Platinum Care Homes Limited

Church View Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 19 February 2018 and was unannounced. Our last inspection was in July 2017 where we identified four breaches of the legal requirements. These related to medicines, risk management, dignity and respect, person-centred care and governance.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions, Safe, Effective, Caring, Responsive and Well-led to at least 'Good'. At this inspection, we found that the provider had taken action to meet the legal requirements in all these areas. We found improvements to medicines management and risk assessments. There were also improvements to staff training and leadership at the home. People's care was planned in a more person-centred way and the provider had found ways to involve people and relatives in the improvements that had been made.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Church View Care Home 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.

Church View Care Home accommodates up to 78 people across three separate units, each of which have separate adapted facilities. The provider is registered to provide nursing care to people living at the home. People living at the home had physical disabilities, long term medical conditions and most people were living with dementia. At the time of our visit, there were 39 people living at the home.

There was a registered manager in post who had joined since our last inspection and had recently registered with 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 were supported by trained staff that knew them well. Staff were kind and caring and took time to interact with people. Staff routinely involved people in their care and ensured that where people had specific preferences, these were addressed. Care was planned in a person centred way and care plans reflected people's needs, wishes and routines. Staff responded appropriately to any changes in people's needs and where any complaints had been raised, these had been investigated and addressed.

The provider had a plan to improve and develop the service. Actions had beenne taken in response to our findings at previous inspections and an ongoing plan to improve the service was underway. People, relatives and staff were involved in the running of the service. People's wishes were taken into account when developing the service. Staff had regular meetings where they could make suggestions to improve people's care. Staff benefitted from regular one to one supervision that was used to identify and address any training needs.

We received mixed feedback about the food on offer at the home. The provider had taken action to address this and had involved people and relatives in changes to the menu. People's nutritional needs were met and people had access to healthcare professionals whenever this was required. Staff managed and administered people's medicines safely. Where people had specific clinical needs, these were met by trained nurses that had ongoing support to maintain their competencies.

There were improvements to the activities on offer at the home and the registered manager was introducing further improvements in this area. Staff supported people in a way that encouraged them to maintain independence and skills. The home environment was suitable for people that used mobility aids as well as people living with dementia. People were supported to maintain important relationships and their religious and cultural needs were met. Staff were respectful of people's privacy and dignity when providing care to them.

Individual risks were routinely assessed and regularly reviewed. The actions taken to minimise risks were effective and staff took appropriate action in response to accidents or incidents. Records were kept up to date and the registered manager regularly checked and analysed these. Staff understood their roles in safeguarding people from abuse. There were sufficient numbers of staff to keep people safe and the provider carried out appropriate checks on all new staff.

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.

Staff followed best practice when managing and administering people's medicines.

The home was clean and safe infection control procedures were followed.

Risks were routinely assessed and managed effectively. Where incidents occurred, appropriate action was taken to keep people safe. There were procedures to keep people safe in the event of an emergency.

There were enough staff at the home to meet people's needs. The provider carried out appropriate checks on staff to ensure they were suitable for their roles. Staff understood their roles in safeguarding people from abuse.

Is the service effective?

Good

The service was effective.

People's food preferences and dietary needs were met. Where there had been some negative feedback on the food, the provider was taking action to address this.

People lived in an environment suited to their needs. Staff had the right training and support to provide appropriate care to people. People's healthcare needs were met.

People's needs and preferences were captured and recorded before they received care to ensure that their needs were met. Staff protected people's legal rights by following the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff that knew them well. Staff routinely involved people in their care

People's independence was encouraged by staff. Staff supported people to maintain important relationships as well as supporting people in a way that promoted their cultural and spiritual needs.

Staff provided care in a way that was respectful of people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People had access to a range of activities and the provider was in the process of continuing improvements in this area. Care was planned in a person centred way in line with people's needs, preferences and routines.

People's needs were regularly reviewed and any changes in their needs were responded to appropriately by staff. People and relatives knew how to make a complaint and complaints were investigated and responded to.

People's needs and wishes in relation to end of life care were documented in their care plans.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There had been a number of improvements at the service and the provider will need to demonstrate consistency before receiving a 'Good' rating in Well-led.

The provider carried out audits to monitor the quality of the care that people received. People's records were kept accurate and up to date and were regularly checked by management.

The provider regularly involved people, relatives and staff in the running of the service. Surveys were carried out to gather feedback on the quality of people's care.

