Sycamore Meadows Homes Limited

Kings Court Nursing Home

Inspection report

Church Street
Grantham
Lincolnshire
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 18 January 2017 and was an unannounced inspection. The home is registered to provide accommodation with personal and nursing care for 29 people. At the time of our visit there were 28 people living at the home.

There was a manager in post who had a pending application to become the registered manager. 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 home is run.

People's relatives told us that people were safe at the home. Staff were trained in adult safeguarding procedures and knew what to do if they considered someone was at risk of harm, or if they needed to report concerns.

There were systems in place to identify risks and protect people from harm. Risk assessments were in place and carried out by staff who were competent to do so. Risk assessments recorded what action staff should take if someone was at risk. Referrals were made to appropriate health care professionals to minimise risks and meet people's health needs.

There were sufficient staff to keep people safe and meet their needs. The registered manager had followed safe recruitment procedures. Medicines were given to people on time and as prescribed. However we raised concerns with the manager regarding the way medicines were dispensed.

Policies and procedures were in place to guide staff in relation to the Mental Capacity Act 2005. Staff understood the processes in place for ensuring decisions were made in people's best interests. Staff and the manager were ensuring these steps were taken for people living at the home. Staff sought people's consent and recorded this.

Staff were caring, they knew people well, and they supported people in a dignified and respectful way. Staff acknowledged and promoted people's privacy. People felt that staff were understanding of their needs and they had positive working relationships with them.

People and their relatives were involved in the assessment and reviews of their needs. Staff had knowledge of people's changing needs and they supported people to make changes to their planned care when people wanted to. Staff were not always consistent in their approach to offering choices. People told us that they had access to activities and hobbies.

People and staff knew how to raise concerns and these were dealt with appropriately. The views of people, relatives, health and social care professionals were sought as part of the service's quality assurance process.

Quality assurance systems were in place to regularly review the quality of the service that was provided.

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.

Medicines were given on time and as prescribed.

The service managed risk effectively and regularly reviewed people's level of risk. There were enough staff to meet people's needs and to keep them safe from harm.

Is the service effective?

Good

The service was effective.

The service provided staff with training and they received supervision and observations from the manager.

People were supported to maintain good health, and were encouraged to eat a healthy diet.

There were effective processes in place to work in accordance with the Mental Capacity Act 2005. Staff sought consent and recorded this.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and dignity. They took time when they delivered support to people, and they listened to people. Staff promoted people's privacy.

People were consulted about their care and had opportunities to maintain their independence.

Is the service responsive?

Good

The service was responsive

Most people had their preferences upheld. Staff were not always consistent with offering choice.

People were supported to maintain hobbies and interests they

enjoyed.

There were processes in place to identify if people had concerns about the home.

Is the service well-led?

Good

The service was well led.

The manager sought the views of people regarding the quality of the service. Improvements were made when needed.

There were quality assurance processes in place for checking and auditing safety and the service provision.

Kings Court Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 18 January 2017 and was unannounced. The inspection team consisted of one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information we held about the provider. This included notifications, which are events that happened in the service, that the registered provider is required to tell us about. We also contacted social care professionals within the county for their views.

We spoke with eight people living at the home and two visitors and one social care professional after the visit. We also spoke with the manager, four staff members and the chef. At the time of our visit, the provider representative was also present. We spent time observing care provided to people during the day.

We reviewed the care records of three people, training records and staff files, as well as a range of records relating to the way the quality of the service was audited.

Good

Is the service safe?

Our findings

People told us that they felt safe living at the home. One person told us, "I feel safe, they are always here if you need them", another person confirmed, and said, "I feel safe".

Staff had knowledge of how to protect people from harm and told us that they were confident that they could refer concerns to the manager. Staff were able to explain the processes that they had in place for protecting people from harm and the signs they needed to look out for. Additionally they told us that they could discuss issues at their formal one to one meetings, which they had with the manager. Staff undertook relevant training to keep people safe from harm and we saw records that confirmed this. The manager had a training qualification that meant they could deliver this specific training in-house. When we spoke with staff they told us that they found this training very useful as the manager knew the people as well and examples used.

