Amson Care Ltd

Shiels Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

This inspection was unannounced and took place on 28 and 29 June 2016.

During our inspection of the home in December 2015, we found that the provider was in breach of nine Regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. These were in respect of sufficient staffing, safe care and treatment, safeguarding service users from abuse, the need for consent, meeting nutritional and hydration needs, providing person centred care, statutory notifications and good governance. We placed positive conditions upon the provider and imposed a condition to restrict admissions. We also placed the service into special measures.

At this inspection, we found that the necessary improvements had been made. Therefore the provider is no longer in breach of these Regulations. However, improvements were required to make sure that people consistently received care that was well planned and ensured that their needs were met at all times.

Shiels Court Care Home is a service that provides accommodation for up to 43 older people, many of whom may be living with dementia. On the day of inspection, there were a total of 30 people living at the home.

There was a manager employed at the home who had recently applied to become the registered manager. They had been in post since December 2016, when the previous manager left suddenly. 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 provider had recently put systems in place to protect people from the risk of abuse and risks to peoples safety had had been assessed. However, these systems had not yet become fully embedded and were not used consistently for all people living in the home. The home and equipment that people used was clean.

There were enough staff to meet people's care needs safely, and people received their medicines when they needed them. Staff had received appropriate training and supervision to provide them with the necessary skills and knowledge to provide people with effective care.

People were treated with dignity and respect by staff that were kind and compassionate. People were asked for their consent about their care, staff understood how to support people who were unable to consent to this.

People received enough to eat and drink to meet their individual needs and timely action was taken by staff when they were concerned about people's health. However systems that had been put in place to monitor people's intake of fluid were not always completed. We brought this to the attention of the manager who made changes regarding the overview of these records immediately.

People's individual care needs and preferences had been assessed. However the records used by the provider contained out of date information and had not been regularly updated with changes. The provider had taken action to address this, but progress was very limited. People were able to participate in a wide range of suitable activities, both in the home and within the local area.

The staff were happy working in the home and felt supported in their role. They were clear about their individual roles and responsibilities. However, some staff lacked the confidence and experience to interact with people with communication difficulties when providing one to one support. People, their relatives and staff were positive about the changes the new manager had made. People told us that the manager was very approachable and were confident that planned improvements would continue to be made.

Any complaints or concerns that were raised were listened to and dealt with. The provider had recently purchased a system to monitor the quality and safety of the care provided which was to be introduced shortly.

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 home and equipment was clean.

Systems were in place to protect people from abuse.

There were enough staff to meet people's needs and to keep them safe.

People received their medicines when they needed them.

Is the service effective?

Good

The service was effective.

Staff had received training and supervision to provide people with effective care.

Staff sought peoples consent before providing support. However, care records did not show that people's consent had been obtained in line with legislation and guidance.

People had enough to eat and drink. Improvements had been made to the monitoring of peoples intake of these.

Is the service caring?

Good

The service was caring.

Staff were kind and treated people with dignity and respect.

People and their relatives were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Not everyone's individual needs and been recently assessed.

People were able to access activities that they enjoyed and

received stimulation to enhance their wellbeing.

People knew how to complain and felt that concerns were acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements had been made to systems to monitor the quality and safety of the service provided. However, not all of these had been fully implemented at the time of inspection.

The manager had listened to people living in the home, their relatives and staff. This feedback was used to make changes and improve the quality of service.

Shiels Court 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 inspection took place on 28 and 29 June 2016 and was unannounced. The inspection team consisted of two inspectors, a pharmacy inspector 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 that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us.

During the inspection, we spoke with seven people living at the home, three relatives of people, three care staff, the cook, the manager and a director of the company who own the home. We observed how care and support was provided to some people who were not able to communicate their views to us. To do this, 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 to us.

The records we looked at included six people's care records, medicines records and other records relating to peoples care, three staff recruitment records and staff training records. We also looked at maintenance records in respect of the premises and equipment and records relating to how the provider monitored the quality of the service.

