The Orders Of St. John Care Trust

OSJCT Meadowcroft

Inspection report

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Date of inspection visit:
07 April 2016

Date of publication:
16 May 2016

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

We inspected this service on 7 April 2016. This was an unannounced inspection.

Meadowcroft is registered to provide accommodation for 71 older people who require nursing and personal care. At the time of the inspection there were 69 people living at the service.

The service had a registered manager in place. 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 registered manager had transferred from another of the providers locations. Their previous location had been well led and the registered manager had recently been recognised with a county award for 'Leader of the Year 2014'. People, visitors, staff and visiting health and social care professionals felt the service was well led and were very complimentary about the registered manager.

There was a calm, warm and friendly atmosphere at the service. People felt respected, cared for, valued as individuals. People benefitted from a wide range of activities and social interaction. Staff knew the people they cared for and what was important to them. Staff appreciated peoples unique life histories and understood how these could influence the way people wanted to be cared for. People's choices and wishes were respected and recorded in their care records. Staff offered support in a way that promoted people's independence

People had been involved in reviewing their care. People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Care plans were detailed and reflected the care, support and treatment people were receiving. Staff followed guidance in care plans and risk assessments to ensure people were safe and their needs were met. Where required, staff involved a range of other professionals in people's care. Staff were quick to identify and alert other professionals when people's needs changed.

People were supported to have their nutritional needs met. People were complementary about the food. The menu offered people choice and variety and alternatives were available if people did not want what was on the menu. Mealtimes were flexible according to people's choice and preference.

Medicines were stored and administered safely.

People felt supported by competent staff. Staff were motivated to improve the quality of care and benefitted from regular supervision, team meetings and training to help them meet the needs of the people they were caring for.

Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty

Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. Where restrictions were in place for people these had been legally authorised and people were supported in the least restrictive way.

The building was well maintained. The service was clean and people were protected from the spread of infection. Equipment to support peoples care was clean, serviced regularly and stored appropriately.

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.

People told us they felt safe. Staff followed guidance in risk assessments and were knowledgeable about the procedures in place to recognise and respond to abuse.

Medicines were stored and administered safely. There was enough staff to meet people needs.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge needed to care for people.

People were involved in the planning of their care and were supported by staff who acted within the requirements of the law in relation to the Mental Capacity Act 2005.

People were supported to maintain their independence. Other health and social care professionals were involved in supporting people to ensure their needs were met.

Is the service caring?

Good

The service was caring.

People felt cared for and spoke highly of the staff and the care delivered.

Staff understood people's individual needs and people were cared for in a kind, caring and respectful way.

Is the service responsive?

Good

The service was responsive to people's needs.

People benefited from regular activities that interested them.

People were involved in the planning of their care. Care records contained detailed information about people's health needs.

People knew how to make a complaint if required.

Is the service well-led?

Good

The service was well-led.

There was a positive and open culture where people, relatives and staff felt able to raise any concerns or suggestions for improvements to the service.

The registered manager had developed positive relationships with the staff team, relatives and people who lived at the service.

The quality of the service was regularly reviewed. The registered manager continually strived to improve the quality of service offered.

OSJCT Meadowcroft

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 April 2016. This was an unannounced inspection. The inspection team consisted of three inspectors, a specialist advisor in nursing and dementia care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the home, this included previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

The methods we used to gather information during the inspection included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care. We spoke with 11 people who were living at the service and five relatives. We also 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 spoke with the registered manager, the head of care, two activities coordinators, one nurse, 11 care staff, two housekeeping staff, one maintenance worker, two kitchen staff and the chef.

We looked at records which included the care records for 12 people, medication administration records for all people living at the service and six staff files. We also looked at records relating to the management of the service, which included minutes of meetings, complaints and compliments, a range of audits and quality assurance feedback.

Good

Is the service safe?

Our findings

People told us they felt safe and supported by staff. One person told us, "I am confident about my safety. Nothing has ever happened to make me think that it isn't safe". Another person said, "Don't worry about a thing but I do feel really safe, good people (staff) here". A family member said their relative was, "Safe and happy, never complains, tells me she is not worried about anything". Another relative told us the service was, "A very good safe home".