At our previous inspection on 3 November 2014 we identified some issues around staff not knowing who had entered the building. This mean there was a risk to people living at the home. When we arrived at the home for this inspection visit, a staff member opened the door to us and alerted the manager. The manager's office was by the door and we were asked to sign in. Later in the day we asked another member of staff, that we had not yet met, where the manager was. This staff member also asked who we were and checked our identification badges. This showed us that staff were committed to knowing who was in the building and checking who they were if they did not know. This reduced the risks to people living at the home.

Risks had been identified and assessed in order to keep people safe. One person living at the home was at a high risk of developing pressure areas. We saw this was detailed in the individual care record, with the appropriate risk assessment. This record contained information that this person should be turned on a regular basis to reduce the risks of developing a pressure area. There was also a pressure relieving mattress in place. Staff told us that they repositioned this person regularly and what signs they needed to be aware of if the person's tissue viability changed. We reviewed the daily records for this person and could see that repositioning took place at regular and timely intervals.

Another person was at high risk of falling however was very mobile and liked to walk around the home. This person had a risk assessment which identified this risk. They also had a care plan which guided staff how to manage this need. We saw this person walking around the home and that staff regularly checked to see where the person was. Staff were able to explain to us that they encouraged this person to keep as mobile as possible, however ensured that mobility aids where used at all times.

We saw information and records which related to the safety of the premises, equipment and included environmental health and safety checks. This was up-to-date and where issues had arisen they had been dealt with promptly. There were plans in place to support people in the event of an emergency and what support people would need to evacuate. Staff could tell us the process they would follow and where to find the information quickly.

Records we looked at contained information about the appropriate way to keep people safe while providing care. We observed that people were provided with appropriate equipment to reduce the risk of harm. This showed us that staff were aware of the risks people faced and followed people's care records and risk assessments, in order to keep people as safe as possible.

People told us that staff were always available to help them. One person told us, "There is a call bell close by, I've called my bell and they came quickly". A relative confirmed and said, "There is always staff around".

Staff told us that staffing levels had improved and none of them reported being on a shift that had been short staffed in the last month. The manager told us and staff confirmed that there were now more staff on shift in line with people's needs. We also observed call bell response time, and staff responded in a timely manner even at busy times. The manager confirmed how they had addressed staffing levels and how this was based on people's requirements. We saw from records that these requirements had been met.

The manager followed safe recruitment practices, which included the appropriate criminal record checks and references. The manager told us about the recruitment process they followed and staff confirmed this to be the process they experienced. This meant only staff that were deemed suitable were employed to work with people living at the home.

Part of our inspection looks at how people received their medicines. During our inspection visit we observed the nurse administering people's medicines during lunch. We noted that they did not always follow best practice. We saw that a person's medicine administration record (MAR) was being signed by the nurse when the medicine was dispensed, not when the medicine had been administered. Additionally we saw that someone's medicines had been dispensed but the person was still eating their lunch. The nurse waited for a few moments and then continued to dispense the next person's medicines. The pot containing the previous person's medicines was left on the trolley. This meant that there was a risk the medicines could have become mixed up and given to the wrong person. There was an additional risk that this person may not have received any medicines as the MAR had already been signed, to indicate they had taken their medicines. We spoke with the manager about this and they agreed that this was not acceptable practice. They told us that they would speak with the staff member and organise some refresher training.

One person required all of their medicines to be administered via a PEG system, this is a system used for people who are nil by mouth. We saw that there was detailed information for this process in place. We saw that daily records for this person showed that all medicines administered were consistent with the planned care. Staff told us that they were confident with using the PEG system and they knew what signs to look out for if there were problems with it.

We found that there were systems in place to ensure that medicines were available for people when they needed it and in a timely fashion. Where medicines needed to be adjusted we saw that this had taken place. For example where someone required a medicine to thin the blood, relevant blood checks had taken place and recorded. We saw that when people required a medicine at a certain time this had taken place and was in the person's daily record. Where a person required a medicine that was as and when they needed it (a PRN medicine), these too had been administered and recorded. We observed staff asking a person if they wanted a PRN medicine before administering it to them.

