Laudcare Limited

Blackwell Vale Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18 December 2018 and was unannounced. A second visit was carried out on 19 December which was announced.

Blackwell Vale is a 'care home'. People in care homes receive accommodation and nursing or 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. Blackwell Vale provides nursing and personal care to 60 older people. The home has two floors, the upper floor accommodates people who have a dementia related condition and the ground floor accommodates people who have general nursing and personal care needs. There were 44 people living at the home at the time of the inspection.

At our previous inspection in January 2018, we found two breaches of the Health and Social Care Act 2008. These related to good governance and staff competencies. We rated the service as requires improvement.

Following the inspection, the provider formulated an action plan to address the breaches. At this inspection, we found that sufficient action had been taken to address those breaches. Continued improvements were still required in some areas of the service.

Since the last inspection the acting manager had registered as the manager. 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.

During this inspection we identified some practices that required attention, for example keeping the kitchen door locked, and gaps in daily temperature records and fire drills. Action was taken to address these issues.

People said they felt safe and comfortable at the home. Risk assessments were in place about people's needs and about the premises. The home was comfortable, clean and maintained. Medicines were managed in a safe way but there were some shortfalls in relation to recording.

People who could express a view told us they received a "good service". Staff had opportunities for relevant training. Staff supervisions had not always been carried out because of the previous gap in the management arrangements, but staff said they felt supported.

The staff team were aware of their responsibilities under the Mental Capacity Act 2005 and best interest meetings had been held to make sure people were not restricted unnecessarily. 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 to support this practice required further development. We made a recommendation about this.

People received the right support with their nutrition and hydration needs. Risks to people's nutritional well-being were assessed and managed. People said they enjoyed the meals and the quality of food was good.

Before people moved to the home their needs were assessed to check if the home could provide the right care for them. The home worked with other health services to make sure people were supported with their health needs.

People and relatives told us staff were kind and caring. Staff were considerate, respectful and helpful when assisting people. There were friendly relationships between staff and the people who lived there.

There was a welcoming atmosphere in the home. Staff supported people to make their own individual choices and used different ways to help them do this.

Staff were knowledgeable about people's individual care needs and how they wanted to be assisted. People had opportunities to join in activities and go out into the local community.

People had information about how to make a complaint. They were asked for their views and these were acted on. The registered manager had an open-door policy and made themselves available to speak with people, relatives and care professionals.

Staff made positive comments about the registered manager and said they felt supported by the management team. Staff told us that the atmosphere in the home was very good. They enjoyed working at the home.

The provider had a quality assurance system that included the views of people, staff and visitors. Regular audits and checks were carried out and action was taken if issues were identified, although some issues seen during this inspection had not been identified. The management team was aware this was an area for continued and sustained improvement.

This is the second consecutive time we have rated the service as requires improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider had not always made sure the right practices were carried out with fire drills, access to the kitchen and medicines storage temperature records.

People felt safe and staff knew how to report concerns. The home was clean, warm and comfortable.

There were sufficient staff to attend to people when they needed support. New staff were recruited in a safe way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Decisions made in the best interests of some people who lacked capacity were not always recorded.

There had been improvements to the training and competency of staff.

People were supported with eating and drinking in a way which supported their choices and health.

Staff helped people to access health care services when they needed them.

Is the service caring?

Good

The service was caring.

People and relatives felt staff were kind, caring and friendly.

Staff were attentive and considerate when supporting people with their care needs.

People were offered choices in a way that helped their communication needs.

Is the service responsive?

Good

The service was responsive.

People received care that met their specific needs.

There was a good range of interactive activities for people to participate in to support their social care needs.

The service had a complaints procedure in place and people felt they were listened to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service had acted on previous breaches although there were still areas for improvement.

There was a registered manager and strengthened management structure which was committed to continuing to improve the service.

Staff said the culture and morale in the home had significantly improved.

