informed staff where she was going and reminded them she was available to be contacted by pager. Staff took part in a handover between shifts to pass on information about changes in people's needs or well-being and maximise continuity of care. Staff had individual handover books in which to record issues relating to their shift and significant events for later inclusion in people's care notes. A collective' communication book' was also maintained to pass on messages to the team.

We saw that staff explained what was going to happen and sought people's agreement before providing them with support. People had varying capacity to consent to daily care, although some could indicate their wishes. Where more major decisions needed to be made in a person's best interests an assessment of capacity under the Mental Capacity Act 2005 (MCA) was completed. A best interest decision was then made regarding the issue. A few people had also made 'advance decisions' under the MCA which related to particular issues such as end of life care. The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The MCA also requires that any decisions made in on behalf of a person who lacks capacity, are made in the person's best interests.

One relative told us they had power of attorney, which gave them authority to make decisions on behalf of their relative regarding their care or health needs and finances. They told us the service involved them appropriately in such decisions and were kept well informed about the person's welfare. They told us the staff: "Communicate very well". The service had copies of relative's power of attorney in

some, but not all cases where this was in place. The manager undertook to seek copies where these were absent or at least record that the documents had been seen.

Where people would be unable to leave the service safely without supervision a service must apply to the local authority for a 'Deprivation of Liberty Safeguards' (DoLS) authorisation. DoLS authorisations are provided under the MCA to safeguard people from illegal restrictions on their liberty. The service had submitted applications under the (DoLS) on behalf of eighteen people and had identified that the remaining people also required an application and had notified the authority of this. The local authority had requested these be submitted in a phased way and this was being done.

The service supported some people with behaviours which may cause distress or harm to themselves or others. The advice of the psychiatric team had been sought. Individual behaviour management plans were on file to help staff manage behaviours in a consistent way. Records were completed of instances of behaviours of concern to enable them to be monitored and reviewed. These had helped identify some people who required reassessment because their needs fell outside of those the service could meet. The 'dementia in-reach team' had provided some staff training in this area of their work.

Good

Is the service caring?

Our findings

We saw staff had a positive approach to people and encouraged them to make choices and day–to-day decisions. People were given sufficient time to make decisions in an unhurried way. Staff provided explanations to people when they sought reassurance and people were enabled to do what they could for themselves with prompting and encouragement. For example during lunch staff noticed a person was dozing off so they were engaged in conversation and prompted to continue eating. Another person was complimented on how well they had done eating lunch. Staff offered people drinks regularly and talked to them about things they were doing. An external health professional told us: "The staff always seem to me to be caring and sometimes have to cope with some very difficult situations".

Interaction between people was limited at times but staff took the time to acknowledge them when passing by, even when engaged with supporting others. People's facial expressions suggested they enjoyed this and for some it provided reassurance and enabled them to remain settled and happy. People's responses to staff were mostly positive and there was evident warmth and trust in the staff supporting them.

One person smiled when asked if they were happy living in the service and said: "Yes I am happy here". Another person was also happy in the service and told us: "They are very gentle and nice to people, I get on with them all", and added that they had: "never had any bother". A relative told us they visited regularly and had: "Built a good relationship with staff" and added: "I am more than happy". They confirmed they were appropriately involved in decision making and were kept informed of any concerns. The visitor said of their relative: "She has blossomed" since moving to the service. "She is up and about, watches activities and has joined in the singing". Another relative told us the staff were: "Very friendly and helpful". One relative did say that clothing laundry wasn't always well managed but added that their relative: "Is very happy and settled in after the first day". A relative told us: "[Name] is being looked after very well here, they do all they can to make [name] comfortable".

Where people were unable to provide background information about their life history, likes and dislikes and interests, these were sought from family. Information was recorded within a record called 'All about me' where it might assist staff to build rapport and engage with people. Where people had spiritual needs this was also identified and provided for. Care plans also described how people preferred their support to be provided.

Because people were living with dementia the majority of involvement in care planning and decision-making was with family or care managers acting on behalf of people. Few people attended their review meetings although the manager told us the reviewing officers tried to meet with people afterwards to explain any decisions.

