Lantraz Co. Ltd

Westfield Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 21 February 2018. Westfield Care Home is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Westfield Care Home is registered to accommodate up to 45 older people in one building. Some of these people were living with dementia. At the time of the inspection, 12 people were using the service.

Two registered managers were present during the inspection. 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.

During the home's previous inspection on 26 January 2017, we rated the home overall as 'Requires Improvement' although the service was rated as Good for the questions, 'Is the service effective, caring and well-led?' During this inspection, we found improvements had been made and the overall rating has now improved to Good.

The home was clean and tidy. However, the provider was currently working towards making required improvements to ensure it met the local clinical commissioning group's infection control standards. People's medicines were managed safely however, protocols for the consistent administration of as needed medicines were not always in place. The risks to people's safety had been assessed and care plans were in place to support people safely. Some risk assessments would benefit from more personalised information to ensure they were always specific to people's individual needs. People were protected against the risks of experiencing avoidable harm. Staff could identify the potential signs of abuse and knew who to report any concerns to. People were supported by an appropriate number of staff to keep them safe. Accidents and incidents were regularly reviewed, assessed and investigated by the registered manager.

People's physical, mental health and social needs were assessed and provided in line with current legislation and best practice guidelines. People were supported by trained staff who had their performance regularly assessed. Staff felt supported by the registered manager. People spoke positively about the food. The risks in relation to people's nutrition and diet had been assessed and appropriate action taken. The registered manager had built effective relationships with external health and social care organisations and people's health was regularly monitored. The environment had been adapted to ensure people who had mental or physical disabilities were able to lead fulfilling lives. 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.

People enjoyed living at the home and felt the staff treated them with dignity, respect and were kind and

caring. Staff listened to what people had to say and they had formed positive relationships with people. Staff were knowledgeable about their needs and people were involved with making decisions about their care. People's diverse needs were respected. People were encouraged to lead as independent a life as possible. People were provided with information about how they could access independent advocates.

People's care records were detailed and person centred. Some records required reviewing to ensure they were reflective of people's current health needs. People felt their personal preferences and choices were respected. People were treated equally, without discrimination and systems were in place to support people who had communication needs. People were encouraged to take part in group activities and the provider had plans in place to provide more individualised activities for people. People felt able to make a complaint and were confident it would be dealt with appropriately. End of life care was not currently provided, however, systems were in place to support people with this if they needed it.

People felt able to give their views about the service. Relatives had been asked for their views and responded positively about the home. Staff felt valued and able to give their views about the how the service could develop and improved. The registered manager was keen to develop their role and skills. They were supported by the provider in doing so. Quality assurance processes were in place to assist the registered manager with monitoring the home and the quality of the service people received.

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 not consistently safe.

The home was clean and tidy. However, improvements were needed to ensure the home met the local clinical commissioning group's infection control standards.

People's medicines were managed safely however, protocols for the consistent administration of as needed medicines were not always in place.

The risks to people's safety had been assessed and care plans were in place to support people safely. Some risk assessments required more personalised information.

People were protected against the risks of experiencing avoidable harm.

People were supported by an appropriate number of staff to keep them safe.

Accidents and incidents were regularly reviewed, assessed and investigated by the registered manager.

Is the service effective?

Good

The service was effective.

People's physical, mental health and social needs were assessed and provided in line with current legislation and best practice guidelines.

People were supported by trained staff who had their performance regularly assessed. Staff felt supported by the registered manager.

People spoke positively about the food. The risks in relation to people's nutrition and diet had been assessed and appropriate action taken.

The registered manager had built effective relationships with external health and social care organisations and people's health

was regularly monitored.

The environment had been adapted to ensure people who had mental or physical disabilities were able to lead fulfilling lives.

People's rights were protected by ensuring when they were unable to make informed decisions; decisions were made for them, in their best interest.

Is the service caring?

Good

The service was caring.

People enjoyed living at the home and felt the staff treated them with dignity, respect and were kind and caring.

Staff listened to what people had to say and they had formed positive relationships with people.

Staff were knowledgeable about their needs and people were involved with making decisions about their care. People's diverse needs were respected.

People were encouraged to lead as independent a life as possible. People were provided with information about how they could access independent advocates.

Is the service responsive?

Good

The service was responsive.

People's care records were detailed and person centred. Some records required reviewing to ensure they were reflective of people's current health needs.

