Babbacombe Care Limited

Hadleigh Court

Inspection report

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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

Hadleigh Court is a long established care home without nursing, set in a residential area of Torquay, and providing care for up to 31 people. People living at the home were older people, many of whom were living with dementia.

This unannounced inspection took place on 12 July 2016, and started at 6.30am to allow us to meet with the night staff and see how people were supported from the start of their day. It was a comprehensive inspection, and was unannounced. It followed on from a focussed inspection carried out in May 2016, and a comprehensive inspection of October 2015 where concerns had been identified. You can read the reports from our last inspections by selecting the 'all reports' link for Hadleigh Court care home on our website at www.cqc.org.uk.

On this inspection of 12 July 2016 we looked to see that the improvements that we had seen in May 2016 had been sustained. We found that the improvements were ongoing, but those seen in May 2016 had been maintained. Quality and safety had improved, and risks were being managed with improved communication both within and outside of the home. Comprehensive training was being provided and the new staff team had been boosted with additional management and leadership support.

There was 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.

People were being protected because systems for the management and assessment of risks had been put in place. Where risks had been identified measures were taken to reduce these wherever possible. Internal and external audits were used to identify concerns, and where issues were identified, action plans showed the progress being made to resolve them. For example, new systems had been put into place to ensure the risks of cross infection were reduced. This included more regular audits, cleaning schedules and improved equipment. Cleaners understood their roles, and could demonstrate how a safe environment was kept maintained, and we found the home was clean, warm and comfortable. Developments were under way to make the environment more 'friendly' for people with dementia.

Staff understood how to safeguard people from abuse. There were clear policies and procedures in place and staff had received training in how to identify abuse and what to do about it. Staff told us they were clear about what to do if they had any concerns about people's safety or wellbeing.

There were enough staff to meet people's needs in a timely way. Additional staff had been provided at times of high need to make sure people received the care they needed in the way that they wished. We saw staff were skilled at identifying changes in people's needs or behaviours and taking action to reduce anxieties

before they increased. Staff told us they had received the training and support they needed to carry out their role, and although there had been a significant staff turnover recently, the staff team were working well together to protect and support people. Records identified the training given to staff and when updates were needed. Staff were positive about training. They told us the manager and training provider were approachable and would access any training they needed.

Risks relating to the recruitment of staff were identified, and a full recruitment process was being followed for new staff. Communication systems were in place including handovers and regular staff meetings. Staff we met were enthusiastic about providing good care for people, and told us they were happy with the standards of care at the home. We saw them working well as a team.

People's care files and plans reflected people's needs or wishes about their care and how this was to be delivered. Relatives had in many cases been involved in giving information about their relation's care needs, wishes and social and personal history. This helped staff understand people's behaviours and choices in the context of the life they had lived.

The home was supporting people in line with the Mental Capacity Act 2005 (MCA), and protecting their rights. Assessments of people's capacity and decisions made in their best interests were being carried out and recorded in accordance with the MCA. People had access to the community healthcare services they needed and positive relationships were being built with the local district nursing teams. Many people living at the home had complex needs for care with both physical and mental health needs. We saw that prompt referrals were being made for professional support when needed, for example to support people with distressed behaviours.

People were being protected from the risks associated with medicines. Staff had received training to administer medicines and had clear protocols in place for the administration of 'as required medicines. The home had worked with local GP practices to review and reduce people's medicines which had resulted in improvements in their health.

People ate a good diet, with meals reflecting their preferences. Where people needed support with eating this was provided sensitively, and where people needed additional supplementation to maintain a healthy weight referrals were made to dietician or speech and language services.

Staff were caring and people told us they were kind. We saw good relationships in place, with staff trying to understand people's needs and respect their individuality. People's dignity was being respected with attention paid to clothing, and grooming. Staff had guidance available on how to respond to people's communication needs. Systems were in place to respond to any complaints.

Records, policies and procedures had improved. People's care plans reflected their needs, wishes and aspirations regarding their care in more detail, and policies and procedures had been updated. The home had returned to using a paper based recording system, as a trial of a computerised system had not been effective in improving the quality or accuracy of the care plans. The plans that we saw were up to date and were being used by staff. We saw that they were reflective of the care being delivered.

People had opportunities to take part in activities, including twice weekly outings. People were encouraged to have a say in the activities provided, and tailor them to meet their interests where possible. We saw staff interacting with people and discussing activities that had been undertaken.

