HC-One Oval Limited

Highfield Care Home

Inspection report

London Road
Halesworth
Suffolk
IP19 8LP

Tel: 01986872125

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Highfield Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Highfield Care Home is registered to provide support to 40 older people, some of whom may be living with dementia. At the time of inspection there were 30 people using the service.

In 2017 the service was bought by HC One and registered with the Care Quality Commission as a new provider. Shortly before this visit the registered manager had stopped working for the service and the deputy manager had stepped into their role. After the inspection visit they told us they had been offered the permenant post of registered manager.

Improvements were required to ensure that the service was clean in all areas to prevent the potential spread of infection. The manager and provider had identified improvements required and there were plans in place to make these.

The provider and manager needed to consider the safety of the stairs in the service and carry out a risk assessment. Checks were carried out on other areas of the service to ensure that the environment and equipment remained safe. Where actions were identified, these were signed off as completed.

Improvements were required to the provision of activities to ensure people felt engaged and had access to meaningful activity. The provider and manager had identified this shortfall and plans were in place to address this.

We observed that there were enough staff to meet people's needs during our visit. However, staff and people using the service told us they felt there were not enough staff at night. Further consideration needed to be given to the effectiveness of the staffing level at night and how staff were deployed to ensure people felt supported.

Staff had received appropriate training and support to carry out their role effectively. Recruitment procedures were safe.

Medicines were stored, managed and administered safely. Systems were in place to identify issues in medicines administration and records demonstrated that these issues were resolved.

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) People were supported to have maximum choice and control of their lives and staff

supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

There were appropriate risk assessments in place for people to reduce risks such as malnutrition and falls. People and their relatives told us they felt safe living in the service and that staff made them feel safe.

People received appropriate support to maintain healthy nutrition and hydration. The support people needed to reduce the risk of malnutrition and dehydration were set out in their care plans. People told us the food was good quality and they had a choice of meals.

People told us staff were kind to them and respected their right to privacy and that staff supported them remain independent. Our observations supported this.

Records demonstrated that people and their relatives were encouraged to feed back on the service in a number of different ways. The views people expressed were acted on and changes made. People told us they felt listened to and involved in how the service was run. People told us they knew how to complain and felt they would be listened to.

People received personalised care that met their individual needs and preferences. Improvements were planned to further personalise care plans and implement life histories for people. People and their relatives were actively involved in the planning of their care.

The manager created a culture of openness and transparency within the service. People made positive comments about the approachability of the manager. Staff told us that the manager was visible and led by example. Our observations supported this.

There was an adequate quality assurance process in place capable of identifying shortfalls. There was an improvement plan in place and plans were already in place to address shortfalls we identified.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mostly safe.

Some improvements were required to ensure people were protected from risks associated with stairs.

Some parts of the service required further cleaning to reduce the potential spread of infection.

Medicines were stored and administered safely.

Risks to people were minimised because there were plans in place to guide staff on reducing risks to individuals such as falls and malnutrition.

There were enough staff to meet people's needs. However, further consideration needed to be given to how supported people felt at night. The service practiced safe recruitment procedures.

Is the service effective?

Good

The service was effective.

The service was meeting the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.(DoLS).

Staff had the training and support to deliver safe, effective care to people.

People were supported to eat and drink sufficient amounts.

People were supported to have contact with other healthcare professionals such as GP's.

Is the service caring?

Good

The service was caring.

People were treated with dignity, kindness and respect by staff.

People were supported to remain as independent as possible.

People and their relatives had been involved in the planning of their care.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

Improvements were required to activities provision.

People received personalised care that was responsive to their needs. Improvements were being made to further personalise care records.

People told us they knew how to make complaints and were confident these would be acted on.

The service was implementing end of life care planning which reflected best practice guidance.

Is the service well-led?

Good

The service was well-led.

There was an adequate quality assurance system in place. The manager and provider had identified the issues we identified at this visit. Plans were in place to address these shortfalls.

The manager and provider were open and transparent, involving people in the process of making changes to the service.

Highfield 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 checked 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 comprehensive inspection was carried out by one inspector on 21 & 25 June 2018 and was unannounced.

Prior to the inspection we reviewed the contents of notifications received by the service. Services have to notify us of certain incidents that occur in the service, these are called notifications.

Some people using the service were unable to communicate their views about the care they received. We carried out observations to assess their experiences throughout our inspection. We spoke with six people using the service, one relative, three care staff, the acting manager and the team leader.

