Bupa Care Homes (HH Bradford) Limited

Crossley House

Inspection report

885 Thornton Road
Bradford
West Yorkshire
BD8 0HH

Tel: 01274497551
Website: www.hadrianhealthcare.co.uk

Date of inspection visit:
24 April 2017

Date of publication:
19 May 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection of Crossley House took place on 24 April 2017 and was unannounced.

Crossley House provides accommodation and personal care for up to 58 older people and people living with dementia. The bedrooms are all single en-suite and communal areas are located throughout the home. At the time of our inspection there were 55 people living at the service.

The home should have a registered manager in position. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our inspection there was no registered manager since the previous manager had commenced the registration process but recently left the service. The home was being supported by an interim manager over a three month period during which the provider hoped to appoint a new manager. A full time deputy manager was in post and the home was also supported by the provider's area manager and quality manager.

People felt safe at the service, staff had received safeguarding training and understood how to recognise and act on signs of abuse. The interim manager was aware all appropriate safeguarding concerns should be reported to the Care Quality Commission as well as the local authority adult protection unit. Accidents were documented and risks to people's safety were assessed although not all risk assessments or analysis of accidents/incidents were in place.

Medicines were mostly managed safely. However, some improvements were required regarding the management and administration of topical ointments and creams and ensuring medicines administration charts were completed. These issues had also been identified through the improved medicines audit process and plans were in place to address this.

Staffing levels were sufficient to keep people safe and staff were recruited safely. A range of staff training had been completed or booked. However, a programme of staff supervision and appraisal needed to be embedded. Staff knew people well and supported them with kindness and compassion, respecting their privacy and dignity.

Care records needed further work to improve person centred planning and to reflect people and/or relatives' involvement. No evidence was found in care records to reflect the use of best interest processes. However, consent was seen to be sought in practice as well as respecting choice and personal preferences. Some improvement was required in documentation such as charts to show how often people were turned in bed when needed. However, the interim manager was aware of these and an improvement plan was in place to update and improve care records.

Some activities were in place according to people's wishes and the interim manager had introduced people

to some social activities within the local community.

Complaints were documented although investigation reports needed completing to reflect outcomes.

A range of audit and quality processes were in place and these had identified many of the concerns found at inspection. A service improvement action plan had been developed and it was clear some improvements had already been put in place.

The service was welcoming and the atmosphere relaxed and calm. Staff told us morale had improved and they felt supported by the management team. The interim manager was passionate about continuing with the improvement process and supporting the new manager when appointed.

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 always safe.

Some improvements were required with the management of medicines.

Analysis of accidents and incidents needed to be in place.

Enough staff were deployed to keep people safe and robust recruitment processes were in place.

People told us they felt safe living at the home.

Is the service effective?

Requires Improvement

The service was sometimes effective although improvements needed to be made.

Best interest processes were not always followed where people lacked capacity to make their own decisions.

Staff training was generally up to date although a process for regular supervision and appraisal needed embedding.

People were encouraged to consume a varied and healthy diet.

Is the service caring?

Good

The service was caring.

People told us they were happy living at the service and there was a calm and relaxed atmosphere.

Staff treated people with kindness and compassion and knew people well.

People's privacy and dignity was upheld.

Is the service responsive?

Requires Improvement

The service was responsive although some improvements needed to be made.

Some care records required work to improve information and personalisation.

Activities had been identified as an area for improvement and the interim manager had put plans in place to address this.

Investigation reports for complaints needed to be completed.

Is the service well-led?

Requires Improvement

The service was well led although improvements needed to be made and sustained.

A range of audits were in place although some of these needed to be more comprehensive.

Staff morale was improving and staff felt supported by the management team. However, a plan for regular staff meetings needed to be put in place.

The management team were passionate about making improvements to the service and a service action plan was on-going.

Crossley House

Detailed findings

Background to this inspection

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

This inspection took place on 24 April 2017 and was announced. We gave the provider short notice because the location provides a domiciliary care and supported living service and we needed to make sure the registered manager would be available.

The inspection team consisted of two adult social care 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. The expert used on this occasion had experience in elderly and dementia care.

We spent time speaking with people who lived at the home and observing care practice. We looked at elements of six people's care records, medication records and other records relating to the management of the service including staff recruitment and training records and policies and procedures. We looked around the home including some people's bedrooms.

