Care Quality Commission

Abbey Healthcare (Cromwell) Ltd

# Cromwell House Care Home

## 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? | Requires Improvement |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

Cromwell House Care Home is registered to provide accommodation and nursing care for up to 66 people. At the time of our inspection there were 48 people living at the home. The home is located in the town of Huntingdon close to local shops, amenities and facilities. The home is a three storey premises. These are accessible by stairs or a passenger lift for people or visitors whose mobility requires this. En suite as well as bathing and shower facilities are available.

We carried out a focused unannounced comprehensive inspection of this service on 5 November 2015. A breach of two legal requirements was found. These were in relation to the management of medicines.

After the focused inspection on 5 November 2015, the provider wrote to us to say what they would do to meet the legal requirements in relation to the safe management of medicines.

We undertook this unannounced comprehensive inspection on 30 March 2016 to check that the provider had followed their plan and also to confirm that they met legal requirements. We found that the provider had followed their plan which they had told us would be completed by the 15 January 2016 and legal requirements had been met.

The service did not have a registered manager. The previous registered manager left in August 2015. A registered manager is a person who has registered with the Care Quality Commission (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.

Staff had a good understanding of the identification, prevention and reporting of any incident of harm. People's assessed needs were not always met by a sufficient number of staff who were qualified and competent in their role. Satisfactory pre-employment checks were completed on staff before they were offered employment.

Action had been taken, and sustained, in the administration and management of people's medicines. Staff had been regularly trained and assessed as being competent to safely administer people's prescribed medicines. An effective staff training and induction process was in place to support staff in their role.

Risk assessments to help safely support people with risks to their health were in place and these were kept under review according to each person's needs. This included risk assessments to support people in an emergency such as a fire should this ever occur.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The regional manager, home manager and staff were knowledgeable about when an assessment of people's mental capacity was required. Appropriate

applications had been made by the provider to lawfully deprive people of their liberty as well as people being cared for in the least restrictive manner. This meant that, where appropriate, people were being lawfully deprived of their liberty.

People were supported to eat and have sufficient quantities of their preferred food and drink choices. This included the provision and choice of appropriate diets for those people at an increased risk of malnutrition, dehydration or weight loss.

People were supported to access a range of health care services and their individual health needs were met.

People were cared for with dignity in a compassionate way. People were given the opportunity to be as independent as possible. People were involved in the planning and provision of their care

Information was made available for people or their relatives who may need access to independent advocacy services. People were given various opportunities to help identify and make key changes or suggestions about any aspects of their care. Some opportunities were missed to support people with their care needs in an individualised manner.

A range of effective audit and quality assurance procedures were in place. This was to help identify what worked well and any area that required improvement.

## 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.

The provider had put measures in place to ensure people's medicines were safely managed. People were administered their medicines as prescribed.

Recruitment procedures helped ensure that staff were safely recruited.

The number of suitably qualified staff in post helped ensure that people's nursing needs were met.

Risk assessments were in place and up to date to support people in their safe care. Reporting of accidents and incidents were recorded, investigated and responded to in a way which reduced the potential for recurrence.

### Is the service effective?

**Good**

The service was effective.

People were asked to consent to the care they were provided with. Staff respected people's decisions and ensured people were only deprived of their liberty where this was lawful.

Staff were supported with regular training and supervision

People's health and nutritional needs were met. Improvements had been sustained to the way people were supported with their health care.

### Is the service caring?

**Good**

The service was caring.

People were looked after in a caring way and their rights to independence privacy and dignity were valued.

Staff knew the people they cared for well and they understood people's preferences and rights to a family life.

People were encouraged and included to be involved in making decisions about their care.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Opportunities were missed to support people with their care in an individualised way.

Not everyone's care was responded to in a way the person preferred.

People's complaints, suggestions or concerns were investigated and acted upon in line with the provider's policy.

### Is the service well-led?

**Good**

The service was well-led.

The provider had notified the Care Quality Commission about important events that by law, they are required to do so.

Effective quality assurance and audit processes and procedures were in place and these were used to drive improvements.

People and staff were involved in the development of the service. There were arrangements in place to listen to what people, relatives and staff had to say.

Care Quality Commission

# Cromwell House Care Home

**Detailed findings**

## Background to this inspection

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

This unannounced inspection took place on 30 March 2016 and was undertaken by two inspectors 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. Their area of expertise was in caring for older people and those living with dementia.