Quality assurance systems and feedback had led to improvements for people. For example changes had

been made to improve the environment and people were enjoying more trips out. Feedback from people living at the service or visiting was positive about the changes being made.

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

Risks to people's care were being assessed and mitigated. Risks from the environment had been identified and were being addressed.

Staff understood how to safeguard people from abuse.

Medicines were being managed well.

Staff recruitment processes had been strengthened to help protect people and provide greater assurance of the character and work performance of the staff member in their previous role. There were enough staff to support people and meet their needs.

Is the service effective?

Good

The service was effective.

Staff told us they had the skills and training they needed for their job role and were knowledgeable about people's care needs. Staff had not received regular supervision, but told us they felt supported by the home's management at all times. Systems were prepared to re-establish the supervision systems following a significant change in the staff group.

The service was supporting people in line with the Mental Capacity Act, and protecting their rights. Assessments of people's best interests were being carried out where they lacked the capacity to make a decision.

People received support from community healthcare services. People were supported to make choices about meals and ate a balanced diet.

Work was being undertaken on the premises to provide a more comfortable environment for people. This included people living with dementia.

Is the service caring?

Good

The service was caring.

Good relationships had been built up between people living at the home and the staff supporting them.

Staff took time to understand people's wishes and spoke with them discreetly about their care.

Staff demonstrated respect for people's dignity and individuality.

Is the service responsive?

Good

The service was responsive.

Care files and plans reflected people's needs or wishes about their care and how this was to be delivered. Staff understood people's needs and wishes about their care.

Activities provided were aimed at meeting people's individual needs and wishes as well as those who enjoyed them in groups. Some activities were being developed to better meet the needs of people living with dementia.

The home had complaints policies and procedures for people to use to raise any concerns.

Is the service well-led?

Good

The service was well led.

Improvements had been made to the leadership and management of the home.

Risk assessment and management systems including internal and external audits had been put into place.

Records, policies and procedures had improved. People's care plans reflected their needs, wishes and aspirations regarding their care in more detail, and policies and procedures had been updated.

Action plans for the development of the service had been implemented and had been or were being completed.

Quality assurance systems had led to improvements for people.

Hadleigh Court

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and in particular to look at actions taken by the provider and registered manager in relation to the warning notice issued following the inspection of 8 and 13 October 2015.

This inspection took place on 12 July 2016 and was carried out by one adult social care inspector. We looked at the information we held about the home before the inspection visit, including the inspection history, previous reports and the action plan sent to us by the provider. We also looked at the service improvement plan being worked through with the local authority quality team, which identified progress being made, and minutes of safeguarding meetings.

On the inspection we met with the nominated individual, who is the person representing the company that owns the home and the registered manager. We spoke with three people receiving a service, nine staff members from both day and night shifts, two visiting district nurses and two visitors. We also met with a consultant the service was using, to look at the training and development plans for the home. We looked at areas of the building, and sampled policies and procedures. We viewed the changes to the quality assurance and management systems that had been made since the last inspection and sampled records including five care plans and four staff files.

We spent time observing the care and support people received, including staff supporting people with their moving and transferring and being given medicines. We spent two periods of time carrying out a SOFI observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care.

We also looked at risk assessments, minutes of meetings and feedback received and analysed from people using the service, staff and their relatives. We discussed the home's action plans and progress being made on the overall concerns identified in October 2015.

Good

Is the service safe?

Our findings

At the inspection of 8 and 13 October 2015 we identified concerns over the assessment and management of risks related to staff recruitment processes, risks to people from the care they received and risks from the environment. In May 2016 we inspected the home and saw that improvements had been made. On this inspection in July 2016 we saw that improvements made had been sustained.

People were being protected because there were systems in place to ensure any risks associated with staff recruitment were identified. The files we saw contained copies of references, disclosure and barring (police) checks and a full work history. The registered manager told us that staff would not work with people unsupervised until their full disclosure and barring check had been returned but may work alongside more senior staff following the return of an initial check. We identified that the home's systems did not identify a clear record of this and the registered manager agreed to amend them to reflect this. A system was in place for a full audit of staff recruitment files and the registered manager had recruited administrative support to have this completed and any gaps explored. Systems were in place for monitoring and addressing concerns about staff work performance where they were identified.

