C.T.C.H. Limited

Parton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which took place over two days on the 8 and 9 December 2016. Parton House provides care to 36 older people with a physical and/or sensory disability. At the time of our inspection 23 people were living in the home. Accommodation was provided over two floors with shaft lifts to access the first floor. There were 36 bedrooms, each of which had en suite facilities and there were an additional bathrooms and shower rooms. People had access to three lounges and a dining room. There were pleasant grounds around the home which were accessible to people.

The registered manager had been in post just under two months at the time of the inspection. She had been previously registered at another home owned by CTCH Limited. 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.

At the inspection on 10 May 2015 the overall rating was requires improvement. We asked the provider to take action to make improvements to:
•□the accuracy of people's care records
•□the way in which people were treated, ensuring dignity and respect at all times
•□people having access to the appropriate diet and nutritional input
•□staff recruitment procedures
and these actions had been completed.

Despite the action taken to address issues we identified and on-going positive changes to people's experience of their care, there was still room for improvement. People's dignity was not being promoted when they were assisted with moving and handling. Staff did not use blankets provided to cover them when being hoisted. A new range of quality assurance audits had been introduced which identified where further improvements were needed. However actions had not been recorded to evidence what was going to be done to address these issues, by whom and by when. Other quality assurance audits also failed to identify actions although the registered manager was able to evidence through other records these had been completed. We made a recommendation in relation to this.

People received individualised care which reflected any changes in their health and wellbeing. Improved communication by staff ensured their changing needs were addressed and they had access to health care professionals when needed and action had been taken to keep them safe and well. Accidents and incidents had been monitored and staff had looked for explanations of possible causes, taking action to minimise these where they could. People's needs had been assessed and new care plans put in place which reflected their individual wishes and needs.

People were supported by staff who understood their needs. They had been appointed after all the

necessary recruitment checks had been completed. They had access to training and support to develop in their roles and reported that morale had significantly improved and they felt valued in their roles. People's rights were upheld and staff understood how to recognise and report suspected abuse. People were supported to make day to day decisions and were supported to make larger decisions in their best interests if they were unable to do this. When people had been restricted, the least restrictive option had been explored, and deprivation of liberty safeguards had been requested. There were enough staff with the right skill mix to meet their individual needs.

People had access to a range of meaningful activities reflecting their likes, interests and hobbies. They enjoyed entertainment by local choirs, schools and other services. Consideration was being given to the needs of people living with dementia, making their environment more accessible to them. Signs around the home helped them to find their way around and brightly coloured crockery helped them to eat and drink. There were plans to provide pictures and rummage draws which they could interact with.

The registered manager had plans to further improve people's experience of care by refurbishing the home, increasing staff awareness of dementia and to develop a staff team with the skills and knowledge to enhance people's wellbeing. Staff found her to be open, accessible and approachable. They reported an improvement in staff morale and were working as a team. People and their relatives would confidently raise concerns with the registered manager who one relative said was "a breath of fresh air". The registered manager was supported by the provider to drive through changes to deliver a higher standard of care.

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. People's rights were upheld and they were kept safe from the risks of harm or injury.

There were sufficient staff employed with the right skills and knowledge, to meet people's needs. Recruitment procedures prompted the relevant checks to be completed for all new staff before they started working in the home.

Improvements had been introduced to make sure medicines were managed and administered safely.

People were protected against the risk of infections. The premises and equipment were managed to keep people safe.

Is the service effective?

Good

The service was effective. People were supported by staff who had access to a wide range of training to equip them with the skills and knowledge they needed. Staff felt supported in their roles and had opportunities to develop professionally.

People's consent was sought in line with the essence of the Mental Capacity Act 2005. The appropriate authorisations had been submitted for people deprived of their liberty.

People were supported to stay healthy and well through access to a range of healthcare professionals. Their nutritional needs had been assessed and reflected their individual dietary requirements.

Is the service caring?

Requires Improvement

The service was not always caring. Although there had been improvements in the way in which people were treated, further thought needed to be given when assisting people in hoists to promote their dignity.

People were involved in making decisions about their day to day lives. Their individual religious beliefs were respected.

