Care Quality Commission

Barchester Healthcare Homes Limited

Austen House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

Austen House is a care home with nursing which provides a service for up to 79 people with needs arising from old age, some of whom are also living with dementia. The building is divided into four units. One unit caters for the elderly frail, with the other three providing for people living with varying degrees of dementia.

At the last inspection, the service was rated Good overall with a rating of Requires improvement in the Effective domain. This was because improvements were needed to the provision of ongoing support and development to staff through supervision and appraisal. We also found some omissions within daily monitoring records which could potentially have placed people at risk from less effective care being provided.

At this inspection we found the service had made significant improvements in these areas under the new manager, Staff were now receiving regular supervision and a programme of developmental appraisals had been carried out. Omissions in records had been addressed and improved monitoring systems put in place to help ensure people's needs were effectively monitored.

However, there was a need for additional improvements to the physical environment, which was scheduled to take place as part of a planned refurbishment. Also, further developments were required to enhance the dementia-friendliness of the environment.

People were safe and well cared for. Their needs were assessed and identified risks monitored, with action taken to minimise these. The safety of the environment and equipment was maximised through regular checks and servicing. People's medicines were managed safely on their behalf.

A robust staff recruitment system was used to try to ensure staff had the necessary skills and approach to provide appropriate care. Staff now received ongoing support as well as training, to perform their role effectively.

People received care based on detailed assessment and plans of care which reflected their needs and wishes. People and their representatives were involved in decision making about them and their rights and freedom were protected. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

Staff respected people's dignity, privacy, cultural and spiritual needs. People were treated with patience and kindness by staff.

The views of people and their representatives were sought through surveys, meetings and reviews and action was taken to address identified issues. People found the manager approachable and accessible and said she responded when issues were raised with her.

The service had a new manager who was in the process of applying to become a registered manager. She had already improved the consistency of care, record keeping, management governance and staff support. The manager had a clear vision of her expectations and communicated these to staff through regular meetings. Where issues had been raised they had been addressed, including the requirements of an action plan provided by the monitoring local authority.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains requires improvement. Significant improvement had been achieved in the provision of regular support to staff through supervision and in terms of greatly improved recording practice. Further redecoration was required to bring the environment up to a satisfactory standard and with respect to providing a dementia-friendly environment.	**Requires Improvement**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Care Quality Commission

Austen House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planed 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 was a comprehensive inspection which took place on 13, 14 and 15 September 2017. The inspection was unannounced on the first day. It was carried out by one inspector. We last inspected the service in October 2015. At that inspection we rated it Good overall, although it required improvement in 'Effective'. Improvements were needed in terms of staff support through supervision and appraisal, and with regard to some daily well-being monitoring records. On this occasion we found improvements had been made in these areas.

The service had submitted a Provider Information Return (PIR) in April 2017, prior to the inspection. 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.

Prior to the inspection we reviewed all the current information we held about the service. This included notifications we had received. Notifications are reports of events the provider is required by law to inform us about. We reviewed the last inspection report and contacted representatives of the local authority who funded people supported by the service, for their feedback.

During the inspection we spoke with the manager, the deputy manager and five other nursing and care staff about various aspects of their roles. We examined a sample of four care plans and other documents relating to people's care. We looked at a sample of other records related to the operation of the service, including recruitment records for five recent recruits, management monitoring systems and medicines recording. We spoke with three people receiving support and three relatives to seek their views about the service.

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 also observed the lunchtime service in

different units on two days and informally observed the care provided at various points throughout the three days of our inspection.

Good

Is the service safe?

Our findings

People were still protected because the service had an effective safeguarding process which staff understood and applied where they had any concerns. Appropriate issues and concerns had been reported, whether they related to events within the home or were to do with external services or people outside the home. Staff had received regular updates to training relating to maintaining people's safety and freedom from harm. Wherever possible, the views of the person themselves were sought as part of investigating instances of potential harm. The service had shared concerns appropriately with external agencies including the local authority safeguarding teams. People and relatives said people were safe in the service. Two people said, "I feel safe." One added, "I've not a bad word to say about staff." Another told us, "I feel safe and happy." A relative said, "He is safe here." Another told us, "He is in good hands and safe here. "

Potential risks to people and staff relating to the environment and equipment within the service, were assessed and monitored to minimise the risk of harm. The least restrictive option was considered as part of risk assessment in order that actions taken did not unnecessarily restrict people's freedom. The required safety checks and periodic servicing of equipment had taken place to ensure it remained safe and suitable for use. Where people's needs had changed, exposing them to increased risk, assessments had been reviewed to ensure effective steps were taken to address the change. For example, through consultation with external healthcare specialists when increased risk of skin breakdown or falls had been identified. Nutritional risk assessments were completed for each person and external specialist advice sought where a risk was identified.

