Swanton Care & Community (Autism North) Limited

Eastholme

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?	Good

Summary of findings

Overall summary

The inspection took place on 12 and 13 December 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Eastholme on 3 and 4 November 2015 and informed the registered provider they were in breach of two regulations: staffing and good governance. The provider subsequently submitted an action plan detailing how they would address these breaches of regulation.

Whilst completing this visit we reviewed the actions taken by the registered provider to address the above breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the registered provider had ensured improvements were made regarding the governance of the service and a new manager had been recently appointed. We found this manager had made improvements to the service in the areas identified at the last inspection.

Eastholme is a residential home in Seaham, County Durham, providing accommodation and personal care for up to 4 people with learning disabilities. There were 4 people using the service at the time of our inspection.

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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. We saw that, since the last registered manager had left the service the new manager had applied to register with CQC and had been given an interview date with CQC. The manager had their registration with CQC confirmed shortly after the inspection. The manager had introduced a range of improvements in the seven weeks they had been at the service.

People who used the service acted in a trusting manner with staff whom they knew well and relatives expressed confidence in the ability of staff to protect people from harm.

Staff we spoke with demonstrated a good understanding of how to keep people safe, both through formal safeguarding procedures if needed, and through adhering to risk assessments and support plans.

There were sufficient numbers of staff on duty in order to safely meet the needs of people using the service and to maintain the premises. All areas of the building including people's rooms, bathrooms and communal areas were clean.

We found one instance of a pre-employment check via the Disclosure and Barring Service (DBS) not being appropriately acted on. The manager took prompt action to assess this risk and we saw other pre-employment checks, including references and ID checks, were in place.

The storage, administration and disposal of medicines was safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). Specific plans were in place for people with 'when required' medicines.

There was regular liaison with GPs, nurses and specialists such as psychiatrists to ensure people received the treatment they needed. Professionals we spoke with confirmed staff communicated well with them.

Staff were trained in areas specific to meeting people's needs, for example Positive Behaviour Support (PBS) training, and were also trained in areas the registered provider considered mandatory, such as safeguarding, fire safety, health and safety, medication administration, equality and diversity, human rights and infection control.

Staff were supported by regular supervision and appraisal processes as well as regular team meetings. The service manager had reviewed the amount of supervision meetings staff had received and ensured adequate future meetings were planned.

We observed people being supported to choose a range of meal options and make their own drinks. Staff were aware of people's dietary needs and preferences.

Group activities included outings to outdoor activity providers and local parks, as well as day-to-day activities such as shopping.

A complaints process was in place and, whilst no one we spoke with had raised a formal complaint, one relative confirmed the manager had listened to a specific concern of theirs and taken appropriate action.

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. The manager displayed a good understanding of capacity being specific to individual decisions and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

The atmosphere at the home was welcoming and calm. People who used the service, relatives and external stakeholders told us staff were caring and we saw numerous friendly and patient interactions by staff.

Person-centred care plans were in place and regular reviews took place with the involvement of people, their family members and relevant professionals.

Staff, people who used the service, relatives and external professionals we spoke with expressed confidence in the manager, particularly commenting on their positivity and enthusiasm, although all acknowledged they had not been at the service long. The manager was registering with CQC at the time of inspection and was able to explain how they intended to sustain improvements already made and make other

improvements.

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.

Pre-employment checks of staff were in place. The manager acted promptly to assess the risks associated with the information contained on one returned Disclosure and Barring Service check.

Risk assessments had been recently improved and were sufficiently detailed and personalised to help staff reduce the risks people faced.

There were safe systems in place for the storage, administration and disposing of medicines, with specific plans in place for 'when required' medicines.

Is the service effective?

Good

The service was effective.

Staff communicated well with people who used the service, adapting their style in line with people's care plans to ensure they could understand and act on people's needs.

Staff liaised well and shared information with external healthcare professionals to ensure people's medical needs were met.

The manager displayed a good understanding of capacity being specific to individual decisions and we found the provider had followed the requirements in relation to Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

Staff interacted in a patient and warm fashion with people who used the service, who displayed trusting and contented behaviours during our inspection.

All relatives we spoke with commended care staff on their treating people with dignity and respect.