Blackwell Vale 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 18 December 2018 and was unannounced. We carried out a further announced visit to the home on 19 November 2018 to complete the inspection. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

Prior to our inspection, we checked all the information which we had received about the service including notifications which the provider had sent us. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable CQC to monitor any issues or areas of concern.

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.

We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used their feedback to inform the planning of this inspection.

We spoke with 14 people who lived at the home. We also spoke with eight relatives during the inspection. We spoke with the regional manager, the registered manager, the deputy manager, two nurses, two care

home assistant practitioners, a senior care worker, four care staff, two activities coordinators, a catering staff and the maintenance staff member.

We looked at five people's care records and 15 people's medicine records. We reviewed four staff files, including records of the recruitment process. We also looked at supervision, appraisal and training records as well as records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection, we rated this key question as requires improvement. We found a breach of regulation regarding the management of medicines and ineffective monitoring of the premises.

At this inspection, we found that improvements had been made; however, further action was required in relation to some safety practices.

Throughout the first day of the inspection the kitchen was left unlocked and at times unoccupied. The kitchen was in a main corridor of lounge and bedroom accommodation which meant people could walk into that room unsupervised. There were people living at the home who were at risk of mistakenly entering the kitchen where there was hazardous equipment. The kitchen door was fitted with a keypad lock but this was not being used by catering staff. We informed the registered manager of this risk. They re-instructed catering staff (who were employed by an external catering company) that the kitchen door must be kept locked, especially at times when it was not occupied by catering staff. During the second day of inspection we found the kitchen door was locked. The registered manager stated they would monitor this situation and take action where necessary.

The ambient temperature of the room where medicines were stored had not been recorded for several days. Although the remaining records showed the store room was within the right temperature range, the missing records meant the provider could not be assured that medicines were being stored in a safe way on those days. The registered manager stated this would be included in the daily medicines checks and staff would be instructed to make sure their colleagues were recording these.

Fire drills had been carried out four times since May 2018, but more than a third of the staff team had not been present to take part. It is the provider's policy that staff take part in at least two drills a year. This was also reported at the last inspection. The maintenance staff who took responsibility for this said they would make sure all staff, including night staff, had the opportunity to take part in two drills each year. Following the inspection, the registered manager said these were now up to date.

In the kitchenette in one unit there were opened packets of cereal that had no covers and were not dated. The registered manager said new containers had been ordered and staff would be instructed to record the date of opening of any foods.

People and relatives told us the home was a safe place to live. Their comments included, "I am safe here, they are nice to me" and "I have never seen anything to worry us and believe me I would tell you if I had."

Staff completed regular training in safeguarding vulnerable adults and knew how to report concerns. The registered manager responded to any concerns raised and reported these to the local safeguarding authority. Any actions recommended by the local authority safeguarding team were carried out. The provider had safeguarding and whistleblowing policies and this information was prominently displayed. This meant staff had access to information to enable them to report any concerns via appropriate methods.

People and relatives felt there were sufficient staff to support people in a timely way. People told us, "There are enough girls on" and "they come if you call and they will fetch you anything you want." Relatives comments included, "There seems enough staff", "there always seems enough staff about when I come in" and "we see plenty of lasses about."

The provider used a dependency tool to calculate how much support each person required and this was used to calculate the staffing levels. Staff rotas showed that the staffing levels were in line with the dependency tool. We saw staff were always present in the lounges, dining rooms or in the corridors. Call alarms were mainly responded to quickly. There were only a couple of occasions when call alarms sounded for a few minutes. In one case, staff were already in the room and had not switched off the call.

Daytime staffing consisted of one nurse, two care homes assistant practitioners (CHAPs), and nine care staff. The service had made significant improvements in the reduction of agency staff hours. Two daytime nurse posts were vacant. As a result, on the day of this inspection, the registered manager was also the nurse on duty. The home had a rolling programme of recruitment for nursing and care staff in order to build up a pool of relief staff.

The provider used safe recruitment practices to make sure new staff were suitable to work in the care home. These included application, interviews and reference checks. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people.

