Winifred Healthcare Limited

Winifred Dell Care Centre

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 18 April 2017 and was unannounced.

Winifred Dell Care Centre provides accommodation and personal care for up to 76 older people who may also have dementia. Care is provided in four units over two floors. At the time of our visit there were 69 people living in the service. The service does not provide nursing care.

A new manager was in post who had applied to become registered.. 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 our previous inspection we found a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not always minimise the risk of falls for people. At this inspection we found the service had improved how risks were assessed, reviewed and managed. There were robust systems in place to assess and manage risks to people. Risk assessments were regularly reviewed and evaluated to ensure they remained relevant. Staff demonstrated a good awareness of the individual risks to people and how to manage them.

People were protected by the service's approach to safeguarding and whistleblowing. Staff were aware of the different types of abuse and action to take if abuse was suspected.

People who used the service told us that they felt safe, could raise concerns if they needed to and were listened to by staff.

Checks of the building, equipment and maintenance systems were regularly undertaken to ensure people's health and safety was protected.

There were sufficient numbers of staff that had been safely recruited to meet people's needs.

Appropriate systems were in place for the management of medicines so that people received their medicines safely. Only staff who had received training and been checked to ensure they were competent administered medicines.

Staff received on going training and regular supervision and appraisals to support them to carry out their duties and responsibilities effectively.

The service was meeting the requirements of The Mental Capacity Act 2005 (MCA). Assessments of capacity that were of a high quality had been undertaken when required and appropriate applications for

Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority.

People were supported to have enough to eat and drink that met their preferences and any dietary or health requirements. However people living with dementia were not always adequately supported to make their own decision about what they would like to eat. We made a recommendation that the provider refer to best practice guidance on supporting people with dementia to make choices at mealtimes.

People were supported to maintain good health and wellbeing. The service was good at involving external healthcare professionals and obtaining advice and guidance when needed from specialists such as, the community nurse, dietician and GP.

Independence was promoted and people were treated with kindness, dignity and respect by staff who listened to them and knew them well.

Assessments were undertaken to identify people's care and support needs. People's care and support plans were regularly reviewed with people and their relatives. Care records contained up to date information about the care and support needed and included information about people's likes, dislikes and personal choices.

There was a wide range of activities and events available for people to participate in. People were supported to access the community and provided with varied opportunities for social interaction.

The provider had a system in place for responding to people's concerns and complaints. Any issues were investigated and dealt with appropriately by the manager.

There had been improvements in managerial oversight of the service and staff. Robust systems were now in place to monitor the quality and safety of the service. A wide range of audits had been undertaken to help identify any areas that required improvement.

People, relatives and staff were included in the running of the service. Any feedback provided was received positively and the service responded by making the necessary changes.

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 assessed and reviewed as necessary to keep people safe.

Staff were knowledgeable in recognising signs of potential abuse and were aware of action to take if abuse was suspected.

There were sufficient skilled and experienced staff deployed to meet people's needs safely.

Safe recruitment procedures were in place with appropriate checks undertaken before staff started employment. .

Procedures were in place for the safe management of people's medicines.

Regular checks of the building and maintenance systems were undertaken, which ensured people's health and safety was protected.

Is the service effective?

Good

The service was effective.

Staff received regular supervision and training to support them to develop the necessary skills to meet people's needs.

People were supported with decision-making and any decision made on their behalf was made in their best interest.

Staff supported people to have enough to eat and drink that met their health needs and preferences.

The service worked with other professionals to promote people's health and wellbeing.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and discreetly supported people with all aspects of their daily lives.

People were treated with respect and their independence, privacy and dignity were promoted.

Staff were knowledgeable about people's care and support needs.

People's end of life care choices were recorded and respected.

Is the service responsive?

Good

The service was responsive.

Support was tailored to meet individual needs.

There was a range of activities available for people to engage in to provide opportunities for stimulation and socialisation.

People were encouraged to raise concerns and any complaints were investigated and dealt with appropriately.

Is the service well-led?

Good

The service was well-led.

There was a new manager in post who was enthusiastic about developing the service.

Feedback from people was sought and people, relatives and staff were all included in the running of the service.

There were systems in place to monitor and improve the quality and safety of the service.

