Avery Homes (Nelson) Limited

Darwin Court Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 9 August 2018, and was unannounced. At the last inspection on 1 March 2017, we rated the service as Requires Improvement. At this inspection we found the service had made improvements, however, further improvements were needed.

Darwin Court Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Darwin Court Care Centre accommodates up to 112 people in one adapted building. At the time of the inspection there were 100 people living in the care home.

There was a registered manager in post at the time of the inspection. 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.

Improvements were needed to ensure people had consistent access to staff at the times they needed support. Checks on the quality of the service provided to people were not always effective.

People were protected from abuse and risks to their safety were assessed, identified and managed appropriately. The home and equipment were maintained to minimise the risk of cross infection. The registered manager had systems in place to learn when things went wrong. People had their medicines as prescribed.

People's needs were assessed and plans were in place to meet their needs. The home was adapted to meet people's needs. Health care professional were involved in peoples care as required. Care was delivered consistently and we found staff newly appointed received an induction, had their competency checked and received regular updates to their training.

People had enough to eat and had a choice of meals. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received support from caring staff. People were supported to make choices and were supported to maintain their independence. People had their communication needs assessed and systems were in place to support them to communicate effectively. People were treated with dignity and respect.

People received support from staff that understood their needs and preferences. Staff understood how to provide end of their life. People understood how to complain and these were responded to.

People and their relatives had the opportunity to share their feedback. Staff felt supported by the management team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always sufficient staff to support people at the times they needed it.

Medicines were administered as prescribed.

People were protected from abuse.

People were supported to manage and reduce risks to their safety.

Staff were recruited safely.

People were protected from the risk of cross infection.

The registered manager had systems in place to learn when things went wrong.

Is the service effective?

Good

The service was effective.

People had their needs assessed and plans were in place to meet them.

The environment was adapted to meet people's needs.

Staff were trained and had their competency assessed.

People received consistent care.

People had enough to eat and drink and had a choice of meals.

People's rights were protected.

Is the service caring?

Good

The service is caring.

People were supported by caring staff.

People were offered a choice and staff supported them to communicate effectively and independence was promoted.

People were treated with dignity and their privacy was respected.

Is the service responsive?

Good

The service was responsive.

People had access to activities.

People's preferences were understood by staff.

End of life care was understood by staff.

People's complaints were investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems in place to drive improvements were not always effective.

People, relatives and staff were engaged in the service.

The registered manager understood their responsibilities.

Darwin Court 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 August 2018 and was unannounced. The inspection team consisted of two inspectors, a nurse advisor and two experts 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.

As part of the inspection, we reviewed the information we held about the service, including notifications. A notification is information about events that by law the registered persons should tell us about. We reviewed feedback from the commissioners about people's care to find out their views on the quality of the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with 14 people who used the service and seven relatives. We also spoke with the registered manager, the deputy manager, regional manager, four nurses, two team leaders and five staff.

We observed the delivery of care and support provided to people living at the location and their interactions with staff. 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 reviewed the care records of seven people and three staff files, which included pre-employment checks and training records. We also looked at other records relating to the management of the service including complaint logs, accident reports, monthly audits, and medicine administration records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 1 March 2017 the safety of the service was good. At this inspection we found improvements were needed and we rated this key question Requires Improvement.

People had mixed views about whether there were sufficient staff available to support them. One person told us, "There is plenty staff." Another person told us, "When I press my buzzer, they respond very quickly." A visitor told us, "Normally there is lots of staff when I visit in the daytime." However, this feedback was not consistent. Some people felt there were not enough staff, with one person commenting, "I feel safe in these surroundings but sometimes there is not enough staff." Another person said, "There are long queues in the morning and because there are not many staff to assist you, you have to wait for a long time." Another person said, "When I press the buzzer the staff come and say they are coming back and you have to wait for a long time until they assist you." A visitor told us staff were not always present when people were walking around the home to monitor them. The visitor commented, "Staffing levels is a big concern for [person's name] safety. Lack of supervision enables people to wander around." Another relative commented, "I don't think that there is enough staff around."

