Ms P Goss

St. Catherines Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 24 and 27 May 2016. This was an unannounced inspection.
St Catherine's Residential Care Home provides accommodation and personal care for up to 22 people. At the time of our inspection, there were 19 people living at the home.

There was not a registered manager in post at the time of our visit because the person who was registered to manage the home had recently left. However, the provider had appointed a new manager who was in the process of applying for their registration with us. 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 was not always safe because the provider had not always followed safe recruitment practices and ensured that people were receiving their care from staff that had been recruited safely. People were also at risk of not receiving their medicines when they required them because the provider's quality monitoring systems and processes had been ineffective in monitoring safe medication management. The quality monitoring systems had also failed to ensure that staff had access to the correct information about people's individual care needs and related risks in order to promote people's safety.

The service was effective because care was given with consent, where possible. Whilst key processes had not always been fully followed to ensure that people were not unlawfully restricted, immediate action was taken by the new manager to rectify this. We also found that staff had the knowledge and skills they required to care for people and to protect people from the risk of abuse and avoidable harm. They also knew what the reporting procedures were.

People were supported to maintain good health because staff worked closely with other health and social care professionals when necessary. People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration.

The service was caring because people were supported by staff that were kind, caring and who took the time to get to know them, including their personal histories, likes and dislikes. People were also cared for by staff that protected their privacy and dignity, respected them as individuals and promoted their independence as far as reasonably possible.

People were encouraged to express their views in all aspects of their lives including the care and support that was provided to them and people felt involved in the planning and review of their care. This was because the staff communicated with people in ways they could understand.

People were actively encouraged and supported to engage in activities that they enjoyed. People were also supported to maintain positive relationships with their friends and relatives.

Staff felt supported and appreciated in their work and reported St Catherine's Residential Home to have an open and honest leadership culture. The management team endeavoured to improve and develop the service and had plans in place to improve the quality monitoring processes. People were encouraged to offer feedback on the quality of the service and knew how to complain if they needed to. They felt that the new manager was responsive to feedback.

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.

People were supported by enough members of staff but safe recruitment processes had not always been followed to ensure that staff had been recruited safely.

People were at risk of not receiving their prescribed medicines when they required them because medication monitoring systems were ineffective.

People were not always guaranteed to receive the care they required or be protected from risks associated with their care needs because staff did not always have access to the correct information.

People were protected from the risk of abuse and avoidable harm because staff were aware of the processes they needed to follow.

Is the service effective?

Good

The service was effective

People's rights were not protected because key processes had not always been fully followed to ensure people were not unlawfully restricted. However, immediate action has been taken to rectify this.

People received care from staff who had received adequate training and had the knowledge and skills they required to do their job effectively.

People's nutritional needs were assessed and monitored to identify any risks associated with nutrition and hydration and they had food they enjoyed.

People were supported to maintain good health because they had access to other health and social care professionals when necessary.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind and caring.

People received the care they wanted based on their personal preferences and dislikes because staff spent time getting to know people.

People were cared for by staff who protected their privacy and dignity.

People were encouraged to be as independent as possible and were supported to express their views in all aspects of their lives including the care and support that was provided to them, as far as reasonably possible.

Is the service responsive?

Good

The service was responsive.

People felt involved in the planning and review of their care because staff communicated with them in ways they could understand.

People were actively encouraged and supported by staff to engage in activities that they enjoyed.

People were supported to maintain positive relationships with their friends and relatives.

People were encouraged to offer feedback on the quality of the service and knew how to complain.

Is the service well-led?

Requires Improvement

The systems and processes in place to assess and monitor the safety and quality of the service were not always effective.

The service did not have a registered manager in post. However the provider had employed a new manager who was in the process of applying for their registration.

Staff felt supported and appreciated in their work and reported St Catherine's Residential Home to have an open and honest leadership culture.

St. Catherines Residential 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 unannounced inspection took place on 24 May 2016 and we returned for a second day on 27 May 2016, on which occasion, the provider knew about. The inspection was conducted by one inspector and an Expert by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of service who we employ to assist us on our inspections.

Before the inspection, the provider completed a Provider Information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make.

As part of the inspection we looked at the information that we hold about the service prior to visiting the location. This included the PIR, notifications from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also requested feedback from the local authority with their views about the service provided to people at St Catherine's Residential Care Home.