Good

Is the service safe?

Our findings

At our previous inspection in December 2015, we found that risks to people's safety were not being managed adequately and the recording of incidents did not always take place. We also found that medicines were not managed safely, there were not enough staff to meet people's needs and staff were not always recruited having undergone the necessary checks. These concerns were in addition to issues regarding the cleanliness of the home and staff awareness of safeguarding people from abuse. This meant there had been a breach of Regulations 13 and 18 and two breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found that improvements had been made and that the provider was no longer in breach of these Regulations.

People that we spoke with told us that they felt safe. One person told us, "I don't get anxious about anything because I know everyone is looking after me." A relative of a person living at the home told us, "My [relative] is safe and secure here and it gives us peace of mind to know he is well looked after."

Staff we spoke with knew how to keep people safe and knew how to report concerns. Staff had recently undertaken training in the safeguarding of adults, and could tell us how to recognise indicators of abuse. The manager had reported any incidents of alleged abuse to the local authority safeguarding team, and had notified the Care Quality Commission (CQC). We were therefore satisfied that the provider had systems in place to protect people from the risk of abuse.

We reviewed records and saw risks to people had been assessed. This included risks associated with people who may fall, poor eating and drinking and developing pressure areas. Staff had a good understanding of risks to people and took actions to reduce these, for example reminding people to use their walking frames. However, not all records had been updated regularly to show that these reviews had been completed even when changes were not required. We spoke with the homes manager about this who told us that they were aware of this. They told us that to address this, records of people deemed as having the highest levels of risk had been prioritised. The manager told us that they expected to update all peoples risk assessments records in the coming weeks. This meant that although we were confident that staff knew how to manage people's risks, records relating to this were not regularly updated at the time of our inspection.

We saw that risks associated with the premises were well managed. Records we viewed showed the homes fire detection system was regularly serviced and tested. The homes maintenance officer carried out regular checks on water temperatures to ensure that these were within safe levels. We saw that fire doors were kept closed, and emergency exits were sign posted and clear of obstacles.

Since our last inspection, the provider had employed additional cleaning staff to ensure that the home was clean and free from risks associated from cross infection. During this inspection we found the home to be clean and there was a schedule in place that gave cleaning staff clear instruction on what items required cleaning and when. Staff wore personal protective equipment, such as gloves and aprons when supporting people with personal care or during the preparation of food.

At our last inspection we saw that staff had been recruited without the required checks being made to ensure that they were suitable to work at the home. Records we viewed at this inspection showed that staff recruited since then had undertaken the necessary checks to work at the home. However the homes manager had not kept records of the interview process that was used. When we spoke to them about this they agreed that records of staff interview would now be kept on file. This meant that we were satisfied that staff recruited to work at the home were suitable to do so.

People and their relatives that we spoke with told us they felt that there was enough staff to meet their needs. The manager told us that since our last inspection, where we identified concerns regarding the number of staff, staffing ratios had been increased. The manager told us that although they used a dependency tool to calculate ratios, they also met with the homes deputy manager and senior staff to calculate how many staff were required. They reviewed the needs of people at various times of the day. For example, additional staff were provided at breakfast time, because this was identified as a time where a high number of people needed support at the same time. As well as additional care staff being on duty, the home had also recruited additional ancillary staff and an activities coordinator. This meant that care staff did not have additional duties to perform such as cleaning or cooking and could focus their time on providing direct support to people. One person told us, "There seem to be enough staff and I don't need to wait if I need help." One relative told us, "There are enough staff as far as I am concerned." Another relative told us. "I do feel there are sufficient staff, I haven't noticed an occasion when they were short staffed." During our inspection, we observed this to be the case. Staff responded quickly to peoples requests for assistance.

During the inspection, our pharmacist inspector looked at how information in medication administration records and care notes for people living in the service supported the safe handling of their medicines.