We reviewed six care records, two staff personnel files and a sample of records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

The service had not fully assessed some risks in the environment. For example, stairs did not have gates to reduce the risk of people with poor mobility climbing the stairs. The service had not carried out a robust and detailed enough risk assessment to demonstrate that individuals were not at risk and to reflect any appropriate measures for reducing the risk. It was also unclear how the service would monitor whether these measures remained effective.

The service had maintenance staff who carried out regular checks on water temperatures, window restrictors, fire alert systems, call bell systems, electronic appliances and gas appliances. The service had a legionella policy in place and an external company carried out regular testing on the water quality at the service. The maintenance person carried out regular flushes of the water system to ensure the risk of legionella was reduced. Checks were also carried out regularly by an external company on the fire systems in the service. Records demonstrated that equipment such as hoists and wheelchairs were serviced yearly. Regular checks were carried out on the condition of walking frames to ensure that they remained fit for purpose and to reduce the risk of people falling.

People told us they were happy with the cleanliness of the service. One said, "It is clean enough. [Staff] come in and hoover, dust. It's all done." Another person told us, "I think it's cleaned to a reasonable standard. My bedroom is certainly clean." Whilst the service appeared mostly clean and free from unpleasant odours, some areas of the service required further cleaning to reduce the risk of the spread of infection. For example, we observed that there were spills of liquids on walls, furniture and carpets which had not been cleaned. Some chairs were soiled and required cleaning and the bottoms of dining room chairs had a significant build up of dust, indicating they had not been cleaned for some time. Checks were carried out on the cleanliness of the service and the manager had identified other issues which had been rectified. However, they had not identified all of the issues we observed. There were cleaning rota's in place and night care staff were required to clean parts of the service. We told the manager about the cleanliness shortfalls in the service. They told us they would look at the duties of the night staff to ensure that staff had the time to meet people's needs and keep the service hygienically clean in all areas.

We observed that staff wore appropriate protective clothing and gloves when providing care to people and these were discarded between tasks. Kitchen staff wore appropriate protective clothing when preparing food and the kitchen had been awarded a five out of five at a Food Standards Agency inspection.

People had mixed views about the staffing level in the service. One person said, "During the day, yes there's enough. At night, no there are never enough." Another person told us, "At night you can wait a while. If they only have three on it isn't enough, with four it's just about ok." One other person commented, "I don't think there are enough at night but during the day it is fine." Staff we spoke with confirmed they had the same views, and felt that the staffing numbers for the day were sufficient but that at night people had to wait longer for staff to support them. The manager told us that there were either three or four members of care staff on at night depending on whether people required more support at night because they were unwell. These care staff were also required to carry out cleaning in the service. The manager showed us the

dependency tool they used to calculate the staffing level, and demonstrated that they took into account what checks and support some people may need at night. When we fed back the comments of people using the service and staff, the manager told us they would talk to people and look into the staffing level at night and the duties of the staff. They had been carrying out random checks on call bell response times during the day, but said they would carry out additional checks at night to look at how responsive staff were to people's requests for support.

We observed that throughout our visit, there were enough staff available to meet people's needs. Call bells were responded to quickly by staff and we observed that staff were available in common area's where people were seated. We observed that staff had time to sit with people throughout the day and engage them in conversation.

The service practiced safe recruitment procedures. Checks were carried out on prospective staff to ensure that they had the skills, knowledge, experience and character for the role. This included ensuring they did not have any criminal convictions which may make them unsuitable for the role. This demonstrated to us that the recruitment procedure was robust.

People told us they felt safe living in the service. One said, "I feel very safe, it is very secure." Another person said, "I haven't to worry about safety, there is always a carer around and that's peace of mind." The provider had a procedure in place to investigate instances such as unexplained bruising which ensured people were protected from avoidable harm and abuse. Staff knew of their responsibilities around recognising and reporting potential signs of abuse and demonstrated a good knowledge of safeguarding policies and procedures.

Risks to people were monitored, planned for and minimised. Each person had a set of individualised risk assessment. These assessed the level of risk to people in areas such as pressure care, falls, malnutrition and choking. Where people were identified as at risk, there were clear isntructions that staff could refer to in order to minimise the risk. Due to a recent change in the ownership of the service, care records were still being transferred onto the paperwork provided by the new owner. We saw that the new risk assessments were more detailed than the older ones and included an enhanced level of information for staff. The staff member completing these risk assessments had included clearer information for staff and specific information about people's conditions or medicines and how this could impact their risk level. This demonstrated progression in minimising risks to people using the service.

