

Sefton New Directions Limited

Sefton New Directions Limited - Chase Heys Resource Centre

Inspection report

26 Chase Heys
off Bibby Road, Churchtown
Southport
Merseyside
PR9 7LG

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Tel: 01704214279

Ratings

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

Summary of findings

Overall summary

Sefton New Directions Limited – Chase Heys Resource Centre is a purpose built establishment providing accommodation and personal care for 30 older people. The service has 19 respite places and 11 intermediate care places (these are places supported by rehabilitation services from the local NHS provider.) The service accommodates people across three separate units. At the time of our inspection there were 15 people using the service.

Sefton New Directions Limited - Chase Heys Resource Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

This was an unannounced inspection which took place on 8 June 2018. The last inspection was on 4 and 5 October 2017 when the service was rated as 'Required improvement'.

The service had a registered manager in post. A registered manager is a person who has registered with the CQC 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.

At our last inspection, we identified breaches of Regulations 12 (safe care and treatment), Regulation 16 (receiving and acting on complaints), Regulation 17 (good governance), and Regulation 19 (fit and proper persons) of the Health and Social Care Act (Regulated Activities) Regulations 2014. During this inspection we checked to see if sufficient improvements in these areas had been made and we found that they had.

At our last inspection, the way staff were recruited was not always robust. This was because the required pre-employment checks necessary to ensure staff were suitable to work with vulnerable adults had not always been made. At this inspection, we saw that this had been addressed. We looked at the recruitment records for three members of staff. We saw that each staff member's suitability to work at the home had been checked prior to employment.

At our last inspection we found that some medication administration records (MARs) could be improved upon with regards to being double signed. Most MARs had been double signed by two members of staff as best practice to help ensure a correct record of medicines but three had not. Medication storage facilities for people who self administered their own medication also required improvement. During this inspection we found that people's MARs were now completed appropriately and that people who self administered their own medication had safe storage facilities to ensure their medicines were kept secure at all times.

At the last inspection we found that the care plans belonging to people in receipt of intermediate care were not fully developed with regard to people's care choices. In addition, some people told us that they did not

always receive a bath or shower when they had asked for one.

We looked at the care records belonging to four people. We saw that they contained a detailed assessment on people's admission to the home. This helped to identify people's requirements and preferences in relation to their care, whether people preferred a bath, shower or full body wash. People's choice and preferences were also now reflected in other areas of their care plan for staff to be aware of. For example, the types of food people enjoyed and how they preferred their tea or coffee to be prepared were specified.

At the last inspection, we found that quality assurance processes to seek the views of people using the service and their families were not always collated or used to improve the service. At this inspection people's suggestions and opinions on the service had been sought and acted upon where practicable. For example, more choice had been provided at mealtimes in response to people's feedback.

During our last inspection people's complaints had not always been handled appropriately. During this inspection we saw that improvements had been made. The manager and provider had responded to any complaints received about the service appropriately.

During our inspection we saw that staff supported people in a person centred way and treated them with respect. People we spoke with including relatives said that staff had the skills and knowledge to ensure people received adequate care. When we checked some staff training records however we found that some staff training needed updating. We saw that the manager had made arrangements to address this.

People we spoke with using the service told us they felt happy and safe. People were positive about the care they received and the staff team.

We found that there were sufficient numbers of staff on duty to meet people's needs. People told us that friends and relatives could visit them at anytime.

Staff we spoke with were able to describe how they would recognise abuse and the action they would take to ensure people were protected from harm. Staff were aware of the importance to report any concerns they had.

Staff sought consent from people before providing support. Staff we spoke with understood the principles of the Mental Capacity Act 2005 (MCA) in order to ensure people consented to the care they received.

Appropriate arrangements were in place for checking the environment was safe. For example, health and safety audits were completed on a regular basis and any accidents and incidents were reported and recorded appropriately.

People felt involved in their care and there was evidence in their care plans to show that they had been consulted about decisions. People were supported by a range of other health care professionals, for example, GPs, district nurses, physiotherapist and occupational therapists.

The service employed a designated member of day care staff who facilitated varied social activities and people told us they were able to take part and have a say in what activities that they would like to do.

