

Care UK Community Partnerships Ltd

Whitebourne

Inspection report

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

The inspection took place on 07 March 2018 and was unannounced. Our last inspection was in April 2017 where we identified seven breaches of the legal requirements. These related to risk management, safeguarding, staffing, dignity and respect, person-centred care, governance and notifying CQC of important events. At this inspection, we found that the provider had taken action to meet the requirements of the regulations in these areas. There was a new registered manager in post and they had implemented improvements to staffing, risk management and care planning. We noted they were finding innovative ways to involve people in the running of the service, as well as improving levels of support and communication for staff.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

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

Whitebourne accommodates up to 66 people in one purpose built building. Care is provided across two floors, each with their own communal areas. The service specialises in providing care to older people who are living with dementia. At the time of our inspection, there were 45 people living at the home.

There was a registered manager in post. 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.

Risks were managed safely, in line with people's needs. Detailed plans were drawn up to manage individual risks and staff were knowledgeable about them. Where incidents, such as falls, had occurred, staff took action to ensure people's safety. Staff understood their roles in safeguarding people from abuse and where necessary had raised concerns appropriately. The provider worked alongside the safeguarding team where necessary and had been notifying CQC of important events.

People's care was planned in a person-centred way. People were given regular opportunities to express wishes or preferences and these were responded to by staff. People's care was planned in a way that reflected their needs and was regularly reviewed. Staff knew people well and routinely involved them in their care. People received care promptly and in a dignified manner. Staff were respectful of people's privacy, as well as finding ways to encourage people to maintain independence. Staff sought people's consent and

where appropriate, applied the Mental Capacity Act 2005.

Staff felt supported by management. The registered manager delegated tasks appropriately which had caused a significant improvement in staff support and communication. Improvements were being identified and implemented as planned and these involved people, relatives and staff. The provider had improved the communication systems in place and was finding ways to reward staff for good practice. The provider had developed important links with the local community that had led to improvements in activities and staff training. Staff had received training to enable them to be confident in their roles and they received regular one to one supervision meetings with their line managers.

People's medicines were managed and administered safely. Staff followed best practice in administering medicines and the provider had systems in place to regularly audit this area. People were supported to access healthcare professionals when required. The home was clean and regular checks were undertaken to reduce the risk of the spread of infection. The environment was suited to people's needs and work was underway to further improve the decoration of the home. There was a range of activities available to people and people had choices with regards to food. People's individual dietary needs were met.

There were sufficient numbers of staff at the home and all staff had undergone appropriate checks to ensure that they were suitable for their roles. The provider carried out regular checks and audits to identify any improvements that were necessary at the home. There was a complaints policy in place and this showed complaints had been investigated and responded to.

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.

Risks to people were routinely assessed and plans were implemented to manage them. Where incidents had occurred, actions were taken to reduce the risk of them happening again.

Staff understood their roles in safeguarding people from abuse. There were sufficient numbers of staff to meet people's needs and the provider had carried out appropriate checks on new staff.

People's medicines were stored, managed and administered safely by trained staff that had their competency assessed.

The provider had systems in place to reduce the risk of the spread of infection. There were systems in place to keep people safe in the event of an emergency.

Is the service effective?

Good ●

The service was effective.

People were happy with the food provided to them and it matched their preferences. People's individual dietary needs were met.

Staff sought people's consent and provided care in line with the Mental Capacity Act 2005. People were supported to access relevant healthcare professionals.

People were supported by staff that had the right training and support to carry out their roles. Staff had regular one to one supervision.

People lived in an environment that was suited to their needs. Before coming to live at the home, people received a thorough assessment to ensure their needs could be met.

Is the service caring?

Good ●

The service was caring.

People were supported by kind and caring staff who knew their needs well.

Staff provided people with dignified care that was sensitive to their needs. Staff were respectful of people's privacy.

People were involved in their care and staff took time to encourage people to maintain their independence.

Is the service responsive?

Good ●

The service was responsive.

People's care was planned in a person-centred way. Staff responded to people's wishes and preferences and provided care that met people's individual needs. People received appropriate end of life care.

People had access to a range of activities and had opportunities to make suggestions in this area.

The provider investigated and responded to complaints appropriately.

Is the service well-led?

Good ●

The service was well-led.

Staff felt supported by management. There were significant improvements to staff support and communication.

The provider carried out a number of checks to measure the quality of people's care. Where improvements were identified, these had been actioned.