Staff could tell us what the process was if they suspected a medicines error, but that they had not had to do this. We looked at the audits and records for the medicines and these had highlighted no errors. Previous MAR records were appropriately completed and there showed no gaps in information recorded. This showed that medicines were given at correct times and administered as prescribed.

Good

Is the service effective?

Our findings

At our previous inspection on 3 November 2014 we reported that staff were not always provided with the support or training they needed to effectively carry out their roles. There was a lack of training with supporting people living with dementia and limited daily guidance from the manager.

At this inspection visit we found that this had improved. The manager had been in post since May 2016 and gave us information of the positive changes that they had made.

Staff told us that they had received online training for dementia care and that they had found this useful. We spoke with the manager and they told us that they were also sourcing face to face training in dementia care. Whilst we were at the inspection visit we saw plans for this training. The manager confirmed to us that all staff needed to do this training and they had a plan in place to provide this in the coming weeks. We observed staff working with people with dementia. We saw that staff were empathetic, encouraging and gave people extra time with tasks. We saw that one staff member did not always offer choices in a consistent manner, which some people with dementia might find confusing. We spoke with the manager who told us that they would address this with all staff.

We concluded that the manager had made progress to improve support for staff. The manager had additional plans in place to improve this further. This meant that the manager was committed to supporting staff and ensuring that they could effectively care for people living at the home.

People told us that they felt staff understood their needs and could therefore provide them with effective care. One person told us, "Staff know about my needs and how to help". Another person told us, "I am confident about staff, they are very good".

Staff told us that they received training for their roles, and that the manager would support with any training they requested. Staff told us that they were supported to obtain formal qualifications in health and social care. The staff member who was responsible for providing activities told us that they were also being supported to obtain a formal qualification, for the role of activities coordinator. New staff told us that they undertook the Care Certificate (the Care Certificate is a set of standards that social care and health workers should adhere to in their daily working life).

Staff told us that they received an induction period when they started at the home. They told us this was normally for about a week to 10 days. They did tell us this was dependent on their individual needs. The manager confirmed this and at the time of our inspection visit we saw a new member of staff was on their first day of induction. They were being supported to access training and being orientated within the home. Staff went on to tell us that they worked with more experienced team members to learn how to support the people living at the home. Staff and the manager told us that if someone felt they needed more shadowing experiences then this was put in place.

Staff received regular supervisions from the manager, and records confirmed this. Supervision is a meeting

between staff and their manager to discuss their roles, training needs and personal development. Staff told us that they felt like they could discuss anything they needed to at this time. The manager told us, and staff confirmed they did not have to wait for formal supervision to discuss issues.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Three people living at the home had a DoLS authorisation already in place and others applications had been applied for. One person had a DoLS for restricting them at night; this was because the person was more active at night, as they had been a night shift worker in the past. Staff were aware of this and were able to tell us how they reassured this person at night and kept them safe. We observed this person in the day and staff spoke with them about their previous life and the work they used to do. This showed us that staff ensured that they knew people well so they could effectively support them if they became distressed. Another person had an advocate to support them, and we saw information for this in the persons care records. We saw that the advocate and this person had supported with care planning, this was part of the person's DoLS and staff had acted upon this.

Staff told us that they had received training in the MCA and could explain the principles of the Act. They continued with how they supported people with their care and support. We saw, where appropriate, people had best interest meetings in place to support with decision making. These meetings also identified what the least restrictive plan was, for example one person required bed rails. Records confirmed that there was a best interest decision and that this was the safest and least restrictive method, this was accompanied by a risk assessment for the person. This meant that staff had all the appropriate information for people and could ensure they received effective care.

People told us that they enjoyed the food. One person told us, "The food is very acceptable and you have a choice". They went on to comment that, "Drinks, I am never without even if it is just water". Another person we asked, told us, "It is not bad".

