Anchor Trust

Oakleigh

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

This inspection took place on 23 February 2018 and was unannounced.

Oakleigh is a 'care home' providing residential care for older people with dementia. 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. Oakleigh accommodates up to 50 people set over three floors, and is divided into five units; each unit accommodates approximately 10 people. There were 48 people using the service at the time of our inspection.

At the last inspection on 29 November 2016 we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found people were not always protected from unsafe care or treatment, the provider had not always safeguarded people by taking the appropriate action and notifying relevant bodies such as the local safeguarding team without delay. People were also not supported to be involved in meaningful activities to meet their individual needs and the provider did not regularly assess and monitor the quality of service provided to people. Following that inspection the provider sent us an action plan showing how they planned to make improvements. At this inspection we found improvements had been made.

The service did not have a registered manager in post. The previous registered manager left the service in January 2017. However, the provider had appointed a new manager to run the home. The new manager's application to the CQC to become the registered manager was being processed. 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.

The service sought the views of people who used the services, their relatives, and staff to improve the service. Staff felt supported by the manager. The provider had effective systems and processes to assess and monitor the quality of the care people received which helped drive service improvements. The service worked effectively with health and social care professionals, and commissioners.

Staff knew how to keep people safe. The service had clear procedures to support staff to recognise and respond to abuse. The manager and staff completed safeguarding training. Staff completed risk assessments for every person who used the service and they were up to date with detailed guidance for staff to reduce risks.

The service had an effective system to manage accidents and incidents, and to prevent them happening again. The provider recognised people's need for stimulation and social interaction. People had end-of-life care plans in place to ensure their preferences at the end of their lives were met. Staff completed daily care

records to show what support and care they provided to each person.

The service carried out comprehensive background checks of staff before they started working and there were enough staff to provide support to people. Medicines were managed appropriately and people were receiving their medicines as prescribed. Staff received medicines management training and their competency was checked. All medicines were stored safely. The service had arrangements to deal with emergencies and staff were aware of the provider's infection control procedures and they maintained the premises safely.

The provider trained staff to support people and meet their needs. People and their relatives told us that staff were knowledgeable about their roles and that they were satisfied with the way staff looked after them. The provider supported staff through regular supervision and yearly appraisal.

The manager and staff understood their roles and responsibilities under the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People consented to their care before they were delivered.

Staff assessed people's nutritional needs and supported them to maintain a balanced diet. Staff supported people to access the healthcare services they required, and monitored their healthcare appointments. The manager and staff liaised with external health and social care professionals to meet people's needs.

People or their relatives, where appropriate, were involved in the assessment, planning and review of their care. Staff considered people's choices, health and social care needs, and their general wellbeing.

Staff supported people in a way which was kind, caring, and respectful. Staff protected people's privacy and dignity.

The service had a clear policy and procedure about managing complaints. People knew how to complain and told us they would do so if necessary.

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.

People and their relatives told us they felt safe and that staff and the manager treated them well. The service had a policy and procedure for safeguarding adults from abuse, which the manger and staff understood.

Staff completed risk assessments for every person who used the service and they were up to date with guidance for staff to reduce risks. The service had a system to manage accidents and incidents to reduce reoccurrence.

The service had enough staff to support people and carried out satisfactory background checks on them before they started work.

Staff were aware of the provider's infection control procedures and they maintained the premises safely. They administered medicines to people safely and stored them securely. The service had arrangements to deal with emergencies.

Is the service effective?

Good

The service was effective.

People and their relatives commented positively about staff and told us they were satisfied with the way they looked after them. The provider supported staff through training, supervision and an annual appraisal, in line with the provider's policy.

Staff assessed people's needs and completed care plans for every person, which were all up to date. Staff completed daily care records to show what support and care they provided to each person.

Staff assessed people's nutritional needs and supported them to have a balanced diet.

People consented to their care staff provided them. The manager and staff knew the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and acted

according to this legislation.

Staff supported people to access the healthcare services they needed. The manager and staff liaised with external health and social care professionals to meet people's needs.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind and treated them with respect.