The provider worked alongside relevant stakeholders and had links with the local community, which impacted positively on the care people received.

The provider had been notifying CQC where necessary, in line with the responsibilities of their registration.

Whitebourne

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.

The inspection took place on 07 March 2018 and was unannounced.

The inspection was carried out by three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

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.

As part of our inspection we spoke with thirteen people and two relatives. We received further feedback from one more relative after the inspection. We spoke with the registered manager, the regional manager, two deputy managers, one team leader, one kitchen staff, one laundry staff and six care staff. We also observed the care that people received and how staff interacted with them.

We read care plans for six people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty. We looked at two staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We also looked at records about food, activities and minutes of meetings of people, staff and relatives.

Is the service safe?

Our findings

At our inspection in April 2017, we found that people were not always adequately protected from known risks. We found instances where risks relating to people's behaviour, falls and skin integrity had not been addressed appropriately, causing people to suffer harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, we found that the provider had taken action to meet the requirements of the regulation.

People felt safe with staff. One person told us, "Yes I feel safe." Four other people responded positively when asked if they felt safe. We also observed people with staff and they looked comfortable with them. People were observed moving around the home with staff support. Staff were patient and gave people time to move at their own pace when walking around the home. Throughout the day, people looked confident being supported by staff with their walking aids.

Risks to people were assessed and plans were implemented by staff to keep people safe. People's records contained evidence of assessments of known risks such as falls, malnutrition, behaviour and pressure sores. Where risks were identified, plans were implemented to keep people safe. For example, one person was living with dementia and staff had identified risks relating to their behaviour. Their care plan recorded that certain things could cause the person to become anxious. These included sitting down for meal time and when relatives visited the home. Detailed information on what could cause the person anxiety and how staff could engage positively with the person were recorded. The plan stated that the person enjoyed books and there were certain phrases staff could use to reassure the person that they responded well to. A member of staff was knowledgeable about these when we spoke with them. Another person had been assessed as at risk of falls. To manage the risk, their plan recorded that they used a walking frame and required the support of one staff member to move around the home. During the inspection, we observed staff supporting this person to the dining room as outlined in their care plan.

Where accidents or incidents occurred, appropriate actions were taken to keep people safe. The provider kept a log of all accidents or incidents at the home and staff recorded the actions that they had taken. Records showed that the actions taken by staff were appropriate to reduce the risk of a similar accident reoccurring. For example, one person had fallen at night time. Staff supported the person and contacted the out of hours GP due to changes in the person's health. The person's care plan was reviewed and updated to include increased checks at night time. With this change in place, the person had not suffered any further falls. The provider also analysed falls to identify and address any patterns or trends. For example, one person had fallen three times in a month. After each fall, new measures were introduced to keep the person safe. A staff member told us, "We put crash mats next to [person]'s bed and a sensor mat. We also called the GP who took bloods as they were not well." Records showed that the person's risk assessment and care plan had been updated to address the increased falls and changes to the person's health.

At our inspection in April 2017, the provider did not ensure all safeguarding incidents were reported to the local authority and staff lacked knowledge in safeguarding adults procedures. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, we found

that the provider had taken action to meet the requirements of the regulation.

Staff understood their roles in safeguarding people from abuse. Staff had been trained in safeguarding procedures and were knowledgeable about the types of abuse, how they might identify them and where to report them to. There were posters displayed around the service that informed staff, people and relatives on how to raise any concerns that they may have. Where staff had found concerns, we saw evidence that these were being raised appropriately with the safeguarding team.

At our inspection in April 2017, there were not enough staff present to meet people's needs. People were observed spending long periods of time unattended and staff told us that numbers were not sufficient for them to carry out their roles effectively. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, we found that the provider had taken action to meet the requirements of the regulation.

There were sufficient staff present to meet people's needs. One person said, "There's always someone [staff] around." Since our last inspection, the ratio of staff to people had increased significantly. New staff had been recruited and there was a significant decrease in the numbers of temporary agency staff working at the home. Staff told us that they had enough time to meet people's needs and take time to provide people with engagement and interaction, as outlined in their care plans. Throughout the day we observed staff were able to sit with people and talk, play games and provide the levels of supervision required in people's risk assessments to keep them safe. For example, one person had assessed risks relating to their behaviour. They liked to move around the home independently but required regular engagement and reassurance as they could become anxious or confused. Throughout the day, the person was observed moving between communal areas and staff supervision was available to them at all times.