We asked people about how they thought the home was managed and their feedback was positive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Staff had been recruited safely and there were enough staff on duty to ensure people's needs were met.

People's medicines were ordered, stored and administered in line with good practice and staff had received training to administer medications safely.

The premises were safe and well maintained.

Is the service effective?

Good ●

The service was effective.

Staff were supported to do their job role through training and supervision.

People were supported with their dietary needs and got enough to eat and drink.

Although people using the service had capacity to make decisions about their care, staff had knowledge of the principles of the Mental Capacity Act 2005 and knew how to apply these if required.

Is the service caring?

Good ●

The service was caring.

People told us that staff were kind and caring and treated them with respect. We observed people's privacy and dignity being protected during the inspection.

People had a choice regarding how they spent their day and we observed many people engaging in activities.

People's personal information was stored securely to maintain confidentiality.

Is the service responsive?

The service was responsive.

People were involved in decisions around their personal care and people's needs were met by a range of health and social care professionals.

There was a complaints procedure in place and any complaints received were responded to appropriately.

Systems were in place to gather feedback from people who lived at the home.

Good 

Is the service well-led?

The service was well led.

A range of audits were carried out to monitor the quality and safety of the service. Where issues had been identified we saw that they had been acted upon.

Feedback regarding the management of the service was positive. The registered manager knew the service well and was committed to continuous improvement.

Good 

Sefton New Directions Limited - Chase Heys Resource Centre

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 was an unannounced inspection which took place on 8 June 2018. The inspection team consisted of an adult social care inspector and an assistant inspector.

As part of the inspection process we reviewed information we held about the home such as the statutory notifications sent to us by the provider. Statutory notifications enable the provider to inform us of any significant events which have occurred at the service, the provider must send this information to us by law. We also contacted the local authority to ask for their views.

During the visit we spoke with six of the people who lived at the home. We spoke with three members of staff, the registered manager, the deputy manager, the team leader and the head of quality and compliance.

We looked at the care records belonging to four of the people, a sample of people's medication administration records, three staff recruitment files and other records relevant to the management of the service.

We undertook general observations of the service and the care people received.

Is the service safe?

Our findings

At our last inspection in October 2017 we found breaches of Regulations 19 and 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because staff recruitment was not always robust and the management of medication was not always safe. Some staff members had not had a criminal conviction check or appropriate previous employer references obtained prior to employment. This meant that the provider had not done all that was reasonably practicable to ensure the staff members were safe and suitable to work at the home prior to employment.

During this inspection we looked at the recruitment records belonging to four members of staff. We saw for one staff member their job application form was missing. On another file a reference was missing. We asked the manager about this and they told us that this information was stored electronically. They provided evidence to confirm this. We saw appropriate action had been taken and improvements had been made as to how staff were recruited.

At the last inspection we saw that medication was not always managed safely. This was because some medicine charts had not always been checked by two members of staff and some people living at the service kept medication in an unlocked cupboard in their bedroom. During this inspection we looked at the systems in place for managing medication in the home and saw that improvements had been made.

Most of the people living at the home had capacity to make their own decisions about their medication. Self-medication was encouraged by the manager as some people living at the home were only living for short periods of time before returning home and so supporting people to manage their own medication promoted independence. One person told us, "I self-medicate; the staff checking [the medicines] are very good. They make sure [the medicines] are safe."

People who self-medicated kept their medication in their own bedroom, we saw a locked cabinet and drawer was provided in people's bedrooms so this could be stored safely. We saw that the service checked the medication kept in people's bedrooms four times per day to ensure that the correct amount of medication was being taken by the person.

We saw that staff had received training in how to administer medication safely and that their competency to do so had been assessed each year. We saw that a medicine policy was in place to advise staff on the provider's medication procedures and we also saw that staff had access to nationally recognized best practice guidance on the administration of medication.

MAR (medication administration records) charts contained information about people's allergies with regards to medication to ensure people were not prescribed unsuitable medicines. We observed that although application of topical medication (such as creams) was completed on topical MAR charts, there was no information on the chart about how often the person should have their medication. MAR charts were hand written due to the acute nature of the admissions and high turnover of people using the service. We saw that the majority of MARs had been checked and signed by two members of staff to ensure that the

handwritten entries were correct. We drew the manager's attention to those MAR charts that had not been signed by two members of staff so that this could be addressed.