Staff also had mixed views about staffing levels with some staff reporting that they felt there were enough staff to keep people safe and others stating they had to rush people and could not always support them in the way they would like to. One staff member said, "We are often short of staff, most people need two staff to help them and it can mean we are delayed with giving people a drink or helping to reposition them." We found one person's care records had not been completed at lunchtime, despite their care plan identifying fluids needed to be pushed and their intake needed to be monitored. We spoke to staff about this and they told us the person had received fluids but they had been rushed and therefore had forgotten to maintain the record. We spoke to the nurse about this and found checks were done on fluid charts daily to ensure staff had completed them however these had not yet taken place as they were busy.

Our observations showed people on one unit did have to wait for their care and support for example, at meal times on one unit people had to wait for up to an 30 minutes to have support with their meal as there were not enough staff to give everyone the support they needed at the same time. In another example there was not always sufficient staff available to support people who were in the lounge and dining room. Whilst risks from the interactions between people were managed the staff available had little opportunity to engage people in activities or things to do. This meant improvements were needed to ensure there were sufficient staff available to offer support when people needed it. However, in other areas of the home people were not waiting and staff were available to meet their needs. For example, some people needed one to one care from staff and this was observed to be in place during the inspection. We spoke to the registered manager and regional manager about this and they told us staffing hours were dependent on people's needs, however there was not a specific tool in place to determine the number of staff hours people needed to provide support. This shows improvements were needed to ensure people consistently had sufficient staff available to support them.

People received support from staff who had been safely recruited. Staff told us checks were carried out to

ensure they were suitable to work with people and the records we looked at confirmed this. The provider checked to ensure staff were safe and suitable to work in the home. A Disclosure and Barring Service (DBS) check was carried out. The DBS helps employers make safer recruitment decisions. This meant safe recruitment procedures were being followed.

People were kept safe from harm. People and their relatives told us they felt the service kept people safe. One person said, "Having 24 hour care seven days a week makes me feel safer than being home alone." One visitor told us, "There is a secure front door and people have assistance to stay safe." Staff were able to describe how they would recognise the signs of abuse and the procedures in place to report it. We saw where incidents of alleged abuse had taken place these had been reported to the appropriate authorities for investigation. This showed people were safeguarded from abuse and protected from the risk of harm.

People were protected from risks to their safety. One person told us, "The staff use the hoist to move me, I hate it, but I feel safe when it's being done." One relative told us, "When [person's name] had a fall the home provided a bed rail. They also provide a special mattress for preventing pressure sores." People's risks were assessed and care plans were put in place to guide staff on how to manage the risks. For example, where people required support with manual handling this was assessed and guidance was in place for staff. Staff could describe how they supported people to move safely and we observed staff supporting people to move using a hoist safely. In another example, people who displayed behaviours that challenged, had their needs assessed and plans put in place to enable staff to keep them and others safe. We observed staff following the plans for one person to intervene and distract the person which prevented them from harming themselves and others.

People received their medicines as prescribed. Training was received for medicine administration and competency was checked. Staff were observed supporting people to take their medicines safely. Where people needed medicine on an 'as required' basis, which means people only need medicines on occasions for example when they are in pain, there were clear guidelines in place for staff to follow. People had pain assessments to help manage their pain. Medicine administration records (MAR) is a record of people's prescribed medicines which are signed by staff when medicines have been given to the individual. We checked the records and most were accurately completed, however we found some records did not have the required signatures to confirm people had their medicines administered; these had been investigated and found to be administrative errors.

We found medicines were stored safely. Medicine storage rooms were clean, tidy and secure with lockable doors, cupboards and trollies available. Medicines requiring refrigeration were stored safely and dates were recorded to show when liquid medicine had been opened. Temperatures in the refrigerator and medicines storage rooms were checked daily to ensure medicines were stored at the correct temperature. Medicines stock was monitored and opening dates were clearly displayed. Medicines were returned and disposed of safely with records in place.