The provider carried out appropriate checks to ensure that people were supported by appropriate staff. Staff files contained evidence of robust checks being carried out before staff came to work with people. Checks included references, work histories and a check with the Disclosure & Barring Service (DBS). DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services.

People's medicines were managed and administered safely. The provider stored people's medicines securely and took steps to ensure that they were stored in line with the manufacturer's guidance. The temperature of storage areas was controlled and regular checks were carried out to ensure temperatures remained within the range outlined in the storage instructions. The provider maintained accurate medicine administration records (MARs) and these were regularly checked to identify any shortfalls. MARs contained information on people's medical conditions and allergies as well as photographs of people so staff could be sure they were administering medicines to the correct person.

Staff had been trained in how to administer medicines and their competency had been assessed. We observed a staff member administering medicines to people and they followed best practice. Staff checked medicines against those listed on people's MARs and checked the identify of people against their name and photograph. The staff member then dispensed tablets into a pot and took them to people. We observed the staff member taking time to tell one person which tablets they were taking and what they were for. After administering medicines, the staff member then documented that they had done so on the MAR, which ensured accurate records were maintained.

The provider took steps to reduce the risk of the spread of infection. The home environment was clean and smelt pleasant. The provider employed housekeeping staff and we observed them cleaning throughout the

day. Housekeepers had schedules to follow and they signed off work completed to ensure accountability. The laundry was organised and clean with clear processes that were followed to ensure that soiled linen was washed separately. The provider regularly audited infection control to identify if any improvements were necessary in this area.

People's safety was assured in the event of an emergency. The provider had systems, procedures and equipment in place for an emergency such as fire or a flood. Regular tests and drills were carried out to ensure these measures worked correctly. Staff had received training in fire safety and were knowledgeable about what they would do if they needed to raise the alarm. There was a plan in place to ensure that people's care could continue in the event of a fire. People had individual personal emergency evacuation plans (PEEPs) in place that informed staff of the support they would need in the event of an evacuation.

Is the service effective?

Our findings

People told us that they liked the food on offer. One person said, "I like the food, if its something you don't like you can always get something different." Another person said, "I'm happy with the food."

People received food in line with their preferences. People's care plans documented foods that they liked and disliked and they were served food that matched this. For example, one person's care plan documented that they liked apple pie and fish and chips. These items had been included in the menu for the previous month and staff had documented that the person had eaten them. The kitchen had a record of all people's preferences which ensured if people did not like specific foods, these were not included in their meals. The kitchen took daily feedback from people on the meals that they were served and regular meetings took place in which people could make suggestions about food or provide feedback to staff. People were offered a choice each day and the kitchen made sure they took information from people on their preferences. The chef told us, "In the morning we go and ask the residents what they want to have for lunch." The kitchen records were up to date and kitchen staff had attended training in areas such as food safety and allergens.

People's dietary needs were met. Where people had specific dietary requirements these were documented in their care plans. Each person had a nutrition care plan which was regularly reviewed. Where specific needs were identified, care was planned to ensure that they were met. For example, one person was assessed as at risk of malnutrition. Their nutrition care plan stated they should have foods that had been fortified, to encourage them to gain weight. It also said staff should document what the person had eaten and weigh them weekly. Records showed this was being carried out in line with the person's care plan. Another person was living with dementia and found meal times difficult. This was because they could become confused or anxious and could forget their meal choices. To support this person effectively, their care plan stated they should be shown meals on offer and offered a visual choice at meal times, as this would enable them to make an informed decision. We observed this person being supported to eat in line with this guidance at lunchtime.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were protected because staff followed the correct legal process, as outlined in the MCA. People's records contained evidence of decision-specific mental capacity assessments being carried out. Where people were assessed as unable to make specific decisions themselves, best interest decisions were documented that had involved relatives and healthcare professionals. Where restrictions were placed upon

people, applications were made to the local authority DoLS team. For example, one person had been assessed as unable to make a decision to consent to care at the home. A best interest decision was recorded that involved the person's relative and staff. As the best interest decision involved restrictions being placed upon the person, an application was made to the DoLS team who visited them and approved the restrictions in place.