During our inspection, we spoke with five of the people who lived at the home, three relatives and six members of staff including the provider, the new manager, two senior carers, a care assistant and a member of the catering staff. Some of the people living at the home had complex care needs, such as dementia for example and were unable to tell us about their experiences of living at the home. Therefore, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us to understand the experience of people who could not talk with us. We also reviewed the care records of three people, to see how their care was planned and looked at the medicine administration processes.

Furthermore, we looked at training records for staff and at three staff files to check the provider's recruitment and supervision processes. We also looked at records which supported the provider to monitor the quality and management of the service, including health and safety audits, accidents and incident records and compliments and complaints.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at St Catherine's Residential Home and were aware of having risk assessments of any risk associated with the care they received. One relative we spoke with said, "When [person] first came here, they [staff] asked us everything they needed to know about [person's name] including any risks; there wasn't anything they didn't ask, so I know they do risk assessments and I was confident that they had all of the information they needed". Records we looked at showed that people had some risk assessments and care plans in their care files. Whilst these were not always in great detail or specific to peoples individual needs, the staff we spoke with were knowledgeable on people's individual risks and knew what support they required to keep them safe. One member of staff told us, "We get to know people really well and we know what they need and recognise quickly if anything changes with their health for example, which keeps them safe".

Staff we spoke with told us how they kept people safe in an emergency situation such as a fire. One member of staff said, "We have fire training and we do fire drills. If there was a fire, the fire doors will shut automatically to prevent the spread of a fire and we are all to evacuate by the nearest exit. The official fire evacuation point is at the front but you are not meant to open a fire door once it is closed so you would just go to the nearest fire exit". However, whilst records we looked at confirmed that the provider had a fire risk assessment, it did not include personal emergency evacuation plans (often referred to as PEEPs) for people with reduced mobility and we did not see any equivalent risk assessments in peoples care files either. We found that some people who preferred to stay in their rooms or were cared for in bed were located on the second and third floors of the home. Staff we spoke with confirmed that these people had reduced mobility and would need to use the lift to access the ground floor. However, in the event of a fire staff were unsure if or how they would support these people to evacuate the building safely. We discussed this with the manager and the provider at the time of the inspection and explained that for the safety of the people living in the home and for the safety of staff, it is important that risk assessments and fire evacuation plans are in place to ensure that staff know what is expected of them and what the appropriate procedures are in the event of a fire. The provider assured us that this would be addressed as a matter of urgency.

Everyone we spoke with told us they received their medicines when they needed them. One person said, "They are good, we get it [medication] when we need it". Another person told us, "I don't have to worry about my tablets, they sort it for me". A relative we spoke with told us, "One of the first nights they [staff] were having trouble getting [person] to take her tablets; they called me and I came to help them. The staff were really interested to learn how and what techniques I used to encourage her to take the medication and we haven't had a call since".

We were told that all of the people living at the home required support to take their medication and that staff received training to administer medicines safely. We saw that this duty was allocated to a senior member of staff and we observed a senior carer administering medications safely and effectively during our inspection. We saw that medications were stored appropriately and staff we spoke with were aware of the disposal policy for unwanted or refused medication. However, we found that processes in place to monitor the risks associated with medication errors were not always effective. During our inspection we asked the

senior carer to show us how they identified medication errors. They explained that the previous registered manager used to do weekly medication audits with the senior carers whereby they counted the medication to see if they were all accounted for, but this had not been done recently. We asked the senior carer to show us this process. In doing so, we found that some of the medication counts did not tally which meant that some medications were unaccounted for. The senior carer also noticed that a person was due their morphine patch on the day of the inspection but this had not been recorded correctly on the Medication Administration Record (MAR) chart. They confirmed to us, that had we not have asked them to show us this process, this recording error would have gone unnoticed and this medication would have been missed, meaning that the person would not have received their pain relief when they required it, as prescribed. Both the new manager and the provider recognised that improvements are required to ensure that people receive their medications safely and effectively.

During our inspection we looked at the provider's recruitment processes to check whether they were following safe recruitment practices. We found that the provider had a recruitment policy in place which required staff to complete a formal interview, two references, and a Disclosure and Barring check. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care. Upon reviewing staff files, we found that the previous manager had not always followed these processes robustly. For example, we saw that a DBS check had not been done by the provider for one member of staff. This member of staff was in the process of leaving the organisation and therefore no further action was required at this time. However, the Provider assured us that they would ensure that the new manager was aware of the policies and procedures relating to recruitment in order to prevent this from happening again in the future.