People and their relatives were involved in making decisions about their care and support.

Staff respected people's choices, preferences, privacy, dignity, and showed an understanding of equality and diversity.

Is the service responsive?

Good

The service was responsive.

Staff recognised people's need for stimulation and social interaction.

Staff involved people or their relatives in the assessment, planning and review of their care.

Staff prepared, reviewed, and updated care plans for every person. Care plans were person centred and reflected people's current needs.

People had end-of-life care plans in place to ensure their preferences at the end of their lives were met.

People knew how to complain and would do so if necessary. The service had a clear policy and procedure for managing complaints.

Is the service well-led?

Good

The service was well-led.

People and their relatives commented positively about the manager and staff.

The service had a positive culture, where people and staff felt the service cared about their opinions and acted on their feedback

to make improvements to the service.

Information about the management of the service was shared with staff through regular meetings to ensure they understood the responsibilities of their roles.

The service had an effective system and process to assess and monitor the quality of the care people received. Action was taken by the provider to drive improvements based on their monitoring of the service.

The service worked effectively with health and social care professionals and commissioners.

Oakleigh

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 23 February 2018 and was unannounced. An inspection manager, two inspectors and an expert by experience inspected the service. 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 we looked at all the information we held about the service. This information included the statutory notifications that the service sent to the Care Quality Commission. A notification is information about important events that the service is required to send us by law. The provider had 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 contacted health and social care professionals involved in people's support, and the local authority safeguarding team for their feedback about the service. We used this information to help inform our inspection planning.

During the inspection we spoke with six people and 11 relatives, nine members of staff, the deputy manager, the manager, the regional manager and the director of care. We also spent time observing the support provided to people in communal areas, during meal times, and medication round.

We looked at 11 people's care records and 12 staff records. We also looked at records related to the management of the service such as the quality audits, administration of medicines, accidents and incidents reports, Deprivation of Liberty Safeguards (DoLS) authorisations, health and safety records, and the provider's policies and procedures.

Good

Is the service safe?

Our findings

At the last inspection on 29 November 2016 we found that the provider had not always safeguarded people by taking the appropriate action and notifying appropriate bodies such as the local safeguarding team without delay. At this inspection we found the service had made improvements.

The service had a policy and procedure for safeguarding adults from abuse. The manager and staff understood what abuse was, the types of abuse, and the signs to look for. Staff knew what to do if they suspected abuse. This included reporting their concerns to the manager, the local authority safeguarding team, and the Care Quality Commission (CQC) where necessary. Staff we spoke with told us they completed safeguarding training. The training records we looked at confirmed this. Staff knew the procedure for whistle-blowing procedure and said they would use it if they needed to. The service maintained records of safeguarding alerts and monitored their progress to enable learning from the outcomes when known. The manager implemented performance improvement plans for staff to make sure they used incidents as an opportunity for learning. The service worked in cooperation with the local authority, in relation to safeguarding investigations and they notified the CQC of these as they were required to do. The local authority safeguarding team confirmed that they do not have any current ongoing safeguarding enquiries.

At the last inspection on 29 November 2016, we found people were not always protected from unsafe care or treatment. Following that inspection the provider sent us an action plan showing how they planned to make improvements.

At this inspection we found the service had made improvements. One person told us, "Yes, I think this place is very secure." Another person said "Oh, goodness, I feel safe." A third person commented, "I do feel safe. I have no reason not to feel safe". One relative said "My [loved one] is much safer than if my [loved one] was at home. Staff really keeps an eye out." Another relative commented "I am sure my [loved one] is safe". We observed staff kept a close, but discreet, eye on individual people who posed risks to themselves as they moved around the home.