Winifred Dell Care Centre

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 18 April 2017 and was unannounced. The inspection team was made up of two 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, the previous registered manager had 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 looked at the PIR and at all the information we had collected about the service. This included information received and notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law. We also reviewed information from the local authority and quality improvement team who had worked with the provider and were familiar with the service.

As part of the inspection we spoke with the manager, the chef, the HR/training officer, the activities co-ordinator and nine other members of staff. We received feedback from thirteen people and four relatives of people who use the service. Some people who used the service were living with dementia and were unable to tell us about their experience so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at six people's care plans and associated records, three staff recruitment files, four staff training and supervision records. We reviewed a number of other documents relating to the management of the service including policies and processes regarding aspects such as safeguarding, handling complaints, incidents and accidents and medicine management.

Good

Is the service safe?

Our findings

At our previous inspection we found a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had not effectively minimised the risks to those people at risk of falls. The service had not always analysed the reason why people fell or made any necessary changes to the support being provided in order to keep people safe. At this inspection we found the service had made the necessary improvements to reduce the risk of people falling and they were no longer in breach of the regulations.

Accidents and incidents, including falls, were recorded on the provider's electronic database and the information was sent to head office for analysis. Incidents of falls were also discussed at a daily morning meeting with the registered manager and senior members of staff to help identify any patterns or trends and put preventative measures in place where appropriate to minimise future risks to people. We saw that where people were identified at risk of falling, equipment had been put in place such as chair and bed sensors to alert staff when people moved or stood up so that staff could provide the help they needed. We observed that where people required support from staff they were assisted to stand and move around the building safely.

We found that there were now more robust systems in place to assess and manage risks to people. Risk assessments were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and kept people safe. Risk assessments were tailored to each individual and provided detailed guidance for staff. Falls and mobility risk assessments included information on the type of equipment people required, for example, which type of hoist staff should use and the type and size of sling. The assessments also provided staff with guidance on the variability of people's abilities day to day. These assessments formed part of the person's care plan and there was a clear link between care plans and risk assessments, both included clear instructions for staff to follow to reduce the chance of harm occurring.

Staff were able discuss individual risks to people and tell us how these were managed. For example, one staff member told us, "[person] is on warfarin and has had one fall; we must always make sure they always have their frame as they will sometimes forget and try to walk without it." We found that the information staff told us about risks to people matched what was written in their care records. This demonstrated that information gathered about risks to people was up to date and was shared effectively with all staff to keep people safe.

Staff had an excellent understanding of risk prevention and were pro-active about measures to prevent harm or injury, for instance, liaising with the district nurse if they saw a person's skin was sore. The responsibility to minimise risk was shared effectively amongst all staff and was not limited to the senior carers, for example, the activity coordinator and the chef both understood how to minimise risk in their roles.

People told us they felt safe living at the service. One person told us, "It's nice and safe here, I feel very contented here and very safe." Another said, "It's a very safe home, I do feel safe here." A relative told us,

"We feel [family member] is safe, which is nice to know isn't it."

People and staff told us that there were sufficient staff deployed to meet people's needs. One staff member told us, "We didn't have enough staff but recently it's been back on track and we have enough now; we have a good team." A relative told us, "We're very content with this home and can't speak more highly of the staff, there's never any smells, and the staff seem to be available at all times". We saw that staff checked on people regularly and if people used their buzzers to call for assistance staff came promptly. A person told us, "I've never used my buzzer as the girls walk by regularly and I have my door open so I just call out – but there's never any problem; they look after me well."

The manager told us that they tried to limit the use of agency staff so that people were supported by a stable and consistent staff force. When agency staff were used, the service was provided with a training profile which was checked by the manager to make sure the agency workers had the right skills and experience to support people safely. The manager told us that all agency staff received an induction which was overseen by the manager so that their skills and competence could be assessed.

People were protected from harm whilst at the same time enjoyed the freedom to move around the home as they wished and their choices and independence was respected. We saw that the measures in place to protect people from harm were not unnecessarily restrictive, for example, one person was able to access the garden independently by using the door codes which were written discreetly by each door.

Staff we spoke with had completed training about how to support people safely and recognise the signs of and how to report abuse. They knew the actions to take, such as reporting issues to their manager and other agencies, including the local authority safeguarding team. Staff demonstrated a commitment to alerting the relevant authorities regarding any concerns. One staff member told us, "When it comes to our residents we are their ears and eyes. " Staff told us they knew about the whistle blowing process and said they would not hesitate to report other staff if they had concerns.