The management team had a process in place to oversee people's risk levels and ensure prompt action was taken where needed. For example, the manager reviewed people's weights regularly so that they could determine if they were losing weight and may need input from a dietican or a change to their care. We saw that where people's risk levels had increased, action had been taken by the management team to seek prompt advice from specialist healthcare professionals such as dieticians, GP's or district nurses. This meant we were reassured that people were protected as far as possible from risks.

The manager had a system in place to oversee incidents and accidents. Each month the manager reviewed the incident forms submitted by staff and recorded how many types of each incident there had been. For example, they reviewed the number of falls that had occurred and compared these to previous months. The manager considered the times of these falls and carried out thorough and questioning investigations into possible causes. They told us this helped in determining whether changes needed to be made to the staffing level or whether a person needed care interventions at a certain time. Records demonstrated that falls in the service had decreased in the months prior to inspection. Clear actions were taken to protect people from the risk of repeat incidents, such as by implementing new care planning or by gaining advice from specialists

such as the falls team.

People told us they received their medicines when they needed them. One said, "They're very prompt. They never forget." Another person told us, "They bring me the tablets and watch me take them. I've not been missed before."

We compared the number of remaining medicines to the number of doses recorded as administered on the medicines administration records (MARS) and found that these matched. This meant we were reassured that people were receiving their medicines in line with the instructions of the prescriber.

There were protocols in place for 'as and when' (PRN) medicines to guide staff on when it might be appropriate to administer them. For people with the newer care planning, there were detailed care plans in place which stated the purpose of their medicine, how it worked, potential side effects and how it might affect them. These would be helpful in supporting staff to better understand people's individual health needs.

Regular audits were carried out to check whether medicines were being administered and recorded correctly. We saw that these audits had been effective in identifying some gaps in records and this had been included on an improvement plan. This action had been effective in resolving these issues prior to our visit.

Good

Is the service effective?

Our findings

Improvements were required to how the service was decorated in order to ensure it provided stimulation and orientation to people living with dementia. For example, corridors were not painted in different colours which made it difficult for people to distinguish between them. Some bedroom doors were not personalised which meant people may not always be able to identify which room was theirs. The décor was plain and did not provide stimulation to people. We recommend the service refers to best practice guidance around providing an environment which is suitable for people living with dementia.

People told us and we observed that care was delivered by staff with the appropriate skills, knowledge and experience for the role. One person said, "Those carers do know what they are doing. Experts in their field." Another person commented, "You see them going for training. They seem very skilled, very knowledgeable. How they respond [to people living with dementia] shows that they know their stuff."

Records of staff training confirmed they received training in subjects such as food hygiene, health and safety, fire safety, moving and handling, dementia and the Mental Capacity Act. Staff told us that they were asked about additional training they would like during meetings and during supervision sessions with their manager. A new member of staff told us they found the training they had received helpful and was complimentary about it's quality in comparison to previous training they had received at other services. Other staff were complimentary about the training they received and said that the manager was always open to suggestions. For example, one said they wanted to do training in end of life care and this had been arranged for all staff by the manager. Staff told us that the manager encouraged them to obtain higher qualifications, such as NVQ's and supported them in achieving this. Staff we spoke with were knowledgeable about subjects they had received training in and at the time of our visit, all staff were up to date with the service's mandatory training.

Staff told us they had the support they needed to carry out their role effectively and were positive about the manager and team leaders approachability. Staff told us and records confirmed that they had access to regular supervision sessions with their manager where they could discuss any concerns or training and development needs. Staff told us they found these sessions helpful and one said they found the feedback useful for improving their practice. Staff also had an annual appraisal to set goals and aspirations for the coming year. This demonstrated the management team's commitment to continually improving the knowledge and skills of the staff team.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes

and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People using the service had their capacity to make decisions and consent to their care assessed appropriately under the MCA. Prior to our inspection, the manager had identified shortfalls in the way the service assessed people's capacity and the care planning around people's capacity and ability to consent. We found that improvements had been implemented and that people's capacity had been assessed appropriately. There was sufficient information for staff about how people could consent and how staff could support them with day to day decision making. The manager was in the process of transferring people's care records to a new format provided by the new owner. We saw that this new paperwork was much improved in comparison to the older paperwork. The author was prompted on each care plan to state how the person could make decisions or consent. For example, a care plan for washing and dressing set out whether the person could choose their own clothing or the methods by which they could consent to being supported with washing.