Care plans were written in a way that encouraged and supported people's independence and decisions were taken with the help of those who knew people best.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and people's individual preferences were known by staff and respected.

Staff sought advice from healthcare professionals when people's needs changed.

The service had a complaints procedure in place and, when concerns were raised, the service manager had acted responsively and dealt with the concern appropriately.

Is the service well-led?

Good

The service was well-led.

The service did not have a registered manager in place but the new manager had applied to register with CQC and had received an interview date. Since the inspection their registration with CQC was confirmed.

Quality assurance and auditing systems had been reviewed recently and the manager had used these to make improvements. They were confident these improvements could be sustained.

We found the culture to be one that had undergone managerial and some staffing changes but remained focussed on providing a continuity of care to people who used the service.

Eastholme

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.

We visited the service on 12 and 13 December 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector.

We spent time observing interactions between staff and people who used the service and speaking to five relatives. We spoke with five members of staff: the manager, two team leaders and two care staff. Following the inspection we spoke with two safeguarding professionals, two social care professionals and one healthcare professional.

During the inspection visit we looked at four people's care plans, risk assessments, staff training and recruitment files, a selection of the home's policies and procedures, IT systems, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. A notification is information about important events which the service is required to send to the Commission by law. We spoke with professionals in local authority commissioning teams and Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection. We also used the action plan the registered provider had sent us to inform our inspection.

Good

Is the service safe?

Our findings

People who used the service acted in a calm and relaxed manner with all staff we observed interacting with them and displayed signs of trust and affection, such as laughter and hugs. Relatives we spoke with expressed confidence in the safety of the service and the ability of staff to keep people safe. One relative said, "If there were any concerns whatsoever we would raise them," and, "There was an incident a while back of someone lashing out but they dealt with it very openly – we have no concerns." We looked at documentation relating to the risks associated with this person's behaviours and found there were risk assessments in place detailing how staff should best support them in a positive way. The risk assessments detailed particular stressors and indicators of when behaviour might escalate. Staff we spoke with demonstrated a sound understanding of how to support the person and how to identify indicators that their behaviour may change.

At the previous inspection we had raised specific concerns about the lack of staff training with regard to Positive Behaviour Support (PBS). PBS is an approach used to support people with learning disabilities who display behaviour that might be challenging. PBS is a means of positively encouraging people to engage in meaningful behaviours rather than relying on methods such as restraint. We saw staff had received introductory and intermediate accredited training from the British Institute of Learning Disabilities (BILD) in 'Positive Behaviour Support and working with behaviour that challenges'. When we spoke with staff, they were able to describe how they positively encouraged people to behave in ways they found meaningful as a means of distracting them. This meant staff had received appropriate training to help keep people safe and at a reduced risk of being restrained.

We saw that pre-employment checks including enhanced Disclosure and Barring Service checks had been made. The DBS maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We found one employee had a previous conviction and there was no record of a risk assessment on the employee being carried out. The manager told us the previous registered manager had held a conversation with the member of staff but that this had not been documented. We saw the previous registered manager had asked for at least two references and gathered proof of identity from prospective employees.

During the course of the inspection the manager held an interview with the member of staff to establish whether there were any risks requiring specific management for that member of staff to continue employment. We saw they had assessed that the offence itself and the date at which it occurred did not indicate a significant or imminent risk to people.

This meant, whilst an area of potential risk had not been adequately acted on prior to employment in one case, the new manager had taken prompt action to assess the risk and put appropriate measures in place.

We found there were sufficient staff on duty to meet the needs of people who used the service. Relatives and staff all told us they felt there were sufficient staff to keep people safe. The manager explained that further recruitment was ongoing and the plan was to have an additional member of staff on duty during the

day to provide 'floating' support and therefore more flexibility. This meant people using the service were not put at risk due to understaffing.

We saw the storage, administration and disposal of medicines was safe and adhered to guidance issued by the National Institute for Health and Care Excellence (NICE). We saw people's individual medical records contained their photograph, any allergy information, emergency contact details and instructions regarding how they preferred to take their medicine. We reviewed a sample of people's medication administration records (MARs) and found there to be no errors. Medication audits took place weekly and we found the manager to have an excellent knowledge of people's medicinal needs.