Medicines were given to people in a safe and appropriate way. People's individual medicine administration record (MAR) sheets had their photograph and name displayed so that staff could identify people correctly before giving medicines to them. This minimised the risk of people receiving the wrong medicines. We saw that people's MAR sheets had no gaps or missed signatures which indicated that people had received their medicines as prescribed. Where people had medicines that were in patch form, their medicine records included a body chart to illustrate where the patch should go. There were protocols in place for PRN (as needed) medicines with guidance for staff regarding when to give the medicines and in what doseage.

We observed a senior member of staff completing the medication round. Medicines were safely stored and administered from a lockable trolley. The staff member was competent administering people's medicines and talked to people politely. Water was provided to support people to take their medicine and they were allowed enough time to take them without being hurried. Where people required creams or eye drops the senior took people to a private space to administer these to protect their privacy and dignity. There were appropriate facilities to store medicines that required specific storage and medicines were stored at the correct temperatures.

Safe recruitment processes were in place for the employment of staff. Relevant checks were carried out as to the suitability of applicants before they started work in line with legal requirements. These checks included taking up references, obtaining a full employment history and checking that the member of staff was not prohibited from working with people who required care and support. We saw that where a member

of staff had an 'eligibility to work in the UK' issue this had been dealt with efficiently, and the required documents sought.

People were safe in the service as there were arrangements in place to manage and maintain the premises and the equipment both internally and externally. Mobility equipment such as wheelchairs, hoists and slings were all checked and had passed safety inspections. The service employed a maintenance person who was responsible for keeping the building and equipment safe and we saw that health and safety and equipment checks had all been regularly completed and recorded and any necessary action taken.

We saw that the service had recently had a visit from the fire inspector in January 2017 and the service had passed the inspection. Staff received training in fire safety and some staff were designated fire marshals. We spoke to a member of staff who was a fire marshal. They were able to explain the evacuation procedures and showed us copies of people's emergency evacuation plans. These provided guidance for staff to provide the correct level of support should people need to be evacuated from the building.

Good

Is the service effective?

Our findings

Staff told us when they began work at the service they completed an induction programme which included reading company policies and procedures and shadowing more experienced members of staff across the whole of the service, irrespective of which unit they were going to work on. This ensured they had some basic knowledge about all the people living at the service before they began work.

New staff were also required to complete a mandatory training programme which was delivered via E-learning and face to face. For those workers new to care, the service supported them to complete the Care Certificate. The care certificate represents a set of minimum standards that social care and health workers should stick to in their daily working life. Face to face training was provided in the more practical elements, such as moving and positioning, first aid and fire safety. All staff administering medicines received training in medicine management which included practical and E-learning elements and had their competency assessed regularly throughout the year.

Well organised systems and processes were in place to monitor and promote staff learning and development. The manager kept a training matrix to monitor staff learning and identify where refresher training was required and we saw that staff training was up to date.

Aside from mandatory training, staff were supported to undertake specialist training which met the specific needs of the people they cared for, for example, training in end of life care and dementia awareness. Staff told us they had been provided with all the training they needed to enable them to feel confident to carry out their roles and responsibilities. If staff were interested in developing their skills and knowledge the service helped them to do so Staff we spoke to told us they were being supported to take further advanced qualifications in health and social care.

The manager also kept a supervision matrix to ensure that staff received regular supervision and appraisals of their practice. This provided an effective system of monitoring and supporting staff to help them develop the skills and knowledge to support people effectively. We looked at supervision records and saw that staff received regular supervision which had provided them with opportunities to talk about any concerns and identify their strengths and any training needs.

We saw that the manager also used supervision sessions as opportunities to improve the quality of practice. For example, at January's supervision, all staff had been provided with a list of guidance on various aspects of their daily practice such as reminding staff to make sure they updated people's assessments after a hospital discharge. Staff confirmed that they received regular supervision and told us they felt well supported. One staff member said, "I have supervision monthly with a senior, It's helpful, if you have any concerns you get to talk about them."

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 be the least restrictive possible.