People we spoke with told us that they were happy with the care they received at St Catherine's Residential Home and that they felt safe. One person told us, "I feel safe here; there is nothing for me to worry about". Another person said, "I feel safe here, they [staff] don't let people come and go without knowing who they are". A relative we spoke with told us, "I feel happy that she [person] is safe here; I think it is a wonderful place". Another relative said, "I feel relieved that she [person] is here; I know I have made the right decision; she is safe and well cared for".

All of the staff we spoke with felt that people were kept safe at the home and that the provider supported them to maintain people's safety. One member of staff told us, "It's a nice home and we all do our best to look after people and keep them safe. We [staff] are well supported by our managers [referred to the new manager and the provider]". Another member of staff told us, "People are definitely safe here; I would have my mom cared for here, if she needed it".

All of the staff we spoke with knew what action to take to keep people safe from the risk of abuse and avoidable harm. One member of staff told us, "We have safeguarding training which we all have to do. If we are concerned we have to report it to management and if we didn't feel like they were acting on our concerns we can take it further and call the safeguarding number or CQC ourselves, all the numbers are outside the office". Another staff member said, "The [safeguarding] training we have tells us all about the different types of abuse like physical, mental abuse, financial abuse and what we are looking out for, such as unexplained bruises, a change in behaviours, if they [people] seem scared or withdrawn; I would report it straight away to the person in charge, or to the manager or to yourselves [CQC]; all of the numbers we need are downstairs by the office". Records showed that staff had received safeguarding training and they were knowledgeable in recognising signs of potential abuse. Staff knew how to escalate concerns about people's safety to the provider and other external agencies. The new manager was also aware of their roles and responsibilities in raising and reporting any safeguarding concerns. Information we hold about the provider showed us that any safeguarding concerns that had been raised since the last inspection had been reported

to the relevant agencies and had been investigated thoroughly with appropriate action taken. The new manager told us, "We take it very seriously and even if we are unsure, we will always report it to make sure it gets looked in to properly".

During our inspection, we saw that staff were available for people throughout the day and no one had to wait for their care and support to be provided for unreasonable lengths of time. Most of the people we spoke with told us they thought there was enough staff available to meet people's needs. One person told us, "The staff are good; they come if we need them". Another person said, "Sometimes when I press my buzzer it can take them a while to answer, but not always. I suppose it is a big place". Any concerns that were raised with us about staffing levels seemed to be mainly related to the night shifts in particular; however some of the staff we spoke with during the day said that they, "Could do with an extra pair of hands". We discussed this with the new manager at the time of our inspection who explained that they had recently increased the staffing levels to three members of staff at night (where required) due to a change in care needs within the home and that the manager had also contacted social services to review a person's care needs to enable them to increase the staffing levels during the day too. We saw records to confirm this at the time of our inspection. We also saw that the provider was in the process of recruiting new staff to cover recent staff departures and upcoming maternity cover. In the interim, they told us they used an agency to cover any staff shortages and only used a pool of four members of staff from the agency to ensure consistency within the service.

Good

Is the service effective?

Our findings

People we spoke with, observations we made and records we looked at showed that staff had the knowledge and skills they required to do their job. One person told us, "The [staff] are good here; they look after us well". Another person said, "They [staff] are very good at their jobs". A relative we spoke with told us, "They [staff] seem to have a lot of experience and are very knowledgeable. I have a lot of confidence in them". One member of staff we spoke with said, "We do a lot of training here including safeguarding training, first aid, and manual handling…all the essentials". We saw that the manager kept a record of the dates when staff had completed various training as well as a rolling programme of updates that staff were required to undertake on an annual basis. The provider knew when staff were due any refresher or additional training and ensured that this was facilitated.

The provider told us that the new manager had introduced plans to involve people and their relatives in training to help them to enhance their knowledge and understanding about the care they require. The new manager explained to us that some people like to go out with their friends and relatives and therefore, including people and their relatives in the training enables them to feel confident that they have the knowledge and skills they require to promote their safety in the absence of staff. One relative we spoke with told us, "The new manager did a training session on dementia recently; I was able to join in. It was interesting".