The chef was able to tell us about the different diets people had, and that some people received a pureed meal or one that was fortified, depending on their needs. The chef, and staff, confirmed that a choice was available at all meals and we saw that people were asked their preference. However some staff were not clear when describing what the choices were and listed all the elements of the meal rather than what the meal was. We observed that some people were confused with this and it took staff a while longer to ascertain their choice. One person told us that they preferred a cold lunch and their main meal in the evening; we saw this person had sandwiches at lunch. Drinks were readily available and accessible to all people, during the visit we observed that people could get their own drinks at any time. Additionally fruit was also available throughout the day and people could take any whenever they wanted some.

At the time of our visit there was no one at risk of not receiving enough to eat or drink. In the past where

people had been at risk we saw that action had been taken. Everyone living at the home was weighed on a regular basis to support them to maintain a healthy weight. During a routine weigh, one person had lost a significant amount of weight during the month. We saw that the doctor had been notified and the person had been weighed weekly. Records showed that this person was had a food chart started and their food was fortified with doctors recommendation. The person's weight was monitored closely until it stabilised and had returned to a healthy range. This showed us that staff were able to identify when a person was at risk of not receiving enough to eat or drink and took the appropriate steps to support this person.

Only one person commented regarding accessing healthcare, they told us that they had never required a doctor. However, they did feel confident that staff would request a doctor if they needed one.

Staff told us that they felt confident to call health professionals when they felt it appropriate. Staff also confirmed that they would ask people first if they wanted help. We saw in care records that there were visits from other health professionals and that staff responded to instruction that was left. For example, where people required support from a chiropodist we saw that visits were regular and had been recorded.

Good

Is the service caring?

Our findings

People told us that staff were caring and kind. One person said, "They make it as near home as possible, they do bend over backwards for you". Another person said, "It is very nice here". This was confirmed by another person who said, "It's lovely, staff are good".

Staff told us it was important to interact with people and get to know them. They explained that they should ask a person before delivering any care and tell the person what they were doing. Staff told us that they encouraged people, where appropriate, to carry out all or part of the care task themselves.

We observed during the day that a person had fallen forwards at the table. The staff member placed a cushion underneath the person's head before encouraging the person to decide what they wanted to do next. We saw that the staff member gave the person time and then reassured the person that they were there to help. On another occasion we saw that a person had sat on the floor of their room. We saw that staff encouraged this person to mobilise as much as they could, as staff offered reassurance and support.

Staff knew the people that they cared for. We heard conversations between staff and people about things they liked to do, or about the jobs they had done. The manager knew each individual and could tell us a bit about the person's life. We saw that care records contained information about a person and their lives. Staff were cheerful and people who lived at the home communicated to staff about different subjects in a relaxed manner. Staff were kind, caring and gentle with people and we did not see any person that was rushed with tasks.

People we spoke with either did not know what a care plan was or if they had one. However everyone told us that staff knew their needs and asked them about their care. One person told us, "I've never seen a plan but staff know about what I want".

When we reviewed people's records we saw evidence that people were involved in planning their care. People had a formal care review at least once a year which was recorded with outcomes and actions. The manager confirmed that they carried out these reviews and would visit each person individually. We saw that people's reviews and care records were up-to-date. The manager told us, and we saw that the service was in the process of moving from paper records to an online system. This was a staged approach so during the transition duplicate records were in place.

We also saw that people had a nominated member of staff who informally reviewed care on a day-to-day basis. This is known as a key worker and this information was also used to inform changes to planned care. Each care record contained documents that showed consent had been obtained and discussed with the person. Where a person lacked capacity this was done with best interest care planning and relevant people were involved. This showed us that whilst people did not understand the terminology used for a care plan, they confirmed that they were asked about their care.

People told us that they felt their dignity and privacy was respected. The home had three rooms which were

double rooms. Two of these were occupied by two people at the time of the inspection visit. We asked people if they were happy to share, and one person told us, "I am happy to share, I couldn't ask for a better partner, it is good". We observed that double rooms had a curtain was available to pull across the centre of the room. Screens were also available for staff to use when delivering care. A relative told us that they felt their relative was treated with dignity and said, "I see them treating [person] nicely, and you cannot fault them".

Staff told us what they would do to protect a person's dignity. This included closing doors and curtains and knocking on people's doors before entering. We observed during the day that staff did knock before entering people's rooms. Additionally we saw that staff were discreet when asking people if they wanted to visit the bathroom.