With three minor exceptions which we pointed out to the manager, people's records seen were clear, detailed and accurate to help ensure they received the care and support they needed. The manager undertook to address the identified inconsistencies in the records. Some people sometimes required support with their behaviour, to minimise the risk of harm to themselves or others. This support was provided consistently in accordance with written behaviour support plans with which the staff were familiar.

To help ensure consistency of care, the manager had established dedicated teams of staff for each unit. Staff also worked 'long days' from 8am to 8pm with breaks to maximise the continuity of support provided. An appropriate skill mix of staff was provided in each unit. Each shift was led by a nurse, working with senior carers, carers and activities staff, supported by cleaning, maintenance and catering staff. Some people and relatives commented staff were often over stretched and felt there was a need for additional staff, particularly in the units for people living with dementia. One relative commented, "Staff ratios, especially upstairs, don't sufficiently reflect care needs. Demands on staff are high." Another observed the service was, "Short of staff, always. They always seem to lack back up for sickness." They added, "Staff do as well as they can but there are too few." The manager had identified this through the use of a dependency monitoring tool and had submitted a request for two additional care staff posts to the provider. The manager had also improved staff deployment to make more efficient use of available staff. We saw and were told the process of getting people up in the mornings could be delayed at times, by current staffing levels. The fact that some people opted to have their breakfast in bed may also have impacted on this, as it might have delayed their

receipt of personal care until later in the morning. There were times when no staff were available within communal areas to provide immediate support to people which could lead to a delay in them receiving the support they needed. Additional staff would help alleviate the pressure on staff at key times of day.

The provider had a robust recruitment system to ensure as far as possible, the suitability of staff for their role. The records showed this system had been applied rigorously. For example, the reasons for any gaps in people's employment history had been explored with them. The required records of the recruitment process were in place. Staff retention had improved recently with only one staff leaving over the three months leading up to this inspection. The service had successfully recruited to all existing vacancies plus an additional 15% over the assessed complement to allow for staff holidays.

People still received their medicines appropriately because the service had an effective system to manage these on their behalf. None of the people supported were able to manage their own medicines. Medicines were managed via a nationally recognised monitored dosage system. This provided the service with most medicines pre-dispensed in separate labelled doses for the relevant times of administration. Medicines were only administered by trained nurses, who attended regular training updates and whose competence was reassessed at least annually. Records and storage were appropriate and any un-required medicines were correctly destroyed. Controlled drugs, which require specific systems for recording and storage, were managed in accordance with these. When medicines were administered, 'when required', appropriate records of this were kept. Individual administration protocols for anxiety medicines described the circumstances for their administration and any other interventions which were to be tried first. Individual protocols described how people expressed pain, to help ensure they received painkillers when they required them. Where medicines errors had occurred (one in the previous three months), they were fully investigated to learn any lessons for the future.

People were provided with a clean environment to reduce the risk of cross-infection. Domestic staff worked to maintain good standards of hygiene. Staff used appropriate personal protective equipment when providing personal care. We saw staff changed gloves and aprons as required, between tasks. For example, between providing personal care and giving mealtime support.

The management team met daily. They discussed, monitored and reviewed accidents and incidents to identify any learning, in order to reduce the risk of recurrence, where possible. Appropriate steps were taken to reduce identified risks. For example, through the provision of specialist mattresses where an increased risk of skin breakdown had been identified.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection we rated the service "Requires improvement" in this domain. This was because staff had been provided with insufficient support and development through systems such as one to one supervision and appraisal. We also found some omissions within daily monitoring records which could potentially have placed people at risk of receiving less effective care.