Staff who were responsible for administering medicines had training in this and periodic competency assessments. Staff carried out daily checks of people's medicines to check these were being given correctly. Staff recorded a count of medicines to make sure the right amounts remained. People's medicines records were up to date and completed at each dosage time.

There were individual protocols for people who were prescribed 'when required' medicines, including medicines for occasional pain or episodes of agitation. Some people's protocols were not descriptive so did not guide staff as to when people might benefit from these medicines. For example, several people's pain-relief protocols did not describe how people might express their pain. Other people were prescribed when required medicines for anxiety but the protocols simply said it was for "agitation". This meant staff might be inconsistent in when they administered when required medicines.

There were some minor discrepancies in the recording of ointments and creams. The topical medicines administration records (TMARs) did not always include the directions for use, for example, how often or when the ointments should be applied. For example, staff had recorded they offered one ointment to a person four times every day but the actual directions were for this to be applied twice a day. This was not unsafe but was contrary to the prescribed direction.

Risks about people's individual health and safety were assessed, managed and reviewed. For example, there were risk assessments in place for people who needed support to manage their medicines, skin integrity, nutrition, falls and mobility. We saw staff helping people to move using a variety of mobility aids including wheelchairs and hoists. Staff used the equipment competently and with quiet instruction and encouragement for people. The service employed a full-time maintenance staff member who carried out checks to ensure the premises and equipment were safe.

Accidents and incidents were recorded and acted upon. The registered manager used this information to learn lessons about any changes in people's well-being and to support people in a way that helped to

prevent falls. For example, by referrals to the falls clinic, GP review of medicines and sensor equipment to alert staff to people movement in their bedrooms.

The provider had an infection control policy and there was personal protective equipment (PPE) such as aprons and gloves readily accessible for staff around the building. Staff used PPE appropriately when attending to people's personal care. We noted that cardboard files in people's bedroom for records of support, such as positional changes, were not cleanable, so could pose a risk of cross-infection when handled by different people.

The deputy manager had plans to carry out a thorough infection control audit. The deputy manager was the designated infection control lead for the service who checked hygiene practices. It would be helpful if hand hygiene checks were recorded to show which staff had been observed. We did note a staff member had false nails, which is contrary to good hygiene practices. The deputy manager stated acceptable standards of uniform and fingernails were to be addressed with all staff members.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, we rated this key question as requires improvement. We identified a breach of regulation relating to staff competencies and training.

At this inspection we found improvements had been made. However, there were other areas that required some improvement

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

Mental capacity assessments and best interest decisions about restrictions, such as the use of sensor mats, were referred to in care plans. However, the records of the discussions were not always present in people's care files. The registered manager said the decisions were properly reached but the records had not yet been completed.

A best interest agreement for one person to receive their medicines covertly (that is, disguised in food) was recorded but had not been reviewed since January 2017. Also, there was no record of a pharmacy involvement in this decision.

In other people's care files there were references to some relatives making complex decisions on behalf of their family member, for example about their health and finances. However, there were no copies of power of attorney documents to show whether they had the legal right to make those decisions. The registered manager said she would contact the relevant relatives and request copies of these documents. There was also some confusion about the terminology of a relative signing their 'agreement' when they did not have the legal status to do so. The registered manager said this document should have read that the relative had signed to show their involvement, not agreement.

We recommend that agreed arrangements relating to best interest decisions are clearly recorded and periodically reviewed.

At the previous inspection we found there was not always information available about the clinical skills and competencies of the nurses who worked at the home, including agency nurses. We found improvements at this inspection.

Nurses had recent training in catheter training and syringe drivers. There was also a competency framework to use with staff working with percutaneous endoscopic gastrostomy (PEG) tubes. These are tubes that are placed directly into the stomach so people receive nutrition, fluids and medicines.

New nurses worked under supervision until any required training and competencies were completed. The home was now using a different nursing agency to cover gaps in the nursing rotas. It was good practice that the home could check agency nurses' profiles, experience and reliability to decide if they had the right competencies to support people's needs. This meant the registered manager could be discerning about which agency staff they would accept in terms of their previous training.