There were enough staff on duty to support people and meet their needs. The registered manager did not use a tool to identify staffing levels based on people's needs. However we saw that staffing levels and job roles had been altered to reflect the dependency levels at the home. People had their needs met quickly and staff were able to respond to changes in people's mood or physical care promptly. We saw for example that a member of care staff came in at 7am to support people who wanted to eat their breakfast in the dining room. Each person's breakfast was prepared individually for them as they came down, or was served to them in their rooms if they wished. There had been a significant turnover of staff at the home since the last inspection in May 2016. However, staff we spoke with told us they felt there was now a good staff team in place and that everyone was working well together.

Systems were in place to assess, monitor and reduce risks to people at the home. A room by room audit had been carried out of the environment and areas of concern identified had been addressed. For example hard corners of furniture that could present a risk were covered, and new heating systems had been provided where there had previously been electric radiators installed. These plans were being reviewed when people moved rooms to ensure they were relevant to the person. New windows were being fitted throughout much of the home, and new beds purchased that better met people's needs. Fire precautions had been upgraded in accordance with advice from the local Fire Authority.

The registered manager had increased the infection control audits at the home, put in place cleaning schedules, and purchased new equipment. A relative told us that one of the first things they had noticed about the home was a "lack of smell". All areas we saw were fresh and clean, with the exception of three bedrooms which had an odour problem which was being managed. We saw carpets being cleaned as soon as there was any concern. A cleaner we spoke with showed us their cleaning schedules and charts used to identify daily cleaning tasks. They said they had the products and equipment they needed to carry out their role. The laundry area was clean and free from a build-up of laundry, even at 7am following a number of bed

changes. Where a person had an identified infection control risk there was clear information in their care plan on how to manage this. All areas of the home seen were clean and warm. Risks from hot water were being regulated and testing of temperatures carried out regularly. The maintenance person showed us records of environmental testing to reduce risks from water borne bacteria.

Systems had previously been put in place to ensure risks to people were being analysed and had been reduced where possible. Incident forms were being reviewed by the registered manager, and it was clear if any further actions needed to be taken. We checked through people's care plans and found where they had fallen there was clear information about recent falls and actions identified to ensure the incident did not happen again. However we also identified a recent fall that had not been seen by the registered manager. This was immediately addressed, and the registered manager took steps to increase the robustness of the system.

Concerns about people's health and wellbeing were being raised appropriately with other agencies, such as the district nursing team, GPs or speech and language services. District nurses we spoke with told us they were visiting the home every day and the home's staff asked them to look at any concerns they had about people. We saw a nurse visited to check the skin of a person who had recently been admitted. The home had already taken precautions such as ensuring the person had appropriate pressure relieving equipment in place to prevent any deterioration in the person's skin following their own assessment. Risks from poor nutrition were being managed. People were being weighed regularly and their notes indicated that where there were concerns people were referred to appropriate services for dietary advice and support, including supplementation where needed. One person had been working with the home successfully to lose weight to improve their health.

Risks in relation to the management of long term health conditions were being managed. For example one person with diabetes was seen by district nurses each day. The district nurse told us the person's blood sugar levels had been maintained at a stable level, which told us that their diet was being managed appropriately. Risk assessments, for example for falls or moving and handling risks were in people's files and kept up to date. We identified one person needed a choking risk assessment. We saw that concerns about the person's ability to swallow had been identified and appropriate actions taken. A care plan was in place to support the person including managing the risks, but this was not documented in a formal risk assessment. We spoke with the home's cook who was aware of the appropriate texture of food needed by this person to support their swallowing and reduce any risks of choking.

People were being protected against the risks associated with medicines. Staff who administered people's medicines had received training to do so, and the systems for storage and administration had been audited by the supplying pharmacist on 7 June 2016, which had identified only minor issues with the some creams not being marked with an opening date. We saw this had been done. We saw staff supporting people to take their medicines, which was done with patience and an appropriate level of explanation of what the medicines were for. Protocols were in place to record where the person was prescribed "as required" medicines, for example for pain relief or to manage distress or anxiety to ensure staff were clear as to when this could be given.

Systems for reporting concerns and safeguarding people's welfare were well understood. The home had a policy and procedure in relation to safeguarding people, and whistle blowing policy. Staff told us they had no concerns over the quality of care or safety people were experiencing at the home, but would report them if they did. Staff at all levels throughout the home had received training in identifying different types of abuse and how to keep people safe. The home had no current safeguarding concerns, but had reported any there had been to the local authority since the last inspection. These had been resolved.