Church View 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.

The inspection took place on 19 February 2018 and was unannounced.

The inspection was carried out by four inspectors and a specialist advisor in nursing care.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

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.

As part of our inspection we spoke with four people and eight relatives and two visiting healthcare professionals. We spoke with the registered manager, the general manager, one nurse, the housekeeping supervisor, one kitchen staff and five care staff. We also observed the care that people received and how staff interacted with people.

We read care plans for eight people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty. We looked at six staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We also looked at records about food, activities and minutes of meetings of staff and residents.

Good

Is the service safe?

Our findings

At our inspection in July 2017, we found that medicines were not always administered safely and in line with best practice. We identified shortfalls in the monitoring of risks relating to people's hydration and a lack of safe infection control processes. This was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the provider had taken action to meet the requirements of the regulation.

People told us they felt safe living at the home. One person said, "A hundred percent marvellous, that's my feedback." One relative said, "Yes it is safe, especially for people with Alzheimer's, there's good security here." Another relative told us, "In my heart I know [person] is safe."

People received their medicines safely. Staff were observed administering medicines to people and they followed best practice. Staff offered people their medicines sensitively and administered them in line with their preferences. Medicines were administered by registered nurses and their competency had been assessed in this area. Medicines were stored securely and in line with the manufacturers guidance. The provider carried out regular checks to monitor the temperature of the storage area.

Medicine administration records (MARs) showed pictures of people so staff knew who they were administering medicines to. People's allergies were clearly listed on the MAR to ensure these could be avoided if necessary. MARS were completed accurately. Where people had not received their medicines, this was made clear on their MAR. For example, where people had been in hospital or had refused their medicines, the MAR clearly recorded this. Medicines records were regularly audited to ensure that they remained accurate. The pharmacist had visited recently to complete an audit and they had identified no concerns.

Risks to people were managed safely. Where people had specific risks relating to their care, the provider had assessed these and identified plans that managed risks to keep people safe. For example, one person had developed a wound. Staff identified this and put a plan in place to reduce the risk of the wound becoming infected and to support healing. Staff took regular photographs of the wound, applied dressings and recorded that they had done so. Another person was assessed as at risk of falls due to their mobility. To manage this risk the person was supported by two staff and a hoist when they wished to move. Staff also checked the person regularly to ensure that they were safe. During the inspection we observed two staff supporting the person to move, as outlined in their risk management plan. Risk assessments also covered risks such as falls, pressure sores or behaviour. Risk assessments were reviewed monthly and any changes were actioned by staff.

Staff took action to keep people safe following accidents or incidents. The provider kept a record of accidents and incidents and records showed that staff took appropriate action to ensure people's safety. For example, one incident recorded that staff had identified a minor injury on a person when delivering personal care. Staff provided first aid to the person and documented the injury. The person was then seen by their GP and additional monitoring was put in place to ensure their safety. The provider also regularly analysed

incident records to identify any patterns and trends, therefore there were systems in place to learn lessons if anything ever went wrong.

Staff understood their roles in safeguarding people from abuse. Staff had received training in safeguarding and information on safeguarding procedures was on display around the home. When we spoke to staff, they were able to tell us the potential signs of abuse and what they would do to report it. Records showed that staff had raised concerns where they had them and the provider had a good relationship with the local authority safeguarding team and had been contacting them when required. At the time of inspection there were no open safeguarding investigations.

There were systems in place to reduce the risk of the spread of infections. The home environment was clean and smelt pleasant. The provider employed housekeeping staff and we observed them cleaning the home throughout our inspection. Staff had been trained in infection control and were observed following best practice. Staff made use of personal protective equipment (PPE), such as gloves and aprons, when providing care to people. For example, we observed staff using gloves and aprons when serving food to people. Later, we observed a staff member washing their hands before administering medicines to someone. The provider carried out regular checks such as an infection control audit and regular checks of people's rooms and equipment such as mattresses to ensure their cleanliness and suitability.

There were sufficient numbers of staff at the home to safely meet people's needs. One person told us, "The staff are always around." During the inspection, we observed that staff were able to provide people the support that they needed. In the morning, we observed staff playing games with people and responding promptly where people requested help. Staff were able to sit and speak with people which showed that they had enough time to support them and engage in meaningful activities. The provider had calculated staffing numbers based on people's needs and records showed that this level of staffing had been sustained.