When we asked people and their relatives about their medicines, they told us that they received them on time. Improved arrangements were in place for the storage of medicines. Medicines prescribed for external application or to be taken orally were stored safely for the protection of people who used the service and at correct temperatures. Supporting information was available to assist staff when giving medicines to individual people. There was personal identification information to help ensure medicines were administered to the right people and information about how they preferred to have their medicines given to them.

There were charts were in place to record the application and removal of prescribed skin patches. When people were prescribed medicines on a when required basis, there was written information available to show staff how and when to give them these medicines consistently and appropriately.
Records showed that people living at the service were receiving their oral medicines as prescribed. Frequent internal audits were in place to enable staff to check records and monitor and account for medicines. These were overseen regularly by the manager. However, for medicines prescribed for external application, there were gaps in records so the records did not confirm that all were being applied appropriately and as intended by prescribers.

Staff authorised to handle and administer people their medicines had received training and had been assessed as competent to undertake medicine-related tasks

Good

Is the service effective?

Our findings

At our last inspection in December 2015, we found that staff did not have a good understanding of their legal obligations when supporting people who could not consent to their own care and treatment. We also found that the provision of food and the monitoring of peoples nutrition and hydration was not adequate. We identified that staff did not receive regular supervision and had not completed all the training they needed to. This meant there had been a breach of Regulations 11, 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We told the provider that improvements needed to be made in these areas. At this inspection, we found that improvements had been made and that the provider was no longer in breach of these Regulations.

People and their relatives told us that they felt staff were well trained and knew how to support people. One person told us, "The people who work here all seem to know what they are doing." Another person told us, "The staff who look after me do a good job." A relative of a person we spoke with said, "Staff always seem to know what they are doing, so the training must be good."

All of the staff we spoke with told us they felt that they had received enough training to provide people with effective care. Staff told us that they had undertaken a lot of training recently, and that the manager made this a priority. The training records we checked confirmed that staff had received training. Staff's competency to perform their role had also been checked. The manager told us that this had not always been done in the past, so they had implemented a schedule to ensure that this was completed regularly. Staff told us that they now had regular supervision with the manager, and this was something that had recently been implemented. Staff said that they found these sessions supportive and helpful in developing their skills.

The staff we spoke with knew how to support people who were not able to consent to their own care. Staff followed the principles of the Mental Capacity Act 2005 (MCA). Any actions taken by the staff were made in people's best interests.

The 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 provider was working within the principles of the MCA.

The registered manager told us that since our last inspection, the staff had received further training in the MCA and DoLS. The staff we spoke with confirmed this. They were able to demonstrate to us the importance of seeking consent from people before they offered support. One person living at the home told us, "The carers ask permission before they do anything for me." We observed that staff always asked people before

providing them with support. For example we saw two staff explain to a person that they were going to support them to transfer into their wheelchair. They checked with the person first before doing this who initially accepted the offer. However, when the person changed their mind, the staff stopped and waited. They then offered the help again which was accepted and the person transferred to their wheelchair. This demonstrated to us that staff understood the need for people to consent and agree to the support that was offered.

Assessments of people's capacity to consent to certain decisions had been made when necessary. We also saw that applications had been made in accordance with the DoLS where this was considered appropriate. However, although staff understood the importance of seeking consent, people's ability to make informed decisions about their care was not always documented. For example where people had the capacity to manage their own medicines, but preferred that the home managed this for them, this was not identified to reflect this choice. When we spoke to the manager about this, they told us that they were aware that the information regarding people's capacity required improving. They told us that this was being addressed through the redevelopment of peoples support plans

People told us that they enjoyed the food and that they had a choice of meal. One person told us, "I like the food. We can choose from a menu, and if I don't like what they are offering, they will make me something different." Another person said, "The food is very good and to be honest I am always happy with the choice, but they would give me something else if I asked."