At this inspection we found the manager had set up an effective supervision and appraisal plan to help monitor their delivery. This scheduled the five one-to-one supervisions and annual appraisal, expected by the provider and showed these were 90% up to date. Staff had been receiving regular supervisions and felt supported. We found daily monitoring records, such as dietary and fluid intake charts were in place where necessary and their completion and monitoring had improved. For example, fluid intake records specified the daily target, the achieved input and actions to address any significant shortfalls.

People and relatives were complimentary about the effectiveness of the service and were generally happy about the ability of staff. One person said, "I can't fault it so far, staff are excellent, they have to work hard." Another told us, "Most of the staff are top of the tree, but some [staff] have favourites. They are mostly very nice, all very good." A third person said, "The nurse lead is fantastic and very attentive, he offers and encourages." Two relatives did comment that not all staff had been reliable at passing on information they had been given. Daily seniors meetings, instigated by the manager, discussed peoples' needs and highlighted identified concerns. We saw this provided a forum for sharing key information. One relative commented, "The staff do their best". Another said, "The service is nice." Relative's feedback via an external rating website scored the service 4.6 out of 5 over the past year. Comments included, "Exceptional group of nurses and carers," and "Care and nursing staff are first rate, demonstrating good observational skills, patience, respect, constant and ongoing care and concern."

The environment was not yet fully optimised for the needs of people with dementia. The provider was working towards this through the implementation of their dementia strategy. This incorporated ideas from recognised national dementia care organisations. The two upstairs dementia units in particular, were undergoing a programme of refurbishment and adaptation to maximise their suitability. Recent damage caused by a roof leak had slowed this process to some degree, but work was under way to address the improvements in these units.

The units had been designed to provide a square corridor layout around a central outlook onto the ground floor or courtyard garden. This provided people who liked to walk with the opportunity to do so, without finding confusing dead end corridors. However, further work was awaited with regard to enhancing the colour scheme and other aspects of décor, for the needs of people living with dementia. Some period pictures and photos were provided together with some three dimensional tactile images, but again these aspects could be further developed.

The units provided a choice of private or communal space and a number of dementia adaptations, such as drawer units for people to rummage in. However, these contained very few items so far and needed repair to

some of the drawer knobs so were not yet effectively utilised. A few other vintage items were located through the building, which would be familiar to people, such as old cameras and a manual sewing machine. Some dementia friendly signage had been provided and some aspects of the colour scheme promoted orientation. For example the contrast colour of toilet and bathroom doors. However, other things such as optimally coloured toilet seats and handrails had yet to be provided. The manager told us there were plans to provide memory boxes beside people's bedroom doors to help them locate their room and for bedroom doors to be painted in a contrasting colour to the walls. Ensuite toilet doors within bedrooms were already painted in this way to assist this.

People's needs were identified by means of a thorough assessment and included within detailed care plans, which were available to, and used by the staff. Care plans and associated documents were subject to regular review to ensure they remained current. A resident of the day scheme in each unit, helped ensure each person's needs were frequently reviewed. Letters on care files showed relatives were invited to contribute to people's care reviews.

Staff received a thorough induction and training programme to equip them for their role, leading to completion of the nationally recognised 'Care Certificate'. All staff received training on 'dementia awareness' and 'managing challenging behaviour and distress reactions,' as part of their induction. We saw staff intervened effectively on a number of occasions to support people who were becoming agitated or distressed. Training was regularly updated and backed up with observations of competency. Staff had received regular ongoing support through one to one supervision and annual appraisals. Nurses were provided with opportunities to maintain and update their professional competencies.

People's rights and freedom were safeguarded by staff. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found the staff worked to involve people where possible in decision making. Where significant decisions had been made on people's behalf in their best interest, this process was being recorded. The manager told us she was still working to ensure proper documentation of all best interest decisions across the service, but this was in hand, via new best interest care plans being put in place.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the service was working within the principles of the MCA. Consent was sought as far as possible before care was delivered. Where people did not have the capacity to make more complex decisions the service had applied for DoLS. The views of family and other representatives were give due consideration.