We did receive feedback from one person and one relative that at busy times staff were sometimes stretched. One person told us, "Sometimes it can be a job to find them [staff]." We were told that staff responded quickly when people needed help urgently and we observed that staff were available during our inspection. People had got up at their preferred times and their needs had been met. Staff were also observed spending time interacting with people, providing appropriate supervision and preparing drinks for people whenever required. At the time of inspection, one unit of the home was closed. The provider informed us that they will start taking new admissions for empty rooms after the inspection and they will continue to calculate staffing numbers based on needs. We will follow up on this at our next inspection.

The provider carried out appropriate checks to ensure that staff were suitable for their roles. Staff told us that they had waited for checks to be carried out before they came to work at the home. Staff files contained evidence of references, right to work in the UK and DBS. DBS is the disclosure barring service. This is used to identify potential staff who would not be appropriate to work within social care.

People were cared for in a safe environment. The provider had risk assessed the building in relation to health and safety and fire risks. There was equipment and procedures in place to keep people safe in the event of a fire and this was regularly serviced and tested. The provider had a plan to ensure that people's care could continue in an alternative premises in the event of an emergency such as a fire or flood at the home.

Good

Is the service effective?

Our findings

We received mixed feedback on the food on offer at the home. One person said, "I do like the food." Another person said, "The food is 'comme ci comme ca' [so so]." A relative told us, "The food isn't amazing." Another relative said, "They have lovely meals."

The provider was already aware that some people were not satisfied with the food and was taking action to address this. The most recent survey showed both positive and negative responses to the food. An outside catering company provided and prepared meals at the home. Some people and relatives had raised negative feedback about the quality of vegetables, saying they were pre-prepared and did not taste fresh. In response, changes were made to how vegetables were sourced and prepared at the home. The caterers also came to a meeting with people and relatives. We saw that changes to the menu had been developed and were being implemented at the time of our visit. We will follow up on people's satisfaction with the quality of the food provided at our next inspection.

People received food in line with their preferences. People's care plans contained information about foods and meals that they liked and menus showed they ate food in line with these preferences. For example, one person's care plans recorded that they like traditional English foods such as stews and they also liked curries. Records showed that they had eaten these types of foods regularly. The kitchen had records that documented people's preferences and menus were discussed at residents meetings. People were also regularly asked for feedback on food at reviews and through surveys.

People's dietary needs were met. Where people had specific dietary needs, these were documented and met. Information about people's dietary needs was gathered at assessment and documented in care plans and kitchen records. For example, one person was living with dementia and regularly refused food, which placed them at risk of malnutrition and weight loss. To monitor and manage this risk, the person was weighed regularly. Staff worked with the person to find foods that they responded well to. The person had always liked milky drinks and ice cream, so where the person refused meals staff encouraged them to eat these foods to maintain weight. We observed staff supporting this person to eat on the day of inspection. Staff provided encouragement to the person and they were observed eating some of their meal. Records showed that the person's weight had been stable in recent months. Another person was living with dementia and required their food to be cut up to minimise the risk of choking. This was in their care plan and we observed them being served food in line with this guidance.

People benefitted from a home environment that was tailored to their needs. The home was purpose built and spacious and we observed that there was space for people who used walking aids and wheelchairs to easily access all areas of the home. There was signage in place to enable people to orientate themselves within the home. The provider also had plans to improve in this area to ensure the environment and equipment was suited to people living with dementia. For example, the provider was introducing coloured plates that where dementia had affected people's vision, they would be able to see food on their plate and eat independently.

The provider carried out assessments of people's needs before they received a service. There had been no new admissions since our last inspection, but we saw evidence of assessment documents that were used to identify people's needs and preferences. Assessments captured medical conditions, preferences and needs in relation to personal care, nutrition, medicines and behaviour.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were protected because staff followed the guidance of the MCA. People's care records contained evidence of mental capacity assessments to identify whether they had the mental capacity to make specific decisions. Where people lacked capacity, we saw evidence of best interest decisions being documented that involved professionals and relatives. For example, one person was assessed as lacking the mental capacity to make the decision to consent to receiving care. Their mental capacity assessment documented that due to their dementia, they were unable to understand or retain the information in order to make a decision. As the person lacked mental capacity to make this decision, a best interest decision was documented that they should stay at the home and receive care. As this decision would involve restrictions being placed upon the person, an application had been made to the local authority DoLS team.