People felt their personal preferences and choices were respected. People were treated equally, without discrimination and systems were in place to support people who had communication needs.

People were encouraged to take part in group activities and the provider had plans in place to provide more individualised activities.

People felt able to make a complaint and were confident it would be dealt with appropriately.

End of life care was not currently provided, however, systems were in place to support people with this if they needed it.

Is the service well-led?

Good

The service was well-led.

People felt able to give their views about the service. Relatives had been asked for their views and responded positively about the home.

Staff felt valued and able to give their views about the how the service could develop and improved. The registered manager was keen to develop their role and skills.

Quality assurance processes were in place and these were effective.

Westfield 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 took place on 21 February 2018 and was unannounced.

Before the inspection, we reviewed information we held about the service, which included notifications they had sent us. A notification is information about important events, which the provider is required to send us by law. We also contacted Local Authority commissioners of adult social care services and Healthwatch and asked them for their views of the service provided. We had received some information of concern about infection control procedures at the home. This informed our inspection planning.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection team consisted of an inspector, a specialist advisor who advised us in relation to infection control practices 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.

During the inspection, we spoke with three people who used the service, five relatives, two members of the support staff, the senior care staff member, the two registered managers and a representative of the provider. We also spoke with two visiting health and social care professionals. They were a deprivation of liberty safeguard assessor and community nurse.

We looked at all or parts of the records relating to six people who used the service as well as staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints. We asked the registered manager to send us their training

matrix and gas safety certificate after the inspection, which they did.

Requires Improvement

Is the service safe?

Our findings

On 11 September 2017, an infection control nurse from the local clinical commissioning group (CCG) carried out an audit at Westfield Care Home. This audit was to assess how the provider ensured people were protected from the risk of the spread of infection. Some concerns were highlighted during this audit and the provider was asked to complete an action plan to advise the CCG how they were going to make the required improvements. During our inspection on 21 February 2018, we discussed this action plan with a representative of the provider and they assured us they were in the process of completing all required actions.

People and relatives we spoke with told us they felt the home was clean. A relative said, "Yes the home is cleaned to my standards. Very occasionally [my family member's] bedroom smells but that's during a transition period when it's being cleaned."

During this inspection, we noted the communal areas, bedrooms, bathrooms and toilets were visibly clean. However, we did note the cover of a pressure relieving cushion on a chair in the lounge was sticky and stained. We spoke with a housekeeper and they showed us the cleaning schedules for the service, which they signed daily to show they had cleaned each room. The housekeeper had completed training in cleaning processes and infection prevention and control.

Personal protective clothing and equipment (PPE) was available for staff. However, we noted it was not positioned conveniently for staff to access from some bedrooms and bathrooms, which could pose a risk of cross infection. The sluice area was unlocked but no chemical or cleaning fluids were kept in the room. Domestic staff were able to explain how they ensured people's equipment was kept clean.

The laundry room was small and this made it difficult to adequately separate clean and dirty linen, which could pose a risk of cross infection. However, the member of staff responsible for managing the laundry spoke confidently about how they ensured people's clean and dirty laundry did not become mixed.

We will continue to liaise with the CCG to determine whether the appropriate action has been taken to address their concerns.

People told us their medicines were managed safely. One person said, "They [staff] see to my medication." Another person told us staff helped them to put cream on their legs when they needed it. A relative said, "They [staff] handle [relative's] medication and they've never run out." We observed the administration of medicines and saw staff stayed with people until they had taken their medicines.

People's medicines administration records (MARs) contained a photograph of each person to aid identification, a record of allergies and information about how the person liked to take their medicines. Records showed a person received their medicines covertly and we saw there was a record of involvement of the person's GP and the pharmacist in the decision making process. A mental capacity assessment and best interest decision were completed in relation to this decision. This ensured the person's rights were

protected.

Protocols were in place for some but not all medicines that were administered on an 'as needed basis'. These medicines are sometimes referred to as PRN and are only given in specific, agreed circumstances, such as, when people show signs of increased pain or agitation. We noted there was not a protocol in place for a sedative medicine prescribed for a person and a pain medicine for another person. The failure to have these protocols in place could increase the risk of inconsistent administration by staff.

The temperature of the rooms where medicines were stored was recorded daily and were within acceptable limits. Medicines were stored in a locked cupboard or trolley. Staff told us they completed medicines administration training and competency assessments prior to administering medicines independently. Records reviewed confirmed this.