Records showed assessments had been carried out, where necessary, of people's mental capacity to make particular decisions. These assessments were of a good quality as had been completed using best practice guidance and included consultation with relevant parties when considering best interest decisions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found that the manager understood their responsibilities under the legislation and had developed a system to track DoLS applications so that they had a clear picture of any applications that were outstanding. They advised us that since joining the organisation they had made all of the necessary applications and were now going through the backlog to ensure that all applications were processed so that people were not being deprived of their liberty unlawfully.

We spoke with staff to assess their working knowledge of the MCA. Staff understood the right people had to make their own choices. A member of staff told us they had supported a person to make their own decisions about their daily routine, even when this differed from their family's wishes. The staff member told us, "They chose to have their door closed as they felt it was like they were in a gold fish bowl " We asked staff how they helped people who experienced difficulties making choices, for example, about what to eat. A staff member told us, "We have visual menus I would show people pictures or I would go and get items to show them "

Staff understood that people's capacity could vary depending on how they were on a particular day or on the choice to be made. For example, a member of staff told us that a person had the capacity to decline a meal but that after 24 hours there were concerns about the person's capacity to understand the potential risks of their decision if they continued not to eat. The member of staff therefore said they would refer this to the GP for review and discussion.

There were systems in place to ensure people were supported to meet their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Staff completed daily 'food and fluid' balance charts to record the amount of food and drink people took each day. People identified at risk were referred for professional input and treatment such as the prescribing of food supplements.

We observed the mealtime experience on three of the units and found this was a social event with people choosing to sit in friendship groups. The tables were laid nicely and people were offered a choice of drinks which were regularly re-filled. People selected their main meal the day before but were able to choose their choice of potatoes and vegetables on the day. If people didn't want what was on the menu they were able to choose alternatives. For example, we saw one person had a jacket potato with cheese and had their own butter dish..

On the dementia unit we observed that people were verbally offered a choice of food and drink but were not shown pictures or the dished up plates of food which would help them make an informed decision about what they wanted to eat. We also saw that gravy and sauce was added to people's plates without asking them if they wanted it.

We recommend that the provider refer to best practice guidance on how to support people living with

dementia to make choices at mealtimes.

People received assistance with eating and drinking if needed. We observed staff discreetly ask people if they needed help cutting up their food. The service had given thought to how to stimulate people's appetites. For example, we saw some people had their food served on small plates as it had been identified that if those people were given a large plate of food this discouraged them from eating. Where a person had a poor appetite we saw that a member of staff sat and ate lunch with them to encourage the person to eat more.

We received mixed feedback from people about the food. Some people told us they really enjoyed the food, comments included, "I really enjoy my dinners, if I don't care for something there's always an alternative." And, "They do give us good dinners here, and you can have a sandwich and cake for supper." However, some people were not so positive. One person said, "Lunch could be better, sometimes it arrives a little late; the alternatives for dessert today were not great, either ice cream or semolina, I hate semolina. " Another person said, "The food is not so good here, I'm generally satisfied with breakfast but the lunch is under par. "

We shared the comments we received about the food with the manager who told us that they were pro-active in trying to meet people's needs and preferences and had re-introduced the food committee to support people to give their feedback and improve the quality of meals and enhance people's satisfaction.

We spoke with the chef who told us they met with the food committee once a month and took on board people's comments. For example, where people had asked for meals from their youth the chef had researched traditional meals such as bubble and squeak. They told us that they had been given feedback that the food could be boring so they now changed the menu every three months. The chef was able to demonstrate that they had a good awareness of people's dietary needs and preferences. For example, who was diabetic or needed fortified food. They told us they had been on a course for specialist food preparation and needs to meet the needs of people on soft textured or pureed diets.

People were supported to maintain good health. A relative told us, "When [family member] came here they had very swollen legs but since they have been here, they've looked after them very well and their legs are fine now." People's care records showed they had regular input from a range of health professionals. We saw that staff involved external professionals and obtained advice and guidance when needed, from specialists such as, the community nurse, dietician and GP. Records were kept of any health visits and any changes and advice was reflected in people's care plans. We spoke with a visiting health professional who was positive about the service. They told us, "They care, if a home is able to care that's the name of the game," And, "They are on the ball here, they know where people are."

Good

Is the service caring?

Our findings

We received positive feedback from people and relatives about the kind and caring nature of the staff. One person said, "They look after me very well here, I need their help to get around and they are so good and kind at helping me." Another person told us, "All the girls [carers] are good and we have a laugh together, they're all nice girls." We observed two carers having a chat with the person with lots of laughter between the three of them. Visiting relatives also told us that the staff were caring. One said, "The carers are all lovely, they do a difficult job and they are so supportive; when I leave here each day I know [person] is in a nice place so I'm very content about that; it's a relief really."