Before the inspection the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what it does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made judgements in this report. We also looked at the number and type of notifications submitted to the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with 15 people living at the service, four visiting relatives, the home's manager, and regional manager; two nurses, one senior member of care staff, and four care staff. We also spoke with the kitchen assistant, the office administrator and a visiting hairdresser.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed people's care to assist us in understanding the quality of care people received.

We looked at five people's care records and the minutes of staff meetings. We also looked at medicine administration and records in relation to the management of the service such fire safety checks. We also looked at staff recruitment, supervision and appraisal process records, training records, complaints and quality assurance records.

Good

# Is the service safe?

## Our findings

At our focused inspection of Cromwell House Care Home on 5 November 2015 we found that people were not always supported to have their medicines managed safely.

There were two breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During our comprehensive inspection of 30 March 2016 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 described above.

People told us that they received their medicines on time and they were aware of the medicines that they were prescribed. Staff explained what the medicines were for and ensured that people took all their medicines as prescribed. Staff had been trained in the safe administration of medicines and staff who administered medicines had had their competency to do this safely, regularly assessed. We observed that medicines administration and management was in line with current guidance. We were told and saw that one person received their medication covertly. We found that a protocol and authorisation by a GP were in place. This is where people, who lacked capacity to make decisions, are not aware that they were being administered medicines in their best interests. Guidance and protocols were in place for people's pain relief as well as for those medicines which had to be administered at a particular time and in a particular way.

We found from records viewed that staff had records in place to evidence that they had been safely recruited. However, we found that one staff recruitment file was not in place. We gave the provider 48 hours to locate this information. They located and provided us with this information with allocated time. We found that checks included recent photographic identity and proof of their previous employment history as well as checks to ensure that nurse's registration with the Nursing and Midwifery Council was current. Other checks included a Disclosure and Barring Service check which had been carried out to ensure that the service had only employed those staff who were suitable. Where staff had been deemed unsuitable to continue working at the service, we found that the provider had followed their staff disciplinary procedures. Care staff told us about the records that they had been required to provide, such as those mentioned above as well as their job interview before they were offered employment. This demonstrated that staff who were employed had undergone rigorous checks that deemed them suitable to work with the people who used the service.

Staff had a good understanding of the procedures to help protect people from different types of harm and how these were put into practice. One staff member said, "We have had training on challenging behaviour in our safeguarding training." Staff were trained to recognise, and if required, report any incidents of harm people may have experienced. One person said, "I feel safe here because when I ask for assistance the staff come quickly." Another person told us, "I do feel safe yes, it's just that If I do ring my bell it does take a little while for them [staff] to come. In the morning it can be a long while." We saw that people had call bells in their rooms that were easily accessible.

Staff commented that that there was not enough staff available in the morning on the ground floor and that sometimes staff absence had not been covered. People and relatives commented how busy the ground

floor was and that this contributed to the delay people experienced when they wanted to get up or go to bed. One person told us that they had used the call bell at night time and the care staff came quickly. Another person said, "I do feel safe because I know there is always somebody about – not like at home when was on my own."

The provider used a dependency assessment tool to help determine the number of staff to safely meet people's needs. This was reviewed regularly and always after a person had been to hospital where their care needs may have changed. Staff, people living in the service and our observations confirmed that there were sufficient numbers of staff on duty to ensure that people remained safe. The home manager told us that five new staff were in the process of being recruited. This was to increase the permanent staff as well increasing domestic staff. A staff member told us, "We do get offered to work some extra shifts but after working 12 hour shifts I am ready for my days off." Comments from people included that they were "never taken out into the garden" and "we never go out into town unless our relatives take us". The home's manager said, "We have had situations where rostered staff failed to come into work and did not follow the provider's absence reporting procedures but wherever possible we request and usually get agency staff." They added that when required they [the manager] also assisted staff with people's care. We saw this was the situation during lunch. Although some people and their visitors told us that there were not always sufficient staff, at the time of our inspection we noted that call bells were responded to.

There were staff whose presence around the service helped ensure that people were kept as safe as practicable. People we spoke with all told us that they felt safe. Several people were seen to use walking frames or a wheelchair to move around. One person told us, "There are two male carers down here [ground floor] who make me feel safe." One person said, "I feel safe here because when I ask for assistance the staff come quickly." A relative told us, "[Family member] does feel safe here – [they are] very content."