Staff completed risk assessments for every person who used the service. These included manual handling risks, falls, eating and drinking, pressure sore prevention and wound care. The risk assessments we reviewed, all were up to date with detailed guidance for staff to reduce risks. For example, where the risk of pressure sores was identified, the risk management plan addressed the use of correct equipment and support needed for preventing pressure ulcers. Staff monitored people's skin regularly and records we saw confirmed this. In another example, where people had been identified as being at risk from choking staff sought advice from the Speech and Language Therapy(SALT) where a person had been identified as having swallowing difficulties. A risk management plan had been put in place which identified the type of food and the level of support people needed to reduce the level of risk. We observed during the lunch time that people were getting the correct type of diet suitable to reduce risk to them. Records further confirmed that staff followed the prescribed guidance. In a third example, where a person was identified with a risk of falls, their risk management plan and correct equipment was put in place. This person told us, "Staff are always about if you are stuck."

The service had a system to manage accidents and incidents to reduce them happening again. Staff completed accidents and incidents records. These included actions staff took to respond and minimise future risks, and who they notified, such as a relative or healthcare professional. The manager and the deputy manager saw each incident record and monitored them. Records we looked at showed examples of changes made after incidents occurred. For example, following an incident of fall the person was referred to the falls clinic and another person had a sensor mat introduced as a result of falls. In another example, one person was referred to their GP for reviewing their medicines as this was impacting on their mobility. We noted that their care plan had subsequently been updated to include further guidance for staff on how best to support them, and records showed that this had been discussed with staff during staff meeting. The service had a process for analysing accidents and incidents and identifying if there were any trends. For example, the service had identified that falls were happening in people's bedrooms. This was tracked and managed by reviewing risk assessments and management plans, and having the relevant equipment in people's bedroom.

Staff administered prescribed medicine to people safely and in a timely manner. One person told us, "Yes, they [staff] always give me my medicines on time". One relative said "I am sure my [loved one] is getting the right medicine on time". Staff checked medicines against the MAR sheet, ensured that people were positioned correctly and comfortably before giving them medicines. The medicines trolley was locked at all times. The service trained and assessed the competency of staff authorised to administer medicines. The Medicines Administration Records (MAR) were up to date and the medicine administered was clearly recorded. The service had PRN (as required) medicine protocols in place for any medicines that people had been prescribed but did not need routinely. The protocols gave information about when the medicines should be given. A monthly medicines audit was carried out by the manager and the areas if improvement identified were put into an action plan. Improvements made included discussion at staff meeting, updating medicines management plan, and fridge temperatures are recorded twice a day, we saw all the actions identified were completed.

There were enough staff on duty to help support people safely. The manager carried out a regular review of people's needed in order to determine staffing levels which met people's needs. Records showed that staffing levels were consistently maintained to meet the assessed needs of the people. The manager told us if they needed extra support to help people, they arranged additional staff cover by using staff rota or the agency. Staff rotas we saw confirmed this.

The service had a call bell system for people to use when they required support. People told us and we saw that staff were quick to respond to their room call-buttons. One person said "Oh yes, they [staff] are here in a flash". Another person commented, "As soon as I ring my bell, they are here". One relative told us, whenever they visited their family member had their call bell (if the relative was in their room) and staff responded quickly when their relative used it.

The service carried out comprehensive background checks of staff before they started work. These checks included qualifications and experience, employment history and any gaps in employment, references, criminal records checks, health declaration, and proof of identification. This ensured staff who worked with people were suitable to do so.

The service had arrangements to deal with emergencies. The service carried out regular fire drills and records we saw confirmed this. Staff completed personal emergency evacuation plans (PEEP) for every person who used the service. These included contact numbers for emergency services and provided advice for staff on what to do in a range of possible emergency situations. Staff received first aid and fire awareness training so that they could support people safely in an emergency.

Staff kept the premises clean and safe. They were aware of the provider's infection control procedures. Bedrooms and communal areas were kept clean and tidy. We observed staff using personal protective equipment such as gloves, and aprons to prevent the spread of infection. Staff and external agencies, where necessary, carried out safety checks for environmental and equipment hazards such as hoists, and safety of gas appliances.

Good

Is the service effective?

Our findings

People and their relatives told us they were satisfied with the way staff looked after them, and that staff were knowledgeable about their roles. One person told us, "Yes, they [staff] understand my needs very well." Another person said, "They [staff] are very good. They help me to get in and out of bed". One relative commented, "I believe they [staff] understand my [loved one's] care needs". Another relative said "My [loved one's] care needs are well understood by staff. The staff seems to be well trained".

