Tamaris Healthcare (England) Limited

Warrior Park Care Home

Inspection report

Queen Street
Seaton Carew
Hartlepool
Cleveland
TS25 1EZ

Tel: 01429234705
Website: www.fshc.co.uk

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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

At the last inspection of this in August 2015, we asked the provider to make improvements. This was because safeguarding concerns had not always been investigated. Risk assessments about people's individual needs were either inaccurate or not in place and fire safety shortfalls had not been addressed. Recruitment checks of new staff had not always been carried out so the provider had not made sure staff were suitable to work with the people who lived there. Staff had not understood people's rights about their mental capacity to make their own decisions. People's individual care records were not accurate so people might not have received the right care. Also, the provider's quality monitoring processes were not effective in addressing these shortfalls.

After the inspection the provider wrote to us to say what they would do to meet the legal requirements. We carried out this comprehensive inspection to check whether the provider had addressed these breaches and to provide a new rating for the home. We found there had been improvements in all these areas.

Warrior Park is registered to provide care for up to 56 people, but there are only 48 bedrooms in use following the reduction of shared rooms and conversion of some bedrooms for storage. It is a two storey, purpose-built home with secure gardens. The ground floor provides accommodation for people needing personal or nursing care whilst the first floor provides accommodation for people living with dementia who require personal or nursing care. There were 31 people living at the home at the time of this inspection.

Last year there had been several different temporary managers at the home. However in October 2015 a new manager was appointed who has since registered with the Care Quality Commission (CQC). 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.

People told us they felt "safe" and "well cared for". People were seen to be relaxed and engaged with the staff. Relatives told us they felt confident in the safety of the service and in the staff. All staff had completed updated training in safeguarding adults and they knew how to report any concerns.

There were enough staff on duty to support the people who lived there. The staffing levels and skill mix throughout the day and night was suitable to meet people's needs. The provider carried out checks to make sure only suitable staff were employed.

People and relatives we spoke with felt staff were competent to provide the right support. Staff felt well trained and supported in their roles. People were supported to eat and drink enough and they had choices about their meals. Staff were knowledgeable about individual people and were able to spot any changes in their wellbeing. They liaised with other health agencies to meet people's healthcare needs.

People said they were happy living at the home and felt the care and support they received was very good. When asked if they felt well cared for, one person said, "Oh yes absolutely, some of the girls in here are excellent." Another person said the care they received was "exceptional" and "in all aspects they are very good indeed".

Relatives said they were "very happy" with the way their family members were cared for. One relative said, "Staff are brilliant, I have no concerns over them at all, they really do care." Relatives told us they felt their family members were treated with dignity and respect.

People received personalised care. Their individual needs had been assessed and their care plans had been rewritten and updated to make sure they got the right support to meet their specific needs. Staff were knowledgeable about people's history as well as their likes and dislikes.

All the people, staff and visitors we spoke with said there had been significant improvements to the running of the home since the last inspection. They said the registered manager was open and supportive. People, relatives and staff now had more opportunities to comment on how the home was run.

All the staff we spoke with were very positive about the improvements that had already been made and about the future development of the service. One member told us, "We've come a million miles since the last inspection. We're on the right road now. We've made so many improvements – we'll always be trying harder but I feel we're on the way."

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 said they felt safe living at the home and were comfortable with the staff who supported them. There had been improvements to the way any concerns were looked into.

There were sufficient staff to meet people's needs.

The provider had taken action to make sure it employed staff that were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective. Staff had training, supervision and support to be competent in their roles.

People felt their needs were met and were positive about the support they received from staff. People were supported to eat and drink enough to maintain their nutritional health.

Staff now understood how to apply Deprivation of Liberty Safeguards (DoLS), where applicable, to make sure people were not restricted unnecessarily, unless it was in their best interests.

Is the service caring?

Good

The service was caring. People felt staff were caring and helpful. Staff were passionate and committed to the people they cared for.

Staff understood how to support people in a way that upheld their dignity and privacy.

People's choices and preferences were respected. Staff of all roles engaged with people in a positive way.

Is the service responsive?

Good

The service was responsive. People's care records had improved so these now included clear information and guidance for staff to make sure each person's specific needs were met.

There was a range of activities for people to take part in, either individually or in groups, to meet their social care needs.

People had information about how to make a complaint or raise a concern, and these were acted upon.

Is the service well-led?

Good

The service was well led. There were improved opportunities for people to give their views and suggestions about the service.