Correct processes had been followed where best interests decisions needed to be made to protect people's safety and welfare. People's relatives and other professionals had been involved in the process of making these decisions and DoLS applications had been submitted as necessary.

We observed that staff encouraged people to make decisions independently based on their ability. Observations concluded that staff knew people well, and this enabled them to support people to make decisions regardless of their ability to verbally communicate their views.

The manager assessed people's needs prior to them moving into the service to ensure that the staff group had the right skills to meet their needs. Relatives of one person who was moving into the service described the managers pre-admission assessment as 'very thorough' and stated that they had been very helpful in supporting them with the admission process. We saw that the manager completed a 'seven day care plan' for new admissions to ensure that staff had enough knowledge to provide them with appropriate care while more detailed care plans were being written with input from the person and their representatives. The service had taken into account best practice guidance from organisations such as the National Institute for Health and Care Excellence (NICE) when writing and reviewing people's care records. Staff knew where to access information about people and we saw them referring to people's care plans for information about how to meet their needs. This meant we were assured that staff had the information required to provide people with effective care in line with best practice guidance.

People were supported to maintain good nutrition and hydration. People told us that the food and drink they were provided with was of good quality. One person said, "The food is excellent, consistently good. There is a lot of choice and if you don't want what is on the menu, they will just make you something else." Another person told us, "All the food is lovely, the portions are good and there is always more if you want it. They ask you what you want to eat, there is a good choice." One other person commented, "They do everything to your preference. I prefer boiled potatoes instead of mashed, and the cook always does me boiled potatoes."

We observed that the meal time experience was a positive one and people were able to choose their meals from a hot trolley. People with limited verbal communication or who were living with dementia were shown the different options to enable them to make a visual choice. People were provided with adapted cutlery and crockery where required and staff provided people with different portion sizes dependent on their preference. Staff sat with people and offered them ad hoc support, such as offering to cut up their food. Where people required full assistance to eat their meals, staff delivered this support in a dignified way, encouraging independence where possible.

The support people required to reduce the risk of malnutrition and dehydration was clearly set out in their care plans. Their risk of malnutrition was reviewed regularly and we saw that actions were taken to obtain specialist advice from a dietitian where this was required. Staff we spoke with were aware of people who required extra support to reduce their risk of malnutrition and dehydration. Records of people's food intake reflected that they were offered extra snacks between meals to boost their intake, such as home made cakes and snacks. This reassured us that people were supported to reach and maintain healthy weights.

The service supported people to maintain good health and access support from other healthcare professionals. One person said, "The doctor comes round weekly. If you need to see them then the staff will sort that for you. If you need to see someone another time then you only have to ask." Another person commented, "They are prompt, they will call the doctor if you want them to. I also see the chiropodist and the optician. They arrange it all for me." Records demonstrated that referrals were made to other professionals in a timely way and records were kept of the contact people had with other professionals. Care plans had been updated to reflect the advice given to ensure that people received effective care.

Good

Is the service caring?

Our findings

There was a positive atmosphere in the service and the manager promoted a culture of kindness in the service. People told us staff and the manager were kind and caring towards them. One said, "The staff are very kind. So cheerful, you never see a grumpy face." Another person told us, "The carers are nice people, very caring and treat me like one of their family." We observed that both the manager and care staff treated people with kindness.

People's needs were responded to quickly by staff to reduce their distress. For example, we observed one person becoming distressed because they needed the toilet. Staff reassured them promptly and met their need for support in a timely way.

People told us staff knew them well. One said, "They all know me, everything there is to know. We chat and joke, they know what I like and what I don't." Another person told us, "We all know each other very well. It's family orientated here and that means a lot." We observed that staff and the manager knew people well, and this enabled them to provide people with personalised and individualised care. The manager and staff talked with people about their particular interests, such as what was happening in television programmes they enjoyed or sports they liked.

The manager had taken into account people's social and emotional needs when calculating the staffing level during the day, and this meant that staff had time to spend with people one on one, engaging them and reducing the risk of distress, social isolation and loneliness. One person told us, "I never feel lonely, there is always someone about to chat to and staff come and see me regularly even though I prefer to stay in my room."