Good

Is the service responsive?

Our findings

People told us that they could make choices about their care and the things they wanted to do. One person told us that they choose to get themselves up and dressed in the mornings. We asked them if they were happy with that choice and they said, "I am more independent, I can manage, it's brilliant". Another person confirmed and said, "You have got a choice".

We observed some good examples of offering choice throughout our visit however we also observed staff that did not always maximise a person's ability to choose.

We saw that some staff asked people where they wanted to be. One person had fallen forward at a table and staff asked them, "Would you like to be in your room, or would you like to sit here [lounge]". This showed us that they wanted the person to be comfortable and where they wanted to be. Staff asked people if they were happy to have a male or female carer and this was recorded. We also saw that staff checked again before offering any personal care. People had the opportunity to have a shower, bath or a wash in their rooms. One person confirmed to us that they could have a bath whenever they wanted one. Another positive example was when a staff member asked a person if they liked scrambled eggs and bacon. The person did not know and another carer suggested that they show the person the food so they could decide. When lunch was served we noticed that condiments were available for people to use independently and one person had asked for yoghurt instead of a desert, this was given to them. People had access throughout the day to fruit and biscuits and choose when they had a snack. We saw people helping themselves at different times of the day. These examples showed us that some staff were committed to ensuring people remained independent and were offered choices.

However we also observed times when choice was not maximised and upheld by staff. For example the menu board was not clearly written and was written in a faint colour. The board in the downstairs lounge was dated 14 January 2017 when we arrived and was updated that morning to 18 January 2017. This meant that people were not able to make decisions about their food, as the right choices were not displayed. This meant it was hard to read and therefore people might not be able to read the choices. One person asked for two sausages and was told they were only allowed one, however the next person requested two and received two, staff offered no explanation to this person as to why this was the case.

We observed that people were not given the opportunity to pour their own cream on their desert. This was done for them once the staff member ascertained if they wanted cream. This showed us that there was not a consistent approach by staff when it came to choice.

We spoke with staff about how they asked for choices, and they were knowledgeable about people's likes and dislikes. Staff could tell us those people that may have required additional time to make choices. They told us that if they allowed some people more time, they felt assured people understood and could make their own choices. Staff explained how they used visual aids with people to help them choose clothing and toiletries. One staff member explained how they would give multiple choices to a person for a breakfast choice so they could decide. Care records showed a high level of detail for people's choices. For example

one person did not want to be checked at night and this was recorded. Daily records showed that this had been upheld.

We spoke with the manager regarding choices and reviewed records that showed they had carried out observational checks on shifts, to check choice. For example we saw that one evening shift had been observed. It stated that people who were in bed had chosen to be in bed by that time. The manager confirmed that they discussed choice with people and this was recorded and communicated to staff.

We concluded that whilst we had seen some instances where staff had not promoted choice we also saw a number of good examples regarding choice. We spoke with the manager about these, and they agreed that they would address our comments with staff.

Staff told us that they found the care records useful and helped them to support people living at the home. Staff told us that they were transferring to a new online system and said this was much better. Staff had access to a mobile device which enabled them to update a person's daily records immediately after delivering any care or support. Whilst at our inspection visit we saw that one person had received support from staff. We checked their online record a few moments later and this had been updated. Staff told us that this system meant they had the most up -to -date care records and this helped them to carry out their roles.

People told us that they had access to activities that they enjoyed. One person told us, "I am quite happy as long as I have a good book and my TV". A relative confirmed and told us, "Always activities, always something on [activities co-ordinator] is brilliant.

The manager had employed a member of staff to lead on activities and this person was being supported to undertake a formal qualification to support their role. We saw that there were a number of activities on during the week of our visit. We saw that there were some one to one activities and some group activities. We saw people were colouring pictures, playing board games and taking part in an interactive group game. Two people liked to go into the town centre to do shopping or go for a coffee. The activities co-ordinator confirmed that they supported these people to go into town regularly, and we saw from daily records that this happened. People could access the secure garden and we saw people during our visit enjoying the garden. We saw that people's records also included information on activities they enjoyed. For example one person was interested in music and playing musical instruments. Due to this person's health they could not play all the instruments they wanted to now, however this person still played the mouth organ. Staff told us that this person regularly played this instrument.