Staff ensured that people's healthcare needs were met. People's care records contained evidence of involvement of relevant healthcare professionals as well as regular visits from the GP, dentist and optician. Where people had ongoing support from professionals, we saw evidence of their input in care planning. For example, one person was under the care of a community psychiatric nurse (CPN). Their notes contained evidence of regular visits from the CPN. Where staff had noted changes to the person's behaviour, the CPN visited and made changes to the person's medicines. The person's care plan was reviewed and updated in line with the CPN's guidance.

People were supported by staff that had the training and support needed to carry out their roles effectively. Staff received an induction before starting to work with people and they told us that this made them confident in their roles. We spoke to a staff member who had recently come to work at the home, they told us, "I have a good idea of my induction structure and schedule." Induction involved shadowing experienced members of the team as well as attending training courses in mandatory areas. Staff training covered important topics such as safeguarding, moving and handling, health and safety and medicines. Staff completed the Care Certificate. The Care Certificate is an agreed set of standards in adult social care. The provider kept a record of training completed and ensured staff received regular refresher training and updates.

Staff received training specific to the needs of the people that they supported. Staff had received training in dementia care, as all people they supported had a diagnosis of dementia. Staff had regular one to one supervisions where they discussed people's needs and any training they needed. The provider also had an appraisal system in place and this was underway at the time of inspection.

People lived in an environment that was suited to their needs. The home environment was bright and easy to navigate. There was signage throughout the home to enable people living with dementia to orientate themselves within the environment. People's rooms had memory boxes outside. These are boxes containing pictures and mementos that reflected people's backgrounds. These, alongside name signs, helped people to find their rooms within the home. Corridors were wide to allow people to mobilise easily with walking aids such as frames. There were handrails throughout the home to allow people to steady themselves as they walked around the home. We observed that people were able to move easily around corridors by making use of the rails or their walking aids.

People received a thorough assessment before receiving a service. The provider had assessment documentation to be used when people came to live at the home. One person who had recently come to live at the home had a detailed assessment and we noted that a full care plan had been drawn up within days of them arriving at the home. The information captured provided detail on what the person required support with, but also what time they liked to go to bed, their favourite foods and their interests.

Is the service caring?

Our findings

At our inspection in April 2017, we found that staff did not always treat people with dignity and respect. People sometimes waited a long time for staff support and their hygiene needs had not always been met. We also found that staff did not know people well. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, we found that the provider had taken action to meet the requirements of the regulation.

People told us that they were supported by caring staff. One person said, "I'm glad I'm here. The staff are all kind." Another person said, "The staff are very nice, I couldn't ask for more." Another person said, "I'm very happy, I love life here."

People were treated with dignity and respect by kind, caring staff. Throughout the day, we observed interactions that showed staff were caring and considerate of people's needs. In the morning, we observed staff engage with one person who was confused and not sure where their room was. The staff member took the person's hand and showed them to their room. Staff then talked to the person about photographs in their memory box, asking about their family and their working life. Later, we observed staff talking to people about music. Staff asked what people wanted to listen to and we noted that they made suggestions of songs people had enjoyed previously. This showed that the staff had got to know people and their preferences.

People looked happy and well kempt. Personal care tasks had been completed as planned and we noted that daily notes documented when people had been supported each day. Staffing levels meant that where people requested support, they were responded to promptly. We heard call bells responded to quickly and the provider regularly checked response times. Staff had received training in dementia care and were confident in how to support people who could refuse care. Staff demonstrated a good understanding of people's needs and how they would respond if people declined care. A staff member described to us how one person who was living with dementia would often decline support to wash. They said that when this happens, they would leave the person and come back later when they usually accepted. Care was provided in a way that was respectful of people's privacy. People's room doors were closed and we observed staff knocking and waiting for people's permission before entering. Where personal care was given, this was done discreetly and behind closed doors.

People were supported by staff that knew them well. Staff demonstrated a good understanding of people's needs and backgrounds when we spoke with them. People's care records contained information about their backgrounds, such as their family background and working life, and staff were knowledgeable about these. People's rooms contained photographs about them and memory boxes on people's doors contained artefacts from people's pasts to provide staff with points of reference to ask people about. One person had a relative who was involved in the church and staff were knowledgeable about this and they had photograph to reflect this in a memory box outside their room. We also noted that people had life story books. These were books staff had worked with people to prepare in which they documented their lives. Staff told us that they enjoyed reading these as it gave them more insight into people's backgrounds and helped them to build better relationships with them.