We saw that people had access to regular snacks and drinks. Where people were at risk of not eating or drinking enough, this was monitored by staff. The manager had implemented a system for staff to record people's intake of food and drink, which included a target amount taken from best practice guidelines. However, we saw that it could not be easily identified if people were not eating or drinking enough over a period of days, because these records were not reviewed. We also saw that staff did not complete these records consistently, which gave an inaccurate picture of how much a person had drunk. We brought this to the attention of the manager, who agreed that they would review this system. When we returned on the second day of our inspection, the manager told us that they had done this. Daily reviews now included checks to identify any gradual decline in a person's intake over time and we saw the amended records that were to be implemented.

A relative we spoke with told us, "My [family member] attempts to feed them self, but I know that if they are struggling [staff] will help them. We saw that people received help to eat or drink if they needed it, and that this was identified in their support plan. However we did observe that some staff did not engage in conversation or offer encouragement when supporting people to eat.

We spoke with the homes cook who had a good understanding of people's different needs. This included high calorie diets, soft or pureed meals and diets for people with diabetes. We saw that there was a rotating menu of choices, which was adjusted for seasonal preferences. We were satisfied that people's nutritional and hydration needs were being met.

The people and relatives we spoke with told us that their health care needs were met. One person told us, "I can see a doctor or dentist whenever I ask." The manager told us that people were able to see a GP from the local surgery when they needed to. The manager had established with the regular GP a system to gather key information about a person's current state of health so that this could be provided when contacting the surgery for an urgent appointment. This allowed the GP to prioritise a person's needs before visiting them at the home and ensure they received healthcare in a timely manner.

People's records showed that advice had been sought from other healthcare professional where this was needed to ensure people's health and welfare needs were met. Where people had been identified as having difficulties with eating and drinking, advice had been taken from the speech and language therapy services. This meant that staff had access to the information they needed to support people safely at mealtimes.

Good

Is the service caring?

Our findings

People we spoke with told us that staff were kind and caring. One person said, "The staff treat you like a relative and that is nice. They chat about family things." Another person told us, "Everyone is kind to me and I am happy here." A further person told us, "The staff are really kind and I mean every single one."

The relatives we spoke to also felt that staff were kind and compassionate. A relative we spoke to told us, "The staff who have been here for some time have become like friends, they are lovely. It makes it a pleasure to come and see my [relative] knowing how kind and decent they are." Another relative told us, "There's a good team here, very professional, but friendly also. Whenever I arrive it seems the first thing they do is offer me a cup of tea, a friendly and welcoming gesture."

We observed a staff member supporting a person to make choices for their main meal that evening. The carer positioned themselves at the same height as the person and was talking to them carefully and respectfully. We saw people participating in an activity in the garden with the activity coordinator. This member of staff spoke with people consistently throughout the activity and encouraged people to be involved in the conversation.

We saw that when people requested support that this was attended to quickly. Staff asked people how they could help in a polite respectful manner and reassured them that nothing was too much trouble. People told us that they felt comfortable asking for support because staff always responded to them so positively. We observed that staff approached people in a warm and friendly manner, greeting people and asking them how they were. In communal areas such as the dining area, we saw staff sitting and talking with people who had become withdrawn. People responded positively to this by smiling and conversing. Staff who were finishing their shift walked around the communal areas and said goodbye to people before they went, explaining to people when they would be back.

We saw that some people had been involved in the planning of their care. For example, people's preferences about their likes or dislikes were included in care plans. People's choices about what that time they got up or went to bed had been discussed with them. Where people were not able to participate in those conversations, we could see that their relatives had been asked on their behalf. We saw for one person that they had expressed a wish for their independence to be promoted, and this information was clearly detailed for staff to follow. Staff we spoke with were able to tell us how they supported people to maintain their independence and knew about peoples individual preferences. We observed during the lunch time meal that staff encouraged people to be independent with gentle prompts and reminders.

Relatives we spoke with told us that they felt involved in their family members care. They told us that they were consulted with when planning or making decisions about the care of their relative. All of the relatives we spoke with told us that they felt that communication with the home had improved greatly since the new manager had started in post. One person we spoke with told us, "They do encourage me to do things for myself here."