People's healthcare needs were met. People's care plans contained information about any medical conditions, medicines and any ongoing treatment that they were receiving. Where healthcare professionals were involved in people's care, staff kept records of visits and correspondence from them. For example, one person had ongoing support from a community psychiatric nurse (CPN). Staff documented the CPN's visits and we saw records of calls to the CPN when the person's behaviour had changed. This led to changes in the person's prescribed medicines which had addressed the changes in their behaviour. We also saw evidence of ongoing involvement from the GP, dentist and optician in people's records.

People were supported by staff that were trained to carry out their roles. Staff told us that they had access to a range of training courses that equipped them for the roles. One staff member told us, "When I started I did an induction and went to training courses." Records showed that all staff had received an induction and staff told us they shadowed experienced staff before working independently. Staff had received training in areas such as safeguarding, health and safety and fire safety. Staff training followed the care certificate; the care certificate is an agreed set of training standards in adult social care. Nurses received regular clinical supervision and told us that they had appropriate support from the provider to maintain their competencies and revalidate their PIN with the Nursing and Midwifery Council (NMC).

Staff received regular support from their line managers. One to one supervision meetings were carried out regularly and the registered manager had a system to keep track of one to ones. Records showed that these were up to date and meetings were used to discuss people's needs as well as staff skills such as communication and documentation. There was a system for annual appraisals and these were being carried out at the time of our inspection.

Good

Is the service caring?

Our findings

At our inspections in October 2016, February 2017 and July 2017, we had concerns that care was not always provided to people in a dignified manner. Staff did not always treat people with dignity and respect and did not know people well. This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the provider had taken action to meet the requirements of the regulation.

People told us that the staff that supported them were caring. One person said, "I get along with all of them [staff]." A relative told us, "They [people] are all well looked after and staff are all very patient." Another relative said, "Staff are all gentle. I love it when [staff member] is on." Another relative said, "They [staff] are all friendly, you can see them playing games with the residents."

During the inspection we observed numerous caring interactions between people and staff. Staff interacted with people in a way that showed kindness and commitment to them. For example, in the morning one person became anxious. Staff responded calmly to the person, placing a hand on theirs and diverting them by talking about the day. The person appeared calm and settled after this interaction. During a game of dominoes with staff, we observed another person become unsettled. Staff interacted with the person positively and engaged them in the game which helped them to feel calmer. Throughout the day, staff sat with people and either engaged in activities or conversation with them. We looked at compliments received since the last inspection and noted there had been four. These compliments praised staff for their caring nature and the positive impact this had had on people. On compliment from a relative said, 'they [staff] treat [person] with sensitivity, backing off when she resists and coming back when she is calmer.'

People were supported by staff that knew them well. A relative told us, "There is a continuity of staff luckily so they know [person]." Staff had information in care plans to get to know people. For example, one person had lived in a different part of the UK for most of their life. Staff were observed talking to the person about where they were from and they knew about this person's needs and background when we spoke with them. As well as reading information in people's records, staff demonstrated a commitment to learning about people's backgrounds and lives. One staff member told us that they liked to make an effort to chat to people in their rooms in order to learn more about them. During the inspection, we observed staff chatting to one person and their relatives in a lounge. They discussed the person's family and background with the person and their relatives. A relative told us, "They [staff] know [person] doesn't like noise and likes his hand held and they do this."

People were involved in their care. People's records contained evidence of involvement in decisions about their care. Care plans contained a summary of people's preferences and any requests that they had made. For example, one person liked sweet foods and chats with staff and these were listed in their care plan. Daily notes showed that this person regularly had sweet snacks with staff and staff had recorded when they had spent time with the person one to one. Where people were living with dementia, staff had consulted relatives to obtain information about their preferences and involve them. During the day, we observed staff enabling people to make day to day choices regarding their care. When having afternoon tea, one person

declined all the varieties of cakes and biscuits on offer. In response to this, the staff member found the person a packet of crisps as an alternative which they then ate.

Staff supported people in a way that encouraged them to retain independence. One staff member said, "We encourage lots of activities that help people's skills. Some people can do their personal care themselves and others can do a lot of things with supervision." During the inspection, we observed staff encouraging people to retain skills. For example, one person was hungry in the morning and wanted a sandwich. Staff took the person to a kitchenette where they prepared a sandwich together. People's care plans contained information about their strengths to enable staff to provide care that empowered them. One person's care plan recorded that they were able to carry out most personal care tasks themselves and only required staff supervision to ensure their safety. Staff were knowledgeable about this persons strengths and we observed staff prompting the person when personal care was required during the inspection.