Good

Is the service effective?

Our findings

Staff told us they had received the training and support they needed to do their job and felt confident they had the skills they needed. There was a training and development matrix for the home, which identified training staff had undertaken and also training that was planned and booked. Staff told us if they had any specific interest or training need this was met quickly. This included individual support and 1:1 training being sought if needed. One told us "There is loads of training here. We just need to speak with the manager or (name of training provider) and they will set it up for us". All staff at the home were registered or registering on a diploma level qualification, including two staff undertaking a level five which is a management level qualification.

Staff told us they had followed an induction programme when they started at the home which had included shadowing more senior staff for a period of around two weeks. This included forms for the senior staff to complete to confirm that the staff member had the skills needed or identify any additional training they required. Some staff with previous qualifications and experience told us they had received some refresher training over that period. One member of bank staff was in discussion with the registered manager about undertaking the care certificate, which is a set of national standards that social care and health workers should follow as a part of their induction training.

Staff told us they felt they received enough support to fulfil their role. They told us they always had access to senior staff to refer to if they had any concerns, and could call into the office at any time to discuss anything they wished. There were also regular staff meetings and more informal systems for communication. There was a system for staff supervision and appraisal, but due to the high staff turnover this had fallen behind. The management and training consultant who attended the inspection showed us systems that they had that could be implemented to monitor competency and help staff with their professional development. The registered manager was aware the systems needed development and had plans to make changes now that a senior team was in place.

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.

We checked whether the home was working within the principles of the MCA. We found the home was taking appropriate actions to protect people's rights. Staff were aware of people's right to refuse support and understood about people's capacity and consent. Two staff told us about how they had supported an individual that morning. This included strategies for supporting and relaxing the person so they would feel comfortable for personal care to be delivered. Throughout the day of the inspection we saw people being asked for their consent to care. Best Interest assessments in people's files showed that staff had considered the actions they needed to take to support people where they were no longer able to give their consent due to impaired capacity. These recorded where relatives or other supporters had been involved in making

decisions on people's behalf in their best interests. For example one person had been due to have a procedure in hospital. Following consultations with their family, staff and professionals involved with the person's care it was decided the procedure was in their best interests. A small sedative medicine was given to the person to help reduce any anxiety they might experience. The person had not been able to consent to this, but the procedure which was likely to have a significant impact on the person's well-being was able to be carried out without the person being distressed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been made for authorisations to deprive some people of their liberty at Hadleigh Court. None of these had yet been granted due to delays with the local authority. The registered manager told us that they were reviewing one person with a view to making an application for them under the DoLS, but were waiting until the person had recovered from a urine infection before carrying out the assessment, as they felt information obtained would not be accurate. This was in line with the requirements of the MCA.

Most people living at the home were not able to give us their views about the food served to them, but those who did said they enjoyed it. One person told us they were looking forward to their lunch as "it is always good". We saw people eating their breakfasts and main meal which were eaten well, and reflected people's choices. The main meal served at lunchtime was soup or melon and grapes, pork casserole and toffee apple crumble for dessert. Visitors were able to support people with their eating if they wished and we saw one visitor helping their relation to eat their meal. Another person went out for lunch with their family. People also had access to drinks and snacks throughout the day. Staff were thoughtful about how to support people with their eating. We heard staff discussing at the handover how to support one person to eat their meals better.

Hadleigh Court is an older converted building, but all areas seen were clean, comfortable and warm. There was a passenger lift to access the first floor, but this did not reach all the rooms and some corridors were narrow and difficult to negotiate with equipment. The registered manager told us the home was moving towards making the environment more dementia friendly. As rooms were being redecorated patterned carpets were being replaced with more plain ones and painting carried out to reflect best practice in colour and design. Increased signage and visual clues for people was discussed to help people orientate themselves further around the environment. Rooms that had been completed presented a more comfortable environment for people to personalise to their own needs.

People had access to community medical support services such as dentists, podiatry and opticians. We saw in people's files that they saw their GP or the community nurse promptly if they needed to do so, and were supported to attend hospital appointments. Where there had been changes in people's needs we saw referrals were made quickly to services such as GPs, district nurses or the local older person's mental health team for advice and review. One person had recently been admitted to the home in an emergency situation. We saw that the home had identified concerns about their health and the person had been visited by a GP and district nurse. Referrals had been made both for equipment and for advice on supporting a long term health condition.