We saw that staff ensured that people's privacy and dignity was promoted. Staff treated people with respect. One person living in the home told us, "They treat me with respect, which is so important and helps me feel that this is home." A relative we spoke to said, "They treat every resident with total respect." Staff were careful to ensure that people's dignity was promoted. We saw that staff knocked on people's doors before entering. People were encouraged to wear appropriate clothing such as a dressing gown, in communal areas and corridors, and staff quickly attended to items of clothing that had slipped.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in December 2015, we found that care and treatment had not always been planned to ensure that people's individual needs had been met. This meant that there had been a breach of Regulation 9 of the Health and Social Care act 2008 (Regulated Activities) 2014. We found that some improvements had been made and the provider was no longer in breach of this Regulation. However, improvements were required to ensure that all people living at the home had care planned for them which meets their needs and is person centred.

People we spoke with felt that the staff were responsive to their needs and added that they received the care they needed. For example one person told us, "I have a bath twice a week but I dare say if I asked for one now I could have one." We observed that the majority of staff had the skills and abilities to interact and communicate with people well. When this took place, staff knew what people needed and provided this support. We did see however that some staff did not always do this and appeared to lack the confidence to do so. For example when providing people with one to one support during a mealtime, some staff did not speak or interact with a person whilst helping them. The manager told us that these staff were less experienced. This meant that we could not be sure that all staff were responsive to peoples support needs.

People's care needs had been fully assessed before moving in, which helped to ensure the service were able to provide the support required. The care plans we reviewed contained a variety of information about each individual person and covered their physical, social and emotional needs. The assessment forms on the files identified each person's needs and would assist the staff to identify these. When we spoke to staff they were aware of these and people told us they received the care they wanted.

At our last inspection in December 2015, we saw that risks associated with some people's health conditions were not identified. We also saw that where people had behaviour that was challenging for staff to manage, there was no analysis of these incidents. At this inspection we saw that limited progress had been made in reviewing people's support plans. For example, we saw that one person who was prone to contracting urinary infections, did not have a risk assessment in place detailing how these could be reduced. The manager explained that they had prioritised the review of care plans for people who had significant health needs or behaviour that challenged staff. We reviewed these care plans and saw appropriate information had been included. The manager told us that as a result of analysing triggers that may cause people to become distressed or display challenging behaviour, changes had been made to the way in which people were supported during these times. This included measures to protect people's dignity. We concluded that although progress had been made in reviewing care plans since our last inspection, action was needed to ensure that care plans were reviewed for all people living at the home. There was a risk that people may not receive consistent, appropriate care as staff did not have clear guidance to follow.

Systems were in place to encourage people to be involved in the care planning process where possible. People had been involved in producing their own care plans. These included information about the individual's past and included their hobbies and some history about them and their families. They identified subjects that may be important to each person and provided staff with important information about each

individual. This assisted them in providing people with person centred care.

At our last inspection in December 2015, we found that there were not enough meaningful activities to provide stimulation for people living at the home. Since our last inspection the manager had reviewed the times when activities were provided and employed an activities co-ordinator. These were now taking place four days a week from mid-morning until after lunch time. On the first day of our visit people were baking cakes. We saw that walks around the homes garden took place during the afternoon. The manager told us that they were developing an 'activities lounge' so that people could participate in activities without disturbing those who did not want to. On the second day of our inspection we saw that a film afternoon had been arranged, along with a cream tea being served. The manager told us that a coach trip had been arranged to visit a local wildlife park and that relatives had been invited to join too. They told us that they hoped to arrange an outing to take place each month. A relative we spoke to told us, "The residents do get out on trips, such as to the garden centre. They do try and involve residents in daily activities that are on offer."

The atmosphere within the home was friendly and laughter and chatting could be heard throughout the day. People we spoke with told us they could join in with the organised activities if they wished, but some preferred to watch the television or stay in their room, which showed that people's individual choices and preferences were respected.