People were involved in their care. Staff ensured people were given opportunities to make day to day decisions about their care. We observed staff offering people choices when providing people with meals and drinks during the inspection. In the afternoon, we observed one person asking staff about an activity taking place. Staff told them it was a music based activity and waited for the person to make a choice. The person declined the activity and was supported to go to a lounge and sit with staff. We later observed staff talking to the person about a news story. The home also took part in 'butterfly moments'. These were items staff wore that reflected their personality or a fact about their background. For example, one staff member told us that they were wearing bumble bee antennae because they were a 'busy bee'. This provided opportunities for conversation and inclusion at the home. For example, we observed one person touching a scarf one staff member was wearing and talking about the colour.

People were supported to maintain their independence. People's care plans documented their strengths and abilities which showed care was planned in a way that considered people's ability to complete tasks themselves. For example, one person's care plan reflected the fact that they could dress themselves independently. It said that due to the person's dementia, they may require prompting and encouragement with this task. The care plan said that staff needed to provide guidance to the person and ensure their clothes were appropriate for the season. We also noted that all communal areas had facilities for people to make themselves drinks, as well as snacks and newspapers. People were observed preparing drinks for themselves throughout the day. For those that required some support with this, staff were present in communal to ensure people's safety.

Is the service responsive?

Our findings

At our inspection in April 2017, people did not always receive person-centred care. Where people had specific needs, such as skin tears, there were not care plans in place for these. There were also shortfalls in records that meant people's preferences were not always clear to staff. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, we found that the provider had taken action to meet the requirements of the regulation.

People told us that they received care that was person-centred. One person said, "I have good hair washing and cutting here." Another person said, "I'm happy here because I get my own way. Whatever I ask for, they [staff] get it."

Staff understood and responded to people's preferences and wishes. People's care plans contained detailed information on their likes and dislikes and staff were knowledgeable about these. For example, one person's care plan said they liked to be addressed in a certain way and we heard staff addressing this person by their preferred name. Another person liked to watch the television news each morning. We observed staff supporting them to do so as written in their care plan. People were regularly asked about their care and their wishes and the registered manager had introduced a 'Wish Upon a Star' scheme. This was a noticeboard of wishes that people had made and the provider was working through helping people to fulfil them. One person had expressed a wish to go swimming and this was being arranged for them. Another person wanted to learn to knit again and this had been arranged. The registered manager told us some ideas they had for making other people's wishes come true and we noted these were particularly innovative.

Care was planned around people's needs. Where people had specific needs, we saw that they had care plans in place for them. For example, one person was living with dementia and sometimes they could become confused and anxious which meant they may display behaviours that required a response from staff. The care plan listed how certain staff or people could trigger the person to become anxious. There was guidance for staff on how to engage with the person positively, to divert them from their anxiety. The care plan listed that the person responded well to an offer of a cup of tea or a snack. Staff were knowledgeable about this when we spoke with them. Records showed that there had been low numbers of recent incidents involving the person, which showed that the interventions were working. Care plans had been regularly reviewed and we saw evidence of changes being made to care plans where people's needs had changed. A relative provided feedback to us after the inspection to say, 'Despite her dementia, [person] has had a happy, fulfilled, content and extended life as a result of the outstanding care provided by Whitebourne.'

People had access to a range of activities. The provider employed lifestyle co-ordinators who took the lead on preparing a timetable of regular activities, as well as working with people to identify activities they wished to take part in or goals that they wished to achieve. A timetable of activities at the home offered a variety of activities for different needs and interests. Activities included music, arts and crafts, films, beauty treatments and themed events. Staff and people had recently taken part in World Book Day and had dressed up as their favourite characters. A farm had recently visited the home and people had been visited by animals such as donkeys, guinea pigs and rabbits. People were regularly asked about activities at

meetings and care plan reviews.

People received sensitive and person-centred end of life care. People's care plans contained information about advanced wishes. These documented whether people wished to be admitted to hospital and which relatives and professionals should be informed in the event of their condition deteriorating. Where one person had recently had a change to their health that meant they were requiring end of life care, a plan was implemented that documented the person's wishes and preferences with regards to music, food and activities at this stage of their life. We saw compliments from relatives of people who had passed away at the home and these were positive about the sensitive and caring support people received. One letter of compliment said, 'Staff did an amazing job in keeping me updated. They went above and beyond their call of duty throughout.'

Complaints were investigated and responded to appropriately. The provider kept a record of all complaints received and actions they had taken. Records showed that all complaints had been investigated and the provider had responded within the timescales set out in their complaints policy. For example, a complaint from a relative about food choices had been investigated and the kitchen then worked with the person to identify suitable food options to address the complaint.