Accidents and incidents, such as people experiencing a fall or where they had behaviours which challenged others, were investigated and action was taken to prevent recurrence. For example, by the appropriate use of pressure ulcer prevention equipment and strategies to calm people, respectively. Another person told us, "I had a fall and they [staff] helped me." One staff said, "When incidents occur, such as the person having a fall, we talk about it and the nurse/senior [staff] puts new risk assessments in place to tell us how we can help the person from falling again. Sometimes it [a fall] just happens."

Information about how to recognise and report incidents of harm was publicly available throughout the service for people, staff and visitors. We saw that staff were patient to those people who required more time with their support such as those people who required the assistance of two staff. This showed us that that there were systems in place to help ensure people were cared for in a safe way as much as practicable.

To assist people with their safe movement around the service we saw the main dining rooms were light and airy with wide corridors and handrails at each side for people to use to move around the building.

Equipment and services were maintained to help ensure that the service and environment was a place to live and work in. This included checks for fire safety appliances, people's moving and handling equipment electrical equipment and food hygiene.

Good

# Is the service effective?

## Our findings

The regional and home's manager informed us that they were keen to develop all staff's knowledge. We saw that several staff had completed all the levels up to an including level four diploma in health care related subjects. All staff confirmed that they felt that the support mechanisms available to them helped to provide people's care needs safely and effectively. One senior staff told, "We do on line e-learning as well as face to face where the subjects were more complicated such as the MCA [Mental Capacity Act] and DoLS [Deprivation of Liberty Safeguards]."

Staff confirmed that they were supported with training, a formal induction and shadowing opportunities with experienced staff. This was also with formal and regular supervision. Staff confirmed that their supervisions were definitely a two way conversation about identifying any additional support. We found that staff completed their induction prior to working on their own. We found that was a staff training programme in place as well as staff having access to one of the provider's trainers. We saw and staff confirmed to us the training and the refreshers for this was undertaken. This included subjects including moving and handling, fire safety, safeguarding people from harm and first aid as well as caring for people living with dementia. One nurse told us, "I am putting my training, learning and evidence together for my [Nursing and Midwifery Council] revalidation which is in August [2016]." One care staff told us, "We are always being offered extra training and, if I ask, I can do additional qualifications in care." Another staff told us, "Some of our training is out of date. The acting manager is making sure that we all complete all of the necessary training. We have been doing training and other training is planned."

All people told us that about how well staff knew. We observed meal times on all three floors. We saw that people were offered their meals in a relaxed environment and by sufficient staff which meant that people did not have to wait for their chosen meals. All people and relatives told us that the food was good. One person said, "The food is very good. Yes, plenty to eat and lots of choice. We can have what we like from the menu."

People's choices, preferences and assessed needs were met by staff who were skilled in meeting these. For example, for those people with a need for a soft food or vegetarian diet, were offered a choice of appropriate food and drinks. We saw that staff supported people to be as independent as possible with their eating and drinking. For example, by providing rimmed plates or adapted cutlery which people used on their own accord. People were able to pour their own gravy as well as determining their meal portion size.

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and DoLS.

Staff had received training on the MCA and DoLS. We found that staff were knowledgeable about the codes of practice for these subjects and how to put these into practice. This meant that any restrictions on people's liberty were in the person's best interests and in the least restrictive manner. To ensure people's safety there was the use of controlled access to areas of the service as well as staff accompanying people when they went out. Records viewed showed us when and whether people could or couldn't make specific decisions and if they could retain the information. For example, when it was not safe for people to go out on their own as well as the use of lap belts in wheelchairs. Applications had been correctly made to the local authority to lawfully deprive people of their liberty.

People could be assured that the staff would take action to reduce and prevent any risks that were associated with their health. We saw that referrals had been made to the most appropriate health care professional such as tissue viability nurses, speech and language therapists or a dietician. We also saw that people's wound management was in line with national guidelines. We saw that a photograph and personal details were held with the accurate medicines administration records. This was as well as guidance and body maps from an appropriate health professional that were in place for those people who needed this. This covered people using insulin and people who required their medicines to be taken in their food. Guidelines were in place for these prescribed medicines, as well as 'as required' medicines. This helped the staff identify any changes in people's health and also if external health care assistance was required. Where required, we saw that people were being supported with food supplements to help them achieve or maintain a safe weight. This showed us that people's health needs were responded to.