People were supported by staff who understood how to protect people from avoidable harm and to keep them safe. People felt safe with the staff who supported them. One person said, "It's nice here; they're [staff] very helpful. If I have any problems or worries, I can always talk to them. I haven't had any problems or worries since I've been here." A relative said, "Yes [relative] is safe here. They could not cope at home. They were always getting [condition] but since they have been here they've hardly had any. It was so dangerous for them at home."

The risk of people experiencing avoidable harm or abuse was reduced because processes were in place to protect them. A safeguarding policy was in place. This policy was in place to ensure people were protected from abuse, neglect and harassment. Staff had received safeguarding adults training. They spoke knowledgeably about how they ensured people were protected. This included detailed investigations and timely reporting of incidents to relevant authorities such as the local authority safeguarding adults team and CQC. Records viewed confirmed this.

Where risks to people's health and safety had been identified through assessment, regular reviews were carried out to ensure people received the care and support needed to reduce this risk. These assessments including supporting people who could present behaviour that may challenge others. Other assessments included the risk of using a wheelchair, use of a recliner chair, or bathing. Actions to reduce the risks were completed, although we found some of these assessments might have benefited from more personalised information. Risk assessment tools were used to assess people's risk of developing pressure ulcers, nutritional risk, and risk of falling. However, we did note one person had bed rails that were being used to prevent them from falling out of bed. No risk assessment was in place to ensure they were used safely. The registered manager told us they would address this immediately.

We noted environmental assessments were also carried out. Guidance was in place for staff to ensure they used people's equipment safely. We noted plans were in place to improve some of the décor throughout the home and this was being addressed in line with the CCG action plan. Records showed regularly testing of electrical appliances took place. Fire alarm and fire exit tests were carried out weekly with fire extinguishers and emergency lighting checked monthly. We saw a record of all jobs that had been or needed completing were kept and ticked off once completed. A recent gas safety check had also recently been completed.

Our observations throughout the inspection confirmed people's need were attended to in good time. People did not have to wait for long periods without support from staff. People received their meals quickly, received some good quality time to talk with staff and were encouraged to join in with activities. The staff we spoke told us they felt there were enough staff rostered on duty to provide safe care for the people living at the service. They told us if there was staff sickness, they were normally able to obtain cover.

Robust recruitment procedures were in place that ensured the risk of people receiving care and support from unsuitable staff was reduced. We reviewed four staff files and records. Criminal record checks had been carried out and proof of identity and references had been requested before staff commenced working with people.

People's care records were detailed which ensured that when people required a visit to their hospital or other health or social care service, information was available to aid the transition. This would enable those services to provide people with the care and support they needed quickly.

Reviews of the accidents and incidents that occurred took place. The registered manager told us that if changes to people's care and support were needed because of an accident or incident then this would be put in place. Care records showed advice had been requested from external health professionals when risks to people's safety had been identified. Where amendments to staff practice were needed these were discussed during supervisions or team meetings. This meant that sufficient processes were in place to reduce the risk of the reoccurrence of accidents or incidents.

Good

Is the service effective?

Our findings

People's physical, mental health and social needs were assessed and provided in line with current legislation and best practice guidelines. The registered manager was aware of the National Institute for Health and Care Excellence guidelines and could explain how they were used to support people effectively. Where people had specific health needs, such as the risk of developing pressure sores, a nationally recognised tool was used to assess and to reduce the risk to people's health and welfare. A visiting professional told us they felt staff were knowledgeable and understood how to support people safely and effectively.

People's care records contained clear guidance on how to support people with a wide variety of health needs. For example, records showed people who required regular repositioning to reduce the risk of developing a pressure sore were supported effectively and repositioned in accordance with the frequency recorded within their care plans. This ensured people's ongoing health and care needs were met by staff.

People were supported by staff that knew how to care for them. People told us they felt staff understood how to support them and did so in line with their preferences. One person said, "Yes I think the staff are well trained and they know what they're doing." A relative spoke positively about staff who understood how to care for their family member with a health condition and kept them regularly updated.

Staff received an induction, detailed training programme and were supported with on-going professional development such as diplomas (previously known as NVQs) in adult social care. Staff received training in areas such as dementia awareness, food hygiene and safe moving and handling practices. Whilst all staff had completed the required training and the majority was up to date, a small number required refresher courses. We also noted one new member of staff had not yet completed all of their required training. The registered manager assured staff would be supported to complete these courses, to ensure their knowledge was up to date and met current best practice guidelines. Staff told us they felt supported and well trained and as a result were able to carry out their roles effectively.