Staff understood people well and had developed positive

relationships. They were caring, attentive and offered reassurance when needed.

Is the service responsive?

Good

The service was responsive. People's changing needs were responded to and their care records reflected the care and support they received.

People had access to a range of meaningful activities and their independence was promoted.

People and those important to them raised issues as they arose and were confident action would be taken to address their concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led. Quality assurance processes lacked evidence of effectiveness due to limited or no documentation around completion of actions and reassessment.

Feedback on the service was sought however there was no evidence of this feedback being acted upon.

The registered manager was open, accessible and approachable. They had plans to improve people's experience of their care and to raise standards in the home.

Parton House

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 8 and 9 December 2016 and was unannounced. One inspector and an inspection manager carried out this inspection. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we spoke with six people using the service and six visitors. We spoke with the registered manager, two representatives of the provider, the cook, one of the housekeepers, five care staff and joined staff at a handover between shifts. We reviewed the care records for four people. We observed medicines being administered. We also looked at the recruitment records for four staff, staff training records, complaints, accident and incident records and quality assurance systems. We observed the care and support being provided to people. We used the Short Observational Framework (SOFI) for inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We received feedback from three health and social care professionals, local commissioners and Healthwatch in response to an "enter and view" visit carried out on 5 July 2016.

Good

Is the service safe?

Our findings

At our inspection of 10 May 2016 we found recruitment procedures were not effective, potentially putting people at risk of receiving inappropriate care. The provider told us they would address these issues and had put an action plan in place to describe how this would be achieved.

At our comprehensive inspection of 8 December 2016 we found the provider had followed their action plan to meet shortfalls in relation to the requirements of Regulation 19 described above. We looked at the recruitment information for four new members of staff. A new checklist had been put in place which confirmed when checks had been completed such as obtaining references and a Disclosure and Barring Service (DBS) check. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that was reasonably considered relevant to the post applied for. Any gaps in employment had been explored and noted on this checklist. There had been an oversight in the employment history for one applicant and this information was obtained during the inspection. If applicants had worked previously with children or adults in social care, the reason why they left this employment had been verified and also recorded.

People were supported by enough staff to provide their care and support. Although there were fewer people living in the home the staff levels had been maintained in recognition of the increased needs of some people living there. Staff explained how people needed two staff to help them with their mobility and moving and handling tasks. They welcomed the addition of new staff and said they were working well together. Staff confirmed there had been less use of agency staff and if they were used it was always the same staff. The housekeeping team had been maintained at satisfactory levels although there was not always cover available when one of them was absent. The registered manager was currently recruiting to alleviate this problem. Additional kitchen staff had been employed to help out with evening meals, leaving care staff free to provide care and support to people. People and their relatives told us, "Staff are lovely", "Staff are very good, they always answer the call bell" and "Residents need the continuity of staff they know. I have noticed an improvement." Staff commented, "They look at the skill mix and make sure it's right for each shift" and "It's good we have our own team; it's working better."

People's rights were upheld. Staff talked through the action they took in response to unexplained bruising or injuries and accidents or incidents. They made sure records were kept and they reported concerns to the management team. They were confident they would take the necessary action in response to the issues. Staff had completed safeguarding training and had access to local procedures. The registered manager was aware of their responsibility to notify the local safeguarding team, Police and the Care Quality Commission of any allegations of abuse. One safeguarding alert had been raised in September 2016 and the appropriate action had been taken by the provider. One relative told us, "Mum is safer living somewhere like this."

People's safety had been considered when identifying hazards which might result in injury or harm. Risk assessments clearly described how these hazards had been minimised. For example, people at risk of falls had been provided with walking aids, hoists and slings and sensor pads in their rooms to alert staff if they had fallen. People had access to their call bells and staff were observed responding quickly to these. When

people were at risk of developing pressure ulcers they had been provided with equipment to protect their skin such as mattresses and cushions. In response to a bruise on a person's leg staff decided it could have been caused by their wheelchair and so a protective cushion had been obtained to reduce the risk of this happening again.