People were protected from the risk of cross infection. People and their relatives told us they found the home was clean. Staff were trained to minimise the risk of cross infection. Staff wore appropriate personal protective clothing when offering personal care. Checks were in place to ensure the home remained clean and well maintained.

The registered manager had systems in place to learn when things went wrong. Where incidents had occurred, these were analysed and lessons learned and action was taken to prevent reoccurrences. We saw investigations were carried out and analysis was undertaken if a trend was identified, for example where a large number of people had an infection in a particular period this had been investigated to consider any

underlying causes.

Good

Is the service effective?

Our findings

At our last inspection on 1 March 2017 the effectiveness of the service required improvement. This was because some people did not have their drinks monitored effectively and people gave mixed feedback about the meals. At this inspection we found the improvements had been and we rated this key question Good.

People's needs and diverse preferences were assessed and care plans were put in place to meet them. The assessment included looking at people's health needs, mobility needs and support with meals and drinks. People and their relatives had been involved in the assessments. People's preferences were also assessed, for example, people's life history was documented, what was important to them, their religious and cultural needs and preferences were identified. The assessment identified people's communication needs and specific guidance was in place for communicating with people. One visitor told us, "The staff use pictures to communicate with [person's name]." We saw staff using different methods to communicate with people during the inspection. Other health professionals were also involved in people's assessments and care plans. We spoke to one health professional and they told us they had regular discussions with nurses about people's health needs and this information was used to guide people's care.

People received support from staff that had been trained and had the skills to provide effective support. One person said, "The staff seem to know what they are doing. I think they do get training." One visitor told us, "The staff seem to be trained to work with [my relative], I think that they know what they are doing." Staff described having an induction which followed the principles of the care certificate when they started employment and this included some shadowing of experienced staff to help them get to know people. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life based on 15 standards to ensure staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe, high quality care and support. Staff told us the provider enabled access to training and they had regular updates to this and access to regular supervision to discuss their role. The records we saw supported what we were told. Staff appeared knowledgeable about their role and we observed staff using some of the skills they had been taught for example, when moving and handling, administering medicines and supporting people that had difficulties with making decisions.

People received consistent care and support. Staff told us they had a handover at the start of each shift. Staff said this was helpful in keeping up to date about people's needs. We also saw there was a regular daily meeting where people's needs were discussed and staff were made aware of any emerging concerns or issues relating to people. Staff told us they felt able to support people consistently as they had a good understanding of people's needs and most of the time they worked with specific people on specific units. Staff described some of the best aspects of the service being due to good teamwork amongst the staff team. We observed the approach of several members of staff when they were helping a person get ready to attend an external appointment was caring and efficient and demonstrated a united team approach.

The home environment was adapted to meet people's needs. The home supported people living with dementia. Some aspects had been considered, for example memory boxes which contained items to help

orientate people were in place for some rooms. However other aspects of the home such as signs to help people find their way around were not consistently in place to support the needs of people living with dementia. The vast majority of the home was well decorated, light and spacious. A cinema room and hairdressing salon was available for use by all people living in the home and we were advised by staff and relatives they were used on a regular basis.

People had a choice of food and drinks and access to this whenever they wanted. One person told us, "Staff ask me to choose from the daily menu. We have enough to eat and drink. I am quite independent. The staff leave a jug of water every day and also make sure to keep it nearby, so that I can reach it easily due to my poor mobility." Another person told us, "They offer me food of my culture, it is very nice." People had their needs assessed and their preferences were understood. Assessments were carried out which identified what people's preferences were for meals and drinks, this included people's cultural needs. People's risks associated with eating and drinking were assessed and plans were put in place to meet their needs and minimise the risk. For example, where people were at risk of malnutrition this had been identified and plans were in place which included food supplements and monitoring. We found records showed where people needed monitoring of their food and fluid intake and their weight, this was completed and where escalation was needed to a health professional this had been carried out and the advice had been followed. We did however find one fluid chart which had not been fully completed, however we were able to get assurances the person concerned had received fluids and this was a recording error. Care plans gave guidance to staff on how people should be supported with their meals and drinks. Staff were aware of the guidance and were observed following this during the inspection.