We spoke with 19 people who lived at the home, four relatives, the interim manager, three care staff, the quality manager, the area manager, the housekeeper, the chef, the maintenance person and two visiting healthcare professionals.

As part of our inspection planning we reviewed the information we held about the home. This included information from the provider, notifications and contacting the local authority safeguarding and contracts teams. The provider had also completed a provider information return (PIR) and returned it to us in a timely manner. 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.

Requires Improvement

Is the service safe?

Our findings

The majority of people we spoke with told us they felt safe living at the home. Comments included, "Perfectly safe here", "Oh yes it is safe", "Oh yes, safe here. I do not need to lock the door. The staff are more like friends", "I am sometimes scared on my own but staff are around for me", "Yes I am safe. I spend a lot of time in my room. I like my room," and, "I am happy. I am safe."

People's relatives all stated they did not have any safety concerns about the service. One relative told us, "We are happy with the safety. My relative's room is left open all day. We have no problems with safety at all."

Staff we spoke with understood how to recognise and act on concerns about abuse and staff had received safeguarding training. The interim manager told us they were aware all safeguarding concerns should be reported to the local authority and the Care Quality Commission appropriately.

We saw some assessments in place in people's plans of care to mitigate risk. However, other risk assessments needed to be implemented. For example, we saw one person had side rails attached to their bed and another had bed wedges in place to keep them safe although no risk assessments had been completed. We spoke with the interim manager and their responses assured us this would be implemented.

The majority of people informed us they did not have any issues with medication and said this was given on time. We inspected medication storage and administration procedures at the service. We found that medicine trolleys and storage cupboards were secure and clean. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use.

We saw medicines refrigerator temperatures were checked and recorded daily to ensure medicines were being stored at the required temperatures. However, we found the fridge temperatures recorded for one refrigerator were not within permitted limits. This was discussed with a senior care assistant who told us they thought the temperature control monitor was faulty although we saw no evidence to show this matter had been reported or addressed.

We found systems were in place to ensure medicines prescribed to be administered before or after food were given correctly, although the morning medicine administration on two units did not commence until 10:00 hours. This was discussed with the senior care staff on duty who confirmed they usually waited until people had eaten their breakfast before administering medicines. They told us they ensured there was always a four hour gap between medicines administration, however this meant some people could be given their lunchtime medicines from 2pm onwards.

We observed the morning medication round and senior care staff administered the medicine correctly and always asked if people required medicines administered on an 'as and when required' (PRN) basis. We saw most medicines were administered via a monitored dosage system supplied directly from a pharmacy. This

meant the medicines for each person for each time of day had been dispensed by the pharmacist into individual trays in separate compartments.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the contents of the controlled medicine's cabinet and controlled medicines register in two units and found all drugs accurately recorded and accounted for. A senior care assistant told us the senior staff members checked the contents of the controlled drugs cabinet at the start of every shift to ensure all medicines were accounted for.

We saw staff were required to complete a 'Post medication round review' form. This showed the start and finish time of the medicine round and confirmation that all medicines had been signed for correctly on the medicine administration record (MAR). However, we found a number of gaps in the MAR where staff had not signed to show they had administered the medication or entered a code if the person had not taken the medicine for any reason. In addition, we found creams and ointments were not always being applied as prescribed. For example, the topical medicines administration record (TMAR) for one person showed they were prescribed cream to be applied twice daily. However, we found no record to show the cream had been applied on the 18, 19 and 20 April 2017 and a note on the TMAR dated 22 April 2017 which stated 'none in stock will require more.' The cream had not arrived on the day of inspection, 24 April 2017. The TMAR for another person showed they were prescribed two different creams. We found one cream had again been out of stock since the 22 April 2017 and the second was only being applied once daily instead of twice as prescribed. The registered manager was aware of these discrepancies which had been identified through the improved audit process.

Prior to inspection we had received notification of some missing liquid controlled medication. The interim manager was conducting a thorough investigation, interviewing and taking statements from staff and visiting health care professionals and had reported the matter to the police. Additional control mechanisms had been put in place to mitigate the risk of recurrence, such as daily audit and checks of controlled medicines. We saw recent medication audits had highlighted shortfalls in the systems and were in place to ensure medicines were safely administered. An improvement plan had also been put in place. The interim manager told us that since taking up post they had worked with the quality manager to improve the system and ensure medicines were administered safely and as prescribed. From our discussions and observations we were confident shortfalls would be addressed.