The provider trained staff to support people and meet their needs. Staff told us they completed induction training, when they started work. Staff told us they had completed mandatory training identified by the provider. The mandatory training covered areas from basic life support, food safety, health and safety, infection control, safeguarding vulnerable adults to moving and handling and the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff told us the training programmes enabled them to deliver the care and support people needed. The service provided refresher training to staff as and when they needed. Staff training records we saw confirmed this.

Records showed the provider supported staff through quarterly supervision and yearly appraisal. They included discussions about staff members' wellbeing and sickness absence, their roles and responsibilities, and their training and development plans. Staff told us they felt supported and were able to approach the manager, at any time for support.

Staff carried out a pre-admission assessment of each person to determine the level of support they required, which involved feedback from relatives, where appropriate. This information was used as the basis for developing personalised care plans to meet their individual needs.

The Mental Capacity Act 2005 (MCA) provides 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. The registered manager knew the conditions under which an authorisation may be required to deprive a person of their liberty in the best interests under DoLS. Records showed that appropriate applications had been made, and authorisations granted by the relevant 'Supervisory Body' to ensure people's freedoms were not unduly restricted.

Records showed that people's mental capacity had been assessed relating to specific decisions about the

support they received where staff suspected they may not have capacity to make the decision for themselves. Assessments had been completed in accordance with the requirements of the MCA. Where people had been assessed as lacking capacity we saw that the relevant decision had been made in their best interests, with the involvement of staff, relatives and/or healthcare professionals, where appropriate. For example, about their specific decisions such as the use of bed rails.

Staff asked for people's consent, where they had the capacity to consent to their care. One person told us, "They [staff] are very good. They won't let me go anywhere alone. They also ask me for my consent." Records were clear on people's choices and preferences about their care provision and how staff sought their consent before giving them care in relation to giving them a wash, shower or personal care. Staff we spoke with understood the importance of gaining people's consent before they supported them.

Staff assessed people's nutritional needs and supported them to have a balanced diet. People and their relatives told us they had enough to eat and drink. One person told us, "The food is very good. I have never had such good food." Another person said, "The food is wonderful". One relative commented, "My [loved one] eats very well." Staff recorded people's dietary needs in their care plan and shared this information with kitchen staff to ensure people received the right kind of diet in line with their preferences and needs. For example, we saw information available to kitchen staff on which people needed soft or fortified diets.

The service protected people from the risk of malnutrition and dehydration. Staff completed nutritional assessments for each person and monitored their weights as required. We saw action had been taken where risks associated with nutrition had been identified. For example, where people were at risk of malnutrition, records showed that staff sought advice from a dietician and completed food and fluid charts to monitor people's intake. We saw during the inspection that staff ensured people were kept hydrated. Drinks and snacks were available and offered to people throughout the day. People received appropriate support to eat and drink. Interactions between people and staff during a lunchtime meal were positive and the atmosphere was relaxed and not rushed. We observed staff providing support to people who needed help to eat and drink. They had meaningful conversation with people, and helped those who took their time and encouraged them to finish their meal.

Staff supported people to access healthcare services. One relative told us, "My [loved one] is a lot calmer, far less agitated than before my [loved one] went into the Home". Another relative said "They [staff] were very good at nursing my [loved one] back to health after a stay in hospital." The service had strong links and worked across with local healthcare professionals including a GP surgery, district nurses, Speech and Language Team (SALT) and dietician. We saw the contact details of external healthcare professionals in every person's care record. Staff completed health action plans for everyone who used the service and monitored their healthcare appointments. The staff attended healthcare appointments with people to support them where needed.