People were referred to respectfully using their preferred name by staff when they interacted with them. Tables were provided with regular items to promote people's dignity and adapted equipment was only used where it was beneficial. For example, most people were drinking from glasses and beakers were only used where necessary.

When describing people in the handover and in written records, people were usually referred to in a positive and respectful way using appropriate language. We found a small number of instances where staff had used language in written records which was not appropriate or respectful. Care records made reference to people having had the choice of when to get up and this too was reflected in handover comments by staff.

People's dignity and self-image were enhanced through having their hair done by the visiting hairdresser and the activities worker also manicured one person's nails. One man was supported to have a haircut and shave, and was complimented later by staff about his appearance.

Staff described various ways in which they supported people to maintain their dignity, including making sure they remained as covered as possible when supported with personal care and by always working behind closed doors and curtains. Staff said that all personal care was only ever carried out in private. One commented that they always asked people about their needs as discretely as possible. Staff told us people could express a preference regarding the gender of staff who supported them. Male staff were distributed between the home's floors and female staff were always available to provide personal care support. One relative told us they always left the room when staff were supporting their family member with personal care.

Where people were receiving end-of-life care an 'end of life' care plan was devised. These plans identified who had

Good

Is the service caring?

authority to make decisions on behalf of the person if they were not able to do so for themselves. Consent had been sought for the sharing of this plan with the care staff and relevant external professionals such as the GP. The plan included any particular cultural or religious wishes around end of life arrangements.

Good

Is the service responsive?

Our findings

People were happy with the support staff provided. One said: "Can't complain, they do what you ask", and gave the example of being taken to the toilet quickly when they asked. They also said the home called the GP promptly if they were unwell. Relatives were happy the home responded to people's needs in a timely way. One visitor told us their relative had: "Been anxious, but had settled in extremely well", and had: "built good relationships with the staff". Another relative said staff were: "All very approachable, pleasant and welcoming and would answer any questions". Staff had worked with one person to have their haircut and accept support with bathing which had been very difficult previously. An external health professional felt there was still progress to be made but said: "The significant difference is that care staff are willing to change and learn. They are more open to advice and [were] caring for residents in a more person-centred way".

Care plans recorded people's needs and preferences, supported by risk assessments. Individual support needs, for example around behaviour management, were addressed through appropriate plans. Care plans were reviewed monthly in response to identified changes in people's needs. Relatives were appropriately informed and involved in or notified of decisions and changes in wellbeing. One person's relative was happy the person had been provided with a ripple mattress and pressure relief cushion promptly to reduce the risk of pressure sores.

The service had employed an in-house occupational therapist as a pilot project to undertake individual assessments for equipment required to support people. This had been successful in speeding up equipment provision in response to people's needs.

During handover, staff discussed situations where people had shown distress or had been unsettled. Plans were discussed to respond to their needs. The provision of new equipment or medicines to address changes in needs was also discussed so incoming staff were aware of changes. Following a discussion during the inspection about supporting one person with their behaviour, it was discussed in a senior's meeting the same day and plans were amended appropriately

One person told us: "The activities person spends time with us painting and in the garden", and added that they would like to do some gardening. A relative told us people had made cards at Easter time. An external health professional told us: "The activity coordinator is embedding well and this has clear benefits in the wellbeing of the residents."

Activities were provided to small groups or to individuals where this met their needs. Both activities staff were to attend training on providing seated activities. Managers were working with care staff to identify activities relating to the care they provided, to ensure these activity opportunities were recognised and recorded in future. Activities had been added as an agenda item to supervision and team meetings to improve awareness of their importance.

A range of activities were provided, including making cards, baking, painting, games, planting in the garden and nail care. 'Singing for the brain' sessions took place weekly facilitated by the Alzheimer's Society. Seasonal events were also marked by activities such as Easter bonnet making and pancake making. We saw staff took one person who enjoyed the garden, outside to feed the ducks. Future plans included a fun day, farm animals visiting the home and outside singers coming in. The activities coordinator kept records of individual and group activities to make sure they were meeting people's needs. Care staff had not been contributing to these records where they had supported care-related activities. The manager told us discussions were under way about how to improve the integration of activities recording with other records to enable this.