We looked round the home and inspected a random selection of bedrooms, bathrooms and communal living areas. We found the home was clean, bright, well decorated and had a welcoming feel. People's bedrooms were well maintained and it was clear people were encouraged to personalise their rooms according to their wishes, including some pieces of furniture, pictures and ornaments. One person told us, "I am happy; the room is very nice." We saw on the dementia unit memory boards had been placed on people's bedroom doors which provided their name and information about them such as what they liked to do. We saw themed memory corners and dementia friendly signage which clearly indicated areas such as toilets, bathrooms and lounge areas. The relatives we spoke with confirmed the home was kept clean. One person said, "My relative's bedroom is kept spotless and the communal toilets and living areas are always clean and bright." Another person said, "First impressions are so important and it is credit to the cleaning staff that the home is kept so clean and tidy, it must be so difficult with so many people living here."

We spoke with the head housekeeper responsible for maintaining standards of hygiene and cleanliness and they told us the housekeeping staff worked hard to ensure people lived in a clean and comfortable environment. We saw all cleaning materials and disinfectants were kept in a locked room out of the reach of people living in the home and product information relating to the control of substances hazardous to health

[COSHH] was available.

We saw infection control policies and procedures were in place and clinical waste was dealt with appropriately.

We inspected maintenance and service records for the lift, gas safety, electrical installations, water quality, and fire detection systems and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested as required. We spoke with the maintenance person who had a good understanding of their role and responsibilities.

We looked at the accident and untoward incident records and found all accidents, incidents and falls were being recorded. However, we found the interim manager had only recently put an audit system in place to analysis the data gathered. This meant there was no evidence to show the service had looked for themes and trends around accidents and incidents and had not carried out a lessons learnt exercise.

We also found two incidents involving altercations between service users had been referred to the local authority safeguarding unit but had not been reported to the Commission [CQC].This was discussed with the interim manager who confirmed that in future CQC would be notified as required.

We reviewed staff levels and found these sufficient to keep people safe. Two visiting healthcare professionals we spoke with told us there were enough staff around who understood about the care needs of the people living at the home. People told us, "There is enough staff here; I am happy," and, "I think it is really nice here. I am happy. There is enough staff; they are very kind."

The interim manager told us they deployed six care staff and four senior care staff during the day and four care staff and two senior care staff at night. Our review of the staff rotas confirmed this occurred. We saw an activities co-ordinator was also employed full time and was supernumerary. In addition, the service employed housekeepers for 14 hours daily, a laundry assistant, a housekeeping supervisor, a full time maintenance person, a full time administrator, three cooks on a rotational shift basis and two kitchen assistants. We saw the service was currently using agency staff to cover night care duties and employed bank staff to cover holidays and sickness. The interim manager told us they had currently one vacancy for a senior care staff member. They also were hoping to reduce or discontinue agency staff use once staffing was at a full complement and new shift patterns were put in place.

The majority of people we spoke with told us staff would attend to them as soon as possible when they used the call bell. We noted particularly at peak times the call bell sometimes sounded for several minutes before it was answered. However, we reviewed the call bell monitoring system and saw these were answered within three minutes for the majority of times. One person commented, "At times I have to wait when I call them but they do come when they can."

We looked at the recruitment records of four staff members and found robust recruitment procedures in place. Our checks and discussions with staff confirmed all the necessary procedures had been completed before they had started working in the home. These included obtaining references, confirming identification and checking people with the Disclosure and Barring Service (DBS). The DBS is a criminal convictions and cautions check on staff. We found people received a DBS check prior to commencing employment. This meant safe recruitment procedures were followed to make sure staff were suitable to work with vulnerable people.

We observed security measures at the service. Visitors to the service were required to sign in and out and

unknown visitors had their identity checked before entry. We saw people could choose to have their bedroom doors open or closed whilst they were in their bedrooms. Some people told us they preferred to have their bedroom doors closed for privacy and security although they had no concerns.

Requires Improvement

Is the service effective?