With regard to 'when required' medicines such as paracetamol, we found there were individual instructions in place to help staff understand when people who used the service might require these. For example, one person's prescription of paracetamol was support by guidance to staff stating, "If [Person] is in pain they will press their stomach or take staff to the medication area." When we asked staff about how people would indicate they required 'when required' medicines we found they demonstrated a good knowledge of people's individual means of communication.

We saw the treatment room was small but tidy and kept locked when it was unoccupied. Medicines were housed in a locked cabinet with a shelf for each person's medication. We saw room temperatures were regularly recorded to ensure they were within safe limits. We saw topical medicines (creams) that were opened were marked with an opening date to ensure they were not used for longer than prescribed. We also saw the manager was in the process of introducing improvements to the way in which topical medicines were recorded, introducing a body map to ensure staff knew whereabouts on a person to apply the topical medicine. This demonstrated people were not put at risk through the unsafe management of medicines.

The manager and all staff we spoke with had been trained to have a practical understanding of safeguarding. They were able to describe types of abuse, sources of risks and what they would do should they have concerns. We found the manager encouraged a culture where practice could be challenged and where staff were supported to raise concerns if they had them.

We saw incidents and accidents had been documented and shared in a way that meant they could be analysed for specific trends or patterns. We also saw staff had received refresher training in incident reporting.

External professionals we spoke with expressed confidence in the ability of staff to keep people safe from harm. One told us, "I've never had any major issues and the manager seems to have a handle on things." Another said, "There have never been any concerns about [person's] safety or letting things slip."

We found all areas of the building, including people's bedrooms, the kitchen and communal areas, to be clean, bright and free from odours. Relatives raised no concerns about the cleanliness of the service, with one stating, "It's always clean and tidy." We saw appropriate personal protective equipment (PPE) was available, as well as liquid soap dispensers and signage regarding hand cleanliness. This meant people were protected against the risk of acquired infections.

We saw Portable Appliance Testing (PAT) had been undertaken and emergency systems such as the fire alarm and emergency lighting were tested regularly. We saw fire extinguishers/equipment had been serviced and window restrictors were in place. We saw legionella testing had occurred recently and water temperature checks had been undertaken regularly to protect people against the risk of scalding. We saw

monthly health and safety checks by the manager had identified, for example, the need to repair a hand rail and replace some blinds. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

With regard to potential emergencies, we saw there were personalised emergency evacuation plans (PEEPs) in place, which detailed people's mobility and communicative needs. These had been reviewed and improved by the manager to ensure they contained more person-specific details. This meant members of the emergency services would be better able to support people in the event of an emergency. The manager had also reviewed and replenished the emergency grab-bag with additional materials such as snacks and drinks, as well as reviewing the business continuity plan.

Good

Is the service effective?

Our findings

At the previous inspection in November 2015 we identified concerns regarding staff training, namely that staff had not been trained in the Mental Capacity Act 2005 (MCA) and positive behavioural support (PBS). The registered provider gave CQC a plan stating how they would address these shortfalls in training. The action owner according to this plan was the previous registered manager. At the time of our inspection on 12 December 2016 this manager had deregistered with CQC and was not working at the location. We saw they had ensured positive behavioural support training had been delivered to staff, although they had not ensured MCA training had been delivered to all staff as per the original action plan.

The manager had taken over seven weeks prior to our inspection and we saw they had formulated their own action plan for updating all training records and needs. We saw they had ensured any outstanding MCA training had been delivered in December. This demonstrated, whilst all required training had not been refreshed in line with the provider's action plan by the previous registered manager, the new manager had ensured the required remaining training was delivered.

We saw recent staff had been inducted as per the service's induction policy and the manager was aware of the need to ensure any staff new to care would need to undertake the Care Certificate. The Care Certificate is the most recent identified set of standards that health and social care workers adhere to in their daily working life. The registered provider's mandatory training included Safeguarding, Fire Safety, First Aid, Medication Administration, Health and Safety, Human Rights, Equality and Diversity and Infection Control.

We noted staff had not been given moving and handling training. The manager explained, and we saw in people's care plans, that nobody using the service currently, nor since the last inspection, required assistance to mobilise. The manager provided assurances that, should people's needs change such that they required assistance to mobilise, this training would be provided.