Good

Is the service caring?

Our findings

People who were able to discuss their care with us told us that staff were kind and caring. We observed staff supporting people throughout the day, and saw that they responded to and anticipated people's needs well. We saw evidence of affectionate and caring relationships in place. Where people's communication was impaired guidance was available for staff in their care plans to help staff understand the person's communication. For example one person's plan included information on using facial expressions and body language. Another person had a hearing impairment, and staff were using written notes to support their communication with them.

When staff discussed people's needs between themselves they did so respectfully, and took care to ensure this was not done in front of other people. People's privacy was respected and all personal care was provided in private. We heard staff speaking quietly asking people if they wanted to go to the toilet so as not to let others know where they were going. Visitors told us they were able to come to the home at any time and staff told us some came in nearly every day to see their relation. They were able to take part in continuing to provide care for the person if they wished, such as helping them with eating. One visitor told us they had found the home a very welcoming place to come to.

People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. One person told us this was because they liked their own privacy, and found the lounge too noisy. Another showed us their television and said they enjoyed watching this in their room without being disturbed.

People's dignity was respected. Staff took the time to ensure people's grooming was maintained, for example trimming nails and cleaning glasses, and clothing was co-ordinated. They told us "It's the little things that make the difference to people's well-being". Hair had been cut and styled. One staff member told us how they helped the person maintain their chosen personal standards of clothing and dress as this had been very important to the person. Staff understood and had reflected upon people's lives before coming into the home and how this had affected them when living with dementia. For example staff understood how one person's life had led to them being very modest and needing additional reassurances when receiving intimate personal care.

When we spoke with staff about the people they were supporting they spoke about them with affection and compassion. One staff member discussed an article they had read recently which had spoken about the value of older people's life experiences which they had found helpful and thought provoking. Staff were respectful when discussing people and their needs both with us and throughout the inspection. They understood how people liked their care to be delivered and were conscious of people's wishes. They could tell us in detail for example about how people liked their care to be delivered and how they supported them with this. For example, files contained information on whether people preferred all female carers.

We spent a period of time observing the care people received and the ways in which staff engaged with them. When people were being supported to move or being hoisted this was done carefully with staff

speaking to and re-assuring the person throughout. We also saw staff waking a person to give them a cup of tea. We saw the staff member crouched by the person's chair and gently stoked their arm until they woke up. They gave the person their drink and choice of biscuits and the person smiled and said "You are kind". In other interactions we saw staff engaged with people with good humoured banter. We saw people responded well to this, although it always remained respectful.

Good

Is the service responsive?

Our findings

People living at Hadleigh Court all had a care plan based on an assessment of their needs. One person who had been recently admitted had a brief initial care plan in place, along with an assessment and information from their family about how they liked to be cared for. At our last inspection of the home in May 2016 we had seen that care planning was being done on a computerised system. On this visit we were told the home had returned to a paper based system as they had found the computerised system was not working effectively enough to meet people's needs or keep them safe.

Records and care plans were kept up to date and reflected people's needs and wishes. For example we saw that one person's plan stated that they liked to get up early in the morning and liked their breakfast in the dining room. We saw that they were the only person up when we visited the home at 6.30am, and had their breakfast served to them where they wished. They later had another breakfast also in this area because they said they wanted another. Staff told us that they got people up only when they were ready or wished to do so, and we saw that very few people were up and dressed before 8am. Another person's care plan detailed how they were to be transferred using a hoist. We saw this was carried out in accordance with their plan.

Plans were being audited on the day of the inspection to ensure they were up to date and contained all the required information about people's needs. Many plans also included information about people's personal and social histories, particularly where the person was living with dementia. This helped staff to understand the person and their behaviour in the context of the life they had lived. One person who had been recently admitted had come to the home with detailed information about their communication and healthcare needs from their family to help support their transition into the care home. Plans were person centred, in that they reflected the person's wishes and individuality. This included instances where the person might have capacity but had chosen to not take medical advice or treatment in relation to their care.

Plans were in place to support people with behaviours that might be challenging. We saw staff were skilled at intercepting and distracting people from behaviours that might develop into more disruptive or distressed actions. For example we saw one person was beginning to become agitated and request to go home. Staff took the person arm in arm for a walk around the gardens, which distracted them sufficiently to forget that they had wanted to leave the home. They then settled with a cup of tea and biscuits.