We observed people's lunchtime experience. We found staff supported people with eating where needed but encouraged independence where people were more able. Some people had specially adapted plates that enabled them to eat independently of staff. Staff were attentive and if people had food marks on their face, hands or clothes, staff respectfully asked them if they wanted help with cleaning themselves. The food looked nutritious and appetising and people enjoyed their meals, with many plates cleared. We did not see people offered an alternative to the main meal on offer. However, when we raised this with the cook they told us if people did not like what was provided, they would cook them something else.

A relative we spoke with praised the food provided and told us their family member had put on weight since they had come to the home. Records showed nutritional assessments were in place and people were weighed regularly. Where people had lost or gained excessive amounts of weight, dieticians were contacted for guidance. For example, one person had lost weight and staff had been instructed to provide a fortified diet and nutritional supplements for the person to aid weight gain and to improve their health. Their care

records had been updated accordingly and the person received the support they needed. We spoke with the cook. The cook had undertaken a nationally recognised qualification in catering and food hygiene and had a good awareness of people's dietary needs. This included the low sugar diet needed for people who had diabetes. People's nutritional needs were managed effectively at the home.

The registered manager had ensured that positive relationships had been made with other healthcare agencies involved with people's care, to ensure they received effective care, support and treatment. To enable a smooth transition between health and social care services and to reduce the impact on people, care records contained detailed information. These explained how people communicated, their personal preferences and any known risks that other agencies should be aware of. A visiting healthcare professional told us staff assisted them when they came to assess people's health needs.

People had regular access to health and social care professionals when they needed them. Care plans contained evidence people had access to their GP and community nurse when necessary. There were also records of chiropodist and optician reviews. One person told us that when they needed to see their doctor the staff always ensured they were able to do so.

The home had been adapted to ensure that people's individual needs were met by the environment they lived in. Due to the low numbers currently living at the home, the provider had made the decision, with consultation with people and their families, to close the top floor of the home. This ensured that people were not left isolated in parts of the home where few people were living. The home had also been adapted to support people living with dementia. Different coloured handrails and corridors as well extra signage helped people to orientate themselves around the home. We noted some bedrooms, but not all, had people's photos and names on to further aid people's ability to identify their own bedrooms. Communal areas were spacious and well maintained and a large dining area enabled people to meet with friends, enjoy a meal and to take part in group activities. Attempts had been made to support people with personalising their own bedrooms with some bedrooms nicely decorated with photos and pictures of people's choice. We did note a small number of bedrooms would benefit from decoration and the registered manager told us they would address this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

Mental capacity assessments and best interest decisions were completed when people could not make specific decisions for themselves. This included decisions relating to people's medicines and personal care. We noted a person had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order within their care records. This meant that the decision for resuscitation to not be carried out had been taken, if it may have a detrimental effect on the person's on-going health. This was completed correctly and a mental capacity assessment and best interest decision was recorded for this decision. This ensured the person's future health and wellbeing had been taken into account for this decision.

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). Records showed that DoLS applications had been made for people whose care was restrictive and amounted to a deprivation of their liberty. We looked at the paperwork for two of these people and saw the staff adhered to the terms specified. This ensured

unnecessary and unlawful restrictions were not placed on people's liberty.

Good

Is the service caring?

Our findings

People and their relatives told us that they found the staff to be kind and caring. One person said, "Yes they are kind." A relative said, "Staff are kind. They have a laugh with [family member]. They always smile and wave when they go past."

It was clear from our observations throughout this inspection that people, staff and relatives had formed positive relationships, resulting in a friendly and happy atmosphere within the home. A relative praised the way staff engaged with their family member. They said, "I think [name] has a good relationship with the staff, it's surprising because you wouldn't think [name] would know them, but they point to them [staff] when they see them."

We noted staff had the time to sit and talk with people. Although staff were busy at times, this did not affect their ability to engage with people. The registered manager told us they felt the rotas provided sufficient staff to enable them to carry out their daily duties but also to spend time with people. Staff spoken with confirmed this. This contributed to the positive relationships that had been formed between people and staff.

Staff supported people in a calm and caring way. They ensured people were warm, had enough to eat and drink and were involved in group activities and discussions. Where people had chosen to not engage with others living at the home, staff took the time to sit with them and to talk with them about their day. We observed one staff member have an engaging conversation with a person about their past working life and the person responded positively to this.