There was now a registered manager in post and staff said they had clear direction and support about how to improve the service.

There were improved ways of checking the safety and quality of the care at the home.

Warrior Park Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection began on 2 February 2016 and was unannounced. A second, announced visit took place on 3 February 2016.

The inspection team consisted of two adult social care inspectors and a specialist advisor on the first day and two adult social care inspectors on the second visit.

Before the inspection we reviewed all the information we held about the home including any incidents and outcomes. We reviewed the provider's action plan about how previous shortfalls would be addressed. As part of the inspection process we contacted local health authority and local authority commissioners to gain their views of the service provided at this home.

During the inspection visit we spoke with nine people living at the home and three relatives and friends. We joined people for a lunchtime meal. We also spoke with the registered manager, a nurse, two senior care staff and eight care workers, an activity staff member, two catering staff, a domestic staff, a regional manager and an administrative officer. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of eight people, the recruitment records of two staff members, training records and quality monitoring reports.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

At the last inspection we found the provider had breached a regulation relating to safeguarding people. This was because there had been either poor or no investigation and action taken in respect of safeguarding incidents. During this inspection we found improvements had been made. For example, safeguarding concerns had been immediately investigated and acted upon by the new registered manager. They had taken robust action to protect people from further distress whilst carrying out a thorough investigation of alleged incidents. The records of the investigations were detailed and the actions taken were appropriate. The registered manager had kept all agencies, including CQC, informed of the actions until the matter was satisfactorily concluded. There were no on-going safeguarding concerns or investigations at the time of this inspection.

Following the last inspection all staff had received face-to-face training in safeguarding adults. The staff members we spoke with said they understood their duty to report any concerns and were confident about doing this. Staff felt there had been improvements in the way that any safeguarding concerns were managed by the service. One staff member told us they had recently raised an issue and it was immediately looked into. Another staff member told us, "I previously didn't feel that issues were dealt with, but I do now."

At the last inspection we found the provider had breached a regulation relating to risk assessment and taking appropriate actions. This was because risk assessments about some people's individual needs were either inaccurate or not in place, for example about the use of bedrails. Also a fire safety risk assessment had identified several shortfalls but some of these had not been addressed in almost a year. During this inspection we found improvements had been made. The care records we looked at included updated risk assessments that reflected people's needs and were regularly reviewed. Also all the shortfalls in the fire risk assessment had been addressed.

Risk assessments included information for staff on how to reduce identified risks, whilst avoiding undue restriction. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. There were also risk assessments about the likelihood of pressure ulcers developing or to ensure people were eating and drinking enough. The risk assessments were reviewed each month. The provider also had a computer-based reporting system in place to analyse incident and accident reports in the home. This was to make sure any risks or trends, such as falls, were identified and managed.

The provider employed a full-time maintenance member of staff who carried out health and safety checks around the premises, including fire safety and hot water temperature checks. It was good practice that the home had a 'grab file' for any staff member to use in the event of an emergency in the home. This included details of the contingency arrangements for emergencies, such as what to do and who to contact in the event of a flood, fire or staff absence. There were also personal evacuation plans about how to support each person to leave the building in the event of an emergency.

At the last inspection we found the provider had breached a regulation relating to the safe recruitment of new members of staff. This was because records of new staff did not always include satisfactory recruitment checks, such as application forms, references and disclosure and barring checks (DBS) which are checks about criminal convictions and whether applicants are barred from working with vulnerable adults.

During this inspection we found recruitment processes had improved. We looked at the recruitment records for the two new members of staff who had been appointed since the last inspection. We found the posts were subject to satisfactory clearances, including references and DBS checks, before the person could commence their employment at the home. One staff had commenced after all their required checks and references had been received and were assessed as satisfactory. The other new person's clearances were not yet complete so they had not yet commenced their employment at the home. This meant the provider was now making sure that only staff who had been assessed as suitable to work with vulnerable people were employed.

People who were able to express a view told us they felt "safe" and "well cared for". People who were not able to tell us their views were seen to be relaxed and engaged with the staff. Relatives told us they felt confident in the safety of the service and in the staff. One told us they felt able to visit less often because their family member was looked after so well. Relatives' comments included, "The care is second to none" and "they treat them like their own family". Another relative commented, "They are always open with me – there's nothing hidden."

People and their relatives felt there were sufficient staff to meet their needs and they were very visible around the home. A relative commented, "I can call any time day or night and it's the same good care." Another relative told us, "I chose this home because staff take the time to care for people – they don't rush them."