When people had accidents or incidents these had been recorded and the appropriate action had been taken to reduce any further risks of harm. For example, referral to an occupational therapist for equipment for moving and assistance or to their GP to investigate a physical condition or to review their medicines. The number of accidents and incidents had significantly reduced and when they did occur investigations considered how they might have happened and how they could be reduced. A monthly audit identified if any themes were emerging for individual people which had not been identified.

People were safeguarded against the risk of emergencies. Each person had an individual evacuation plan in place which described how to support them to leave the building in the case of an emergency. A summary of these individual plans had been produced for emergency services using symbols and pictures to identify those people who needed support from staff. People's health and safety was promoted through a safe environment. For example checks and servicing for fire systems; food hygiene, electrical appliances and equipment had been carried out at the appropriate intervals. Routine checks on water systems and for legionella had been completed. A fire risk assessment was in place along with environmental risk assessments. An out of hour's system was in place should staff need support or advice from the registered manager. A business continuity plan had been provided for staff to access should there be an emergency such as adverse weather or utility failure.

People's medicines had been administered and managed safely. New systems had been put in place to promote the safe management of medicines. Large stocks of medicines had been reduced and the stocks of all medicines were now monitored on the medicines administration record (MAR). People's medicines had been reviewed with their GP and wherever possible medicines prescribed for use as necessary had been reduced or removed if no longer required. Protocols described when this medicine was to be used and the MAR showed this medicine was used sparingly. People had their medicines at times to suit them; if they refused staff said they revisited them later and offered them again. One person managed their own night time medicines. New medicines audits were being carried out at increased intervals to make sure medicines were being given correctly. The registered manager said the number of errors had reduced. The registered manager said they benefitted from the services of a pharmacist employed by their GP surgery who advised and worked with them to reassess people's individual medicines requirements.

People were protected against the risk of infections. Staff had completed infection control training and practiced safe and hygienic care practices. They had access to personal protective equipment and hand washing facilities. Hand gel was provided around the home for them and visitors to use. Housekeeping staff worked to a cleaning schedule and also said they deep cleaned areas of the home when needed. This included cleaning people's carpets in their rooms. Visitors had previously commented about unpleasant smells but none were noticed during this inspection. A relative confirmed, "The standard of the cleanliness has improved; the lounge used to smell but this is better." There were long term plans to replace carpets around the home and to redecorate shared areas. Some bedrooms had already been refurbished and a new wet room had been created. A relative commented, "Environmental works are being done but not quick enough for some of the residents." The registered manager provided the annual infection control report for 2016 after the inspection in line with the Department of Health's code of conduct on the prevention and control of infections. There had been no outbreaks of infectious diseases during 2016. We discussed with the registered manager the cleanliness of some people's wheelchairs and they said they would address this.

Good

Is the service effective?

Our findings

At our inspection of 10 May 2016 we found people had not been supported to have sufficient to eat and drink. The provider told us they would address these issues and had put an action plan in place to describe how this would be achieved.

At our comprehensive inspection of 8 December 2016 we found the provider had followed their action plan to meet shortfalls in relation to the requirements of Regulation 14 described above. People's nutritional needs had clearly been identified in their care records. Where people were deemed to be at risk the malnutrition universal screening tool (MUST) was used; this was a screening tool which identified adults who were malnourished. Staff used an on line tool to assess people's nutritional risks and this information was then recorded in their care records. When needed their weight had been taken weekly, fortnightly or monthly. Their GP was also informed and if supplements were prescribed people had access to these. The cook confirmed four people needed to have their meals fortified and were offered additional fortified drinks such as hot chocolate or milkshakes and high calorie snacks. Staff were observed offering cold and hot drinks to people as well as snacks in between meals. Staff monitored what people were eating and drinking and ensured staff coming on to duty were aware if they had any concerns. Finger food could be provided for people who preferred to eat buffet style meals. Afternoon tea was served using vintage cake plates and crockery. There was evidence people's weight had stabilised as a result of these interventions.