People told us they were listened to and their choices and independence was respected. For example, people told us they could choose when to get up or go to bed or whether to join in activities. One person told us, "I've always got up early and I choose to get up early here." Another person said, "If I say I don't want to do anything they leave me alone – in here I can choose what I want to do and be involved in and what I don't want to do; it's nice to be independent."

The importance of acting in accordance with people's consent and choices was highlighted throughout people's care plans and there was evidence people had been involved in planning their care and support. People or their relatives, where appropriate, had signed the care plan to confirm they had been involved and agreed to its contents.

People were supported by staff that were warm, kind, caring and respectful. They appeared comfortable with the staff that supported them. Good relationships were apparent and people were very relaxed. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging.

Staff asked people's permission before they provided any care or support. For example, as they offered people drinks or assisted them to move from their chairs to the dining tables. Staff explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. Staff told us when supporting people with any personal care they would always ensure this was done in a way that respected the person's privacy and maintained their dignity. One staff member told us, "I will always keep people covered, close curtains, doors and explain what I am doing".

The staff we spoke with had a good knowledge of the people they supported. They spoke about people with affection and were able to give us information about people's needs and preferences which showed they knew people well. For example, one member of staff told us, "[person] is so funny and adorable; they love Elvis Presley and singing." And, "They are very independent, we just apply cream to their legs and they do everything else; they eat really well and love salt, pepper and vinegar on all their meals."

Important information about people's preferences for their end of life care was stored within their care

records. Records showed that, if appropriate, relatives were involved in decisions about people's end of life care choices, for example, where people had designated family members to have lasting power of attorney. This meant up to date information was available to inform staff of people's wishes at this important time to ensure their final wishes could be met. Care records included "do not attempt resuscitation" (DNACPRR) directives when these were in place for people. Where people lacked capacity to consent to these decisions, mental capacity assessments had been completed and best interest decisions made.

Good

Is the service responsive?

Our findings

People's care plans had been written to ensure they provided a detailed and personalised record of their individual needs, preferences and choices. Each person's care plan addressed areas such as their ability to give consent to their care and the level of assistance they needed. The assessments of people's needs promoted independence as they highlighted what people could do for themselves as well as identifying what they needed help with. Dietary preferences were recorded as were the person's wishes in relation to the gender of the care staff that supported them.

The care and support plans were individualised and included detailed information that helped staff to provide person-centred care. Person-centred care is a way of thinking and doing things that views people as equal partners in planning, developing and monitoring their care and support to make sure it meets their needs and wishes. We reviewed people's care records and found they were written in a person-centred way. For instance, one person's care plan stated, '[person] likes ice-cream but only a small portion." Another person's records stated, "If [person] wishes to go in the garden, they like to wear their cowboy style hat and sit in the shade."

The service employed an activity co-ordinator who organised a programme of activities, entertainment and outings for people who used the service. They were very enthusiastic about their role and told us they tried to plan two activities a day which included church services, singing, arts and crafts and baking as well as arranging external entertainment and activities such as a physical exercise class to promote people's health and mobility. People told us they enjoyed the activities on offer. One person told us, "I like the activities here, we all made a pizza last week, we had great fun; the other people on the table were nice and we all got involved and I had a really good laugh."

We saw there were lots of opportunities for people to access the community on trips out. Helpers were organised and approximately ten people were supported to go on any one trip. We were advised that the opportunities were shared amongst all of the people who wanted to go out and community transport was organised with a volunteer driver.

The service was pro-active on forging links with the community and we were told that volunteers from the community visited the service to run a knitting circle. People were also supported to attend a community tea dance once a month. The service had also organised a dementia support group for relatives of people living with dementia.

Whilst there were lots of organised group activities available we were concerned that those people who did not enjoy those types of events might be overlooked. For example, two people told us they would like opportunities to do their own thing. They told us, "We'd like to do more for ourselves in our rooms; if we had a duster we could dust the rooms ourselves rather than asking the girls to do it for us." We discussed this with the activities staff member who told us that there was time available to have one to one sessions with people who did not like group activities and there were plans to make this a more structured process to ensure that everyone who chose to stay in their room had opportunities to engage in activities of their

choosing.