The provider used a staffing tool, called CHESS, to determine the staffing levels. The tool used the dependency levels of each person (for example, if they had mobility needs or were cared for in bed) to calculate the number of care and nurse staffing hours required throughout the day and night. At the time of this inspection the tool indicated there were sufficient staff on duty to provide the support people needed.

There was a nurse, a care home assistant practitioner, two senior workers and six care workers on duty during the days of this inspection. Night staffing levels were one nurse, one senior and three care workers. Staff rotas showed this was the typical number of staff at this home. Handover meetings were held between all staff coming on and going off duty. The registered manager also attended the handovers so that they were aware of any changes in people's needs and could reallocate staff to ensure appropriate skill mix on each unit. Since the last inspection there had been a low staff turnover and there was only one vacancy for a part-time night nurse.

Medicines were managed in a safe way. Medicines were administered by either the nurse, care home assistant practitioner or the senior care staff. Each person's medicines administration records (MARs) were kept together with their photograph, details of any allergies and the contact details for their doctor and supplying pharmacy. There were also protocols about 'as and when required' (PRN) medicines such as painkillers. These had improved since the last inspection and now included guidance about how people might present if they were in pain. There were a small number of instances where paracetamol had been signed for but not given. Staff felt this was because those people were asleep at the time. We told the nurse and registered manager about this so they could include this in the daily checks of medicines.

Medicines were appropriately stored and secured within the medicines trolley or treatment room. The

service used a monitored dosage system of medication. This means medicines were supplied in colour-coded blister packs for the time of day. The 'lunchtime' drug round was observed, and staff approached people in a caring manner asking after their well-being whilst explaining their medicines. People were observed or helped with medicines, and were not left unobserved with their medicines. We saw how medicines were administered in a timely manner. Prescribed creams for topical application were dated on opening and all were discarded every month. A topical administration chart was available for creams and placed in people's rooms in a file so these were accessible to care staff.

Medicines were stored in treatment rooms on each floor. On the first day of the inspection we noted that the security of the rooms was not satisfactory as the doors were fitted with keypad locks so all staff had access, not just the designated nurses and senior staff. However on the second day these had been replaced with suitable locks so only designated staff would be able to access these rooms. The ambient temperature of both treatment rooms was recorded twice daily and was found to be within the satisfactory temperature limits for storing medicines safely.

Good

Is the service effective?

Our findings

At the last inspection we found the provider had breached a regulation relating to people's rights to make their own decisions. This was because staff had not always acted in accordance with the Mental Capacity Act 2005 (MCA) and were unclear about people's capacity to consent to care. 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 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Previously staff had been unclear about who had a DoLS in place. Also everyone had been treated as if they lacked capacity to make decisions, even where they had not had a capacity assessment. This meant people's rights were not being upheld and staff did not have sufficient support to understand these safeguards.

During this inspection we found these areas of support had improved. There were clear records about individual assessments for people who required support and supervision. Only the people who required this support had DoLS in place and staff were knowledgeable about the people this applied to. Senior staff had completed additional training in MCA and DoLS. Capacity assessments had been carried out for specific decisions, such as whether someone required bedrails on their beds.

It was good practice that the registered manager had discussed the staff training in DoLS with relatives at a recent resident and family members' meeting. Relatives had said they would like more information about this so the registered manager was going to ask the council DoLS officer to come to the next meeting to discuss this further.

Throughout this visit there were many instances where staff were overheard ensuring they had a person's permission before carrying out any support tasks. For example, when offering people their medicines, before supporting them with their mobility, and before offering assistance with eating and drinking. In this way each person's consent was sought and granted before providing care.

People and relatives told us staff were "very good" at their jobs and they had confidence in their competence to care for people. Staff said they felt well trained and supported in their role. For example, one care worker told us, "We get plenty of training. Some of its e-learning and some is long distance workbooks." Another staff member commented, "We had great training in dementia in groups. I'd like to do more training in dementia because it's so important." Another staff member commented, "Things are brilliant now and we all know what we are supposed to do."

Staff told us, and records confirmed, they received the necessary training in health and safety matters, such as first aid, fire safety, food hygiene and infection control. The provider used a computer based training

system for each staff member to complete annual training courses, called e-learning. The home provided care for people living with dementia and staff had had training in dementia awareness and distress reactions (for example, how people might behave if they were upset or anxious). All care staff were encouraged to work towards a suitable care qualification such as a diploma or national vocational qualification in health and social care. Nurses had suitable training in nursing tasks such as catheter care. New staff received induction training before working with people on their own.