People were supported to maintain important relationships and their cultural and religious needs were met. Relatives told us that they were free to visit whenever they wished and we heard feedback that communication with staff and management had improved since our last inspection. Information about people's cultures and religions were picked up at assessment and care was planned around them. For example, one person's care plan stated that they were a practising Catholic. Their care plan said, 'do not disturb me when I am praying'. There was guidance for staff on the support the person when praying, such as giving the person their rosary beads, and staff were aware of this. Another person was a practicing Hindu and their care plan recorded that they did not eat beef. The kitchen had this information on their records and staff were aware of this person's dietary needs in relation to their religion.

People's privacy and dignity was promoted by staff. Throughout the day, care was provided to people in a respectful and dignified way. Where staff interacted with people living with dementia, they did so with patience and consideration. Staff came down to people's eye line when speaking with them. Where people became confused, staff took time to support them to make choices. Where personal care was required, this was done discreetly and behind closed doors.

Good

Is the service responsive?

Our findings

At our inspections in October 2016, February 2017 and July 2017 we found that people did not receive responsive care. There was a lack of appropriate activities on offer for people and inconsistencies in record keeping meant care was not always planned in a person centred way. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the provider had taken action to meet the requirements of the regulation.

People told us that they were happy with the activities on offer at the home, but we did receive feedback that there could be more on offer. One person told us, "We usually play games, they do all sorts of things. Its lovely." A relative told us, "They do play more games and things but I think they [people] must get bored sometimes."

There had been improvements made to the activities on offer. In response to our findings the provider had introduced a new timetable of activities that included games, arts and crafts, exercise, music and visiting entertainers. Throughout the day, we observed staff playing games with people on a one to one basis as well as group activities. People were observed as happy and engaged in the activities taking place. The majority of feedback that we received was positive, but one person and one relative did say that at times people felt bored. The most recent survey had also included feedback from a relative that the provider could 'do more' with regards to activities. The registered manager was already aware of this feedback and was in the process of introducing more activities and arranging more outings for people. The home employed two activities co-ordinators but one had recently left and they were in the process of recruiting another staff member to this role. Whilst there had been significant improvements that meant that the provider was now meeting the requirements of the regulation, we will follow up on the implementation of improvements to activities at our next inspection.

People received person centred care. One relative told us, "It's been the best thing for [person]. I can't fault them [staff]." People's care plans contained important information about their needs, backgrounds and preferences. For example, one person's care plan documented that they required support with personal care and liked to get up at around 10am. It also stated that they responded well to holding hands and cuddles. Records showed this person got up at their preferred time and we observed this on the day. We observed staff holding this person's hand and their relative told us that staff always displayed an understanding of how to support this person sensitively. Another person's care plan recorded that they required supervision due to their behaviour, but could become agitated if they were not given enough space. During the inspection we observed staff supervising this person from an appropriate distance. When the person got up and left the room, staff continued to monitor them and encouraged them to join staff in the dining room, without causing the person to become anxious or agitated.

People's care was regularly reviewed and any changes in need were addressed. Where changes in people's needs were identified by staff, a review took place and staff took action to respond to them. For example, staff had noted changes in one person's behaviour and their care plan was updated to include additional checks and supervision. The person was also referred to the local intensive support team (IST) who helped

identify ways to support them in a person centred way. The IST were present on the day of inspection and told us staff had provided them with the information required to begin forming a plan to support the person.

People's wishes with regards to end of life care were documented. Care plans contained information about people's advanced wishes. These plans included information about people's religions and whether they wished to remain at the home or be admitted to hospital. Where relatives were involved, they were listed on the care plans with information on when they wished to be contacted.

People and relatives were aware of how to complain and complaints were investigated and responded to appropriately. There was a clear complaints policy in place and relatives told us that they felt confident to raise any issues with the management team at the home. Records of complaints showed that they were investigated and responded to appropriately by management. For example, relatives had raised concerns about the amount that one person was eating. In response, the person's care plan was reviewed and additional support was put in place for staff to support them at mealtimes. The provider's most recent survey recorded positive feedback on complaints with relatives stating, 'if I have any worries, I know I can speak to staff' and 'everything we've raised has been actioned'.