We concluded that people living at the home had access to a number of different activities and could participate when they wanted to.

People told us that they had no complaints about the service, but they knew who to speak to if they did. They said they felt confident to do this. One person said to us, "They are very good, I cannot complain [with the home]." A relative confirmed and said, "I would talk to the nurse on duty or manager, they would deal with it."

Staff confirmed that they felt confident to raise any complaints raised by people; they felt these would be listened too and action would be taken. We saw that there was a complaints process in place, and this was effective. We saw the service had not received any formal complaints in the last 12 months. There was a comments and complaints book that was available to visiting relatives. Here they could leave any comments or issues if they wanted to.

Good

Is the service well-led?

Our findings

People who lived at the home and their relatives told us that they knew who the manager was, and that they could approach them. One person told us, "[Manager] is the manager and they sort things out, they are in most days". A relative commented on this and said that they agreed. Another person told us, "[Manager] is the boss; they are there if you need them".

The manager had only been in post since May 2016. At the time of this inspection visit they had an application pending with the Care Quality Commission (CQC) to become the registered manager. At our previous inspection visit in November 2014 the manager's office was across the road from the home and staff said this did limit them when they wanted to see the manager. At this inspection visit we saw that the manager's office was now based inside the home and staff confirmed they saw them all the time.

Staff continued to inform us that they felt well supported by the manager and they enjoyed working at the home. One staff member told us, "I love my job, I love Kings Court". Another staff member told us, "I love working here; [manager] is a very good manager". And another staff member said, "There is a lovely atmosphere here, very homely".

Staff confirmed that they attended team meetings and that they could request items for the agenda. Staff told us that they felt listened to and that their ideas were acted upon when appropriate. We saw that there was a regular 'resident' survey and one for families. The responses were all positive and over half of returned surveys said people 'Strongly Agreed' that the care was good.

Staff understood and were aware of the whistleblowing policy and told us that they felt confident to do this, should the need arise. There was information around the home as to how to do this and staff could tell us where they would find the detail. Staff understood the values of the home, which included encouraging personal fulfilment and individualised programmes of meaningful activity. Staff spoke positively about their roles and how they supported people within the home.

One area of concern was regarding the management of medicines by a member of the nursing team. This nurse was also the clinical lead for the nursing team. Whilst we were assured that the manager had in place methods to oversee the nursing team, they were not aware of the current administration of medicines and the issues we raised. This nurse was responsible for the training and practices of the other nurses. The manager agreed to address this with the nursing team and carry out any additional training. The manager also confirmed that they would carry out further competency checks to ensure this did not happen again.

There was a clear line of accountability for staff for the times when the manager may not be available. The manager booked any holiday with the directors of the home. The directors would then appoint someone to oversee the home in the manager's absence. The manager confirmed that they felt supported by the directors of the home.

The manager had in place a number of quality assurance systems and audits to ensure the safe running of

the home. These quality monitoring systems were established following the concerns highlighted in our previous report of 2014. The manager had also been working with the local authority to improve the quality of the home.

We saw that the manager had put in place audits such as care plan audits; HR audits; risk assessment audits; and observational shifts. They had ensured that training was addressed and there were training audits in place to show the changes. The manager had an overarching view of the service.

We noted that there had been many examples of positive change since our last inspection visit. This was evident when we reviewed action plans and saw the actions the manager had taken, in order to improve the service. The manager could tell us the challenges and achievements of the service. Where there were still challenges the manager had in place a plan to address this, through training supervision and team meetings.

The service had submitted all the relevant notifications that they were required to do and had policies and procedures in place to manage quality care delivery and health and safety. We saw that accidents and incidents were logged and any action taken. We saw that where a person's health had deteriorated then the audits clearly reflected the changes with that person and the action taken. This showed us that the manager had oversight and could be assured that people's health and social care needs were met.

We concluded that the manager had acted upon issues raised in our last report. They had made positive changes to improving the quality of the home and had plans in place for the future development of the home.