Good

# Is the service caring?

## Our findings

All people, relatives and other visitors spoke highly about the care provided at the home. One person told us, "Carers [staff] are kind to me. Yes, everyone [staff] who comes through that [their room] door is very pleasant and can't help me enough – no problem." Our observations confirmed that this was the case. Two examples we saw were when staff supported people with their moving and handling. On both occasions the two staff spoke with each person in a gentle and reassuring manner. As well as giving people time to move in an unhurried manner staff maintained communication with the each person. At the end of the move each person thanked staff for their help. We observed some lovely examples of compassionate care. We saw a staff member sat with person who was calling out in a distressed manner. The staff spoke to them quietly and in a calm, dignified manner, reassured them and tried to engage them in general conversation. They spent time talking to them until they were calmer and then offered to make them a cup of tea. Another example was when two people disagreed over who should sit in a dining chair; two staff members intervened and spoke to each person diverting their attention. Both people responded positively to staff interaction.

At meal times we saw that staff asked people if they would like gravy, where would they like it poured and how much each person wanted. A visiting hair dresser said, "Whenever people come to see me they are always clean, well dressed and happy to see me." We saw that the new care plans now contained detailed history about each person. One staff said, "The old [care] plan was on a page and now it's several pages which tells me so much more about the person including things I never knew. I can now talk about the things in the person's life that are important and memorable for them."

Our observations showed us how staff spoke with people by their preferred name and in a clear manner. During the lunch time we saw that when the home's manager came into the dining room they engaged in polite conversation with people as well as helping serve lunch. We saw how care staff spoke discreetly with people when asking if they needed any assistance with their personal care needs.

People were supported with their faiths and religious beliefs if they preferred this. This was by staff who understood people's beliefs. A regular religious service was offered for those people who had a preference for this. People could also request someone for the faith such as a priest if this was required.

People confirmed to us that they got on really well with staff and felt that staff always aimed to meet their expectations about the aspects of their lives that were important. For example, staff respecting their dignity and privacy. Staff told us how people's dignity was respected such as letting people be as independent as possible and covering people up as much as possible. However, two people expressed some minor concerns such as, "I can be being washed and undressed and they [staff] come in and take my carer away so that they can double up to hoist another resident – that is my only complaint." Another told us, "One or two [staff] rush me and are not patient with me, but I make allowances because they have so much to do." This meant that for some people their care was not always as respectful as it could have been.

People, relatives and the home's manager confirmed that there was never any restriction on visiting or being

visited. One person said, "My family can come at any time which they do." Another person said, "Yes, they [staff] are friendly. My relative likes them and they [staff] remind me when they [relative] are coming to see me. (As) I forget." We saw that pet dogs were able to visit people who had a preference for this.

Care records were held securely and staff ensured that these were only reviewed or read in private.
We found that people had relatives, friends and representatives who acted as an advocate for them if required. Formal advocacy had also been sought for one person, who lacked mental capacity, as an Independent Mental Capacity Advocate. Advocacy is for people who cannot always speak up for themselves and provides a voice for them. The home's manager, staff and office administrator were aware of organisations which offered this service if required. This showed us that people's wishes, needs and preferences would be respected if people were not able to speak up for themselves.

Requires Improvement

# Is the service responsive?

## Our findings

Although there were planned activities, such as painting, ball games and watching a favourite film on DVD, these were limited to small groups of people. There were missed opportunities for people to be more involved in their care. For example, where people were cared for predominantly in bed we saw that staff, on the ground and first floor, did not spend meaningful one to one time with people other than when providing personal care or refreshments and meals. We also saw that there was limited interaction between them and the people living at the service. This was due to the recent departure of an activities staff member. Staff seemed to be concentrating on managing tasks rather than spending any meaningful time with people. This meant that for some people the opportunity for social stimulation and wellbeing was limited. One person told us that they could not go out into the garden as often as they wanted. The manager had plans in place to improve the way people were supported who were not able to take part in communal activities as well as recruiting additional staff for people's social stimulation. This was also confirmed by staff who said, "We could do with more things for each person to do. I think this will be arranged when a second activities person is employed."