People had access to health professionals when they needed and referrals were done promptly. One person told us, "I have a wound on my leg; I need special care and cleaning. The staff provide this to me." A visitor told us, "Professionals are called to [person's name] when needed, like the doctor, chiropodist, optician and dentist." Staff told us there was clear guidance in place to support them with helping people maintain their health and well-being. Care plans had detailed information in about people's history of health conditions and their health needs and we saw professionals visiting gave guidance which staff followed about people's health. A visiting health professional told us they came regularly to the home to visit people and were happy with the response from the staff about the advice and treatment they advised for people. One person had a specific plan in place regarding their fluid intake and this was reviewed by a visiting health professional and staff were following the guidance.

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

People were being supported in line with the principles of the MCA. People had their consent sought by staff where they were able to give this. Where people were unable to consent or make decisions about their care and support a decision specific MCA assessment was completed and a best interest discussion was recorded. For example, one person lacked capacity to consent to using photographs within their care plan and on social media. A best interest's decision had been taken, which involved the appropriate people. We saw plans indicated how staff could seek consent and which decisions people could make without support. Staff were able to describe how they used these plans to guide how they supported people with consent and the provision of their care. This demonstrated how staff applied the principles of the MCA and promoted people's human rights.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where needed there were authorised Deprivation of Liberty Safeguards (DoLS) in place to ensure they received the appropriate care and treatment. People's capacity had been assessed and an application made to the authorising body. The documentation showed there had been consideration of the least restrictive options. There were plans in place to guide staff in supporting people with an authorised DoLS in place.

Good

Is the service caring?

Our findings

At our last inspection on 1 March 2017 we found the service was caring. At this inspection the service continued to be caring and was rated Good.

People told us they had a good relationship with staff and they provided support in a caring way. One person told us, "The staff do care, we have a laugh and a joke." Another commented, "The staff are definitely caring." A visitor told us, "I think that the staff listen to [person's name] and us." We observed interactions between staff and people using the service and these were found to be kind and appropriate to the person's needs. Staff demonstrated a good knowledge of how people liked to be supported and addressed them by their chosen names in ways that were friendly and respectful. The staff were observed using their knowledge of people to ensure they had the care they needed in a compassionate and caring way. For example; where people left the table before their meal had been finished staff supported them and provided encouragement to ensure that they ate well or offered them something else to eat. Some people were more comfortable eating their meals in the lounge area and we saw that staff supported people wherever they felt most at ease. Staff were responsive to people's mood and provided comfort when people displayed signs of being worried or upset. We observed care interactions that were kind, patient and sensitive.

People were encouraged to choose for themselves, make their own decisions and maintain their independence. One person told us, "I am quite independent and do most things by myself, I have a shower by myself, but the staff are always there to make sure I am ok." The person added, "I am allowed to do things which I like and go to bed at any time, there is no restriction." People's care plans guided staff on their ability to make decisions and choices about their care and how to encourage independence. We saw staff offer choice with meals, drinks and how people wanted to spend their time. Staff allowed people to do things for themselves. Staff communicated with people in a way they could understand. One relative told us, "The staff use pictures to communicate with [person's name]." We saw staff had access to picture cards to support people with communication and these were used where needed. People's individual needs had been assessed and clear plans put in place for staff to follow to ensure they could access information and make choices.

People were treated with respect and their privacy and dignity was maintained. One person told us, "The staff are very nice, they treat me with respect." Another person told us, "The staff always knock on my door, even when the door is open." One visitor told us, "Whenever I am here the staff are very respectful to my relative." The dignity of people using the service was protected by staff and when people were supported with personal care this was undertaken in their own rooms. Staff spoke respectfully about the people living at the home. The staff were observed being considerate and ensuring people's dignity was protected when they offered support.

Good

Is the service responsive?

Our findings

At our last inspection on 1 March 2017 we found the service was not always Responsive. This was because people did not always receive person centred care or have the opportunity to participate in stimulating activities and the service was rated as Requires Improvement. At this inspection we found the service had made the required and the service was rated as Good.