Relatives of people who used the service were generally satisfied and spoke positively about the standards of staff competence and knowledge. One relative told us about one person's previous behaviours that had caused them a concern and said, "They have got that completely under control thanks to involvement with GPs – they deserve praise for that." Another relative said, "Their knowledge of the person and their needs is great."

We reviewed care documentation and saw that people received care from a range of healthcare professionals such as GPs, dentists, psychiatrists and opticians. When we spoke with external healthcare professionals they expressed confidence in staff. One said, "There is a care plan in place that meets [person's] needs. [Person] is predominantly non-verbal and their understanding of their communication needs was good. [Person's] presentation of particular behaviours has settled since moving there." We also spoke with one safeguarding professional who noted there had been recent improvements in care planning documentation.

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. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The manager demonstrated a good understanding of mental capacity issues, for example that, whilst people may not have the capacity to make decisions about the medication they needed to take, they made other decisions, such as what they wanted to wear, eat and where they wanted to go. We saw appropriate documentation had been submitted to the local authority regarding the DoLS.

Care plans contained a good level of detail regarding how best to communicate with people given their individual needs. For example, in one person's care file it stated staff should speak slowly, ask simple, short questions then pause and await a response. We saw staff communicating with people who used the service in line with their communication plans.

Staff confirmed they had regular supervision and appraisal meetings and we saw evidence of this in personnel files. We saw the manager had undertaken a review of staff supervision records to ensure all staff had received a recent supervision. We also saw evidence of regular staff meetings.

With regard to nutrition we saw there was a varied menu and we observed people choosing a range of options, for example one person was helped to decide from a range of omelette fillings, whilst another person was offered a range of healthy dessert options and excitedly chose an apple.

We observed people being encouraged and supported to make their own hot drinks. We saw pictorial menus were not in place but the manager had added a whiteboard to the dining room area and we saw in their action plan they intended to trial pictorial menus to ensure people were as fully aware of their options as possible.

Staff displayed a good knowledge of people's dietary needs and preferences, for example they told us about one person who had a tendency to eat food too quickly and needed regular prompting to eat more slowly. We saw one person had been on a mashed diet for a considerable amount of time and the manager was in the process of re-referring this person to the Speech and Language Therapy (SALT) team to establish whether they could now have a more varied diet. This meant people were protected from risks associated with eating.

We found the premises were spacious, homely and appropriate to the needs of people who used the service, with one lounge that accessed the garden area, dining area and another lounge should people prefer time to themselves.

Good

Is the service caring?

Our findings

All relatives we spoke with were positive about the caring approach of staff, their interactions with people who used the service, and their commitment to people receiving good quality care. One relative said, "I never have anything but praise for them and what they do." Another said, "It has a calm feeling when you arrive," and another said, "[Person] is really settled. They're always happy to come and visit us but happy to go back because it's like home. We think it's excellent." Where one person raised concerns about the leadership of the service over the past six months, they noted, "The care is good."

We observed staff interacting with people who used the service and found them to behave in a caring, patient manner, regularly asking people about their opinions on a range of matters. We saw staff sharing familiar jokes with people who used the service and people reacting by laughing or reflecting the joke back. When staff returned from a shopping trip with one person who used the service they thanked the person for their help and asked them to take their shoes off and if they would like to help put things away. We found the atmosphere and culture of the service to be welcoming, inclusive and relaxed, whilst staff had made strong bonds with people who used the service. We observed that a good rapport had been built between staff and people who used the service.

We noted there had been two new managers since the last CQC inspection. Relatives we spoke with were generally positive about the way care staff had managed to provide a continuity of care to people who used the service during this period of change. One relative said, "[Person] really doesn't like change in any form and reacts to it. They were very sensitive to that." Another relative we spoke with told us of the care staff, "Because of how long they've known [person], they're superb." This demonstrated that staff had regard to the importance of people receiving a continuity of care to help them feel at home, safe and properly cared for.

With regard to people's dignity, we observed staff treating people with respect and helping them to choose what they would like to do in a dignified manner. Care plans were sufficiently detailed to ensure people's personal care needs were appropriately met in line with their wishes and with their involvement.