We found that two people who had expressed a wish to be out of bed before 11am were still in their bed at 12.15pm. One person told us, "It is 12.05pm now and I have not had a wash yet. I want to get up off the bed and sit in my chair." Another person said, "I would like to get up a bit earlier than I do. I have asked the staff and sometimes they get to me earlier but then it goes back to a later time. The staff tell me they are busy and will get to me as soon as they can but it has been nearly lunchtime more than once." The manger confirmed that this did not normally happen. The manager said that they were changing the culture in the service and that some people who liked to get up early would normally be helped to do this by the night shift. We found that they were in the process of improving the situation to ensure that people's wishes were respected.

We also observed delays in staff responding to people's requests to be put back to bed after lunch. The person reported to us that they had asked to be put to bed when they were taken back to their room at 1.45pm. From when we started to speak with the person to when care staff responded was 18 minutes. The person was not distressed about this but said, "This happens every day if they take me to the dining room, I have to wait a long time for someone [staff] to come." A relative told us, "The [previous] staff knew [family member] and their quirky ways – now every time you come it's different staff which makes it very difficult for me to feel reassured that [their] needs are being met." In addition, we saw that some staff appeared to ignore people's call bells until we highlighted this situation to them. This meant that people's care needs weren't responded to as quickly as they should have been.

For those people living with dementia on the second floor there was limited memorabilia and information which people could use to help them identify with their surroundings and help recall their memories. For example, with items such as pictures which people could associate with as well as dementia friendly signage. This meant that people weren't always supported in a way which was as individualised as possible. The manager had recently identified this and had plans in place to address this matter. They said, "If required we will buy whatever is needed so that people have the things they may need."

People's needs were assessed before the manager deemed the service suitable and appropriate to meet the person's needs safely. Other information including that from any hospital admissions was also used as a way of identifying what was important to each person. Key information about people such as their pastimes and life histories formed the foundations of people's care and care plans. This information was then used by staff to help them understand what really made a difference to people. One person told us, "I love feeding the birds and sometime the squirrels. Another person told us, "There are people whose relatives bring their pet dogs which I like to fuss over."

Recent improvements had been made, and were also in progress, in the way people were involved in the planning of their care. This was to address previous concerns from relatives that they had not always been kept informed about their family member's health and changes to this. For example, by each person having a key worker [this is a member of staff with a specific role for people's care such as keeping care plans up to date. This was to help identify the finer points of each person's care such as the type of soap and toothbrush they preferred. Other ways people were involved included day to day conversations with staff and if any changes to their care needs were required these were then implemented.

People and their relatives knew how to make a complaint and management and staff knew how to respond. People were actively encouraged to give their views and raise concerns or make suggestions before they had the potential to become a complaint. We also saw that visitors and health care professionals could complete a quality assurance survey on aspects of the service provided. Any concerns raised were added to the regional, and home's manager's action plan. We saw that complaints had been responded to in line with the provider's policy. As part of people's admission to the service they, or their relatives, were given a booklet with information on how to raise a concern or compliment. This included external organisations such as the Local Government Ombudsman for social care as well as the CQC which people could escalate concerns if required. Most people were either satisfied or very happy with their care. One person said, "I haven't made a complaint – I just tell the care staff [if they had concerns about anything] and they [staff] usually do something about it – but it has to be one of the regular carers, and there are not many of them." Another person said, "I have no need to complain, my care is good."

Good

# Is the service well-led?

## Our findings

The service did not have a registered manager. A manager of the service had been in post for four weeks as an interim measure. The provider was in the process of recruiting a replacement manager. The regional manager said, "We want to make sure we recruit someone who has the right skills to manage the service." The provider had notified the Care Quality Commission about important events that by law, they are required to do so.

We saw that the provider was not clearly displaying their CQC inspection rating prominently in the home. The manager told us that this was because they had been focused on the higher priority concerns. We did however note that the provider had this correctly displayed on their web site. The manager immediately displayed their rating's poster prominently where people and visitors could see it.

We found that in response to recent concerns about people's care at the service, the provider had brought in a manager who was registered at one of their other services as well as support from a regional manager. This was to help identify those areas of the service requiring improvement as well as areas which worked well. We saw several examples where improvements had been made such as the way audits of people's prescribed medicines were undertaken. We also found that these audits were effective. Actions had been taken to ensure that there was an adequate supply of people's medicines. Other audits included people's dining experience. Again, we found that these audits had driven the improvements we saw in the way people experienced their meal times.