People's dietary needs were considered. People living with diabetes had access to appropriately prepared meals and snacks. People at risk of choking had been referred to the speech and language therapist and wherever possible they had been advised to have either a soft or a mashed diet. The meals were prepared by a national organisation which provides ready-made meals which are customised to the needs of older people. The cook said people were trying the taster menus over a four week period and were currently on week two. People's preferences were already becoming clear and the menu would be arranged to reflect their individual likes and dislikes. Food was served from a hot trolley in the dining room and people's food was served in table rotation so they took turns to have their meals served first. Arrangements could be made for private dining if people wished to entertain visitors. People had invited their relatives and friends to join them for Christmas lunch at the home.

People were supported by staff whose training needs had been monitored and reviewed. Staff were completing training considered as mandatory by the provider such as first aid, fire, food hygiene and safeguarding. A health care professional said some staff had poor awareness of the needs of people living with dementia. The registered manager was a dementia lead and said two staff would be attending further dementia training. Other staff were registered for dementia awareness courses. In addition staff had access to end of life training, tissue viability and pressure area awareness as well as positive response training with a local mental health trust. Staff had individual meetings with the registered manager and a schedule for 2017 had been drawn up. She said there would be a mix of face to face meetings, group meetings, observations of practice and an annual appraisal. She said she had concentrated her support for night staff initially and doing full performance reviews. Staff meetings had also been arranged and she was planning to develop these to empower staff to raise issues or items they wished to discuss. Staff commented, "We have

the supervision and support to develop" and "The new manager picked up when I was feeling low. We had a chat and I was offered additional support."

People made decisions about their care and support. Staff were observed offering people choices about their day to day lives and respecting their decisions. For example, people chose where to eat their meals; in their rooms, in the dining room or in the lounge. People's care records clearly stated when they were unable to make decisions about their care and support in line with the Mental Capacity Act 2005 (MCA). They identified when people might have fluctuating capacity and prompted staff to consider times when people might need additional help to make decisions for example when unwell. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Authorisations had been submitted for people whose liberty was being restricted and urgent authorisations had been granted when needed. There was evidence wherever possible the least restrictive solution was being considered when placing restrictions on people's liberty. For example, the use of sensors and a door alarm on the front door. We discussed with the registered manager the lack of understanding of some staff around the DoLS and which people these applied to. They said they would address this with staff.

People's health and well-being was promoted. They benefitted from the enhanced services provided by a local surgery, whereby one GP was responsible for visiting each week; this meant that people saw a doctor when they needed to and their medication was reviewed regularly. People's appointments with their GP, community nurses, dentist, optician, chiropodist and specialist mental health professionals were recorded. A summary of the outcome of each appointment and a record of any future appointments were noted keeping staff informed about people's health and well-being. Health care professionals commented about the overall improvements in people's care and support.

Requires Improvement

Is the service caring?

Our findings

At our inspection of 10 May 2016 we found people's dignity was not always respected. The provider told us they would address these issues and had put an action plan in place to describe how this would be achieved.

At our comprehensive inspection of 8 December 2016 we found the provider had followed their action plan to meet shortfalls in relation to the requirements of Regulation 10 described above, although some improvements were still needed. People were not always shown dignity and respect when being assisted by staff using hoists. Blankets had been provided in the lounge to cover people if needed. However we found these were not always being used and several times people were hoisted when the blankets could have been used to cover them whilst being moved. Eventually staff used a blanket to cover a person but only after being prompted by us.

Staff had completed training in equality and diversity and dignity. A dignity champion was due to be appointed to take a lead on promoting dignity and respect. The home had signed up to the national Dignity in Care Campaign and the 10 point dignity challenge prompts were displayed in the home. The dignity challenge describes values and actions endorsed by high quality services which respect people's dignity and what staff should do. People spoke politely and respectfully to people. They listened and gave people time. They respected people's choices and right to refuse care or support. Staff were attentive to people giving each person some individual time when they entered into the room. They chatted with people and offered reassurance when needed. They were observed kneeling down to talk with people face to face, holding their hands and talking through what was going to happen and why. Staff told us, "It's really improved for people, they are getting a better experience" and "It's better here for dignity, for humanity and for people. They are well cared for." A person living in the home reflected, "The atmosphere is very good. They realize we are all lost. They help you when they can."