Other staff said they had sufficient training, both on-line and group training. Staff told us they felt "well supported" by the management team and "can ask the manager anything." Some staff had not had supervisions for several months which was contrary to the provider's own policy. A supervision is a one-to-one meeting between a member of staff and their line manager and can include a review of performance in the workplace. The deputy manager had only recently been appointed so there had been a gap in the supervisory arrangements. The registered manager said there were plans to implement a schedule of supervisions with line supervisors.

People made several positive comments about the meals. One person told us, "The food is better than it was, the cook is doing a lot of their own things now. You do get a choice and they fetch other things if you don't like stuff." Other people comments included, "The food is very good" and "the food is alright. I gobble it up so it must be."

We saw staff asked if people were enjoying their meal, and offered second helpings or alternatives to make sure they ate well. People's nutritional well-being and weight were checked each month. If people were losing weight a food diary was put in place, high calorific drinks and foods were offered and weekly weights were monitored. There were monthly visits to the home by a dietitian and staff liaised with them if they were concerned about anyone's nutritional health.

Staff felt they worked well as a team to support people's health. There were handovers between staff teams to inform them of any changes in people well-being. There was also good collaboration with other health professional services. There were weekly visits to the home by Care at Home nursing services and fortnightly GP visits. This meant any changes in people's health care could be addressed quickly.

There were some design features in the home to support people who were living with dementia. Bathrooms and toilets had large picture signs to help people recognise these rooms. Some lounges had orientation boards with information for people about the time, day, date and weather.

Good

Is the service caring?

Our findings

People and relatives told us the service was caring. People's comments included, "They are very nice to me", "I like it, the girls are very nice and I am very comfortable", "I am very happy with it" and "all the staff are very kind and most attentive."

Relatives also had positive comments about the caring nature of staff. They told us, "I can't fault them, the girls are just brilliant and they are really nice to us as well" and "they are very caring."

People were clearly familiar and comfortable with the members of staff on duty. Staff were able to sooth and diffuse situations where people became confused or agitated. Staff used appropriate and reassuring touch when a person sought comfort. One person who had been upset thanked a staff member for making them feel better. The staff member said, "We're always here for you" and held the person's hands and smiled. The person said, "That's lovely, thank you."

There were instances where staff were considerate and thoughtful. For example, asking people during a meal, "Do you want me to help you turn into the table a little bit?" Staff checked people were warm enough, offered them extra layers and closed windows because it was a cold and windy day.

There were friendly conversations between people and staff. One staff member commented, "I feel we've got time to spend with residents. I didn't have that at the last home I worked in, but there's time to have a chat with people here."

People were offered daily choices, for example about activities and meals. Staff asked people's permission before supporting them and people's decisions were respected. For example, one person required physical support with their meal. A member of care staff sat next to the person and said, "Hello (name), I have come to help you have lunch - can I do that?" The person nodded to show their consent. The staff member described what the meal was and what they were doing before offering the person each mouthful. The staff member gently encouraged them to swallow before taking the next mouthful.

Staff listened to people's decisions about what they wanted and responded accordingly. For example, a staff member asked a person, "Am I okay to pop this on for you? (clothing protector)." The person said "No" and staff responded, "Okay, no problem."

People were offered choices in a way that met their communication needs. For example, there were large print menus on tables but some people needed additional support with decision-making because of their cognitive decline. At mealtimes staff used two 'show' plates of the meal choices on offer, so people could make a visual choice of what they would like. For instance, staff said, "The options are shepherd's pie or fish, do you want me to show you them?" and "How does this look for you?" One person was unsure even when shown the two meals, so a staff member said, "Shall I give you a little taste?" to help them decide which they would prefer.

Staff spoke about people in a respectful and sensitive way. They supported people in a discreet way that upheld their dignity. For example, staff offered people wipes to 'wash' their hands before eating. If people seemed to be hesitant about a task, staff quietly asked, "Would you like a bit of help with that?"