We later spoke with the registered manager about the importance of providing activities that were tailored to the individual and meaningful to people. They were able to provide us with an example of an excellent piece of work the activities staff was doing with a person which demonstrated a strong commitment to person-centred care.

Complaints policies and procedures were in place and information about the complaints policy was available in the service's welcome pack. We saw that an easy read version of the complaints policy was on display in each of the units to assist people to raise any concerns. Records showed that when issues or complaints had been raised, these were investigated and appropriate actions taken to ensure similar complaints did not occur again.

Good

Is the service well-led?

Our findings

There was a new manager in post who was going through the registration process. They understood their registration requirements including notifying us of any significant events to help us monitor how the service keeps people safe.

The manager was newly appointed and we were told that the provider had recently employed a deputy to support them but they had not yet started. In the interim the manager was being supported by two members of the regional team. The manager told us they felt well supported by both the regional team and by the provider.

At our previous inspection we found that the registered manager and provider had not always effectively monitored and improved the safety and quality of the service. During this inspection, we found there was improved managerial oversight of the service. The management team were responsible for quality assurance to ensure people's health and safety and identify and drive improvement. To this end, we saw that a range of audits were regularly completed including medicine and care plan audits. We found the audits had been effective at picking up on areas that required improvement and that any necessary action required was taken.

Improvements had also been made in terms of ensuring the quality and effectiveness of staff. Staff received regular supervision and observations of their practice were carried out to assess their skills and knowledge, identify learning needs and areas that required improvement.

The manager held a daily morning meeting and quarterly seniors meetings. The purpose of these meetings was also to monitor the safety and quality of the service. The meetings were used to talk about aspects such as safety, risk, equipment, safeguardings and complaints. The meetings were minuted and action plans were generated with a designated person responsible for completing the actions required by a specified date to ensure that any necessary improvements were made.

The manager was keen to develop the service and had lots of plans in the pipeline including attending an upcoming conference on how to best support people living with dementia. They had also just started 'Prosper,' a social care scheme to improve safety and reduce harm from falls, pressure ulcers and catheter infections for care home residents. The manager showed us an 'innovations' folder they had created which included creative ideas and best practice guidance they had collected to enhance the quality of the service people received.

We found the manager was receptive to feedback and used this in positive ways to improve the service. For example, where a local authority visit had identified that staff lacked awareness of DoLS, the manager sent out a questionnaire to staff to assess their knowledge and then discussed the results during supervision sessions to promote staff learning and development.

The manager told us they were very familiar with the service having previously worked at Winifred Dell as a

member of the care team. They told us they hoped to be a positive role model for their care staff. The staff we spoke to were very positive about the new manager and spoke highly of them. Comments included, "[manager] is very approachable, I would go to them, I think they are the best manager we have ever had " And, "[manager] has brought us together as a team; they get us the help we need and will organise agency if needed." And, "They will always muck in and help out as well."

People who used the service thought the home was well led. One person told us, "It's a lovely place and I think it's well run as there's never any problems, like a five star hotel really."

We found that the service promoted a positive culture that was open, person-centred and emphasised the importance of including people, listening to them and being responsive so that people were happy with the service they were receiving.

The service was good at communicating with people and generated a weekly newsletter to keep people and relatives up to date with developments at the service. Aside from the newsletters, the service promoted communication and feedback from people and their relatives through residents meetings. We saw that at the last residents meeting the manager had attended to introduce themselves as the new manager and let people know they had an open door policy. This meant people and their relatives could come and talk to them at any time if they had any concerns.

Residents meetings were organised every two months for people so they could be included in the running of the service. We looked at the minutes of the last meeting and saw that the service listened to what people said and raised action points which were followed up. For example, where people had given negative feedback about the food the service had responded by changing the menu.

Staff were also included in the running of the service as staff meetings had been scheduled for every two months. We were told that staff were given the chance to contribute to the agenda and that minutes of the meetings were given out to staff to promote information sharing across the service.

In addition to holding regular meetings the service also invited people's feedback through an annual satisfaction survey. We saw the last one had been completed in March 2017 and the results and action plan were displayed on the public noticeboard so that people could see that the service had listened and responded to what people had said. This meant that people could hold the service to account if it failed to do what it said it would.