Medication was stored safely in a locked clinic room. The temperature of the room and medicine fridge was recorded daily to ensure that medicines were stored at safe temperatures. This is important as if medication is not stored at the correct temperature it may not work as effectively.

Controlled medicines are prescription drugs that are subject to the Misuse of Drugs Act and other relevant legislation. We found that they were stored correctly and regular checks were made to ensure that the stock of controlled drug medication was left correct.

We saw that PRN (as and when required) protocols were in place for some medicines to help ensure people received their medication when needed. PRN medications are those which are only given when needed for example for pain relief. We saw that people's MAR charts reflected when had been administered to then and the reasons why. This was good practice.

We observed staff administering medication and saw that this was carried out safely. We also saw that the staff member administering the medication had protected time and wore a tabard saying 'do not disturb medication round in progress'. This helped reduce the risk of medication errors occurring as the staff member was not interrupted.

We looked at how the service was staffed. On the day of inspection there were five care staff, the registered manager, the deputy manager, the team leader, an administrator, a designated member of day staff for activities, a maintenance person and two general domestics on duty to support 15 people who lived at the home. During the inspection our observations showed that staff were visible and offered assistance in a relaxed and timely manner. We looked at staff rotas which showed that staffing levels were consistently maintained. People told us there was sufficient numbers of staff to provide support. Some staff told us, "There is enough staff at the moment for the amount of people we have. When 'the [residents] board' is full, we might struggle a bit but if there is staff shortage, we sometimes use bank staff".

We found staff carried out assessments to manage clinical risk so that people could be as independent as possible. For example, on admission to the home, people were assessed regarding their ability to self-medicate. We saw people were given choice and that a full risk assessment was carried out to assess whether they could manage their medication safely. In addition, people's mobility was also fully assessed to determine the level of support required by staff which also promoted independence and safety.

People we spoke with during the inspection told us they felt safe at the home. One person said, "Staff keep me safe, they always do". We observed a member of staff giving a person a 'pendant' to wear while in the garden, when pressed this alerted staff that the person required assistance. This was good practice.

We looked at accident and incident records and saw that accident and incidents were recorded and responded to appropriately.

A safeguarding policy was in place for staff to follow should a safeguarding incident occur. The staff we spoke were knowledgeable about the different types of abuse and how to report any concerns. A staff member told us, "Safeguarding means to protect that person. I know about the different types of abuse. If I had concerns, I would speak to my line manager, who would then speak to the manager. I am confident if there was concern about a [person using the service] something would be done about it". Another member said "Safeguarding means keeping people safe. It covers issues and abuse. Notice 'those signs' [of abuse],

whistle-blow when needed, stepping in and taking it to the senior or manager. We document it in the monitoring charts. I have not had to raise any concerns."

Audits were in place for checking the environment to ensure it was safe. For example health and safety audits were completed in order to identify any hazards. During our inspection we observed that the door to the laundry did not have a lock, as the laundry contained detergents and cleaning products, this was a potential hazard for people using the service. The manager informed us they would have a lock fitted to the door. A storage shed had recently been constructed in the garden and there was some building debris left on the floor. We pointed this out to the manager who informed us the work was not yet complete but that they would have the debris removed.

External contracts were in place for gas, electric, fire safety and Legionella. All certificates were in date. Regular internal checks were also completed, such as fire alarms checks, water temperatures, automatic door closure devices, call bells and window restrictors. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) in place. This meant that staff and emergency personnel had important information on people's needs in an emergency situation and the support they required to evacuate in the event of an emergency. This was kept on the outside of people's bedroom doors to ensure it was easily accessible.

The home was clean and well-maintained. There were infection control audits in place which identified any areas for improvement.

Is the service effective?

Our findings

We saw that staff knew people well and supported people in a safe and effective way. One person told us, "Everything staff do, I appreciate it, staff are well trained to look after me."