Staff spoke to people in a way that valued them and complimented them on their appearance. For example, one person told us they were going out for a family dinner at a local pub so staff had arranged for them to have their hair done beforehand. Staff said to them, "Look at you! You look amazing." People showed us photographs of themselves and staff posing in Christmas jumpers together, and were proud of these.

People's personal information and sensitive data was stored securely to uphold confidentiality and protect their privacy. We saw that records containing people's private details were kept locked away.

There was a very welcoming, friendly atmosphere in the home throughout this inspection. Staff helped people to keep in touch with their relatives and encouraged relatives to stay for meals or take part in activities. A staff member said, "Some families come and eat with (their loved ones) and some will come for Christmas dinner. We have a social fund that people can donate to so we can keep that up. We try and keep as much of the contact with family as we can for people."

Most people had relatives who supported them with significant decisions. If people did not have family members to do this, independent advocates had been arranged to support the person. An advocate acts on behalf of a person to impartially represent their views.

Good

Is the service responsive?

Our findings

At our previous inspection, we rated this key question as requires improvement. We made a recommendation about making activities more meaningful. During this inspection we found the range of activities had improved. Activities were more interactive so people were more likely to join in. All the staff we spoke with felt that activities had really improved.

People felt there were sufficient activities if they wanted to join in. Their comments included, "There are things to do", "I was dancing yesterday" and "I went to listen to the school kids the other day." The home had activities boards and an activities newsletter to advertise the different events and entertainment. For example, that week's activities included a male voice choir, Belly dancing, school nativity play, musicians, Christmas movies with hot cocoa and cookies, arts and crafts and music sessions. Future activities planned included hand massages, letter and card writing, plant care, local and national events update and a knitting group.

Staff also described how they were converting a room on the first floor into a shop which was going to be run by people who lived there. It was planned that they would be paid 'weekly wages' and would support other people by taking the shop trolley around the home.

The home had recently become involved in a new project called Kids In Care. Two teenagers who had expressed an interest in working in care were now volunteering at the home once a week. They spent time interacting with people who were living with a dementia, engaging them in chats, crafts, haircare and touch therapy. They also had shared social events together, for example, they joined some people to go to a local pantomime. There were other good links with the local community, including schools and churches who visited the home. There were occasional trips to another care home so that people could meet others and enjoy a day out.

There was a well maintained, private garden with patio furniture and a gazebo shelter. People and relatives said this was now well used and it provided a safe place for people to get fresh air and enjoy better weather.

People and relatives felt the service met people's individual needs. People had a range of needs relating to their physical, emotional and mental well-being. Staff were knowledgeable about each person and spoke about their abilities as well as their needs. Staff were familiar with people's preferences and individual ways. A relative said, "My (family member) can't communicate now so you have to predict what they're going to do and the staff are quite good at it." Another relative commented, "As the staff have got to know my (family member) the way they care for them has got better and better."

Care records documented that they had been written with the person and their representative where appropriate. Relatives also told us they were involved in discussions and reviews about people's care. A relative said "They call us if there is anything wrong or if (family member) wasn't so well." Another relative commented, "They called me as my (family member) had been quite distressed, so I came in to talk to them."

Each person's care records included assessments about their individual needs, the level of support they required and their involvement in managing daily living tasks. Each person had care plans which set out guidance for staff about how to support them with their assessed needs. Care plans had been developed to cover a range of care needs including mental capacity, cognition, continence and mobility. Care plans also covered people's social and cultural needs such as their religion. Care plans were reviewed monthly.

Care plans also contained information about people's life histories which had been developed with people and their relatives. This meant that information was available to give staff an insight into people's needs, preferences, likes, dislikes and interests, to enable them to better respond to the person's needs and enhance their enjoyment of life.

There was a complaints procedure in place and people and relatives told us that they knew how to make a complaint if necessary. A relative commented, "They do let us know about everything and I have to say if I have raised anything that has been wrong or any issues they get resolved very quickly."