People had mixed views about the availability and opportunities to engage in meaningful activities. One person told us, "I sit here all day, I can't see and there is nothing to do." Another person told us, "They support me with my hobbies. I like spitfire modelling, they help me with this." Another person told us, "I like reading, doing puzzles, cross words and watching TV in my room. I don't like to be involved in any activities. I have refused to participate many times and I am glad they do not ask me anymore." A visitor told us, "My relative cannot speak and therefore struggles to participate in any activities, but when the home organised a drum therapy we had noticed that they were enjoying it you could tell through their body language."

The staff carrying out activities told us they tried to personalise activities to people's needs on each unit. They said on some units it was one to one activities such as nail painting and on other units there were more group activities such as quizzes, gentle exercise and bingo. There were activity plans completed for people to tell staff what people liked to do, however some records did not contain details to guide staff about people's preferences.

People's preferences were understood by staff. One person said, "The staff know my likes and dislikes." Another person said, "I don't have a shower or a bath, I prefer a strip wash." Another person told us they preferred to spend time in their bedroom and choose to have their bedroom filled with their belongings. Their wishes were respected by the staff. Another person told us, "My priest comes in and prays with me." A visitor told us, "The staff have a good knowledge and understanding of individual's needs." Relatives had helped inform people's care plans where people had been unable to actively participate. There was evidence that changes had been made as staff had become more familiar with people's preferences. Assessments were undertaken to identify people's diverse needs and preferences, including for example, cultural and religious needs. People mostly received a service that was person centred and focussed on them. Staff were active in supporting people to determine their own routine and preferences whilst protecting their dignity. External professional guidance was sought so that people could receive the best possible care. For one person a psychologist had been involved with the staff group to help one person who often exhibited distressed behaviour and was unable to settle.

People understood how to make a complaint. One person told us, "I would know how to complain and who to speak to if I needed to." People felt able to raise concerns and were confident these would be addressed. A complaints policy was in place and where people had raised concerns these had been investigated and responded to in line with the policy. We saw complaints were analysed and learning was taken to make changes.

People were supported to have a comfortable and pain free death. People's future wishes were considered

as part of their assessment. This identified any advanced decisions that had been made and how the person would prefer to be supported. The plan showed who should be contacted and what arrangements needed to be in place after the person's death. Where people had long term conditions a care plan had been put in place with their doctor to guide staff on how to support the person in the event of deterioration. For example, one person had a care plan in place for their breathing condition. The doctor, relatives and staff had been involved in a best interest's discussion which determined the person should not go to hospital in the event of them deteriorating and they would be cared for by the doctor and staff at the home. Staff could describe how additional checks were carried out when people were at the end of their life. We saw where people were receiving end of life care they had support from external health professionals, their pain was managed and staff provided the support the person needed to maintain their dignity and comfort.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 1 March 2017 we found the service was Well-Led. At this inspection we found the service needed to make some improvements. This was because the systems to monitor the quality of the service were not consistently effective and we have rated the service as Requires Improvement.

The systems in place to check on the quality of the service people received were not consistently effective in identifying areas for improvement. For example, the systems used to identify staffing levels required to meet people's needs were not effective as we found there were insufficient staff available to support people on some units within the home. The registered manager and quality manager told us there was not a specific tool in use to identify people's dependency and determine how many staff were needed to support people. Staffing numbers were agreed following a baseline allocation of staff for each unit and analysis of a range of areas where increases in staff would be made if required. The system in place had not identified the concerns we found with people waiting for their care and support and that staff had little time to engage with people.

There were systems in place to check people had received the care they needed. Daily records and fluid and food charts were checked daily by senior staff and nurses. However, when we looked at where the senior staff and nurses should sign to say the records were checked this was not consistently completed. We found one person's records had not been fully completed by staff on the day of the inspection and the record had not signed to say it had been checked by senior staff. We were however able to determine the person had received their care on this occasion. However, we saw several other records for the week which had not been signed as checked by nurses. We spoke to the nurses about this and they felt the checks were being done, but not consistently recorded due to the busy nature of the home. We spoke to the registered manager about this and they told us nurses would be reminded of the importance of recording checks.