The service met people's needs by suitable adaptation and design of the premises. Staff told us that they had brightened up the décor of the premises following consultations with people. One relative commented "The visuals are great". Many of the new decorations had been chosen by people living in the unit concerned. Doors to people's rooms were in bold colours to help people identify their rooms; each one had a memory box outside as well to further help people find their rooms. There were door guards on all the bedrooms which automatically released in the event of fire. People's bedrooms were personalised and were individual to each person. Some people had bought personalised items from their previous home which had been used to make their rooms familiar and comfortable. One person had a picture of a bearded dragon on it which was obviously something personal to them. We observed people moving freely about the home. Access to the building was controlled to help ensure people's safety.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and treated them with respect. One person told us, "They [staff] are very kind and caring. I regularly get one on one attention." Another person said, "The staff here are absolutely wonderful and do a fantastic job". A relative commented "My [loved one] is very happy here. We think staff are nice and friendly. This has been a very positive experience. My [loved one] tells me she is very happy". Another relative said "My [loved one] is always having a laugh and a joke with the staff. They definitely treat my [loved one] with kindness and compassion."

We observed staff communicating with people in a caring and compassionate manner throughout the time of our inspection. Staff took time to talk to people on a one to one basis, talking softly and in a dignified manner. For example, when a person was distressed and very anxious about their family, Staff pro-actively engaged with them, using touch as a form of reassurance, by holding people's hands, which was positively received.

Staff involved people or their relatives in the assessment, planning and review of their care. Staff completed care plans for every person, which described the person's likes, dislikes, life stories, career history, their interests and hobbies, family, and friends. Staff told us this background knowledge of the person was useful to them when interacting with people who used the service. Staff respected people's choices and preferences. For example, staff respected people's decision around where to spend their time; in their own room, lounge, and walk about in the home. One relative said "My [loved one] says it is very nice here."

People and their relatives told us staff treated them with dignity, and that their privacy was respected. One relative told us, "The staff show great respect for my [loved one]." We saw staff knocked on people's bedrooms before entering people's rooms and they kept people's information confidential. We noticed people's bedroom doors were closed when staff delivered personal care. People were well presented and we saw examples of staff helping them to adjust clothing to maintain their dignity. Records showed staff received training in maintaining people's privacy and dignity.

Good

Is the service responsive?

Our findings

At the last inspection on 29 November 2016 we found people were not supported to be involved in meaningful activities to meet their individual needs. At this inspection we found the service had made improvements. One person told us "Yes, they [staff] respond to my needs very well. They always do their best." A relative said "The staff always encourage my [loved one] to get involved in the activities". Another relative commented, "The service seems to be very well organised. They [staff] are always doing activities."

Staff recognised people's need for stimulation and supported people to follow their interests, and take part in activities. The service employed an activities coordinator who arranged activities on a daily basis. The provider carried out a people's choice of activity survey and developed activities specific to each unit, and if a particular person wishes to participate in an activity in another unit, this was facilitated, if possible. Each unit has a morning and afternoon activity. We observed people responded positively to these activities. We noted that staff had recently celebrated Valentine's Day with people and red paper hearts were festooned around the corridors. Occasionally, the provider brings in outside entertainers for example, singers and magicians.

Staff had developed care plans for people based upon their assessed needs. These contained information about their personal life and social history, their health and social care needs, allergies, family and friends, and contact details of health and social care professionals. They also included dependency assessments which identified the level of support people needed in areas including identifying the things they could manage to do by themselves. Staff told us how they promoted independence by encouraging people to do what they could .One staff member said "I give them the flannel and say, have a go at this yourself and I'll help you if I needed to." Care plans were reviewed on a regular basis and reflective of people's current needs.

Staff completed daily care records to show what support and care they provided to each person. They also completed a diary which listed the specific tasks for the day such as who required a weight check, fluid and food intake monitoring, repositioning of people in the bed and skin care management. The service used a communication log to record key events such as changes to health and healthcare appointments for people. Relatives told us there were no restrictions on visitor times and that all were made welcome. We saw staff addressed visitors in a friendly manner, and they were made to feel welcome and comfortable.

Staff completed Do Not Attempt Cardiopulmonary Resuscitation (DNAR) forms with the engagement of the person concerned and their relative where necessary. Their healthcare professional signed the forms too. Records showed people's end-of-life preferences had been discussed with them, and care plans developed to ensure their preferences in this area were met.