All the staff we spoke with felt there were positive changes to the way they were supervised and managed. One staff member commented, "I had a few supervisions with the nurse, but I know I could also ask the manager for a one-one session if I wanted." Another staff member told us, "I am now so settled and feel so supported. The registered manager is so involved and will listen to ideas." The registered manager had held individual supervision sessions with nursing and care staff about safeguarding, training and career development. There had also been observational supervision of the staff practices, for example whether care staff sought consent before carrying out care tasks.

People were supported with their nutritional well-being. They were offered a choice of at least two main meal options at each mealtime. They were asked by catering staff for their options during the morning but could also ask for alternatives. We noted there were no monthly menus on display for people to make future informed choices. The registered manager explained that menus were being reviewed at this time. We joined people for a lunchtime meal. People who found it difficult to express a choice, for example people with poor communication or living with dementia, were shown the two main meals on plates so they could show staff their preference.

It was good practice that care staff were familiar with people's individual likes and dislikes. For example, one person did not like broccoli so staff left this off their plate. Another person had specifically asked for egg and chips and this was provided for them. One staff member told us, "We can go to the chef and tell them if someone hasn't enjoyed a particular dish and they'll make them something else." Staff provided support in a sensitive way without detracting from the person's independent living skills. For example, staff noticed one person was finding it difficult to manage their meal with a fork so they provided them with a spoon. The catering staff had a list of people's dietary needs, for example diabetic, soft or pureed foods.

There were nutritional assessments for each person, and where appropriate there were nutrition charts and fluid charts to record people's food and drinks intake. There were records of people's monthly weights. Two people were having their weight checked each week because they had been assessed at higher nutritional risk. It was good practice that the new handover records between staff included people's fluid intake totals. This meant the information was passed over from day staff to night staff so they could be aware of anyone who needed extra fluids. Due to significant problems with swallowing, one person received their food through a tube directly into their stomach. The nurse liaised closely with the dietitian and GP to make sure this was carried out in the right way to support the person's nutritional well-being.

Relatives told us they felt their family member's health needs were looked after at the home. One relative commented, "They come in every hour and check that my family member is comfortable, give them fluids and turn them. They really look after them." At the time of this inspection Warrior Park provided care for 15 people who had nursing needs. Since the last inspection a new staff role of 'care home assistant practitioner' (CHAP) had been introduced at the home. The post holder was responsible for supporting the nurse on duty and to relieve them of some of the less complex health care tasks. This meant the nurse could focus on complex nursing needs.

People health needs were documented in their individual files. There was evidence other health

professionals had been contacted appropriately for example speech and language therapist, dietitian, tissue viability nurse and respiratory nurse. All this was documented in the 'professional visits' section of each person's care records together with GP visits, social workers, optician, dentist and chiropodist. This made the information easy to retrieve and review.

There was no-one on end of life care at the time of this inspection. Some people had 'do not resuscitate' (DNACPR) agreements, as it would not be in their best clinical interest to receive such treatment. However for some people with a DNACPR there was no accompanying 'emergency health care plan'. We pointed this out to the nurse and the registered manager as it would be better if these plans were already prepared for such an eventuality.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy living at the home and they felt the care and support they received was very good. When asked if they felt well cared for, one person said, "Oh yes absolutely, some of the girls in here are excellent. Really you know for young girls they are marvellous."

Another person we spoke with said, "Yes, I suppose I am. I don't look for much support but when I do need it they are there. And yes I do think they [the staff] are good."

One other person we spoke with told us the care they received was "exceptional" and "in all aspects they are very good indeed".

Some of the people who lived there found it difficult to tell us what they thought of the service. As a result we did speak with some people about their time living at the home, but we also spoke with visiting relatives and friends to capture their views. One relative commented, "Staff are brilliant, I have no concerns over them at all, they really do care for her." They went on to say, "They [the staff] are superb." Relatives told us they felt their family members were treated with dignity and respect.

Another relative we spoke with said, "It is not just a job to them [the staff], it is clear that they care." They went on to explain they used to visit the home each day. They said as a result of the care their relative received and the peace of mind this gave them they no longer felt they had to visit each day as, "I know that they are being well looked after and are safe."