Records were in place about how people wanted to spend their time. However, specific information about the person's preferences was not always included. For example, where one person had been noted as liking to watch television there was no record of their favourite films or programmes, despite a prompt on the form which had been completed. The audits had not identified these issues. The audit processes in place to identify improvements had not been effective in identifying some people were unhappy with the activities on offer. We found the audit that had been completed stated there were opportunities in place. However, the source of information used to determine this was the activities coordinator and there was a list of activities which had been carried out. There was no evidence that the audit asked for the views of people on the activities or that records had been checked to ensure they gave detail about people's preferences.
We found other audits were similar in that they lacked corroboration. Each of the audits focussed on addressing broad statements that relied on some corroboration to ensure that the quality measure was being adhered to. On reviewing the audits we found the audit asked if residents have community involvement the source of evidence was stated as 'ask residents/observe'. However, there were no details of which residents had been asked or observed or which unit had been the focus of the checks. As the checks were done monthly and people lived on six different units we could not be assured the checks were ensuring everyone using the service was having the same experience.

There were audits in place to check the quality of the environment. One room had very little furniture in place. Staff advised us the furniture had been removed for the person's safety as the person may move the furniture. Staff were unable to advise if consideration to fixing furniture to the wall had been considered to enable the person to benefit from improved surroundings. We found the décor on the walls of some units had not been chosen with the needs of people living with dementia in mind. Some of the decoration required attention as this appeared to have been affected by wear and tear. In one lounge we saw four arm chairs in the room. However, only two were suitable for sitting on due to missing cushions, we were advised the housekeeping staff were attempting to find the missing seat cushions. The deputy manager told us there was a refurbishment plan in place and some areas of the home had not yet been refurbished.

Medicines audits were completed monthly and we found these were identifying concerns and making improvements. Where incidents such as missed signatures were found on MAR charts, immediate action was taken to investigate these concerns and ensure people had received their medicines as prescribed. Accidents and incidents were monitored and an analysis was completed to determine if there were any trends or areas for improvement. We found the analysis had identified areas of concern and investigations had been carried out and actions taken. Complaints were also analysed and the information was used to drive improvement.

Care plans were audited to ensure they were up to date and staff had access to guidance to meet people's assessed needs. There was also a resident of the day process in place which considered all aspects of a person's care once a month. We found these were effective in identifying areas where improvements were needed. There were audits carried out by the provider which identified areas for improvement. Where issues were identified these were sent to the registered manager for action. There was also a weekly clinical risk meeting held which discussed any incidents and clinical risks and this was used to identify any improvements needed.

The registered manager understood their responsibilities in relation to their registration with us (CQC). We saw that the rating of the last inspection was on display and notifications were received as required by law, of incidents that occurred at the home. These may include incidents such as alleged abuse and serious injuries. The registered manager was supported in their role by operational managers and the provider.

People and their relatives felt they could approach the registered manager with any problem they had. One relative told us, "The new registered manager is more engaging with the people and is putting a system in place; they are quite visible and visit every unit." Another relative I spoke with told me, "The new registered manager seems very enthusiastic and talks to people to address any problems. They are also targeting those residents who do not have family and are not visited by others." We were told by relatives they had recently received a questionnaire about the service and there were organised resident and relative's meetings. We found information about the meetings and their outcomes were on display in the home. There was also a regular newsletter which is available for people to keep them informed. The registered manager told us they had plans for welcome meetings to ensure they were able to meet people and relatives. Staff told us they felt able to speak with the registered manager and we saw there were opportunities for staff to meet and discuss the home. This showed people, their relatives and staff had opportunities to express their views about the service.

At our last inspection the service was rated as Requires Improvement. At this inspection the provider had made improvements, but other areas of improvement were needed. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. We recommend you consider support and guidance available to achieve and sustain an overall rating of 'Good'. Where a location fails to achieve and sustain a minimum overall rating of 'Good', we may consider whether there is a breach of regulation 17 (good

governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.