People told us and we observed that their right to privacy was respected by staff. One person said, "They are mindful of my privacy. I like to stay in my room but they always knock, ask if it's ok to come and see me. The cleaners check it's ok to clean my room and ask what I want doing. Everyone is respectful." Another person told us, "[The staff] knock before they come into your room. If I want some quiet time the staff will tell me to call my bell if I need anything and leave me to it." We observed that discussions staff had with people about meeting their personal care needs were discreet and personal care was carried out in private to uphold people's dignity. Staff knocked on people's bedroom doors and asked permission before they entered. This demonstrated to us that staff were mindful of people's right to privacy.

People told us and we observed that they were encouraged by staff to remain as independent as possible and use the skills they had. One person said, "I haven't been here long and it's been a transition. I like to be independent and the staff are always happy to just do what I need and not overstep the mark." Another person told us, "They know what I can and can't do, they do encourage me to do more but some days I am too tired so they help. There is a good balance." We observed that staff supported people to keep safe when mobilising independently, such as by walking beside them or encouraging them to transfer independently. This reduced the risk of people being over supported and losing the abilities they still had.

Requires Improvement

Is the service responsive?

Our findings

Improvements were required to ensure that people had access to appropriate activities which were meaningful and stimulating for them. This was confirmed by people using the service. One person said, "The activities are just OK. It's the same thing all the while, you don't get much different. We never get to go out, I'd love to go on trips. Maybe to Southwold." Another person told us, "I don't join the activities because it's always dominoes, card games or the like. My sight is poor so I can't join in those activities." Another person commented, "We could do with more [activities]. Trips would be a nice addition, I never get to go out. The activities get a bit repetitive."

We observed that there were some group activities taking place, but that these did not engage everyone using the service and only one or two people were engaged at any one time. There was not a range of activities available to suit the differing needs of people using the service. There were no sources of activity people could access independently, such as books, craft materials or items to stimulate those living with dementia.

The manager had identified the shortfalls in activity provision prior to our inspection and had sourced reputable training for staff. They also demonstrated they were looking into the hobbies and interests of people using the service and considering how they could give activities provision more structure. They told us that they did not have their own minibus in order to take people out for trips. However, they demonstrated to us that they had recently raised concerns about this with the provider who had agreed a budget to hire a minibus regularly to facilitate trips out for people. The manager had plans in place to discuss where people would like to visit so these trips could be scheduled.

Whilst some care records had been transferred to the new providers format, others remained on older paperwork. The care records which hadn't been transferred over were not as personalised and did not always include information about people's hobbies, interests, likes and dislikes. Some of these care records did not reflect people's views on their care and how they would like staff to support them. There were not life histories in place for everyone living with dementia. This information could be useful in helping staff to better understand people and to engage with them in a more meaningful way. The provider and manager had identified shortfalls in this area and this was reflected on an improvement plan currently in place. They were currently in the process of transferring all care plans into the new format and implementing 'remembering together' booklets which would record people's life histories and their preferences. The newer care plans we reviewed were much improved and had an enhanced level of personalisation, including information such as where they would like to eat their meals and how they would like to spend their day.

Despite the improvements still required to some records, we observed that all the staff working during our visit knew people well. Staff were aware of peoples preferences such as the foods and drinks they liked, the portion sizes they preferred at meal times and their interests. The service had a stable staff team and this meant that people did receive personalised and individualised care.

Improvements were required to implement detailed end of life care planning for people. Prior to our visit, the manager had already identified this shortfall and was taking steps to implement these. They had booked staff on a reputable end of life training course. In addition, they were attending a training course on the Gold Standards Framework for end of life care to improve their knowledge. They showed us they were also in the process of implementing the 'yellow folder initiative'. This is where information about people's preferences and the care they require at the end of their life are contained within a yellow folder for easy access. This initiative also prompts care providers to include an enhanced level of detail in this care planning.

People told us they had been involved in the planning of their care. One person said, "Yes I remember them asking me about what I wanted. I've seen my plans, they asked me to sign." Another person told us, "They keep me up to date, ask me about reviewing them, I'm happy with what is there." Most care records we reviewed had been signed by the person or a relative to confirm they were happy with the content. The newer care plans better reflected people's involvement and people were asked to sign each care plan to confirm they agreed with the content. Discussions with the manager demonstrated they had taken the time to get to know people and they were able to tell us about people's personal interests and the support they required. This included people who had not been using the service for very long.

People told us they knew how to complain about the service and felt they would be listened to. One person told us, "I have never had to make a complaint but I know how I would go about it. Everyone is very open." Another person said, "I'd tell the manager but I've never had a complaint. I feel like everything would be sorted if I did." At the time of our inspection, the service had received one complaint. We saw that this had been recorded and responded to appropriately. There was a complaints procedure in place which was displayed in a communal area.