Our findings

The majority of people we spoke with told us they were very happy with staff and felt they responded to their care and support needs. Comments included, "Staff are very kind to me. They always listen to me when I need something", "If I need staff they are always there for me", "The staff do help me all the time", "I want half a glass of apple juice (at breakfast) See, they have brought this to me", "They do their best. If they have more time, they can spend more time with us."

We looked at staff records and saw training was either completed, booked, or in the process of being signed off as completed. The service had a number of courses staff were required to complete including fire safety, moving and handling, infection control, safeguarding, health and safety, pressure ulcer prevention and food safety. Staff we spoke with told us the training was good and equipped them to carry out their roles effectively. In addition staff told us they were encouraged to complete additional training such as NVQ2 and NVQ3 in health and social care.

New staff attended a five day induction programme which included observation and completion of a Bupa induction training booklet. Training was provided 'in-house' by a team of dedicated trainers.

We saw some staff had not received supervision for several months and staff appraisals had not been updated for over a year. However, the interim manager was aware this was an area for improvement and had recommenced staff supervision already, with appraisal forming part of the service improvement plan.

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 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). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty.

The interim manager told us one person had a standard authorisation in place and a number of other authorisations were awaiting attention by the supervisory body. We saw some referrals had been with the supervisory body for over 12 months waiting for authorisations to be granted. However, there was evidence the service had recently asked them for an update on the current situation. The interim manager told us they were in the process of reviewing the people on the referral list as their circumstances may have changed.

The senior care staff we spoke with told us they were aware of and had received training in MCA and DoLS.

Care staff we spoke with had a general understanding of the MCA and DoLS although there was some confusion about which people had been referred to the supervisory body. For example, we heard one staff member speaking on the telephone to a medical professional, saying the person was subject to a DoLS when we had seen in the person's care records this was not the case and the person had yet to be assessed.

We saw staff explained to people what they were proposing to do and ensured they had their consent before proceeding. However, we saw no evidence to show where people lacked capacity to make a decision that best interest meetings had been held, for example when bed rails or bed wedges were in use. This meant the service was not always following the principles of the MCA. This was discussed with the interim manager who acknowledged the shortfall in the system.

People told us they were given choices within the home, such as when they got up, what they ate, where they sat, what activities they participated in and when they went to bed. For example, one person told us, "I can go to bed when I want. I stayed up until 2.00 a.m."

We saw people were encouraged to consume a healthy diet. The service had a seasonal menu which was arranged to cater for the dietary needs of people. For example, a staff member told us how they catered for a person who required a diabetic diet and another who required a halal diet. If people did not want the options on the menu, they could choose from an alternative menu. The service also offered a 'night bite' menu for people who wanted something to eat when the kitchen was closed. Menus were displayed in the home as well as delivered to people's rooms and we saw choices of food were available at each meal.

We saw people were offered and shown a choice of meals and encouraged to decide what they wanted to eat. Hot and cold drinks were offered to people throughout the day. We saw fluid and/or food charts were put in place if staff felt people were not taking an adequate diet or had experienced weight loss.

Most people we spoke with were happy with the choice and variety of food being served. Comments included, "I like my food. I eat it all up. It is really nice", "I have enough to eat. They provide me with bacon and eggs. I like that", "Very good food indeed", "I am happy with the food; no problem", "Whenever I need a drink they give it to me," and, "I do not like the dinner. They always give me something else."

We observed the mealtime experience and saw this was relaxed, unhurried and inclusive, with staff sitting and chatting with people whilst encouraging them to eat. Plenty of staff were available to assist people and we saw all staff wore aprons and gloves when serving food. Tables were laid attractively with cloths, napkins, cutlery, condiments and matching crockery. People appeared to enjoy the food they were eating and were offered choices. For example, at breakfast they were offered a choice of four types of fruit juice, cereal, toast or a cooked breakfast. Portion sizes were good and people were offered second helpings. Fluids such as fruit juice and water were encouraged throughout the meal.

We saw staff asked people's permission to sit with them at lunchtime so they could eat their lunch together. This meant the mealtime experience was a period for pleasant social interaction at the same time as staff encouraging people with their food. Once the meal was finished, we heard a staff member thank the person for allowing them to sit with them which meant the experience was an inclusive experience for all parties.

We spoke with the chef and found they were very knowledgeable about people's individual dietary needs and worked with the care staff to ensure people received a healthy and balanced diet.