People were supported to take part in activities if they wished. The home had implemented twice weekly outings which were well supported. Photographs showed where people had been and what they had enjoyed on these outings. One person went out shopping regularly with staff which they enjoyed. Other people enjoyed in house activities, such as crafts, quizzes and singing. We saw evidence of crafts around the home and people being involved in staff lives, for example signs and celebrations up for a staff member who was leaving to have a baby . Some specialist items to support people with dementia were in evidence such as sensory hand warmers, and discussion was held on the use of empathy dolls and other aids. We spoke with the activities organiser who was enthusiastic about their role and how people could be supported to retain interests and skills.

Systems were in place for the management of complaints. The home's complaints procedure was on display in the home. The registered manager told us that concerns raised with them had been investigated and resolved before escalation to a formal complaints process. Concerns had been reported to the safeguarding team as necessary.

Good

Is the service well-led?

Our findings

At the inspection in May 2016 we found that the home had complied with a previously issued warning notice from the inspection of October 2015 regarding good governance at the home. New systems had been put in place to monitor the quality and safety of the services provided.

At this inspection in July 2016 systems were in place to assess, monitor and improve the quality and safety of the services provided. Risks and quality issues were being reviewed regularly through a series of internal and external audits, maintenance contracts and servicing of equipment. These included for example medicines management and infection control. External professional advice and support had been provided, for example to provide supervision and support to the registered manager and carry out the audits to monitor practice. An audit calendar had been produced, and it was clear which areas were reviewed each month. Where issues were being identified as a part of the audit, for example missing information, actions were being taken to address this. The home's management team were also working through and told us they had completed the quality improvement plan from the local authority's quality improvement team.

We saw the home was operating efficiently. Staff were clear about their daily duties which were recorded on a daily sheet and discussed at the handover. We saw staff supporting each other to ensure tasks were carried out during the day in response to people's changing needs. For example we saw that staff had taken longer to support one person than anticipated, so another staff member stepped in to take over their next task. Communication systems had improved, including handovers between shifts, communication books, handover sheets and staff meetings. Regular staff meetings had been held to discuss progress being made on the home's action plans and what still needed to be done. Staff told us the home was improving, and they would be happy for a relation of theirs to be cared for at the home. They said "Its on the up, getting much better", "(name of registered manager) has been brilliant. The way she has turned the home around is fantastic" and "(name of registered manager) has to be complemented for the changes she has made. It wouldn't be this good here without all the work she has put in".

We saw staff working well as a team, supporting each other and sharing skills with more junior staff on duty. Improvements had been made to increase the senior and management teams to ensure that staff always had access to people with more experience and qualifications for advice and support.

The registered manager was aware of the size of the task needed to have made changes at the home, and had sought support from external agencies to enable them to do so. They had also recruited staff to the management team to ensure there were sufficient skilled staff at a higher level to ensure changes made were embedded into practice and sustained.

Quality assurance systems were in place. Questionnaires had been sent to relatives, people living at the home and other stakeholders in February and March 2016. Results and feedback had been analysed and changes were being made as a result. Some of these were small changes, but others had involved changes to carpets and décor which were being attended to. A development plan indicated where actions had already been taken and what was planned. For example, people had requested more activities be provided.

People were now going out twice a week. We saw photographs of these trips out and feedback told us people were very happy with this. The registered manager was planning another resident's and relative's meeting to review developments and look at any further suggestions for change.

External community professionals we spoke with told us they were happy with the changes made at the home, and that they felt people's needs were being met. The home seemed more organised and less chaotic. The home's staff felt they felt more confidence in the relationship with visiting professionals, and were happy to ask questions about people's care.

Records maintained by the home had been improved. Staff recruitment records were well maintained, and staff training needs identified on a matrix. People's care plans had been updated to include more detail. Staff had been encouraged to ensure care plans and daily routines better reflected people's choices and preferences, and this had been reflected in the way staff carried out their overall duties. Daily records and reports such as repositioning charts were kept up to date throughout the day. Notifications that were required to be sent to the Care Quality Commission had been sent appropriately.

Policies and procedures had been replaced with a new system referring to up to date information and legislation. Data protection policies and statements on confidentiality were in place and there were secure facilities for the safe disposal of confidential records.

The registered manager could show us evidence of their own personal training and updates, and staff files contained certificates of achievement. Information and updates on best practice was shared amongst the staff team who were enthusiastic about their roles and the impact that good care could have upon people.