Requires Improvement

Is the service well-led?

Our findings

At our inspections in October 2016, February 2017 and October 2017, there was a lack of continuous monitoring of people's care. There were shortfalls in record keeping and where the provider had drawn up action plans to address breaches of the regulations, these had not been implemented to meet the legal requirements. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the provider had taken action to meet the requirements of the regulations.

People told us they had seen improvements in leadership at the home. One person said, "I've had a chat with [the registered manager]." Another person said, "I can speak to the manager whenever I need." A relative told us, "Since the new manager joined there have been improvements, she keeps them [staff] on their toes." Another relative said, "The new manager is very friendly."

Improvements at the home were being implemented by the registered manager. Following our previous inspection, the provider had submitted an action plan to CQC that documented the actions that they would take to ensure that they would comply with the legal requirements of the regulations. These actions had been taken in line with this plan, and the provider was continuing to identify improvements at the service. For example, the provider told us that they would improve staff training and find a new registered manager. A new registered manager had been recruited and recently registered with CQC. They had identified new ways to measure and assess staff competency and target training through supervisions. This had been completed by the time of our visit and staff told us they found the supervision meetings useful.

The registered manager had a vision for the service and was implementing improvements to food and activities as well as plans to make the home environment more 'dementia friendly', by introducing additional signage and equipment. The provider submitted a provider information return (PIR) to CQC before the inspection. This listed planned improvements in areas such as staff training and auditing. We found that by the time of our visit, these improvements had been implemented. At the time of inspection, the registered manager had only been in post for five months and had only recently been registered by CQC. Following our last inspection, we rated the service 'Inadequate' in the Well-led domain. Whilst we noted the positive impact the registered manager had made in their short time at the home, we will only apply a 'Good' rating to this domain once the provider has evidenced consistency and sustained improvements.

Staff told us that they had seen improvements to morale and the culture at the service. The registered manager said that their biggest challenge had been getting staff on board with their vision for the service to enable improvements to embed. The registered manage had achieved this by using supervision and staff meetings to discuss their vision and improve staff competency. Relatives told us that staff seemed more efficient and committed to their roles since the new registered manager came into post. During the inspection we observed that staff were competent and committed to their roles, which impacted positively on people.

There were regular audits in place to monitor people's care and identify improvements at the home. Audits

covered areas such as infection control, health and safety, medicines and documentation. Where improvements were identified, these had been actioned. For example, a recent audit had identified that some areas of the kitchen were untidy. This had been actioned and we observed that the kitchen was tidy and organised on our visit. Audits also analysed people's care by reviewing accidents and incidents or people's nutrition. A recent nutrition audit had picked up that a person had been losing weight. This had prompted a review of their care plan and additional support to encourage them to gain weight. The registered manager looked at records of incidents such as falls each month to pick up any trends so that they could be addressed if required.

The provider involved people and staff in the running of the home. A relative told us, "There are meetings. I attended one recently and it was very informative." Regular meetings took place that involved people and relatives. Where any issues were raised, these were actioned by management. For example, at a recent relatives' meeting, relatives had helped decide how frequently their meetings should take place and made suggestions around food and activities. The provider also carried out an annual survey to identify any areas for improvement. The most recent survey had identified some relatives wanted the home to appear more 'homely'. In response, the registered manager had ordered new cushions and soft furnishings which were in place on the day of our visit. We saw evidence of the involvement of important agencies and community organisations. People's records showed working alongside the local authority and local community health groups such as the community mental health team. The local authority QA team had been visiting the service and had also noted improvements since our last inspection. Community organisations were involved in activities, for example the local church supported with regular visits to the home for people practicing a Christian faith.

Staff maintained accurate and up to date records. There was a clear system in place to record daily notes and during the inspection we observed that these were up to date. Staff accurately documented that actions in people's care plans, such as personal care and nutritional needs, had been met. Care plans contained up to date information about people and these were regularly audited by management. Reviews took place frequently and where any changes were identified, care plans had been updated in a timely manner.

The provider understood the responsibilities of their registration. Providers have a duty to notify CQC of important events such as deaths, serious injuries and allegations of abuse. We found that where required, the provider had submitted notification to CQC in line with their duties. The registered manager demonstrated a good understanding of when to submit notifications to CQC when we spoke with them.