People's care plans included details about their ethnicity, preferred faith and culture. The service was non-discriminatory and that staff would always seek to support people with any needs they had with regards to their disability, race, religion, sexual orientation or gender. Staff showed an understanding of equality and diversity. Staff supported with their spiritual needs where requested. For example, the provider arranged

activities for people, in order to meet their spiritual needs.

People and their relatives told us they knew how to complain and would do so if necessary. They told us that they were confident that any concerns would be taken seriously. One person told us "Yes, they [staff] respond to my needs very well. They always do their best." A relative said, "Yes, if we have problems, they address them, and they get sorted". The provider had a clear policy and procedure for managing complaints and we saw there was a copy of the provider's complaints policy in the front lobby, and notices about how to register concerns with local social services and Care Quality Commission were made available to people. The service had maintained a complaints log, which showed when concerns had been raised senior staff had investigated and responded in a timely manner and where necessary meetings were held with the complainant to resolve the concerns. These were about general care issues, and missing personal belongings. The manager told us that there had been no reoccurrence of these issues following their timely resolution. Records we saw further confirmed this view.

Good

Is the service well-led?

Our findings

At the last inspection on 29 November 2016 we found the service did not assess, monitor or mitigate risks to people by regularly assessing and monitoring the quality of the services provided. At this inspection we found improvements had been made.

The service had an effective system and process to assess and monitor the quality of the care people received. This included checks and audits covering areas such as accidents and incidents, staff observations, medicines audits, health and safety checks, pressure care and wound management, house maintenance, care planning and risk assessments, food and nutrition, and infection control. As a result of these checks and audits the provider made improvements, for example, care plans and risk management plans were up to date, staff refresher courses had been arranged, fire drills were held regularly and the premises had been redecorated where required and consultations were held with external agencies.

The service did not have a registered manager in post. The previous registered manager left the service in January 2018. The provider had appointed a new manager to run the home. The new manager's application to the CQC to become the registered manager was being processed. 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.

The manager had detailed knowledge about each person living at the home, and made sure they kept staff updated about any changes to people's needs. We saw the manager interacted with staff in a positive and supportive manner. Staff described the leadership at the service positively. Staff comments included; the manager is "brilliant", "flexible", "if you've got an issue they will sort it out." "The manager is always around and is easy to talk with", "The manager listens and takes actions, their finger is on the pulse and is not afraid to get on the floor and help out."

People and their relatives commented positively about staff and the manager. One person told us, "Yes, this place is well managed. Overall it is very good." Another person said "It's [the service] really well run." One relative told us, "Yes, the management is good. There is always someone to talk to if we need to." Another relative said, "This home is very well run. It's clean. They [staff] look after my [loved one] very well, excellent service. They are always on the ball". A number of relatives spoke very positively about the manager. For example, one relative commented "The manager is doing a first rate job."

The service had a positive culture, where people and staff told us they felt the provider cared about their opinions and included them in decisions. People completed satisfaction surveys about service improvements. The results of the satisfaction survey carried out in 2016, showed that the quality of service had significantly improved from what it was in 2015 to 2016. For example, staff understood people as individual had improved from 92% to 100%, staff having time to talk to people had improved from 69% to 97%, and people's access to doctors, nurses and dentist had improved from 92% to 100%.

The manager encouraged and empowered people and their relatives to be involved in service improvements through periodic meetings. Areas discussed at these meeting included menus, activities, care plan reviews and redecoration of the premises. As a result of these meetings the provider made improvements. We observed that people, relatives and staff were comfortable approaching the manager and their conversations were friendly and open.

The manager held meetings with staff where staff shared learning and good practice so they understood what was expected of them at all levels. Records of staff meetings showed that areas discussed had included details of any changes in people's needs, guidance to staff about the day to day management of the service, discussions about co-ordinating with health and social care professionals. Staff also discussed the changes to people's needs during the daily shift handover meeting to ensure continuity of care.

Care records we saw showed that the service worked effectively with health and social care professionals and commissioners. Their feedback also stated that the standards and quality of care delivered by the service to people had improved and that they were happy with the new manager and staff at the service.