People told us they felt safe because staff would come quickly when they called for them. People had call bells in reach. Call bells were answered promptly and people were offered assistance in a timely way. Some people were unable to use a call bell. Staff had identified the risks to people who were unable to use the call bell and regularly checked on them to make sure all was well and to see if they needed anything. One person who stayed in their room said, "Feel safe. People (staff) check on me and make sure I am alright".

Other risks to people's personal safety had been assessed and people had plans in place to minimise the risks. These included areas such as falls, moving and handling, preventing pressure ulcers and using bedrails. Risk assessments were reviewed and updated promptly when people's needs changed. Staff were aware of the risks to people and used the assessments to support people and meet their needs. For example, one person had been assessed as being at high risk of falling. Their risk assessment described the support the person needed from staff to keep them safe from falling whilst mobilising. Staff were observed providing support to this person in line with instructions in the person's risk assessment and corresponding plan of care.

Staff encouraged people to be as independent as possible whilst managing risks. For example, one person wanted to get out of a chair. Staff encouraged the person to stand by themselves and move independently. Staff kept in the background ready to offer immediate support if necessary.

Where advice and guidance from other professionals had been sought this was incorporated in people's care plans and risk assessments. For example, one person had been identified as at high risk of developing pressure ulcers and had a care plan in relation to preventing pressure ulcers. The person had been assessed by the district nurse and a pressure relieving mattress and cushion had been recommended. The person had the mattress on their bed and we observed the person sitting on the cushion. The person did not have a pressure ulcer.

There were assessments in place to address the risks associated with some people's choices or preferences. For example, one person chose to administer their own medicines. Staff had involved the GP and community psychiatric nurse in the person's risk assessment to ensure this person was safe to manage their medicines themselves.

Medicines were stored and administered safely. We observed staff administering medicines; staff supported people to take their medicines in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when

medication had been given or if not taken the reason why.

People had protocols for the use of 'when required' (PRN) medicines kept with their MARs. PRN protocols direct staff as to when, how often and for how long people could take the medicine. This helped to reduce the risk of people taking these types of medicines inappropriately. People told us they were given their PRN medicines when they needed them. For example, one person had pain relieving medicine. We heard the person tell the nurse they were experiencing pain. The nurse spoke with the person about the severity and location of the pain they were feeling. The nurse checked the persons MAR and PRN protocols to see what the person could take. The nurse gave the person their prescribed pain relief, recorded this in the persons care records and returned to the person later to check if the pain relief had been effective.

People were supported by staff who were knowledgeable about the procedures in place to keep people safe from abuse. For example, staff had attended training in safeguarding vulnerable people and had good knowledge of the services whistleblowing and safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. People, relatives and staff told us they would have no hesitation in raising concerns about peoples care and welfare.

People felt there were enough staff to meet their needs. People told us and we observed staff responded to call bells and requests for help promptly. Some relatives told us they felt there were not always enough staff on duty at the weekend. The registered manager reviewed staffing levels on a continuous basis. Numbers of staff on each shift were set according to people's levels of need. The registered manager told us there were some nursing and care staff vacancies at the service. Any shortfalls in staffing rotas were covered with staff doing extra shifts or regular agency staff. Staff told us there were occasions where last minute sickness at the weekend had meant finding cover was difficult but the registered manager and head of care had come into the service and helped with care tasks when that was the case.

Safe recruitment procedures were followed before new staff were appointed to work with people. Appropriate checks were undertaken to ensure staff were of good character and suitable for their role.

People's safety was maintained through the cleanliness, maintenance and monitoring of the building and equipment. For example, water testing, fire equipment testing, lift servicing, electrical and gas certification was monitored by the maintenance staff and carried out by certified external contractors. Equipment used to support people's care, for example, hoists, stand aids and specialised baths were clean, stored appropriately and had been properly maintained. The service kept a range of records which showed equipment was serviced and maintained in line with nationally recommended schedules.

People told us the service was clean. One person said, "They keep us clean and the building clean". Another person said, "My room is lovely and clean, spotless". Staff adhered to the provider's infection control policies. For example, staff washed their hands before preparing drinks or serving food. Staff confirmed the service had adequate stocks of personal protective equipment and staff used them as appropriate to prevent the spread of infection. Housekeeping staff were knowledgeable about the control and safe storage of hazardous substances (COSHH). Cleaning cupboards were locked when not in use and cleaning trolleys were not left unattended. Housekeeping staff used colour coded cloths and mops and ensured they were stored separately on the cleaning trolley to reduce the risk of cross contamination between high and low risk areas.