For people on intermediate care, care plans were drafted with specific rehabilitative goals prescribed by visiting health professionals such as district nurses, physiotherapists, occupational therapists and GPs. The registered manager told us, "There is nursing care on intermediate care. That is done by nurses, but the nurse might leave plans for care for staff to follow, such as wound observations etc." Although care plans for people on intermediate care recorded people's desired outcomes and goals, there was no record of how the service would achieve them; we fed this back to the manager who informed us they would develop this area further.

Care plans showed evidence of the person's involvement in the admission process. A senior staff member told us "We have an assessment for every 'service user'. We do a full process, family and 'carers' also come". Staff recorded people's medication on admission and other health details and requirements for care and this was usually signed by the person. In some care plans we noted they had been signed by the team leader, we pointed this out to the manager who informed us they would ensure all people would sign their own care plan going forward. There were daily notes from the care staff which detailed all care carried out.

For those people in receipt of intermediate care before returning home, we saw that there was a gym in the home which contained a range of equipment to support their rehabilitation. There was also a kitchen where care staff and external visiting health professionals ran a 'breakfast club' in order to provide support for people to regain independence and confidence in this area before going home.

We saw that some people in receipt of respite care would often return to the service for a further period of respite care. If they did not return within six months of their initial stay then the home would carry out a new assessment to determine if any changes in the person's needs and care had occurred. This was good practice as it ensured that the care provided was changed to meet the needs of the person where required.

People we spoke with felt that staff had the skills and knowledge to meet their needs. Records showed that staff members received appropriate supervision in their job role and that an appraisal of their skills and abilities was undertaken each year. We asked staff how often they had supervision meetings. Staff told us, "I had one two weeks ago and one six weeks before that. I feel listened to, at least." Other staff confirmed they had regular supervision, "It is a chance to speak, get things off your chest."

The manager provided us with information on staff training. We saw that training was provided in a range of health and social care topics such as health and safety, medication, safeguarding, whistleblowing, infection control and fire awareness. Although all of the staff team had completed training, some staff had not updated this training since 2013. We discussed this with the manager. They told us they were aware of this and provided evidence that they had already organised for those staff members to attend refresher training in the next few months.

We noted that staff meetings were held regularly and staff were able to have an input into the agenda. These meetings helped ensure staff could feel supported and provided any feedback to the registered manager. We saw minutes of staff meetings were recorded.

A new magnetic menu board which showed pictorial images of the menu for that day was displayed in the dining room. A weekly menu planner was on the wall and individual menus provided on dining room tables for people to refer to. We saw people had two menu options for their main meal and that they could have an alternative if they did not like either of the two options on offer that day. We saw that the range of menu options available to people had been improved upon following people's feedback on the lack of choice at mealtimes. One person we spoke with told us, "There is not enough variety when it comes to food. Since I came here, I have never had any rice or pasta. They do make me something else though. Like tonight, it is cheese on toast, so they are doing me spaghetti instead."

We joined people for lunch and found there was a choice of main meal available and a dessert. Lunch was a mixed grill followed by upside pineapple pudding and cream which people seemed to enjoy. At the time of our inspection a new chef was being recruited and there were plans by the manager to develop menus further in order to promote more choice. People's special dietary requirements were catered for and there was a drinks station which provided people with unlimited access to hot and cold beverages. One person told us, "There are always drinks. There are regular tea and coffee rounds, there is tea and coffee at breakfast, at 10.30 [am], 12.30 [pm], 3.00 [pm], 5.00 [pm], 7.30[pm] and 10.30 [pm]."

We looked to see if the service was working within the legal framework of the MCA (Mental Capacity Act 2005). 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The manager told us that people being supported at the home had the capacity to make decisions regarding their care as this was part of the criteria for admission. We saw examples of this such as the admission assessment were people had been supported and included to make key decisions regarding their care.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the 'Deprivation of Liberty Safeguards' (DoLS). Due to the acute nature of care being delivered the home did not support anybody who was on a DoLS. However, both the manager and senior staff were knowledgeable in this area if a referral was needed. Staff said, "[The Mental Capacity Act] is about the person, are they able to speak up for themselves and have they got capacity." We also asked senior staff how they used the Mental Capacity Act in practice, "In care plans, we ask do they have dementia or other mental health issues. If they do, we get the mental health team in. Doors are open, just at night time they are alarmed. We have best interest meetings for people if needed."