People's personal preferences, spiritual and religious beliefs were identified in their care records. People were supported to celebrate religious festivals and to participate in religious services of their choice. Where people had a preference for the gender of staff providing their care this was respected. People's right to a private life was respected and visitors confirmed they had access to a private lounge to meet with their relatives. Private dining facilities were also available. People's personal information was kept securely and their right to confidentiality was respected.

People had positive relationships with staff. They told us, "They are marvellous", "Very friendly and nice." Relatives said, "How mum is looked after is important; everything has gone smoothly" and "They respect what she would have wanted." People were observed laughing and chatting with staff, enjoying light hearted banter and being in each other's company. Staff reflected that they had time to be with people saying "staff morale is better and they are appreciative of our care and time. It's a happy ship."

People's communication needs had been considered with information being provided in easy to read formats which used photographs and pictures to illustrate the text. In line with recent changes in legislation

the provider was reviewing all policies and procedures to make them more accessible. People's sensory needs were highlighted in their care records and the impact this had on their communication. Staff were guided to encourage them to wear their glasses and hearing aids and to speak clearly and slowly. People kept in touch with family and friends through visits, the telephone and Skype (instant messaging using text, voice or video calls).

People's personal histories, likes and dislikes had been discussed with them or their relatives and were recorded in a pen picture promoted by a national organisation called "This is me". Staff understood people well. Each person had a named member of staff who was scheduled to meet with them each month to chat about their care and support. A picture of this person had been displayed inside their wardrobe as a prompt. In this way people could be involved in making decisions about their care. People had information about local advocacy services. Occasionally people had appointed a lasting power of attorney (LPA) for health and welfare property and/or financial affairs. Documentary evidence had been obtained to verify each person's LPA.

Good

Is the service responsive?

Our findings

At our inspection of 10 May 2016 we found people did not always receive care that was responsive to their needs. We followed this up at our focussed inspection on 23 September 2016 and whilst there had been some improvements, there were still some inconsistencies in the quality and accuracy of people's care records. The provider told us they would address these issues and had put an action plan in place to describe how this would be achieved.

At our comprehensive inspection of 8 December 2016 we found the provider had followed their action plan to meet shortfalls in relation to the requirements of Regulation 17 described above. New care plans had been introduced which provided a person centred and up to date summary of people's care needs. They evidenced people's involvement and wherever possible people had signed their care records. They reviewed their care and support needs with a named member of staff each month. A person told us, "If I think anything needs altering I will say." Relatives were also involved in reviews and assessments of people's care. They said, "They tell me what's happened with her" and "I was able to attend an assessment with her, which I really appreciated." People's needs had been assessed to make sure their care and support could be met by the home. The registered manager was very conscious about making sure people were not admitted with complex care needs which they might struggle to cope with.

People's changing needs were responded to making sure their care and support reflected their current needs. Accidents and incidents were analysed and people were referred to health care professionals for their advice and support. For example, the risk of increasing falls resulted in a person having a reassessment for their moving and assistance needs and a hoist was provided. People whose weight fluctuated were closely monitored to make sure their diet was fortified when needed and their care records reflected their current nutritional risks. Staff had a good overview of people's changing needs making sure these were discussed at handovers.

People were encouraged to be as independent as possible, doing as much as they could for themselves. Their care plans clearly detailed what they were able to do and what they needed help with. For example, doing their own personal care and managing their own medicines. People living with dementia benefitted from some small changes to their environment. There were some signs displayed around the home to help them to find their way around. Crockery in bright colours had been provided to encourage people to eat. Each person had chosen a picture which was displayed on their bedroom door so they could recognise their room.

People had access to a range of meaningful activities. People and their relatives had been asked about what activities they would like to be provided. New activity schedules showed an increased range of activities which staff provided alongside external providers. People joined in with a carol concert during our inspection and made Christmas decorations. Two people had sampled a music event at another home and agreed to trial this at Parton House. The registered manager said there were plans for more co-operation and involvement in activities provided by other homes owned by the provider.