We were told and records showed us that the new manager offered regular team meetings and supervision to staff and staff felt supported in their jobs. One member of staff told us, "We are very supported here by [new manager's name] and [provider's name]". Another member of staff said, "We have team meetings every six to eight weeks, we also have supervision. I'm not sure how regular [new manager's name] plans to do them but we have all had one recently". The new manager told us that they planned to meet with the staff regularly to ensure they felt supported and to identify any issues or concerns they may have as well as any training needs. The new manager said, "I have encouraged them all to do the care certificate now so I know exactly where everyone is at with their training and knowledge, I think that's important as a new manager and I am a trained trainer so any gaps, I can look at providing the training they need".

It was evident when speaking to the new manager and the staff that they had an understanding of the Mental Capacity Act 2005 (MCA). The MCA 2005 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. Staff we spoke with confirmed they had received training on the Mental Capacity Act (2005) and were able to give examples of how they worked within these legal parameters and protected people's rights and the need for consent. One member of staff told us, "We always ask people and talk to people and encourage them to make their own decisions. We offer different choices by giving people different options which helps them to choose what they want or need". Another member of staff said, "If people can't tell us, we get a lot of information from their families which helps us to get to know them and what they like or need when they first come here and then we get to know them ourselves too; so we then

get to know their facial expressions or different gestures so we get used to them and understand what they want".

Deprivation of Liberty Safeguards (DoLS) requires providers to identify people in their care who may lack the mental capacity to consent to care and treatment. They are also required to submit an application to a 'supervisory body' for the authority to deprive of a person's of their liberty in order to keep them safe, for example. Staff we spoke with including the new manager were able to articulate their understanding of DoLS. However, they were not always aware if any DoLS applications had been submitted or if any authorisations were in place. Care files we looked at showed that some applications had been submitted but no authorisations had been finalised. We also saw that for some people where restrictions were in place, applications had not been submitted. We fed this back to the new manager and the provider at the time of our inspection and found that they took immediate action to address this issue. The new manager contacted the supervisory body and followed up the status of the existing applications and also submitted any outstanding applications. We also found that people were being cared for in the least restrictive measures possible in order to keep them safe. For example, there was no-one being unnecessarily restricted and people were free to move around the home, but some people required supervision if they wished to leave.

People we spoke with were complimentary about the food at St Catherine's Residential Home and told us that the food tasted 'nice'. We saw that there was a menu available in the dining room and people had a choice of two meals and everyone we spoke with assured us that if people did not want what was on the menu, they were always offered an alternative. As part of our inspection, we joined in with a meal time at the home and saw that the food looked and smelt appealing and people appeared to enjoy the food. We found that the meal time was a social event and people appeared relaxed, receiving the support they required from both the care staff and catering staff.

We saw that nutritional assessments and care plans were in place for people who were at high risk associated with their diet or fluids and they were referred to the appropriate medical professionals as required. Staff we spoke with told us, "Some people have special dietary requirements such as diabetes or they may be losing weight so they will be on a fortified (high nutritional) diet". We saw evidence of this in people's care plans and people's weights were monitored to ensure that any significant changes were identified and medical assistance/advice was sought.

We found that people living at the home had access to doctors and other health and social care professionals. People we spoke with told us they saw the GP, Chiropodist, Optician, Dentist, District Nurses and the hair dresser. One person said, "I have a diary in my room where my chiropodist and optician put the next appointment in". On the day of our inspection we saw that any health care concerns were followed up in a timely manner with referrals to the relevant services. For example, we saw a GP visiting the home, the new manager liaising with a social worker as well as making a referral to the local community mental health service. Records we looked at confirmed that people were supported to maintain good health and to attend any medical appointments they were sent.

Good

Is the service caring?

Our findings

People we spoke with were consistently positive about the caring attitude of the staff and the relationships that were formed between them and the staff team. One person we spoke with told us, "I like it here; the girls [staff] look after me well". Another person said, "They [staff] are always coming around asking if we are ok and how we are feeling". A third person told us, "They [staff] help me here". A relative we spoke with said, "The staff are friendly and very caring; you can see they aren't just doing a job, they genuinely care".