Staff we spoke with told us they felt that the consistency in the core staff group had helped to form good relationships with the people who used the service. Each member of staff spoke of the bonds and attachments that were developed between them and the people they cared for. One staff member talked fondly about someone who had passed away some months before our inspection. They told us, "I cannot walk passed their old bedroom without thinking of them, I still think about [the person] now and miss [the person]."

Another staff member said, "We certainly don't do the job for the wage or the perks. It is a hard job at times but I do it because I care, really I love it." One staff commented, "I love it here and the residents are lovely. It has been really bad but we all stayed because of the residents." Staff felt all their colleagues were caring towards the people who lived there. One staff commented, "Even [the maintenance staff member] is really good with people. He has a chat to them as he passes by."

We observed interactions, between staff and people who used the service, on both units of the home. We saw people were treated with kindness and compassion. Staff demonstrated empathy when interacting with people. These observations highlighted a lot of laughter and smiling between staff and people who used the service.

We saw that staff were proactive in their approach to care delivery and that staff pre-empted people's needs.

For example, when delivering personal care we observed staff made sure that bathroom doors and doors to people's bedrooms were closed. This meant that people experienced care and support in a manner that was respectful to them and upheld their dignity and privacy.

Good

Is the service responsive?

Our findings

At our last inspection in August 2015 we found the provider was in breach of a regulation relating to person-centred care. This was because people's care records did not accurately reflect their individual needs, were incomplete or had not been kept up to date when their needs had changed. This meant that it was not always possible to be clear if a person was being supported in the right way.

During this inspection we found there had been improvements to the way people's individual care needs were identified and recorded. All of the care records for each person had been rewritten. These now included comprehensive details about people's individual needs, preferences and choices. Each person had care plans in place for capacity, medication, mobility, nutrition, continence, communication, personal hygiene, sleeping, skin integrity and any extra areas that were specific for the individual person.

The care plans were kept under regular review and were re-written when any changes occurred. For example, one person's medicines had been changed by their GP so the medicines care plans was reviewed and re-written. This meant staff now had clear, personalised, up to date guidance about how to meet the specific needs of each person.

People who were able to express a view told us they felt they were supported with their individual needs in the way they preferred. One relative told us, "The staff really understand each person. They treat them as individuals and know all their little ways." Another relative commented, "The staff are very respectful of her choices, for example the name she likes to be called. They respect this and only call her by the name she is happy with."

In discussions staff were knowledgeable about each person and were able to describe how they responded to people's needs. We saw staff adapted their approach to each person to meet their differing levels of dementia care and communication needs.

We saw many instances of personalised care during this visit. For example, one person who was living with dementia frequently declined their daytime meals. However staff had noticed the person enjoyed sitting with night staff in the evening and sharing the sandwiches from the staff members' lunchboxes. Care staff had purchased a lunchbox for the person and each day filled it with sandwiches, fruit and crisps which the person then ate whilst sitting with night staff. This personalised support was having a beneficial impact on the person's nutritional and psychological well-being.

Staff were able to describe to us the needs and wishes of people who used the service. They were aware of individual people's backgrounds, their family dynamics and who and what was important to them in relation to their physical health and mental well-being. The information staff had provided us with was corroborated in people's care records. This meant staff had taken time to get to understand the needs and preferences of people who used the service.

People and relatives told us there was a good range of activities and that they enjoyed these. There were

information posters on each floor to let people and their visitors know about each day's activities and forthcoming social events. The activities co-ordinator was enthusiastic about finding new activities and social occasions. They planned an activities timetable each month and the February events included a celebration of Chinese New Year and Pancake day. Other regular activities included walks, weekly pub lunches, shopping trips, baking, flower arranging, manicures and exercise sessions. The home had a large, well-kept private garden at the back that was access through patio doors from the dining room. People made good use of the garden in better weather and their summer activities included outdoor bowls and planting seeds.

People and relatives had information about how to make a complaint and this was displayed in the front entrance. People who could express a view and visitors told us there was an open culture in the home. They said they would have no hesitation in raising any comments or complaints with staff or with the registered manager.

There had been only one complaint recorded since the last inspection. This had been fully investigated by the registered manager who had also kept the person and their relative informed with the progress and outcome. Complaints were now recorded on the provider's database (management reporting tool) so that the provider could analyse complaints for any trends and make sure that outcomes or actions were completed. The registered manager was also planning to keep a complaints log so that she could identify any future trends.

Good

Is the service well-led?