Good

Is the service effective?

Our findings

People were supported to stay healthy and care records described the support they required to manage their health needs. Records in people's care files evidenced they had access to a range of health care services which included GP's, chiropodists, community nurses, opticians and members of the community mental health team. One person told us, "When I came here I had a lot of problems walking. Staff noticed that my feet were in poor condition and they arranged foot care for me. Now I can get around much better". When people had been seen by a healthcare professional, details were recorded in each person's care record, with information on outcomes and changes to treatment if needed. Health and social care professionals were complimentary about the service and told us staff demonstrated an understanding of people's individual needs. They also told us they had a good working relationship with staff, and staff communicated well with them.

People were encouraged to eat and drink and told us the quality of the food had greatly improved since the new chef had been in post. Comments included: "Since the new Chef has arrived the food has been excellent", "Food is very good" and "Very tasty meal today. Not a big eater so just the right amount. Good chef". A relative said, "Food is very good, I know that Mum enjoys it". People were shown plated meals to help them make a choice. Alternatives were available for people who wanted something different from the menu options. One person told us, "Chef makes me things I like if there isn't anything that I fancy on the menu". Mealtimes were a relaxed and sociable event and people who needed assistance to eat were supported in a respectful manner.

People with specific dietary requirements had their needs met. The chef was knowledgeable about people's dietary needs and preferences. One person told us, "Cook comes around and talks to us, finds out what I like". Where people were at risk of losing weight there was a plan in place to ensure they received adequate food and drink. For example, one person had been identified as at risk of losing weight. Staff had involved the GP in the person's assessment and incorporated their advice in the person's care plan. Staff followed the actions and kept a record of food and drink intake and weighed the person to monitor their weight. The chef made fresh fortified smoothies, meals and cakes for people who were at risk of losing weight.

People were offered drinks and snacks throughout the day. People told us snacks were also available throughout the night. People had jugs of water or squash and were offered regular hot drinks, fruit, biscuits and freshly baked cakes. One person told us, "Lovely cakes, can have a snack anytime I like. Very good here".

People could move around freely in the communal areas of the building and gardens. There were several sitting rooms which gave people a choice of where to spend their time. People who were living with dementia benefitted from an interesting and stimulating environment. For example, there were tactile articles available in corridors and some communal areas had a theme, such as a small garden room with a bench. A relative told us, "The building is very homely, lots of little areas where people can sit".

People expressed confidence in the ability of the staff. One person told us, "On one occasion I poured a hot

cup of tea over myself. Staff were absolutely effective. The nurse sent people in all directions to fetch things. No scarring or ill effects they knew exactly what to do". A relative said, "Staff know what they are doing. [Name of relative] came in with a nasty ulcer and they knew how to treat it and it has healed now".

Staff had completed the providers initial and refresher mandatory training in areas such as, manual handling and infection control. Staff were supported to attend other training courses to ensure they were skilled in caring for people. For example, training in dementia care. One staff member told us there was, "Lots of training" and they had particularly enjoyed the 'Living with Dementia' training which had given them "valuable insight" into the disease. They felt this had helped them care for people who were living with dementia in a more effective way. Another staff member said, "We can do any training that will help us look after people and do our jobs better".

Newly appointed care staff completed an induction period. This included training for their role and shadowing an experienced member of staff. This induction plan followed nationally recognised standards and was designed to ensure staff were safe and sufficiently skilled to carry out their roles before working independently. One new member of staff told us they had worked with a more experienced carer for two weeks and had not been asked to do anything they were not comfortable doing. They said, "The induction was good but I learnt more doing hands on; I learn better that way".

Staff were supported to improve the quality of care they delivered to people through the supervision and appraisal process. Staff told us they received an annual appraisal and had regular one to one supervision with their line manager where they could discuss the needs of people they were caring for as well as any training and development they might wish to follow.

People were supported in line with the principles of the 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 people lack the mental capacity to take particular decisions, any made on their behalf must be in their best interests.

Staff had completed training in the MCA and understood their responsibilities in this area. For example, staff were able to describe what action they would take if a person was identified as lacking capacity to make a specific decision. This included following the best interest process and involving health professionals and relatives in the decision to be made. Staff told us that although a person may lack capacity in some areas they would still be supported to make whatever decisions they could. People told us staff asked for their consent before delivering care tasks and gave them the information they needed in order to make choices and decisions.