We found people were supported to be as independent as they were comfortable with, for example, people were helped to make their own hot drinks, tidy their rooms, and one person regularly did their own laundry. We saw people who used the service taking part in the day-to-day upkeep of the home, for example, going shopping and tidying up. One person's care file we reviewed contained detailed instructions for staff regarding supporting the person to the shop. This described how to encourage the person to hand over money for their chosen item but to make sure they waited for change. This meant plans were specific enough to ensure staff knew how to support people to act independently within set support plans that were goal-orientated.

We saw rooms were personalised and decorated in varying styles to meet the preferences of people who used the service.

We found care plans contained good levels of information regarding people's preferences and wishes. Where people were able to consent to aspects of their care and treatment, they had done so. When we spoke with staff they knew about people's individual needs and preferences. The manager displayed a good understanding of advocacy and ensured relatives were involved in decisions relating to people's needs to ensure there was a level of advocacy when making decisions about people's care.

We saw people's personal sensitive information was securely stored in locked cabinets and on a password-protected computer system, meaning people's information was kept safe.

Good

Is the service responsive?

Our findings

Relatives of people who used the service were generally satisfied with the levels of activities available and how these were delivered. One relative said, "They go out, often as a group. They've been to quite a range of places now and they can go back to their favourites." Another said, "They have plenty to do and enjoy going out." We saw people had visited, for example, Gateway Wheelers (a charity that enables people with disabilities to try bikes, tricycles and go karts), visits to a number of parks and horse riding. We saw, for example, staff had risk assessed this activity and ensured the right level of staffing and equipment was in place. We also saw there were in house activities, such as manicures and a fortnightly visit from a music therapist.

One relative we spoke with expressed concerns that the service had not provided a range of outdoor excursions earlier in the year but stated, "It got sorted out and they are taking [Person] out more now. I had to get the social worker involved." They stated they felt the service had been responsive for a number of years prior to this and attributed the more recent concerns to the previous registered manager. They went on to state, "The new manager seems good and we're going to have a meeting about it."

We saw a daily handover sheet detailed planned activities for the day. The manager was in the process of setting up a more easily accessible system for people who used the service, namely using pictures to help people make choices about what activities they would like to do.

Two relatives we spoke with confirmed they had requested and received a weekly call from the service with a quick update and any changes they needed to be aware of. Other relatives we spoke with confirmed they were involved in the review of people's care plans. One relative said, "We had a review a couple of weeks ago and they always involve us. Occasionally they'll ring outside of the weekly catch up if something out of the ordinary has happened or if they need to tell us about something, like medication being changed." This demonstrated that staff communicated well with people's relatives and ensured they were kept informed of changes to people's care.

We found care plans had been reviewed and improved by the manager and were person-centred. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. We found people's individual interests, preferences, as well as their anxieties were taken account of in a section called 'Understand Me.' This contained specific questions answered by people who used the service such as, 'What helps me feel relaxed? We found staff to have a good knowledge of this personalised content. For example, one person's care plan detailed their love of using an etch-a-sketch, both as a favoured activity but also as means of gentle distraction if they were feeling anxious. Staff we spoke with were aware of this and we found it had been incorporated into care plans. Another person had specific goals of going out into the community and we saw they did this regularly. We saw they also had a 'Daily Living Skills' plan which contained detailed preferences regarding the type and timing of bathing they preferred and what level of day-to-day things they liked to do (such as helping set a table or listening to music). During our inspection we observed this person to be pleased about having had a bath.

We saw evidence staff were able to identify when people's needs changed and ensure support was provided by a range of healthcare professionals. When we spoke with an external healthcare professional they confirmed, "Eastholme is a lot more responsive than some other services. I attend the multidisciplinary team (MDT) meetings and they are always helpful." This demonstrated staff ensured people's changing needs were met through regular liaison with external professionals.

Surveys of people who used the service, staff and relatives were used as a means of gathering more information about the service. We looked at the most recent surveys and saw all respondents had responded positively. One relative told us, "We fill in quality surveys regularly and they have regular meetings with us." This meant people's views were sought and listened to.