The service worked effectively with external healthcare specialists, including the 'falls', 'speech and language', 'tissue viability' and 'community mental health' teams. Advice and guidance was sought and followed, through its inclusion in the person's care plan. People's health care needs were effectively met and their wellbeing was monitored on an ongoing basis and regularly reviewed to identify significant changes. The healthcare records system supported this monitoring and demonstrated its effectiveness. For example, one person's skin integrity risk assessment showed the care given had significantly lowered the risk score over their time in the service, from sixteen down to seven.

One person said of the meals, "The food's very good, no fault with the food," and added that they enjoyed

the wine with lunch on 'fine dining' day. Others said, "The food is ok," and "food's fantastic," adding that the soup wasn't very good or popular. People were supported to eat and drink sufficient to maintain their health and wellbeing. Mealtimes were not rushed, enabling people to eat at their own pace. Where prompting or assistance was necessary, this was provided, although not always by staff who had time to sit with the person. Meals were appropriately spaced throughout the day and snacks and drinks were available and offered in between. Special diets and pureed meals were provided where required. The daily menu provided a three course lunch with choices for each course. Dining tables were attractively laid to promote appetite and encourage people to eat. Some food related pictures were present although there was room for improvement in this aspect. Once a week staff provided a 'fine dining' lunch where they provided restaurant style table service to make the mealtime special.

Communal lounges and dining rooms were attractively decorated and furnished to provide light and airy spaces. Each unit had a spa bath and a wet room shower to provide both options to people. Bedrooms all had an ensuite toilet and were equipped with a range of adjustable beds where necessary to allow for people's needs. Specialist mattresses were provided where skin integrity was at risk and other state of the art 'turning' equipment was being obtained.

The garden provided some level areas and paths, as well as raised beds. The changes of ground level in one area meant the space could not be fully utilised, safely, although other level areas, including an enclosed courtyard were provided.

Good

Is the service caring?

Our findings

People and relatives said people were treated with kindness and patience by staff. One person said, "Everyone is very kind. Staff are respectful and patient, I get up when I want." Another said staff were, "very kind and supported their dignity." A relative told us care and nursing staff were, "First rate, regarding professionalism, respect and patience." They added regarding activities, that "What is done is positive and led by people who show respect to service users." Staff received training on respect and dignity as part of their induction and through computer-based training.

We carried out various observations during the inspection to see how staff responded to people and whether their needs were met in a timely way. Staff responded quickly and positively to support people who became anxious and calmly supported them to become more relaxed. Where additional support was needed, this was available and provided by colleagues. People responded positively to being acknowledged by staff, and some staff engaged people in activities. People were given time and were listened and spoken to with empathy and respect. Staff were familiar with individual's likes and preferences and worked in accordance with these. Because people were regularly assessed for their level of pain, this was minimised to improve their quality of life.

People were asked what they would like to do and where they would like to spend time. One person confirmed this, saying, "Staff ask where I want to be, as I need escorting." Where people could not easily convey their wishes, staff used their knowledge of them to try to meet these. If they met with resistance, they tried alternatives to seek to meet the person's needs. While escorting people, staff chatted to them in a relaxed and friendly way, using positive voices and encouragement. While transferring people with the hoist, staff offered reassurance and described what they were doing, to reduce anxiety. At lunchtime, people were shown plated meals to help them make a meaningful choice, rather than just being asked verbally. People's relatives and others were made welcome. Where relatives wished to provide some of the support to a person, this was facilitated by staff. The views of relatives were appropriately taken into account where people were unable to make their own decisions.

A person told us staff, "Look after my dignity. I get on with all the staff. They all chat, we get on well. They always knock if my door is closed." A relative told us, "Dignity is positively maintained," although they recognised people could sometimes resist the support offered with this. Another relative said staff, "Look after dignity well, they leave and try again if [name] is reluctant. Staff are very good with him." Resident's meeting minutes also referred positively to the way staff supported people's dignity. People's wishes and preferences were sought as much as possible, and recorded to enable staff to treat them as individuals. These were recorded in a life history document within the care plan file, although not all had been fully completed. Although people could not recall being asked, their files noted whether they had a preference regarding the gender of staff providing their support. Where people could do things for themselves such as washing or eating, staff enabled them to do this to support them to maintain their skills. We noted the covering over an old glazed panel in one person's bedroom door was missing, compromising their privacy and dignity. We drew this to the manager's attention and it was addressed immediately.