The registered manager understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be deprived of their liberty for their own safety. Where restrictions were in place for people we found these had been legally authorised and people were supported in the least restrictive way.

Good

Is the service caring?

Our findings

People felt cared for and were complimentary about the staff. Comments included: "People look after me so well that I look forward to staying here for the rest of my life", "Care staff are so lovely, very varied, some very cheerful, some more solemn. I like the variety", "Girls are very kind and caring. I can't fault my care in any way at all" and "Can't fault it, any of the staff, anything. Good care. Of all the homes I have visited nothing compares to this".

People's visitors told us the service was caring. Comments included; "Very good care", "Confident that [name of person] is well cared for. I have no concerns", "Mum talks about her angels that come in the night to help her when she rings her bell. She refers to them as my angels" and "'The standard of care is very good. All the carers think that [name of person] is their Nan".

Throughout the inspection we saw many examples of people being supported by staff who were friendly, kind and respectful. Staff interacted with people at every opportunity. For example, we heard care staff chatting with people as they walked around the home, offering people support and reassurance where necessary. Housekeeping and maintenance staff also took an interest in what people were doing and chatted with them whilst they went about their work.

People were well presented and dressed appropriately for the weather. One person told us, "They keep you very clean. Can have a bath or shower when you want". Another person said, I like to have a bath or a shower. Carers know that and make sure I get one". Staff noticed if someone's clothes were dirty and assisted them to change. For example, we spoke to one person who told us, "I like to look smart". When they spilt a drink at the mealtime. Staff immediately supported the person to go to their room and change their clothes. When the person came back to the dining area another member of staff complimented the person on their choice of colour and clothing.

People were supported with their personal care discretely and in ways which upheld and promoted their privacy and dignity. For example, staff knocked on people's doors and waited to be invited in before entering and ensured people's curtains and door was closed during care. Staff spoke with people in a respectful way and staff used their preferred name or title.

People were supported to make choices and decisions about how they received their care. Staff knew people well and people confirmed their choices and preferences were respected. For example, one person told us, "I can go to bed when I like and get up when I feel like it. Can have a late breakfast, nothing too much trouble". Other comments from people included: "I can make my own decisions. I like to sleep with my window open at night but there is a rule that says that all windows must be closed last thing. I spoke to [registered manager] who said that it was alright as long as staff recorded that it was my wish/decision", "I like to be alone. Staff let me do what I like" and "I like to get up early so they get me up at around 6 in the morning and make me a cup of tea and I have an early breakfast at 8am". A relative told us, "Staff do the little things that she likes".

Some people at the service were living with dementia, staff demonstrated a good understanding of the needs of the people they were caring for and how best to work with them. One staff member told us, "People might have dementia but they can still make choices and live fulfilling lives. It's knowing what the best way to offer a choice is and what people used to do before they came here". Staff understood how people with dementia may communicate their feelings through their behaviour. For example, when one person became agitated, staff understood this could mean the person needed the toilet and promptly and discretely asked, "Can I help you to the bathroom?" The person said "yes" and appeared more visibly relaxed. Another person was walking in the corridor and appeared to be anxious. A staff member noticed and took time to find out the person was anxious because they could not remember why they were in the corridor. The staff member invited the person to join them whilst they were going to check all was well with one person who was staying in their room. The staff member linked arms with the person and chatted with them as they walked down the corridor. The person who was staying in their room invited the other person into their room and the visit became a sociable experience that was clearly enjoyed by both people.

Some people had behaviours that might be described as challenging. Staff had identified potential triggers to the behaviour and strategies to manage the behaviour were documented in peoples care records. We observed staff using these strategies in a calm, kind and respectful way.

People were encouraged to be as independent as possible but were available if people needed help and support. For example, one person wanted to go to their room but could be at risk of falling. Staff encouraged the person to walk by themselves but remained close by in case the person needed assistance. One person told us, "They (staff) help me up but encourage me to move by myself". Another person told us, "Staff have encouraged me to become as independent as possible". Some people used equipment to maintain their independence. For example, walking frames and other mobility aids. Staff ensured people had the equipment when they needed it and encouraged people to use it.

Staff gave us examples of how people's quality of life and anxiety had improved since they had been at the home. One person had made significant improvements and had started to go out independently. They had expressed a wish to live independently and staff had sought help and support from other professionals to enable the person to make plans to do this. A relative told us, "So pleased, Mum is so much better since she came in".