People told us they found the staff and management approachable and felt they were able to raise any concerns they may have. One person told us, "I don't need to complain but if anything isn't quite right, they do their best to sort it out for you." Relatives also knew who to complain to and added if they had had any concerns these had always been listened to and acted upon. Meetings had taken place and these provided people with an opportunity to discuss the running of the home and also any issues they may have. One relative stated, "Since the new manager arrived, I have had no reason to complain."

There were effective systems in place for people to use if they had a concern or were not happy with the service provided to them. Staff knew about the homes complaints procedure and that if anyone complained to them they would notify the person in charge. The home had received limited complaints, but those that had been received had been fully investigated and appropriate action taken. The manager told us that they took complaints very seriously and ensured these were acted on as soon as they were raised. They explained that this was so lessons could be learned and action taken to help prevent them from reoccurring. Details on how to make a complaint could be found in the foyer of the home.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in December 2015, we found that the governance systems in place were not effective at monitoring the quality and safety of the care being provided or to mitigate risks to people's safety. This had resulted in some people experiencing poor care. This meant that there had been a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) 2014. We also found that the Care Quality Commission had not been notified of certain events that the provider is required to do so. These are called statutory notifications. The provider had failed to notify the CQC when people living at the home had died, or when there had been a safeguarding incident. This was a breach of Regulations 16 and 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection, we found that the necessary improvements had been made and that the provider was no longer in breach of these Regulations. At our last inspection, the registered manager had recently left and the home was being managed by the deputy manager. Since then they have become the permanent manager, and have applied to the Care Quality Commission to become the register manager.

We saw regular checks took place in order to ensure the safety of premises and equipment. We reviewed documents that showed appropriate checks and servicing of the homes fire detection equipment took place. There were also checks of equipment used to provide care to people, such as hoists and slings. The manager conducted frequent audits of people's medicines and associated records, these were effective in identifying issues. However, audits of other areas did not take place, for example checks on the quality of peoples care records, staff recruitment files or gaps in staff training did not take place.

The manager and provider told us that they had recently purchased a quality assurance and audit system, with the intention of implementing this in the near future. This would enable them to bring together and review all of the separate audits that would be carried out. As the system was not yet implemented, we could not yet be sure that all potential risks could be identified through the homes checks, but the manager and provider had planned to address this. The manager told us that they had reviewed the way that information about people was shared on a daily basis and had made changes to the way in which this was done. They told us that they had implemented handover times between shift changes so that staff could share essential information. This meant that staff had up to date information about the needs and welfare of the people they were supporting.

Plans were in place to gain the opinions of the people who live at the home and their relatives. The provider told us that following our last inspection, they had arranged a meeting with people and relatives to discuss the outcomes of this. However, a meeting had not taken place since. When we spoke to people and their relatives, they told us that they did not get asked for their opinion on a regular basis. Some relatives told us that they had received questionnaires in the past, but not all relatives we spoke with could recollect this. Relatives we spoke to said that they would welcome more information about the home, but felt that they could approach the manager or provider if the wanted to know anything. The provider told us that they felt that this was an area of improvement for the home, and that this was a priority.

Prior to carrying out our visit to the home, we reviewed the notifications that the registered manager had

sent to the CQC. We saw that the manager notified us when people had passed away, or of any serious injuries and safeguarding incidents that had occurred. We were satisfied that the manager notified the CQC of the events that they are required to do so.

All of the staff we spoke with told us that morale was good. Staff told us that they really enjoyed working at the home and that since the new manager began in post, the atmosphere was much more positive and friendly. The manager had an 'open door' approach for staff, relatives and people who lived within the home to use as and when needed. Visitors told us they were made to feel welcome. Staff we spoke with told us that they understood their roles, and that the manager and provider were very supportive to staff. The same staff also said that they felt valued.

People and their relatives told us that they could raise concerns and that they were listened to. They also told us that actions were taken to address their concerns when required. One relative told us, "[Manager] is doing a great job. This home has definitely improved since she took over as manager. There is a closer relationship with visitors and every effort is made to talk to you. She is friendly and a good listener." This demonstrated that the manager had established an open culture within the home.