People's records contained information about how staff could effectively communicate with them. Our observations showed that staff did communicated well. This included people living with dementia. A relative spoke positively about how staff communicated with their family member. They said, "They're kind to [name]. They talk nicely to them, they give them tea and biscuits and stroke their hand to communicate." We observed staff adjusting the way in which they spoke with people, speaking more slowly, loudly or quietly depending on who they were talking with. It was clear staff understood the most effective way to enable and empower people to communicate their needs and these were then acted on.

Staff were respectful of people's opinions and choices. People told us they felt their views mattered. We saw some evidence in care plans that people and their relatives were consulted when changes to care plans were needed. However, examples of this were limited in places. We raised this with the registered manager who assured us people were involved with decisions about their care needs. They told us moving forward they would ensure this was recorded more clearly in people's care records.

Where people were unable to make informed decisions for themselves, people had the opportunity to have an independent person to speak on their behalf if they wished them to. Information was available for people about how they could access and receive support from an independent advocate to make decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at

times when important decisions are made about their health or social care.

People were treated with dignity and respect. Staff had completed 'dignity in care' training and this was reflective of their practice when supporting people. They were attentive to people's needs, spoke discreetly when discussing people's personal matters and ensured people were provided with privacy when personal care was provided. A person we spoke with told us every time staff came to their bedroom they knocked and waited for permission before entering. We noted when people were receiving support with their personal care in their bedrooms, their door was kept shut and staff not involved did not enter. This maintained people's dignity and right to privacy.

People were supported to do things for themselves and their independence was encouraged. One person described to us how staff supported them. They said, "I can dress myself but they stand alongside and encourage you." People's care records contained guidance for staff on each person's ability to do things for themselves. We noted staff were encouraging, patient and supportive when assisting people to move around the home.

People's care records were stored safely ensuring the information within them was treated confidentially. Records were stored in a locked cabinet away from communal areas to prohibit unauthorised personnel from accessing them. The registered manager was aware of the requirements to manage people's records in accordance with the Data Protection Act.

There were no restrictions on people's family and friends visiting them. We observed visitors coming and going throughout the day. Staff interacted well with visitors and made them feel welcome.

Good

Is the service responsive?

Our findings

Before people started to use the service an assessment was carried out to ensure people could receive the support they needed. Once people had moved to the home, more detailed care plans were in place to guide staff on how people wished to be supported. People's care records were extensive and in the majority of cases contained sufficient information for staff to enable them to respond to people's needs. We did note that a small number of care plans required reviewing to ensure the information recorded was fully reflective of people's current health needs and how staff should respond. However, we also noted detailed care plans were in place that enabled staff to support people effectively with their medicines, mobility, nutrition and personal care.

People's personal preferences and likes and dislikes had been taken into account when care plans were written. People had been involved with this process and they and their relatives praised the approach of staff in the way they supported them or their family members. One person told us staff, "Understand what I want." A relative said, "They [staff] know their likes and dislikes, they know [family member] likes chocolate and they leave some chocolate buttons by their bed before they go to bed every night."

We noted care plans included people's life history and detailed background information which staff used effectively when talking with people. A relative told us their family member used to like to cook. They told us staff knew this and, "they let them in the kitchen sometimes to help mash the potatoes."

People were supported to take part in activities within the home. Staff encouraged all to take part to aid social inclusion and to reduce the risk of people becoming isolated. However, staff respected people's wishes if they did not want to take part. A relative told us their family member was reluctant to join in with the activities but staff continually tried to encourage them, which had occasionally worked. One person told us they enjoyed the activities provided and had recently won some prizes. They said, "I won the shampoo, the conditioner and a spray this morning." We noted activities tended to be provided in a group format and discussed this with the registered manager. They told us that they had plans to focus further on people's individual hobbies and interests. They told us when the number of people living at the home increased; an activities coordinator would be recruited to support people more with their personal interests.

People's care records showed their religious and cultural needs had been discussed with them and support was in place from staff if they wished to incorporate these into their life. The registered manager told us when people had specific religious views they would ensure they were supported with this. Staff had completed equality and diversity training that contributed to people being able to lead their lives in the way they wanted, without discrimination.

The Accessible Information Standard ensures that provisions are made for people with a learning disability or sensory impairment to have access to the same information about their care as others, but in a way that they can understand. The registered manager had an awareness of this standard and told us they would review all documentation within the home to ensure it was accessible for all.