During our inspection we observed staff interacting with people with warmth and compassion. We saw that staff adapted their communication and interaction skills in accordance to the needs of individual people. For example, one person required gentle encouragement and reassurance whilst another person responded well to clear and direct verbal instruction with physical gestures as prompts. Staff used their communication skills to support people to express their views and make choices about the care and support they required on a day to day basis. For example, we saw one member of staff offered a person the choice to try and stand up independently, or whether they required a stand aid (a piece of equipment used to assist people to stand up), depending on how they were feeling at that time. The member of staff showed the person both options to allow them to make a decision. The person told the staff member that they were feeling 'a little weak today' and chose to use the stand aid with the assistance of staff. We also saw that people were encouraged to remain as independent as possible. One person told us, "I do as much as I can for myself". A relative we spoke with said, "They [staff] are very good at encouraging people to do things".

Staff we spoke with had a good understanding of people's needs and we found that people received their care and support from staff that took the time to get to know and understand their history, likes, preferences and needs. Records we looked at showed that people had some care plans in place that were personalised with their preferences, hobbies and interests. However, they did not always reflect people's specific individualised needs and both the new manager and provider acknowledged that they would benefit from greater detail. Nevertheless, we found that people received their care from staff who knew them well and therefore there was no impact identified on the care people received at this time.

People we spoke with told us and we saw that staff treated people with dignity and respect. One person said, "It's very private when they help me [with personal care] and they always speak to me". Another person told us, "Personal care is good. I can have a bath or a shower whenever I choose". Staff we spoke with told us that it was important to respect people as individuals and that they promoted people's privacy, dignity and respect at all times. One member of staff said, "We respect people's personal preferences, like what time they want to get up, when they want help getting ready and meal times are flexible; we always mind their privacy". They said, "For example, during personal care, we always make sure doors are closed and they [people] have all the supplies they need ready. We also support them to choose their own clothes and make sure they are suitable for the weather and that people look presentable". Records we looked at confirmed that the provider promoted dignity and respect within the care planning process. We saw people were addressed and referred to by their preferred name within their care files.

We saw that people were supported to express their individuality and staff were aware of how they could

promote equality and diversity within home. One person told us, "I have difficulty hearing, but the staff make sure I have my hearing aids put in in the mornings". A relative told us, "Since coming here [person] has joined in with the church service that they do; she has faith but has never really practiced it but she really enjoys it now". A staff member we spoke with said, "People can decorate their own rooms and bring their own furniture and pictures in if they want to, to make it feel more personalised to them". We saw people's bedrooms were consistently personalised and reflected their interests, likes and dislikes.

Good

Is the service responsive?

Our findings

People we spoke with and records we looked at showed us that staff had spoken to people about their care needs and preferences. One person told us, "They [staff] speak to us every day to make sure we are ok with everything". A relative told us, "I was involved in the initial assessment when [person's name] first came here. It was very lengthily; I felt confident they knew everything they needed to know when I left". Another relative told us, "I have been involved in [person's name] care plan and reviews". We also saw that care plans were regularly reviewed and people and those who are important to them were invited to care reviews.

Most of the people we spoke with told us that they spent time doing the things that they enjoyed at the home. One person said, "I used to enjoy reading, I still do this now. I have plenty of books to read here". A relative we spoke with told us, "They do quite a lot of activities here and have entertainers". Another relative said, "There is always something going on here, they have had the animal lady in, they have church services on a Wednesday for people that want to join in, quizzes and if you notice, the staff include people in the day to day things to keep them occupied". We saw evidence of this on the day of our inspection, for example, we saw the new manager had included a person in administrative type tasks in order to distract them from thinking about historic events that were worrying them as part of their dementia. A member of staff also told us that some people liked to help them to wash up and others liked to water the plants. We also saw people engaged in activities that they enjoyed such as spending time with friends and family as well as reading the newspapers, watching television or listening to the radio. Furthermore, we observed people joining in with group activities such as quizzes that the care staff had organised. People we spoke with also told us that their friends and relatives were always welcome to visit them at St Catherine's Residential Home and they often went out to spend time with people that were important to them. One person said, "I have a mobile phone so I can contact my friends and family when I want to". A relative we spoke with told us, "There are no set times, we come whenever we want to. When we came to look around before [person's name] moved in, we just popped in, we didn't need an appointment. They [staff] are very welcoming, they always offer us a drink and chat with us".