The layout of the environment was simple and easy for people to navigate around and there were plenty of communal areas to encourage social interaction. This helped to promote people's independence and well-being. We observed peoples bedrooms and had been told that the lay out of the rooms had recently been changed to create more space for people to move around. The new layout further promoted independence as people were able to fully access their furniture.

Is the service caring?

Our findings

People told us staff were kind and caring and treated them with respect. One person told us, "The care is excellent, second to none. I do not mind being here." One staff member told us, "People using the service come first."

Everyone we spoke to told us their privacy and dignity was maintained. For example, we noted that staff would whisper into a person's ear if they were situated in a communal area when offering any assistance so that other people could not hear what was being said. This ensured that people's privacy and dignity was respected. A staff member told us, "Residents are listened to. We keep their dignity and respect by always knocking on their door first. We make people feel welcome. We give [residents] '1:1 attention' and keep their door closed during personal time."

We noted that bedroom doors disclosed personal information about residents by a sign which stated what the person preferred to drink to and how they liked to take their drinks for example 'No early drinks'. We asked the manager about this and they confirmed that people consented to this information being on display and some people did not want care staff disturbing them with offers of drinks early in the morning.

We observed positive interactions between staff and people using the service, it was evident staff knew the needs and preferences of the people they were looking after. One person told us, "We are well cared for here. Staff are lovely, always smiling. That is what makes the difference."

The home was relaxed and had a welcoming atmosphere. One person told us, "It is a friendly place, could not fault it. The staff are great. Staff are kind and well-trained. I have never heard them be 'off hand' with anyone." Another person told us "Staff are wonderful. We could not fault the place, everything is great".

People we spoke with had a choice regarding how they spent their day. We saw evidence from people's care files that they were involved in choice around their care and personal preferences, for example, one person preferred to attend their own day to day personal care but preferred assistance from staff when having a bath. We saw that these choices were respected. Staff wore name badges which were easy for people to see.

We asked staff what equality and diversity meant to them. One member of staff explained, "Everybody is equal. We have a variety of staff gender-wise." We asked staff how the home was prepared to meet people's diverse needs, for example around sexual orientation. "We would do our best to accommodate." On the day of our inspection we observed a chaplain visit some of the people in the home to provide spiritual support.

During the inspection we saw that people's relatives visited them throughout the day. The manager told us there were no restrictions in visiting as long as it didn't take place when people were undergoing any rehabilitative treatments. For people who had no family or friends to represent them, we saw contact details for advocacy services displayed on the notice board. Advocacy services help vulnerable people access information and services and ensure that their views and wishes are considered.

Is the service responsive?

Our findings

During the last inspection we saw that people's care preferences for those admitted for intermediate care were not always recorded, this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we looked at care files for people admitted for both intermediate and respite care. We saw that people's care files now contained information noting people's preferences in relation to their care and treatment. For example, people could specify whether to have a bath, shower or full body wash. This meant that the concerns we had identified previously had been addressed.

Staff told us, "People usually have showers in the afternoon or evening. Everyone gets offered a bath." People we spoke to told us they could have a bath or shower if they wanted one.

A personal care chart which was in place for staff to record what support each person had received each day in respect of their personal care. Although it was evident from the daily care notes that people were having baths and showers, some of the charts were not fully completed to reflect this. We spoke to the manager about this.

Care records were maintained by staff who reviewed each person's care on a daily basis. Care files contained a pre-admission assessment which helped to ensure people's care needs could be met from the day of their admission. Some people who lived at the home were there for a short period of respite care and often returned. We saw that if a period of more than six months had elapsed since their last admission for respite care, that a re-assessment of their needs would be undertaken to ensure that any changes in their needs and care were identified before they were admitted again. This ensured the respite care provided remained responsive to their needs.

During the last inspection we saw that complaints had not been recorded and tracked as part of the complaints process. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. On this inspection we saw that people had access to a complaints procedure and this was displayed within the home. We looked at the provider's complaint records and saw that the registered manager maintained a detailed log of all complaints received in addition to any actions taken and the outcome from them. We found that people's complaints were investigated thoroughly and managed appropriately.