Our findings

At our last inspection of this home in August 2015 we found the provider was in breach of a regulation relating to the management and governance of the service. This was because the provider's quality assurance processes had been ineffective in addressing the many shortfalls we had identified. At that time the management of the service had been inconsistent as there had been four different managers in six months.

During this inspection we found there had been improvements to the way the service was managed and monitored. The areas of concern we had identified had been addressed and systems put in place to minimise the risk of future issues. For example, the effectiveness of safeguarding investigations, recruitment processes and personalised care plans had been tightened up and were now kept under continuous review.

A registered manager had been appointed and people, staff and visitors all commented positively on the changes they had made in the few months they had been in post. One relative said that following management changes and improvements within the service, they were now "very happy" with the way the care service was being run. Another relative told us they had appreciated getting a letter from the new registered manager to introduce herself. Relatives were hopeful there would now be some consistency in the management of the home.

All the staff we spoke with were very positive about the improvements that had already been made and about the future development of the service. One member told us, "We've come a million miles since the last inspection. We're on the right road now. We've made so many improvements – we'll always be trying harder but I feel we're on the way."

There was an open, calm, compassionate culture within the home. One staff member told us, "Morale has gone up massively because we've got a decent manager now." Another staff member commented, "The manager is brilliant. She's helped us be a much more efficient team. It's like a different place - we've always cared for the residents but we're well managed in that now."

Staff were committed and passionate about the home and the people who lived there. One staff member told us, "We're a really good team and we'd go to the ends of the earth for the people who live here. If we can find anything that makes their life better we will." Another long-standing member of staff said they felt the service had been failing at the last inspection, no matter how hard the staff worked. They told us, "Now I am so much happier and feel that we are making progress and will become a great home again. The staff have been fantastic and have come in on their days off to do care plans - they have been so loyal and deserve some recognition of this."

The provider sought to gain the views of people who lived there and their visitors. The provider used a 'quality of life' feedback system in its services, including Warrior Park Care Home. People, relatives and other visitors could leave their comments about the home at any time on a computer that was sited in the entrance hallway. Another computer was taken around the home for people to access and record their

comments. The comments were 'live' and any critical comments would be emailed immediately to the registered manager for action and the outcome would be recorded on the system.

We saw the recent responses from people, relatives and professional visitors to the 'quality of life' questionnaire. The questionnaire requested people's views about comfort, cleanliness, respect and care at the home. There were 10 responses from people during January 2016. People's response resulted in a score of 95 -100% satisfaction with the service. People's additional comments were generally positive, for example about the helpfulness of staff. There were a small number of comments about the bath not working on the ground floor and the fact the minibus has never been used. There were three responses by relatives during January 2016 and five by professional visitors. Again the majority of responses were positive and scored the home 85 - 100% satisfaction with the service.

Resident and family member meetings were now held monthly and offered people an opportunity to get information about the running of the home and to make suggestions and comments about the service. The minutes now included any previous actions and progress so people were kept informed about how their suggestions were being addressed. The minutes of the most recent meeting included information about a new hair salon, planned menu improvements, activities programme, deprivation of liberty safeguards and recent staff training.

Staff meetings had been held every month for staff to work together with the registered manager to discuss expected practices, suggestions, actions and improvements for the service. One staff told us, "We have monthly meetings which is great, so we can share information and ideas for the future." Another staff commented, "The staff meetings are going well. The manager lets you voice your opinion and we feel it's listened to. But she'll tell you if we're just whinging, and I respect that. We're able to be open and honest with each other." The registered manager also held heads of department meetings and health and safety meetings each month with relevant staff.

Some staff took on additional responsibilities as 'champions' in various areas of safety or care. These included, for example, infection control, dementia care and fire safety. These lead roles helped to develop staff's knowledge of current best practices. They then monitored their colleagues to make sure all staff were meeting the latest guidelines. For example, observations of staff when using hygiene techniques.

The registered manager and staff carried out a number of regular checks of the service including daily medicines and 'walkaround' checks. There were also monthly audits of the service, including care records, premises safety and infection control checks. Many of the checks were recorded on a new quality tool that involved inputting the information onto an iPad. This computer-based system then analysed the results and identified any actions for improvement. Senior managers of the organisation had access to the results as part of the provider's monitoring of the quality and safety of the service.

One staff member commented, "The registered manager has a vision of the future and has shown us where we need to be aiming for. None of the previous managers did that. She has set us targets and were all working towards these so we know where we're going and how to improve."