People and relatives told us they felt able to make a complaint if they needed to and that it would be acted on. A relative told us they had raised an issue with the registered manager and that it had been "handled well."

Records showed the registered manager was aware of their responsibilities to ensure that when a formal complaint was made, they responded appropriately and in line with the provider's complaints policy. No formal complaints had been received since our last inspection.

We were told by the registered manager that at the time of the inspection no person living at the home required end of life support. We therefore reviewed end of life care plans for two people who had made their wishes clear to staff should they required support later in their life. We found the information contained information for staff to follow which took into account the wishes of the people themselves and where appropriate their relatives.

We spoke with members of staff about the care provided when someone was at the end of their life. They told us and records confirmed that they had received end of life training and were confident they could support people in the way they had requested. The registered manager told us they would ensure that all relatives were supported at this difficult time.

Good

Is the service well-led?

Our findings

People spoke highly about the quality of the service they received. People felt staff understood their needs, supported them well and they enjoyed living at the home. One person said, We're all looked after here, we're well respected." A relative praised the staff and the service provided. They told us since their family had come to the home they had confidence that they were being treated well and this had given them peace of mind. They also said, "We're quite happy and relaxed about [family member's] care here. Now we can have a family holiday together without worrying and knowing they're in good hands. We couldn't do that before they came here." Another relative told us they felt their family member's health had improved since living at the home. They also said, "[Name] is 100% better. They have put weight on; they are a lot cleaner and more talkative. We've no complaints regarding the staff."

People and staff were encouraged to give their feedback about how the service could be developed to improve people's experiences at the home. We noted a survey had been sent to relatives asking for their views. The responses received were positive and highlighted good practice in areas such as, feeling welcome at the home, staff being approachable, good quality food and drink and their queries and concerns being acted on. The registered manager told us a formal survey had not been sent to people living at the home. They told us this was because as there were fewer people living at the home they held regular discussions with people to gain their views. They told us they were considering introducing a more formal questionnaire process in the coming year to help inform the provider formally of how the service could be further improved.

Staff felt valued and their opinions on how the service could improve were welcomed. Staff told us they felt able to contribute to team meetings. Staff attended daily handovers prior to commencing their shift. This ensured staff were aware of any concerns with people's health or whether any specific actions needed to be taken to support people.

A staff member told us the registered manager managed the staff fairly and ensured all staff were treated equally. They also said staff were able to "have their say." Another member of staff said feedback from the registered manager in relation to their performance was, "fairly constructive". The registered manager told us they tried to ensure that they and their staff learned from any mistakes made and used guidance from visiting professionals to improve people's lives and experiences at the home. A visiting professional told us they always found the registered manager and staff welcoming, eager to learn and acted on their advice.

Staff understood how to identify and act on poor practice. A whistleblowing policy was in place. Whistleblowers are employees, who become aware of inappropriate activities taking place in a business either through witnessing the behaviour or being told about it.

Two registered managers were in place. They had a clear understanding of their role and responsibilities. They had the processes in place to meet the requirements of a registered manager with the CQC and other agencies, such as the county council safeguarding team. The registered managers had also ensured that the CQC were notified of any issues that could affect the running of the service or people who used the service.

The registered manager with the main responsibility for managing the home was keen to improve their own performance. They told us they were currently undertaking further personal development and training with this enabling them to improve further the quality of the care people received. They also told us they were fully supported by the provider with this. A representative of the provider was also registered with the CQC to manage the home. This ensured when the main registered manager was not available due to this additional training, the home was led by a person who was registered with the CQC. This ensured people continued to receive good quality care.

Quality assurance systems were in place that helped to drive continued improvements at the home. Audits included regular reviews of people's care records, the environment and medicines. When actions were needed, these were delegated to the appropriate staff member and then checked to ensure they had been completed. The registered manager also used nationally recognised websites and professional guidance to help inform them of new policies or procedures which they could implement at the home to improve the care people received.

The registered manager had an open and transparent approach when working alongside other health and social care agencies. This ensured staff were equipped to support people in line with other health and social care agencies recommendations and guidance. Two visiting health and social care professionals told us they felt staff and the registered manager listened to them and acted appropriately on their recommendations.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service and online where a rating has been given. This is so that people and those seeking information about the service can be informed of our judgments. We noted the rating from the previous inspection was displayed both on the provider's website and their office.