The home offered a wide choice of daily activities and people had a choice of what they could participate in. The manager informed us that they had listened to feedback regarding activities and had implemented table top cookery and exercise DVDs. A small greenhouse had also been purchased for gardening. Activities included bingo, charades, sing along and memory games. Activities were provided by a designated member of day care staff who worked in the home Monday to Friday. We were told activities were based on what people liked and they were open to suggestions so that people's preferences were catered for. People in receipt of intermediate care also had access to a kitchen where they could practice their skills under supervision. On the day of our inspection, people were engaged in a variety of games; this included word

games, as well as a game of "Higher or lower". Large playing cards were used so it was easier for people to see. People told us, "It keeps you stimulated." The manager told us that children from a local nursery visited once a month to participate in activities with people. This helped to promote positive intergenerational contact.

There were complimentary sets of headphones and a wide range of talking books for people to use. This helped people who had problems with their vision and were unable to read. Welcome packs in people's bedrooms also contained pictorial instructions on how to use the TV remote and call bell system. There were personal CD players and CDs available and a large selection of reading books. Some books had large print making them easier to read. Communal areas contained televisions so that people were able to watch DVDs and the manager had recently introduced 'Netflix' so that people were able to enjoy a varied selection of films. Wi-Fi was installed in people's bedrooms so they could access the internet. There was a large garden with a paved area with tables, chairs and parasols. We saw people enjoying the outside space and the manager informed us there were plans to develop this area further.

We looked at processes in place to gather feedback from people and listen to their views. We saw that questionnaires were used to gather people's opinions and suggestions about the service. For example, some people had requested greater choice of main meals and this had been acted upon. The manager had a board in the office which documented a 'wish list' in terms of what people had suggested in terms of service improvements. We saw that this list included a spa, a hairdressing salon, garden, social club and a cinema room. During our inspection we saw that the hairdressing salon was under construction which also included a nail bar where people could enjoy a manicure by a beautician who visited the home three times per week. The manager told us there were plans to introduce health and beauty students from the local college to carry out some of the treatments. There were also plans to plant flowers and vegetables in the sleeper beds so that people could get involved with gardening.

At the time of our inspection there was nobody receiving end of life care. This was because the home offered rehabilitative care and people did not live in the home for a prolonged period of time.

Is the service well-led?

Our findings

During the inspection we looked at how the registered manager and provider ensured the quality and safety of the service. A quality and compliance manager was employed by the provider and they visited the service regularly and supported the registered manager to undertake a range of audits that monitored the quality and safety of the service.

We saw that audits were in place with regards to personal care records, health and safety, fire safety, infection control, care plans, medication, compliments and complaints and accidents and incidents. The audits we reviewed were up to date and identified where improvements were required. We saw that where actions had been identified these had been undertaken.

The registered manager had been in post since April 2017. We spent time talking with the manager who was keen to develop the service further. They told us about the plans to improve the service. Areas identified for further development included - promoting the service amongst external health care professionals to make the process for people to access the service simpler. There were plans to redecorate the communal areas and corridors to make them more modern.

At our last inspection, there were no robust processes in place for people to feedback their view and opinions on the service provided. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection there were now systems in place to address this. We saw that people's feedback about the service was now used to improve the service. We saw that people's feedback about the service had been positive. Comments from people who had used the service included 'Thank you to all who looked after me, I am finding it difficult now without you'. A relative had written 'The work you do is amazing and vital to so many families'. One member of staff we spoke to described the culture of the service as "Treat people as we would like to be treated. When people leave, they want to come back again."

People's feedback about the manager was also positive. A staff member told us, "We have a fabulous manager; there have been an awful lot of changes. All are 'service-user' based and all decisions are based around the 'service users'. We have surveys on activities and things such as the gardens."

The manager had implemented regular staff meetings so that staff could have their say. Staff found such meetings beneficial as they felt listened to and had their views taken on board.

The manager had notified CQC of incidents than that had occurred in the home in accordance with registration requirements. We also saw that the last CQC report was on the home for people to refer to. It is a legal requirement for providers to display their CQC rating from the previous inspection.