Confidential information about people and staff was stored securely to maintain their privacy. Information was shared with staff on a need-to-know basis. For example, details about people's finances would only be known to specific staff who needed this in the course of their job role.

People's spiritual needs were identified and provided for through visiting clergy. A vicar visited monthly to hold services and provide Holy Communion for those wanting this. One relative brings in items of spiritual relevance to their family member to support their needs. The manager told us that activities staff or relatives could provide people with support to attend external places of worship if this was desired. Relevant religious festivals had been marked and celebrated, including Easter, and Diwali.

The service provided appropriate end of life care and sought the views and wishes of people and their representatives as much as possible to try and ensure they were respected. Feedback from relatives suggested the service provided good support to people and families around end of life care. Existing systems of pain management and assessment helped to ensure people's pain was effectively managed as part of end of life care.

Good

Is the service responsive?

Our findings

People received personalised care because staff knew them well and had access to detailed care plans which spelled out their needs. Care plans included information about how to provide support to people, as well as what they required support with. They also included examples of detailed knowledge such as one person's soap preference.

The views of people, their legal representatives and relatives were sought and acted upon appropriately to help ensure their needs were met. Care plans were supported by relevant risk assessments to address potential risks to their wellbeing, and included any necessary actions arising from them. Where specialist external advice was needed, this was sought from healthcare specialists and their advice incorporated in the care plan. For example, the service liaised with the NHS Trust 'Rapid response and treatment' (RRaT) team to ensure early health interventions to reduce hospital admissions. The team also provided additional specialist training to staff working in the service.

Care plans and associated documents were regularly reviewed to ensure they responded to changes in people's needs, by means of the 'Resident of the day' scheme in each unit. This entailed a holistic review of the person's wellbeing and any changes in their support needs. Staff were responsive to people's individual needs. For example a relative told us their family member tended to be up a lot at night-time, walking around. They said staff spent time with him, chatting, offered him snacks and sat with him, rather than just ushering him back to bed.

Staff usually kept relatives appropriately informed. One relative told us that messages were not always passed on by staff, but felt they were generally kept well informed of their family member's wellbeing. A relative with power of attorney was happy they were properly involved in care planning and review discussions. Another relative was happy about communication and said, "If you say something, they listen and pass on information OK."

The service sought information on people's previous hobbies and interests as part of planning an activities programme which provided for their social and cultural interests. People's participation was recorded to identify any who might be missing out or at risk of becoming isolated. One relative said people might benefit from additional outings being provided. A second relative was happy that staff tried to encourage their family member to become involved in activities, despite their reluctance to take part. Another relative told us staff danced and sang with their family member, which they enjoyed, although they didn't want to take part in other activities. People were happy with the activities and outings provided. One person told us, "I join in with the activities, I also spend time in my room." Another person said they, "have not really taken part in activities if they involve moving about, but they read a lot." Other people said, "I enjoy the activities here," and "There are plenty of activities going on." They went on to talk about ball games and a quiz and said they had been on outings, most recently to an aerodrome.

The activities programme was publicised via notice boards, although the format used to display the schedule of monthly planned events was rather hard to read. Upcoming events included a visit by a mobile

zoo, a fashion show involving people and staff, a Halloween fancy dress party and a bonfire night celebration. A visiting speaker had also been booked to present a talk on Alzheimer's disease for relatives. The manager planned to introduce a 'wishing tree' scheme for people to identify one thing they really wanted to do, which staff would then facilitate.

A range of activities was offered led by a team of three activities staff, supported by care staff, when possible. We saw some activities take place, including a 'Gentlemen's club' coffee morning, a beanbag game and some one-to-one time with people who tended not to join with group activities. One of the activities staff was off sick on the first day of this inspection, which had some impact on what was provided that day. However, the manager obtained an agency member of staff to help provide them.

People's friendships within the service were supported and encouraged. For example, we saw staff engaged two people who were known to be friends, in a joint activity, which they clearly enjoyed. This meant they sustained the activity even when the staff member had to leave them to deal with another incident. People who got on well together were able to sit together in the lounge or dining room. Where people did not get on, staff worked to try and minimise the risk of confrontations and monitored the whereabouts of individuals. Staff responded promptly when a person had a minor fall and supported them back to their chair having checked for injury.