People we spoke with and records we looked at showed that the provider often asked for feedback on the quality of the service and people were given the opportunity to suggest improvements. One person told us, "We [people] have meetings where they [staff] ask us what we think". We were told that people often see changes from issues that they have raised at these meetings and one person gave us an example of how they had asked for brown bread and now brown bread is available to them. Staff we spoke with told us, "We have residents meetings for people usually one a month; at the last one they said they would like more activities which we try to do now". We saw that the service was responsive to feedback.

During our inspection, the new manager told us that there were no outstanding complaints and everyone we spoke with told us they knew how to complain. One person told us, "I have no concerns but if I did I would speak out to one of the nurses [referring to the care staff]". Another person said, "I don't like complaining but I told my sister about an issue I had and it was dealt with immediately". We saw there was a complaints procedure in place and everyone we spoke with were confident that any issues raised would be dealt with quickly.

Requires Improvement

Is the service well-led?

Our findings

We found that the provider had some systems in place to monitor the quality and safety of the service and that some of these had been used effectively to identify areas for improvement. These included feedback forums and surveys, as well as environmental and maintenance audits. However, some of the quality monitoring systems had not always identified the shortfalls we found during our inspection including the issues around the monitoring of medication processes, care plans and risk assessments as well as the fire safety procedures and Mental Capacity Act 2005. However, the provider had recognised the need to improve on these systems prior to the inspection and had already contacted an external company and arranged for them to provide a consultation to help them to improve their quality monitoring systems.

We also found that the registered manager had recently left the service and a new manager had been employed who was in the process of applying for their registration. The new manager had plans for improving the quality monitoring processes within the service, which they had started to implement in the short time they had been in post. During our inspection, we saw that there was a clear leadership structure which included the provider, the new manager and senior carers.

Everyone we spoke with told us that the new manager had settled in well and had made positive changes within the service. One person we spoke with said, "The new manager is very good, she comes to speak to me every day". Another person said, "The new manager is very approachable, she comes around asking if all is ok". A relative we spoke with told us, "I think there has been a lot of changes since the new manager has come. I think she is more experienced and has settled in quickly". Another relative said, "I was disappointed when I heard [previous registered manager's name] was leaving because we had got to know them but [new manager's name] is amazing, she is very good at her job".

Staff we spoke with told us that both the new manager and the provider were approachable and supportive. One member of staff said, "They [provider and new manager] are both very approachable; I know I can go to either of them if I had any concerns". Another member of staff said, "[New manager's name] has settled in really quickly and sorted a lot of stuff out since being here; we are very supported". A third member of staff told us, "I have confidence in [new manager's name]. She is very good, has years of experience and it shows; she is very professional, straight to the point, honest and approachable".

We saw that the new manager had prioritised meeting with staff on a one to one basis in the first few weeks of employment. They told us that it was important for them to get to know the staff quickly and to build a relationship with them so that the staff could develop confidence in them as a new manager and vice versa.

Information we held about the service showed us that the provider was meeting the registration requirements of CQC. The provider had ensured that information that they were legally obliged to tell us, and other external organisations, such as the local authority, was passed on. The provider was working collaboratively with other external agencies such as the local safeguarding authority, Social Services and community mental health teams to ensure people's needs were met.

Staff we spoke with told us they were aware of their roles and responsibilities with regards to whistle-blowing and that they were actively encouraged to raise any concerns. Whistle-blowing is the term used when someone who works in or for an organisation raises a concern about risks to people's safety, malpractice or illegality without the fear of workplace reprisal. They may consider raising a whistle-blowing concern if they do not feel confident that the management of their organisation will deal with their concern properly, or when they have already raised a concern but the problem within the organisation or with the provider has not been resolved. Staff we spoke with told us that they felt comfortable raising concerns with their new manager and would contact external agencies if they needed to. One member of staff told us, "I can speak to a senior or the manager if I had a problem and if I want happy, I can call CQC".

The manager was able to demonstrate their understanding of the Duty of Candour. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. From talking with the new manager and the provider, we saw that they were both passionate about openness and honesty within the service and they were united in promoting these values within the home. They told us that they had recently consulted with people living at the home about having CCTV camera's installed within the communal areas to promote the transparency within the home. We were told that people were pleased that these were being provided as they offer further protection and security to people. We also found that both the provider and the new manager were open and honest throughout the inspection process and acknowledged some of the shortfalls identified within the inspection with integrity.