People had access to a small cinema at Parton House, which could be used to watch films as well as television. They also had a hairdressing salon which was being extended to include a hand massage and nail bar. Consideration was being given to the needs of people living with dementia. The registered manager said they would also replace pictures around the home to reflect the interests of people living there. There were plans to introduce rummage draws to encourage people to reminisce and interact with their environment. In the good weather people were able to sit in the garden and some people liked to walk around the grounds. Relatives told us, "She enjoys the activities" and "She has engaged with the activities and has company in the day when she spends time in her room."

People and their relatives had information about the complaints procedure. A person told us, "I will complain" and a relative confirmed, "I can feel nervous making a complaint but they responded to me very quickly when I did." Other relatives spoke about the confidence they had in the new manager who they would talk to about any issues they might have. The complaints procedure had been given to people when they moved into the home as part of their service user guide and copies were kept in their rooms. People, their relatives and staff were encouraged to raise matters of concern so that any issues could be looked into quickly and action taken to address concerns as they arose. For example, laundry being mislaid, money going missing and the cleanliness of a bedroom. Eight concerns had been received during 2016 and resolved with actions being taken when needed.

Requires Improvement

Is the service well-led?

Our findings

People did not benefit from quality assurance systems which were effectively implemented. The quality of the service was monitored by a variety of audits including room audits, medicines management and care plan audits. The audits had been completed and where there were issues actions had been identified but there was a lack of recorded evidence to show that these monitoring systems improved the quality and safe of the care provided. Some of the monitoring forms lacked any detail and there was not a consistent record of actions taken, by when and who was responsible. For example in an audit of people's rooms there was an issue identified around the need for window restrictors with an action to inform maintenance. This was identified two months in a row with no indication that it had been completed. However when we discussed this with the registered manager she could evidence that action had been taken and signed off on a maintenance log. The provider also undertook monthly audits of the service looking at outcomes which reflected CQC's key questions. Actions had been identified for improvement. This audit did not however, evidence if the issues had been completed, when and by whom. Therefore the evidence that their quality assurance processes drove improvement was not always there.

We recommend that the service seeks advice and guidance from a reputable source around the development of robust quality assurance records.

In addition to these quality assurance systems the provider had completed an audit of the service looking to assess their performance in relation to outcomes such as 'involving and respecting people' and 'consent to care and treatment'; all outcomes were found to have been achieved in July 2016.

Accident and incidents were audited regularly and included an analysis of any themes or patterns so that the appropriate action could be taken.

The registered manager had been in post less than two months at the time of the inspection. People, staff and relatives said the registered manager was open and accessible. People and their relatives commented, "She is a breath of fresh air" and "The door to the office is always open. There have been improvements all round." The registered manager was aware of their responsibility to submit notifications to the Care Quality Commission. Statutory notifications are information the provider is legally required to send us about significant events. The previous inspection report was displayed with the rating in the reception area as well as on the provider's website. Each person had been given a copy of the summary of the report. Staff were confident any concerns raised under the whistle blowing procedure would be listened to and the registered manager would take the appropriate action in response. The registered manager had responded to reports from Healthwatch and local commissioners putting action plans in place to comply with their recommendations.

The registered manager acknowledged the challenges of developing and improving the service and people's experience of their care. This included reassuring people, their relatives and staff that concerns would be listened to and action taken, to reduce the number of agency staff being used and to nurture a staff team with the right skill mix and culture. Future plans focussed on developing links with the local community.

They had already approached a local supermarket, the community centre and schools. Students from a local school were due to start their Duke of Edinburgh awards at the home. There were also plans to refurbish the home, develop staff understanding of people living with dementia and to maintain improvements in activities. A relative commented, "Staff are smiling again, they are less stressed; they are trying to get it back to what it was."

People, their families and staff recognised the improvements which had been made. Comments included, "Better morale, better support systems and it's improved for people; they are getting a better experience" and "I am very impressed." Staff reflected, "We are pulling together as a team" and "It's getting better, residents are happier, staff are getting there and management listen and talk to you." The provider's website stated their values for the organisation were that, "All staff believe that every person is an individual and as such is unique. All staff acknowledge that residents have the right to expect a high standard of care, delivered by safe, competent team members." Representatives of the provider said they were committed to improving the service.