People were offered choices by staff in ways they could understand. For example the choice of meal courses and drinks were offered by showing people the options to enable them to choose. Other options were given to people such as second helpings and also whether to join in with planned activities. The service was working with the external catering company to provide pictorial menus to assist people to make meal choices. The service made amendments to the caterer's menus to reflect changes in people's known likes and dislikes.

People told us they had not had cause to complain but would be happy to raise anything that concerned them and felt it would be addressed. One relative had complained about an agency staff member and was satisfied with the response they received. The service had a complaints procedure. Four complaints had been made in the last 12 months and each had been addressed appropriately. Records included an action plan to address the problem.

Good

Is the service responsive?

One comment made about the appropriateness of a person's clothing was addressed immediately. Improvements had been made in response to complaints. For example the handover process had been improved and staff had been reminded about supporting people's dignity. Seven compliments about the service had been received in the same period.

The provider carried out surveys across all of their services but these did not provide service- specific information so were of limited use as a tool for managers to enable local improvement. The manager planned to provide comment cards to encourage feedback about the meals and the care provided. An in-house survey was also being considered but was not yet in place.

Good

Is the service well-led?

Our findings

The management team monitored the approach and attitude of staff via attendance at handovers and direct observations of care. The manager acknowledged that to date she had not been able to spend as much time as she wished monitoring these aspects. The manager had worked one day shift and planned to work early, late and night shifts to see for herself the issues faced by staff. The manager had also spot checked the quality of food provided by the caterers and had monthly meetings with them to discuss any issues.

Staff were supported through a range of team meetings. Since the new manager started in late 2014, three senior's meetings, two whole team meetings and a domestic's meeting had taken place. Night staff had also been met with. The manager had held two resident/family meetings to introduce herself and keep people informed about changes in the home. The manager's stated aim was to enable reflective practice and support staff to challenge each other positively to encourage good practice.

Out of office hours staff could contact the manager, managers of the provider's other services or the operations manager for support in the event of an emergency.

Observations about staff practice were fed back during supervision or team meetings and staff competency was checked in key areas to ensure their practice followed the provider expectations. Advice and support was sought from external professionals, including the dementia in-reach team, care quality team and health professionals. The provider had employed an in-house occupational therapist to enable prompt advice, training and support across its services. The provider had overall service development plans covering the development of all of their services.

The manager had planned a series of out of hours checks which were due to commence. These checks would be recorded to evidence the process. The manager told us she was devising a recording system for activities to enable them to be more easily monitored to inform future planning.

A staff survey was last completed in 2013. However, like the survey of users of the service this was provider-wide and not specific to this service so was of limited benefit to the manager in identifying issues specific to this service. It was also undertaken prior to the more recent management changes. The manager thought that this survey was due to be carried out again but if the same format were used, this would remain of limited use to the service manager.

The feedback we received from staff was positive about the new manager and the improvements being made. The manager was described as: "supportive". Two staff had raised issues with the manager which they were happy had been addressed. Another staff member said the service was moving: "generally in the right direction". One staff member was concerned that not all relevant staff always attended staff meetings.

The manager carried out monthly audits across the service. These audits were reviewed by the operations manager. The operations manager also completed monthly audit visits and these reports contained action plans for identified issues and included some staff feedback. Audits included checks on a sample of records and any issues were addressed with the individual or within team meetings.

Action has been taken to address issues when they have been identified. For example procedures and training were improved in response to the outcome of a safeguarding issue. The service has also notified the Care Quality Commission of notifiable events such as the application for DoLS approval. External health professionals were positive about the development of the service. One told us: "Not only have practices been updated but the culture and general environment has altered significantly for the better. The home has a vision and a strong lead". However, one told us they were at times confused about the management structure and lines of responsibility within the service.