Is the service well-led?

Our findings

At our inspection in April 2017, we found a lack of support for staff from management. There was a lack of one to one supervisions and some staff told us that they could not easily access management. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, we found that the provider had taken action to meet the requirements of the regulation.

Staff felt supported by management. Following our last inspection, the previous registered manager left and a new registered manager was in post. The feedback from staff about the registered manager was all positive. One staff member said, "Management was poor when I started 7 months ago, now it's better." Another staff member told us, "[Registered manager] is like a breath of fresh air." Another staff member said, "I love working here now, we work as a team." The staffing structure had changed since our last visit and it now included deputy managers and team leaders. This meant there was always management presence on the floor and staff told us this made them confident. Tasks such as auditing and supervision were delegated to deputy managers and care staff took leads in areas of care such as dementia, dignity and infection control. These staff provided 'on the job' coaching to their colleagues and provided them with training and information during their day to day work.

The registered manager had implemented a plan to improve the culture at the service. They told us that changes to structure, a recent recruitment drive and refreshed training for staff had all contributed to the improvements to staff culture that were observed on the day. We noted that systems for communication were in place. These included regular staff meetings and daily handover meeting. We noted that a staff meeting had been used to discuss changes to one person's needs as well as safeguarding procedures and communication. The registered manager had a clear vision for the service which they were achieving in line with their action plan. The registered manager had recently introduced 'Amazing Cards' which was a staff recognition scheme to reward staff who went beyond expectations. Before the inspection, the provider submitted a Provider Information Return (PIR). In this, they outlined what they do well and any improvements that they planned to make. We noted that improvements listed in the PIR had been implemented by the time of our visit. These included recruitment of staff, changes to menus and activities and decoration of the home environment.

At our inspection in April 2017, there was a lack of checks and audits in place. The provider's audits had not identified our concerns and there were shortfalls in record keeping that impacted on care delivery. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014). At this inspection, we found that the provider had taken action to meet the requirements of the regulation.

The provider regularly checked the quality of the care that people received. The provider carried out a variety of audits to identify any areas for improvement within the home. Audits were robust and covered a variety of areas of people's care. Audits seen included medicines, infection control, health and safety and documentation. When audits identified improvements, actions were taken to address them. For example, a recent audit of falls identified increased falls at night time. In response, the registered manager carried out a night spot check and people's care plans were reviewed. Where audits had identified improvements

required to the home environment, we observed decoration and refurbishment works being carried out on the day of our inspection.

The provider maintained accurate and up to date records. We noted that people's records were up to date and staff had input daily notes in a timely manner. This meant information was available to staff and professionals when needed. Where one person had come to live at the service days before the inspection, they already had a full and detailed care plan and life story written by staff. Another person's needs had changed the night before inspection which meant that they required end of life care. A new care plan, reflecting the changes to the person's needs, had been written up by the morning of our visit.

The provider had strong links with the local community. The provider had a day service that was open to the community and this provided people with a place to go for activities, as well as encouraging social engagement with people from the community that used the day centre. We also saw evidence of work with the Alzheimer's Society. This had benefitted people because staff had received bespoke, specialist training in dementia care, as well as the provider's own training courses. We also saw evidence of regular contact with the local authority and relevant community healthcare organisations when necessary.

People and relatives were involved in the running of the home. Regular meetings took place and records showed that these were open and provided opportunities for people or relatives to make suggestions. We noted that meetings had been used to discuss the concerns raised at our previous inspection, in an open and transparent manner. Relatives had been informed of what actions were being taken and kept up to date. The registered manager had then gone on to further involve relatives by inviting a relative to provide workshop sessions for staff where they had told staff about their experiences as a relative, to help improve practice. People had regular meetings and we noted that these were used to gather feedback and address any concerns. One person had requested changes to food and activities at a recent meeting and this had been actioned by staff. A relative provided feedback to us after the inspection to say, 'The team's empathy and understanding shown to me as a relative has been exemplary.'

At our inspection in April 2017, the provider had not been notifying CQC of incidents that they were required to do so as part of their registration. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection, the provider was meeting the requirements of this regulation. The provider understood the responsibilities of their registration. Providers are required to notify CQC of important events at the service, such as serious injuries, deaths or allegations of abuse. Records showed that where required, the provider had notified CQC where any such events had occurred.