All staff commented favourably in the way changes were being implemented. One staff said, "We now work much better with each other and there are clear lines of management." One person told us, "I do see the lady in charge. She often pops her head round my door and checks that I am alright." Another staff told us, "This is a lovely home that puts the people who live here first." All staff said that the manager was approachable and that they felt listened to and supported. All care staff said the home's manager and nurses listened to them and gave good support and they felt the service was becoming better organised now there was a new acting manager in home. The regional manager told us that there was still work to do but they felt that the service was now heading in a much better direction and that they had confidence in the current management of the service. We saw that the provider had an action plan with dates actions were planned to be completed by and the staff who were responsible for implementing their actions. Other examples of improvements made included more person centred care plans.

On the notice boards in the service we saw that a yearly programme of meetings for people their relatives and staff had been planned. We also saw that the planned meeting for March 2016 had been held when staff were made aware of their responsibilities such as ensuring they followed the correct procedure for reporting their absence. We saw that where staff had not adhered to this that the provider was taking appropriate action to prevent recurrence. We also saw that these meetings gave people, their relatives and staff, the opportunity to comment on the quality of various aspects of their care. This included, for example, the provision of more laundry and activities staff. We saw that this had been acted upon with another member of the laundry team to start once their pre-employment checks had been satisfactorily completed.

People's, staff's and health care professionals' views about developing and improving the service were sought in the most appropriate way. This included quality assurance questionnaires available in the entrance area of the service. Relatives and staff confirmed that the most recent home's manager was always available to talk about anything and was always willing to listen and, where practicable, act on and suggestions or comments. One member of staff said, "The new care plans are now much more person centred." We saw that this was the case. In addition, to help support improvements in the quality of service provided the home's manager had introduced staff champions. This was for roles such as infection control. This was also confirmed in the PIR.

All staff commented favourably about the changes made so far and other planned improvements. One member of care staff said, "Knowing who has to do what, and when, makes our job easier." Another said, "Having the nurses' help with some aspects of people's care has benefitted us and them [the people]." A third staff member said, "We work hard to ensure people receive the care they need."

The regional and home's manager kept themselves aware of staff's day to day performance and the quality of care they provided. This was by regular contact with the clinical and senior care staff leads. Staff confirmed that the support they now received enabled them to do their job effectively. For example, with the provision of additional domestic, and more permanent, staff as well as extra slings for moving and handling people.

Staff meetings also included a daily 'Flash' meeting. This was a sharing information meeting to share important details about people's care. For example, any accidents or incidents and any health care referrals. This meeting and staff shift handover records were now a regular feature. Staff were then able to make the necessary changes to people's care such as new equipment and beds for pressure ulcer care and prevention. We saw that these were being used to the benefit of people's wellbeing.

Links were maintained with the local community and included visiting singers, musicians, religious organisations, members of the various scouting movement, a local community centre and school choirs as well as participating the National Care Homes open day. [This is an occasion where members of the public and relatives can see what a care home is all about].

Staff spoke confidently putting the provider's values into practice about valuing each person as 'a person'. This also included putting people first and foremost first. One nurse said, "The reason I came to work here was the difference I like to see, and make, to people's lives." Another member of staff told us, "It's like home and not just a place for people to be cared for." One person said, "All the staff are dedicated to their job. I couldn't do it, but they try so hard."

From our observations throughout the day we saw that the regional, and home's, manager as well as staff had an understanding about the key risks and challenges in running the service. For example, whilst a registered manager was not in post and the changes that were being implemented to people's benefit. This showed us the service sought to ensure that the quality of people's care was frequently considered and acted upon.

Staff were regularly reminded of their roles and responsibilities at supervisions, annual appraisals and staff meetings. This was to help ensure the right standards of care were achieved and maintained. Staff told us they felt very confident that they would be supported to escalate any issues or concerns they became aware of if this was required. One care staff said, "I, absolutely, would have no hesitation in reporting any concerns [about people's care] if I ever became aware of, or saw them. We are here to make sure people are cared for properly."

The service had been awarded a rating of five out of five for food hygiene [this is the highest award]. Part of this assessment includes the management of food hygiene. We saw that the current systems in place had helped ensure a good standard of food and kitchen hygiene was maintained.