Good

Is the service well-led?

Our findings

In 2017 the service was bought by HC One and registered with the Care Quality Commission as a new provider. The deputy manager is now managing the service and is applying to be registered with us.

People told us that they felt the service was well run and that the manager was good. One person said, "It's all run like clockwork. The manager is great, keeps everything as it should be." Another person told us, "I really like [manager], I've known them a lot of years and they have always been very good to me." Another person commented, "I think [manager] runs a tight ship and I really get along with [manager]."

There was a positive atmosphere in the service and it was clear the manager knew people using the service and staff well. Staff made positive comments about the manager and said they were supportive and got involved ensuring people's needs were met when necessary. We saw that the manager was visible throughout our inspection and staff told us that they were often present in communal area's overseeing the practice of staff and offering guidance. One staff member told us that the manager gave them constructive advice and guidance which they found useful and positive in improving their practice.

Effective systems had been implemented to assess the quality and safety of the service provided to people. There were systems to monitor key areas of service provision such as incidents and accidents. We saw that these systems had prompted the manager to consider things such as staff training needs and what further support people may require. For example, a system to monitor falls had identified that people had been falling more at night. We saw that the manager held a meeting with staff to discuss a new falls protocol they had implemented and to introduce a new structure for where staff should be situated in the building during the night. Records demonstrated that these actions had led to a reduction in falls within the service.

Internal inspections and audits carried out by the provider and manager had found that improvements were required in the area's we identified at this visit. These actions had been included on an action plan. Other actions on this improvement plan, such as changes to medicines administration and audit systems had already been made by the time of our visit. This reassured us that the service was capable of independently identifying shortfalls and taking action to drive improvement in the service.

The provider and manager had focused on promoting people's dignity by considering the appearance of the service. They had carried out a 'one proud home' audit which looked at the outside of the service, the gardens, the quality and condition of soft furnishings inside and whether staff supported people to look well presented. Issues we identified, such as stains on carpets had been picked up during this audit and plans were in place to thoroughly clean or replace these. This audit had also picked up that there were unpleasant odours in parts of the service which could compromise people's dignity. By the time of our visit this issue had been resolved and we did not identify any unpleasant odours.

The manager had been working at the service when it was owned by another provider and there were significant failings in the service. It was clear from our discussions and their actions that they had learned from previous regulatory breaches and were working towards bringing about positive change now that they

were managing the service. For example, in the past there had been significant shortfalls in risk assessment and procedures under the Mental Capacity Act (MCA). These issues were not continuing at our visit.

The manager was open, honest and transparent. They actively involved people using the service and their relatives in the process of driving improvement in the service. People were given the opportunity to feed back on the service in a number of ways. They were invited to regular meetings where they could communicate their views. We reviewed the records of the last meeting and saw that people had requested pendant alarms, so that they could call for staff assistance wherever they were. We observed that these were now in place.

People were also encouraged to complete a survey of their views. The results of the most recent survey had been collated so that trends could be identified. Results of this survey demonstrated that half of the respondents were dissatisfied with the activities on offer in the service. At the time of our visit the manager was already looking at how this could be improved. They were implementing a new survey to find out what people's individual interests and hobbies were. They had also sourced reputable training for staff and were implementing a more structured activities plan based on people's feedback. In addition, they had created a 'relatives committee' to give people using the service more input into how and what changes should be made.

People told us they felt listened to and that their views in terms of how the service was run mattered. One said, "You can go to the meetings or there is a survey. The manager comes and chats anyway so you can say what you think." Another person told us, "We do get asked what we think, they listen and things get done." Two people told us that they had been asked to take part in the recruitment of staff, and formed part of the panel during staff interviews. One person said, "I've never been asked to do that before so I appreciated it, it meant a lot." Another person told us, "It's nice to be involved, to check them out before they start here and see if they are a good fit."

The service maintained good links with the community and other care services. People told us that links with the community were important to them. One person said, "I've lived here all my life and everyone knows me. [Staff] take me to town, to the market or the café so I can see people." They also told us, "My friends are welcome any time, there's no restriction there."

The manager met regularly with the managers of other care services owned by the same company. The manager from another care service came to support the manager during our visit. They spoke about sharing best practice and ideas through meetings. The manager also attended other externally organised meetings, such as on infection control, to ensure they kept up to date with best practice.