We saw refreshments such as tea, coffee, juice and biscuits, fruit on a trolley were offered to people throughout the day both in the communal areas and in their own bedrooms. We also observed chocolates,

Easter eggs and jugs of juice and glasses were placed in the lounge areas for people to help themselves to.

People had access to a range of health care professionals including district nurses, GPs, chiropodists, opticians and dieticians. Health care professionals we spoke with said they had no concerns about the standard of care and treatment people received. They told us staff were quick to refer people if they had concerns, communicated well and always followed their advice and guidance.

Good

Is the service caring?

Our findings

People told us they felt well cared for and were complimentary about the staff and the quality of the care they received. Comments included, "You are an individual here. They consider 'you'. They look after you", "It's a lovely home. Every single staff member is helpful", "I really like it here; cannot fault the staff. It is nice. I can watch TV", "The staff are very caring, nice to me. I really like the company. The staff are friendly; I cannot fault the staff in anyway. I feel I am well catered for here. I am really happy how they take care of me", "I am very happy; it is a great atmosphere. I have lots of friends here," and, "Yes they are caring. They talk to me about things."

Relatives' comments included, "Our relative is really looked after; staff are good," and, "My relative is always smiling; [relative] is so happy here. [Relative] is well looked after; [relative] is always clean and tidy." Care professionals we spoke with also commented on the caring attitude of the staff.

The service had a calm and relaxing atmosphere. People appeared happy living at the service and comfortable in the presence of staff. We saw kind and caring interactions and some people enjoying a laugh and a joke with staff. One person we spoke with clearly enjoyed banter with staff and it was obvious good relationships had developed.

We saw all staff including ancillary and maintenance staff and the maintenance person worked together as a team and appeared to have a genuine desire to support the people living at the home with kindness and compassion. We particularly noted the inclusive way staff interacted with people during the mealtimes.

Staff knew people well including likes, dislikes and care and support needs. For example, one staff member commented on how one person loved cricket and we saw them talking together about the game. One person told us, "Oh yes I am very cared for; they also know my likes and dislikes."

People's privacy and dignity was respected, for example staff knocked on doors before entering and ensuring toilet and bathroom doors were closed when providing personal care. Staff interacted with people respectfully, speaking calmly and gently.

We saw the service had policies and procedures in relation to protecting people's confidential information which showed they placed importance on ensuring people's rights, privacy and dignity were respected. We saw staff had received information about handling confidential information and on keeping people's personal information safe. All care records were stored securely to maintain people's confidentiality.

People and/or relatives were involved in the planning of care although further documentation of this in people's care records would reflect a more person centred approach, including documented discussions and plans about end of life decisions.

Requires Improvement

Is the service responsive?

Our findings

We looked at the care records for six people and saw sufficient information was available to staff about people's needs. Some care records contained a high level of person centred information and others required further personalisation to reflect person centred care and people's personal preferences, although we saw evidence of this in practice. The interim manager told us about the required work and we saw an action plan in place to update care records.

We reviewed the care records for one person who was on permanent bed rest which showed they required repositioning every four hours day and night. However, when we looked at the repositioning chart we found this had not been completed correctly. For example, we saw on the 19 April 2017 the last recorded time they had been repositioned was 18:10. Records showed the next time they had been repositioned was on the 20 April 2017 at 10:10 which meant they had not been repositioned for about 16 hours. This was discussed with a senior care staff member who was confident they had been repositioned four hourly but staff had not completed the repositioning chart as required. They confirmed the person had no pressure sores and their skin was intact. The interim manager was aware this was an area for improvement.

We saw the service had a complaints procedure which was available to people who used the service and their relatives. We looked at the complaints register and found two complaints had not been dealt with in line with the service complaints policy and procedure. For example, we found no evidence to show an investigation had been carried out to look at the concerns raised or if the complainants had been informed of the outcome of their complaint. We discussed this with the interim manager who told us these complaints had been received prior to them taking up post and therefore they were unable to comment on why the complaints had not been dealt with appropriately.

We saw some evidence of activities and an activities board was displayed on both floors showing a weekly and monthly activities plan. The home employed a full time activities co-ordinator and a bank activities co-ordinator. We saw the bank activity co-ordinator engaged with people enthusiastically with a ball game on the dementia unit and people clearly enjoyed the activity. For example, a staff member told us one person had enjoyed playing football when younger and they we saw clearly enjoyed this interaction. The bank activities co-ordinator told us this had been the first time they'd seen them fully engaging and smiling and was delighted to see the person's reaction.