The service had a complaints procedure which was posted on the notice board and was included in the information given to people when they came into the service. People were positive about the service. One person told us, "I have nothing to complain about, I would talk to one of the nurses." Two other people said, "I've not had to complain," with one adding, "although the laundry can be a bit slow." Another commented, "I would complain if necessary, I would go to the top, but I have not had any problems."

The manager responded positively to complaints. A relative had expressed concerns about a behavioural issue which was impacting on their family member. The manager took appropriate steps to address this. The relative felt the new manager was more responsive than previous managers had been. Another relative commented there had been lots of changes made but they had no complaints. They too found there had been a faster response to issues. Positive actions had been taken arising from feedback from people and relatives. For example, activities, outings and events had been increased, together with improved records of people's participation.

Good

Is the service well-led?

Our findings

The service had a recently appointed manager who was in the process of applying to become the registered manager. 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 manager had clear ideas about the care she wished the service to provide and had established systems to enable her to monitor service delivery and outcomes for people. For example, monthly analysis of pressure damage injuries was recorded to highlight people requiring additional specialist support. Similar monthly reporting was required on people's fluid and nutritional needs, whether they were met and the actions taken where this was not the case. Clear guidance was provided to staff on reporting any issues, concerns and errors. For example, new guidance on reporting medicines errors, omissions or near misses. The manager monitored Deprivation of Liberty Safeguards applications to ensure these were re-applied for in a timely way.

The senior staff met daily to share clinical information and other issues as well and there were daily handovers to care staff. The manager regularly completed walk-arounds and it was evident she was familiar to people in the home. Clinical leads met for monthly governance meetings regarding their areas of responsibility and were expected to provide written records to demonstrate effective monitoring and action.

A representative of the registered provider carried out two day monitoring visits in alternate months as part of its governance responsibilities. They provided the manager with an action plan to address any issues found. These were then followed up at subsequent visits. The manager understood her legal responsibilities and the reporting requirements to the Care Quality Commission. Confidential data about people and staff was stored appropriately. Copies of all of the forms which staff might need to complete in the course of their day were available in the deputy manager's office.

One person told us, "The new manager is more attentive and speaks to people." Relatives said the manager was accessible and supportive. One relative told us, "The new manager is a good listener and works late." Another told us the manager held regular resident's and relative's meetings. The move of these meetings to evenings, meant they could not always attend, but were pleased minutes were now provided. They said things that previously took time to be sorted out, now received a faster response and the service was now, "developing." Another relative said the manager was, "Very nice, better than recent ones, and responsive."

The manager ensured staff were supported to maintain and develop their skills and in the day-to-day execution of their roles. For example, through encouraging regular training updates. She also ensured staff received ongoing support through regular supervision meetings and annual appraisals. An employee of the month scheme also promoted good practice, voted on by people, relatives, visiting professionals or their team colleagues. Staff 'champions' had been appointed to take the lead on key areas such as falls, dignity, safeguarding and documentation, to promote good practice. Staff worked collaboratively and supported

each other when managing any issues that arose. One staff member said that communication between team members was good and, "Colleagues are supportive, the new manager is very supportive, she listens to us." Another described the manager as, "Firm but supportive," and added, "She has sorted the staffing out, it's really positive now."

A survey of the views of people and their relatives had been carried out on behalf of the provider by an external company in 2016. The 2017 survey was due to be sent out imminently. Feedback from the 2016 survey, under previous management, was less positive than in 2015. An overall satisfaction rating of between 75 and 77 percent resulted, from both people and relative's feedback. The issues arising were reflected in the involvement of the local authority in a series of monitoring visits and formed part of the action plan which the new manager had been working to address. Significant progress had been made in all areas and the manager felt this year's survey would reflect this. The local authority was happy with the progress made and was now monitoring to ensure that the identified improvements were maintained.

Relatives meeting minutes reflected improved feedback recently, including positive feedback about the role and impact of the new manager. They noted improved staffing levels and consistency and a calmer atmosphere in one of the dementia units. A programme of significant redecoration was also under way and had received positive comments. Feedback from people, relatives and others had led to various improvements to the service. These included better management governance, improved records of management monitoring and more consistent staff deployment to improve continuity of care. The activity and events programme had also been improved and better records now existed of people's participation.