With regard to complaints, we saw information regarding how to make a complaint was clearly displayed in service user guides and all relatives we spoke with knew how to raise concerns. We saw no formal complaints had been raised recently, although one relative had raised concerns about the downturn in the standard of the service as they perceived it. We saw this concern was taken seriously by the manager and a meeting arranged with the relative, who told us they felt the manager had handled the concern well.

With regard to the potential transition to other services, we saw each person had a Hospital Passport in place. A Hospital Passport details people's communicative, medical and mobility requirements should they need to go into hospital.

Good

Is the service well-led?

Our findings

The service did not have a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the CQC to manage the service. The previous registered manager had left the service the previous month and we met the new manager, who had applied to register with CQC and had been given an interview date with CQC. The manager had their registration with CQC confirmed shortly after the inspection. We found the manager to have significant and relevant social care experience working with people with learning disabilities, and they demonstrated a good knowledge of the needs of all people who used the service. For instance, one person who used the service regularly had their nails painted by staff and would often respond to the question, "What colour would you like your nails done?" by saying, "Blue." Due to their levels of understanding, this was not necessarily an indication that they preferred the colour blue, but that they associated the word "Blue" with the act of having their nails painted. As a solution, the manager was planning to use a colour chart the person could point to when deciding on what colour to have their nails painted. Whilst this system was not yet in place, it demonstrated the manager had taken time to understand the individualities of the people who used the service.

The manager also demonstrated an awareness of the procedures and policies of the organisation and where improvements were required. We asked for a range of policies and associated documentation to be provided. They were promptly provided and we found all records to be accurate and up-to-date, or else had identified by the manager as being in need of improvement. For example, the method by which staff documented hot water temperatures was currently in a small notebook with loose pages and hand-drawn lines. The manager had identified that this was not robust and was introducing a new means of maintaining these checks.

We saw the manager had implemented their own action plan since joining the service and had made good progress against this, for instance ensuring that care plans, emergency procedures and training requirements were updated and improved. We reviewed their more recent action plan against the previous action plan in place, which the previous registered manager had been working towards. We found the manager had identified and improved areas that had not been sufficiently rectified by the previous registered manager, such as the on-call arrangements, which were now clear and accountable and ensured a senior member of staff was available should staff on shift have concerns. This demonstrated that, whilst the original action plan sent to CQC had not been acted on as quickly as the registered provider had initially planned, the manager had ensured that target completion dates on the original action plan and their more recent action plan, had been met.

We saw they had spoken or met with relatives of each person who used the service and all relatives we spoke with expressed confidence in them. One told us, "There's a new manager and we've noticed a positive impact. They had a very positive attitude and were looking not just about what has happened but about what they can do in the future." Another said, "It seems to be run well now."

When we spoke with external professionals about the change of leadership, they were similarly optimistic, stating for example, "I think it is improving, definitely. The new manager had a real enthusiasm."

The medication audit took place weekly and the manager and other staff undertook a range of audits on a monthly basis, including care file audits, bedroom audits, finance audits and supervision audits. We saw the manager had to fill in a monthly return detailing the audits they had completed and any outstanding actions required, and send this to the area manager. This approach had been in place prior to the manager's arrival but there was evidence to indicate the previous registered manager had not effectively used auditing procedures to identify areas requiring improvement, for example no concerns were found regarding pre-employment checks or training. This demonstrated that the manager had so far effectively audited the systems and processes in place and had successfully identified areas requiring improvement and made changes.

All staff members we spoke with were positive about the levels of support they received from the manager stating, for example, "They've involved us in decisions and have come to us to ask things and not just assumed," and, "We've been well supported. It was difficult six months back but we have pulled together and [manager] has been really supportive. They've made changes for the better." We found this to be a consistent message, with staff telling us that morale had improved recently. Similarly, one new member of staff spoke positively about how existing staff had welcomed them into the role and had been keen to share their experiences and knowledge of people who used the service.

The manager had a clear vision for how service improvements could continue to be made and how this would impact on people's quality of care. We found the culture to be one that had undergone recent change but that had successfully remained focussed on the needs of the people who used the service. The manager had taken the necessary time to understand people's needs and where the service needed to improve. They had made a range of improvements at the time of inspection and were in the process of implementing further improvements. They told us they had so far been well supported by the organisation and expressed confidence in the ability to sustain the improvements already made.