People were able to have visitors when they wanted. Relatives had a good relationship with staff and received a warm welcome when they arrived at the service. One volunteer told us they had enjoyed coming to the service as a visitor and now helped with supporting social events and coffee mornings. They said, "If I had to come in to a home it would be this one. Mum was safely cared for here for 10 years".

People were involved in decisions about their end of life care and this was recorded in their care records. All decisions relating to resuscitation were recorded on a standard form. The Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form was at the front of peoples care records, allowing easy access in an emergency. Where people were assessed as lacking capacity to be involved in end of life decisions best interests meetings were held with health professionals and peoples relatives.

Where people were receiving end of life care they had been commenced on an 'end of life' pathway. Specialist health professionals were involved in supporting the person and the staff in caring for the person. End of life care plans contained information with regard to any equipment needed to ensure people's comfort, how to maintain oral healthcare, nutrition and hydration, pressure care and keeping people pain free.

Relatives were complimentary about the level of care and support they and their loved ones received. One relative told us, "During her last few days when she was very poorly, several of the young girls (staff) came in on their days off to sit with her".

Good

Is the service responsive?

Our findings

Before people came to live at the service they had an assessment to ensure their needs could be met at the service. These assessments were used to create a person centred plan of care which included people's likes, dislikes, preferences, routines and behavioural triggers, how to maintain their independence and a social history. This information had been incorporated into people's care plans.

Care records were reviewed regularly to ensure all the information was current and reflected the person's care and support needs. People told us they had been involved in developing care plans and reviewing care. One person said, "Staff talk to me and are always asking if things are alright". Where people had given permission or where it was in a person's best interest relatives had been fully involved in the planning of their relative's care. A relative said, ''I have been to care plan review meetings".

Staff completed records that supported the delivery of care. For example, food and fluid charts and charts to record how people's position was being changed to reduce the risk of pressure ulcers. These were up to date and there was a detailed record of the staff input and care being carried out.

Peoples care records included detailed information about their life histories. Staff used this information to stimulate conversations with people. For example, when we were speaking with one person staff proudly told us about the medals this person had received during the war. The person was clearly pleased the staff member had referred to their medals and told us about the occasion when they had recently wore their medals.

Involvement with the wider community was seen as important to give people a wide range of experiences and options for activities of interest. This included links with local schools, colleges, churches, clubs, day centres and supermarkets. As well as people attending clubs outside of the service, clubs and organisations were invited to the service. For example, a local classic car club, singing club and wine tasting club. This meant that people who were not able to leave the service could still benefit from these activities. On the day of the inspection some students who were completing their Duke of Edinburgh (DoE) awards visited the service to join in with a coffee morning with people. The coffee morning took place in the 'heart of the home' which was a bistro and offering catering facilities and comfortable seating. People told us the coffee morning was a regular occurrence and was a greatly enjoyed social occasion. We joined in the coffee morning and found it to be a lively event with much laughter and conversation going on around the room.

Later in the day we observed the DoE students sitting chatting to residents. One resident was talking to a student about their war time experience. The students later told us visiting the service and speaking with the residents enabled them to have an understanding of older people and the conditions that affect them in later life. They told us they really enjoyed talking to residents and having the first-hand experience of listening to real life stories.

The service had two activities coordinators who organised a wide range of individual and group activities. One person told us, "I've been out on a number of trips and I have enjoyed them". Where people were not

able to or did not wish to attend the group activities they had one to one sessions in their room. Staff had also sought volunteers that were 'befrienders' and records showed one person's mood had significantly improved since they were being accompanied on one to one outings. All staff saw it as part of their role to ensure people were not socially isolated and spent time engaging with people.

The activity staff were passionate about providing high quality, meaningful activities for people. They had completed certified training in delivering a seated exercises programme to ensure people could undertake these sessions safely. They had also completed 'Cognitive Stimulation Therapy' training to enable them to do small group work suitable for people living with mild to moderate dementia. This was a set programme and training was provided by one of the authors of the programme. One of the activities staff told us, "Out of the 18 Oxfordshire OSJCT homes we were the first to go with it and I attended UK Dementia Congress where two of us activities staff and our Admiral Nurse presented our work contrasting and comparing outcomes". We saw peoples self-assessment scoring sheets which showed significant increases in their quality of life scores from the start to the end of the programme.