On the day of our inspection the registered manager informed us the activities co-ordinator had tendered their resignation. They immediately put plans in place to ask the bank activities co-ordinator to take over this role on an interim basis which they readily agreed to.

We saw photographs displayed throughout the home of activities enjoyed by people who used the service, such as trips out and social events. A recent resident/relative survey had highlighted activities were an area for improvement and the interim manager was addressing this through increased social activities within the community and more interaction within the home. The hairdresser also attended weekly and we saw they

had a large dedicated room within Crossley House.

Requires Improvement

Is the service well-led?

Our findings

The majority of people we spoke with did not raise any issues regarding the management of the service although comments were made about management changes. One person commented, "Not sure who the management is; they are always changing," and, "Previous management used to take me out to café west; I do miss that." Others told us they did not have much contact with the management team, saying, "I have nothing to do with management; never see them," and, "The (deputy) manager is a nice man; when he has time to speak to me." However, relatives we spoke with were happy with the management team and did not raise any concerns.

The interim manager told us they met with senior staff and the head of each department every morning and shared information about all aspects of the service. These included discussions about what activities were planned, catering arrangements, planned maintenance, hospital appointments and updates on the health and well-being people who used the service. The interim manager also told us they were currently being supported by the provider's area manager and quality manager to review the quality of care and facilities people received.

We saw there was a quality assurance monitoring system in place designed to continually assess, monitor and improve the service. We saw documentary evidence to show a range of meaningful audits were carried out on a weekly, monthly and six monthly basis. These included care plan audits, medication audits, infection control audits and staff training and supervision audits. We also saw the interim manager was required to submit the collated information to senior management on a monthly basis. The interim manager agreed some improvements needed to be made, such as with the medicines audit and complaints and accidents analysis in order to drive improvements within the service. However, we saw they had already put increased medicines audits in place and were working to improve the quality of analysis in the service.

Both the interim manager and the deputy manager were not included in the staff numbers to allow them to concentrate on managerial tasks. However, we saw they were a visible presence in the home, providing support to staff and engaging with people living at the home.

Staff we spoke with told us the morale in the service had improved, staff worked well together, were happy and felt supported by the interim management team. Comments included, "We went through a really bad patch. Morale was low. It's a lot better now. [Management team names] have really supported", "I have been here for over seven years. I feel that it is getting better; a way to go but it is getting better", "I am treated as a part of the team. We all work together. It does not matter what we do," and, "I have been here for two years; I am really happy." We saw the service had started an 'employee of the month' award with the reward of gift vouchers and the interim manager said they were also introducing a points recognition scheme for staff who demonstrated 'above and beyond' in their role.

Staff told us meetings for staff had not been held for several months and we saw the last documented meeting was in November 2016. The interim manager was aware staff meetings needed to be put in place and had plans to implement these.

Meetings were in place for people who used the service and/or their relatives. We looked at meeting minutes and saw they included discussions about activities, concerns and any changes within the service. The service had a display board of 'You Said, We Did' in the entrance which highlighted how the service had responded to points raised at meetings, such as arranging further outings for people. This evidenced how the management team listened to and acted on peoples' views.

We found all the management team were open and honest about the improvements needing to take place and were clear in their strategy. A service improvement plan was in place and we saw this was being followed and actions taken where improvements had been identified. Where areas of possible improvements were identified during our inspection, the interim manager agreed to take action to improve the service. We saw many of the concerns we highlighted during our inspection were already part of the improvement plan therefore we were confident these would be addressed.

We saw a number of improvements had already taken place at the service such as the introduction of dementia friendly signage and memory boards on the doors of people's bedrooms on the dementia unit. The interim manager was passionate about their role and told us of some of their ideas for further improvements. They also explained how they had seen the memory boards had already had an impact on the unit with people gathering around one person's board to discuss the photographs displayed.

The interim manager also told us how they had fostered contacts with the local community. For example, they had started a weekly visit to the local pub where people who lived at the home had the opportunity to socialise and build friendships with people away from the service routine as well as local people. They told us the pub landlord had made provision for them to take a picnic and people enjoyed typical pub games such as darts, karaoke and bingo.