People had emergency health care plans in place which described their preferences for their end of life care. Some people were unable to state their preferences so the home had records of discussion with family members about what their wishes might be for example, about the preferred place of rest. Staff had training in end of life care. No one required palliative care at the time of this inspection but we saw gratitude cards from relatives about the care shown to former residents.

A visiting healthcare professional was also complimentary of staffs' knowledge in recognising when people's health was deteriorating and ensuring that the relevant healthcare professionals were informed. They told us, "Staff were exceptional at the end of life care of [name of resident]. Staff were very good with [name] and were on top of all their needs. Staff are good at picking up deterioration (in people's health)."

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, we rated this key question as requires improvement. We identified a breach in relation to good governance. Audits and checks were carried out but had not always identified issues. At this inspection, we found that improvements had been made, although further work was required to make sure this continued.

The provider had a quality assurance system for frequent checks of the quality and safety of the service. These included 'real time' checks and audits which were carried out on a computerised management system. This meant the management staff could identify any areas for action and monitor whether these had been completed. Many of the checks were daily, such as walk-arounds by the management team and weekly checks of a sample of residents' medicines.

Where audits had identified any trends, the practices had been changed to address these. For example, previous audits had identified missing signatures on medicines records. To address this nurses and care home assistant practitioner (who were responsible for medicines) swapped floors and checked each other's medicines records to make sure these were fully completed. The registered manager said this had resulted in improvements in medicines records. Some issues identified at this inspection had not been identified by the audits or checks and the management team were aware this was an area for continued improvement.

Since the last inspection the acting manager had registered as the manager. People and relatives felt the registered manager was approachable and willing to listen to them. The registered manager offered a weekly 'surgery' for people to visit her but also made herself available whenever she was in the home. People and relatives felt there had been improvements to the running of the home. For example, one relative commented, "Improved? Well, you would think it was a different home now."

Staff felt the management team were open, approachable and effective. Their comments included, "[Registered manager] has done an amazing job", "[Registered manager] is really good and I feel very supported", "The deputy and manager are very helpful" and "I feel I can go to either of them for support and advice."

People, relatives and visitors were invited to give their views about the service including any concerns. This involved completing a survey on an electronic device (iPad). This provided real time feedback for the provider so they could address any issues raised. There was a display board in the hallway of 'you said, we did' suggestions by people and any actions taken. For example, the feedback was that people had asked for more variety in drinks and snacks and more pet therapy. In response, there was more variety of snacks offered, a Zoo lab had visited and a pet rabbit had been living at the home. People had enjoyed the therapy of holding the rabbit but it had been rehomed with a relative as it was taking staff time to care for it.

All the staff we spoke with said morale had significantly improved. They felt the new management arrangements had led to a positive change in culture as well as improvements in the way the service was delivered. Staff said they felt valued and proud to work at this home. One staff member told us, "I think

everything has improved now that we have [registered manager] and a deputy. I really enjoy coming to work now." Other staff comments included, "Everyone gets on now and the home itself looks better", "A year ago I was thinking of leaving but it's so much better" and "I love working here now."

Staff meetings were held so staff had opportunities to make suggestions and views about improving the service. Staff said they felt encouraged to raise any areas for improvement. Some staff were designated as 'champions' in areas that they had particular interests or strengths in. These included nutrition, infection control and fire safety. The champions had responsibility to promote good practice in these areas. We could see the impact of these roles on the quality of care people received. For example, the nutrition champion checked the texture and quality of meals before they were served, and took these back to the kitchen if they were not of a satisfactory standard.

There had been improvements to the premises and furnishings since the last inspection. For example, the garden had been made secure, and new dining furniture and bedding purchased. A shower and bath had been out of action for much of the year but the regional manager was able to evidence the actions the provider had taken to get the suppliers to fix these and this work was imminent. There was a five-year refurbishment plan for the home. For example, there were proposals to upgrade all bedroom door locks and to extend the conservatory. In this way, the provider had plans for continuous development of the home.