People's equality, diversity and human rights were respected. For example, people told us their religious and spiritual needs were being met and that they were able to see a minister from their particular faith. Staff were aware of peoples' spiritual needs and told us they would be prepared to accommodate the needs of people from all faiths. Ministers from four different churches visited the home to conduct services. One person told us, "'Church here every Sunday at 4 O'clock".

People knew how to make a complaint and the provider had a complaints policy in place. Staff were clear about their responsibility and the action they would take if people made a complaint. People and their relatives felt confident in raising any concerns and told us that any recent issues they had raised had been dealt with and resolved promptly. One person said, "Little things only get sorted out in good time".

The service organised regular meetings for people and their relatives to discuss the running of the service. People told us they had been able to offer their views and suggestions about the running of the service. For example, making suggestions about redecoration of some of the communal areas. Minutes of the meetings were kept together with plans that demonstrated action was being taken as a result of any suggestions and feedback.

Good

Is the service well-led?

Our findings

An experienced registered manager had transferred from another of the provider's locations. The registered manager had achieved an outstanding rating in a previous Care Quality Commission inspection and had also recently received a county award for 'Leader of the Year 2014'. The registered manager was being supported by an area management team and deputy manager.

The registered manager promoted a person-centred approach to care and ensured that people were at the centre of everything that happened in the home. When care was not of a high quality the manager took immediate and appropriate action to address concerns. People and relatives were complimentary about the management team and told us the manager was frequently visible in the units and often stopped to chat with them and check all was well. "She (registered manager) is always up here checking we are OK". Another person said, "Manager is a lovely person chats to me, asks me if I am alright". Staff told us the manager went onto the units several times a day to check all was well with people and staff. Comments from staff included: "She (registered manager) keeps us on our toes and if any residents say things are not ok she speaks with us straight away. It's not a telling off though. She does it in a lovely way and asks us for suggestions and how we can work together to put it right. We can say if we feel we might need a bit of training", "She's really good, wants to move us forward" and "The new manager is a lot more firm, she's improving things. standards are a lot higher".

The registered manager had an open door policy and was visible around the service. Staff spoke positively about the leadership of the service and felt supported and valued. Staff told us the registered manager had come in at weekends and at night to support staff. Staff described the registered manager and other senior staff as being supportive and approachable. Comments from staff included: "The manager always comes up to support us on the floor. Asks us if we need her help, interacts with the residents and is friendly and approachable", "Support from the manager is brilliant. I feel a lot more confident" and "Good relationships with the Manager, responsive and on the ball".

There was a range of quality monitoring systems in place to review the care offered at the home. These included a range of clinical and health and safety audits which were completed on a monthly basis. When the registered manager had started work at the service they had worked with all levels of staff to complete a thorough and in-depth audit of all areas of the service. The audits had identified some areas of improvement that were needed and the registered manager had worked with staff to find solutions to any issues raised. For example, Every persons care record had been audited. Staff told us they had been allowed to work supernumerary shifts in order to catch up with reviewing care plans.

The registered manager had promoted a positive culture where staff felt motivated to make the required improvements. Staff showed respect for people as individuals and supported them to continue their chosen lifestyles. Staff described their work with enthusiasm, compassion and empathy. They were eager to develop more skills and expertise. One staff member told us "Standards have defiantly improved and we want to be the best around".

The management team ensured that staff were aware of their responsibilities and accountability through regular one to one supervision and meetings with staff. Staff felt able to make suggestions to improve people's care or the service. A daily meeting took place for unit leaders where important information about peoples care or the running of the service were discussed.

Offices were organised and documents required in relation to the management or running of the service were easily located and well presented.

There was a procedure for recording incidents and accidents. Any accidents or incidents relating to people who used the service were documented and actions were recorded. Incident forms were checked and audited to identify any trends and risks or what changes might be required to make improvements for people who used the service.

Accidents, incidents, concerns and complaints were also discussed during team meetings and during staff supervision to ensure lessons were learnt and to prevent similar incidences occurring.

People were actively encouraged to provide feedback through a satisfaction survey and meetings. People told us they had been able to offer their views and suggestions about the running of the service. Minutes of the meetings were kept together with plans that demonstrated action was being taken as a result of any suggestions and feedback.