Care UK Community Partnerships Ltd

# Hadrian House

## Inspection report

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Date of inspection visit:
05 December 2016
06 December 2016

Date of publication:
14 February 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 5 and 6 December 2016 was unannounced. We had last inspected Hadrian House in November 2015 and found breaches of legal requirements in relation to staffing and meeting people's nutritional needs. At this inspection we judged the necessary improvements to meet legal requirements had been implemented and we have changed our rating of the service.

Hadrian House provides personal care for up to 63 older people, including people with dementia related conditions. Nursing care is not provided at the home. At the time of our inspection there were 54 people living at the home.

The service had a 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 service is run.

The service had established systems for preventing abuse and responding to any safeguarding concerns. Risks to people's safety and welfare were assessed and appropriately managed. People and their relatives told us they felt care was provided safely.

The home was clean, comfortable and free from hazards. Safety checks were conducted and the accommodation was well-maintained. There were plans to further enhance parts of the building, with an emphasis on creating a more dementia-friendly environment.

New staff were checked and vetted to ensure their suitability in working with vulnerable people. Sufficient staff were employed to provide continuity of care and we found that staffing was now much better organised. The staff team received regular training and supervision that enabled them to carry out their roles effectively.

People were supported to receive their medicines as prescribed. The service worked in a co-ordinated way with external professionals to support people's health and well-being. Improvements had been made around mealtime arrangements, the food provided and the help that people required with eating and drinking.

The service worked within the principles of mental capacity law to make sure people's rights were protected. Relatives were involved in decision-making and, where needed, independent advocacy was arranged. People and their representatives were given information and support and were encouraged to be involved in care planning.

Staff understood the needs and preferences of the people they cared for. We observed they were kind, caring and had a good rapport with people and their families. People confirmed that staff respected their

privacy and dignity.

Personalised care plans had been devised that guided staff on meeting people's identified needs. Social stimulation had greatly improved and people now had access to a range of activities and events.

Measures were in place for obtaining people's opinions about the service and feedback was acted on. Any complaints made were properly investigated and responded to.

Staff received appropriate leadership and support. Structured methods were used to monitor the service's standards. The registered manager believed in working inclusively and was open to people, their families and staff influencing the quality of the service.

## 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.

The deployment of staff had been improved and people were provided with a consistent service.

Risks to personal safety were reduced and steps were taken to safeguard people from avoidable harm.

There were appropriate arrangements for managing people's medicines.

### Is the service effective?

Good

The service was effective.

Improvements had been made to menus, mealtimes and the support people required to meet their nutritional needs.

Staff were suitably trained and supervised to enable them to fulfil their roles and provide effective care.

Formal processes were followed when people were unable to give consent to their care and treatment.

People were assisted to maintain their health and accessed a range of health care professionals.

### Is the service caring?

Good

The service was caring.

Supportive relationships had been formed between the staff, the people they cared for and their relatives.

Staff were kind, showed compassion and respected people's privacy and dignity.

People and their families were supported to express their views and make choices about their care.

### Is the service responsive?

Good

The service was responsive.

A proactive approach was now taken to providing stimulating social activities.

People had individualised care plans for meeting their assessed needs.

Any complaints made about the service were taken seriously and acted upon.

## Is the service well-led?

Good

The service was well-led.

The management provided leadership and support to the staff team.

There was an inclusive culture and good governance of the service.

Effective systems were in place to monitor quality and improve standards.

# Hadrian House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 checked if improvements to meet legal requirements had been made following our last inspection in November 2015.

The inspection took place on 5 and 6 December 2016 and was unannounced. The inspection team consisted of one adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted the local authority commissioners and safeguarding team.

During the inspection we talked with 10 people living at the home and nine relatives. We spoke with the registered manager, the regional director, the deputy manager, with 12 care and ancillary staff and a visiting professional. We observed how staff interacted with and supported people, including during a mealtime. We looked at four people's care records, medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

# Is the service safe?

## Our findings

People told us they felt secure living at the home and no-one expressed any concerns about how they were treated. One person told us, "The staff are nice here and I feel well looked after." Another person said, "I feel safe here." Relatives told us they felt their family members were safely cared for. Their comments included, "It is very safe and secure" and "I visit frequently and have never seen or heard anything untoward. There is always enough staff and they never rush anyone." We heard another relative passing on their thanks to the registered manager for the care and vigilance shown by staff towards their family member who was prone to falls.

The service had established systems for safeguarding people against the risk of abuse and for responding to any alleged abuse. Staff received annual safeguarding training and had access to safeguarding and whistle-blowing (exposing poor practice) policies. A policy had been introduced on the 'duty of candour' and disseminated to the staff team. This duty requires registered people to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong. The staff we talked with understood their roles in reporting any concerns or suspicions of abuse.

A high volume of safeguarding notifications had been submitted by the service to the Care Quality Commission (CQC) over the past year. We had further discussion with the management about thresholds and circumstances which did not require being notified. Incidents reported often involved potentially harmful behaviour between people with dementia-related conditions. Actions taken in response had included closer observation and supervision, working in conjunction with a specialist behaviour team. The registered manager reported there was capacity to increase staffing, if needed to ensure people's needs were safely met. The service had also raised safeguarding alerts in respect of other health and social care services where it was felt people living at the home had been put at risk of harm.

One whistleblowing allegation had been made to the CQC in the past year that we had referred to the provider. This was thoroughly investigated by the regional manager, who had also reinforced the use of the provider's whistleblowing procedure with staff.

Cash was held on behalf of some people living at the home for safekeeping. All transactions were recorded and receipts were obtained for purchases, though we noted entries were not always countersigned by a witness. Audits were conducted to check that people's money was being safely managed.

A range of pre-employment checks were conducted before new staff started working at the home. These included seeking proof of identity, a criminal records check, two references with one from the last employer, and carrying out interviews to establish suitability. Where candidates had submitted a curriculum vitae, this had been followed up by completion of an application form to ensure sufficient background information was obtained. A process was followed to assess risks and authorise the employment of any staff member with a criminal record.

We checked the action taken in response to the breach in legal requirements about staffing that we had

found at our last inspection. This had related to the numbers and deployment of staff impacting on the service people received at peak times and the smooth running of the home. People were now being accommodated over three of the four floors of the home. Care staffing levels continued to be determined according to occupancy and a monthly analysis of people's dependency. At the time of our visit, there were between nine and eleven care staff, including seniors, across the day and six staff at night. Team leaders lead shifts and the registered manager's hours and a proportion of the deputy's hours were supernumerary to the staffing levels. Some new care staff were being recruited and the home was using bank staff and occasionally external agency staff to provide cover for vacancies. An established on-call system was operated that enabled staff to contact the management for advice or support outside of office hours.

We found there was now a full complement of ancillary staff and a new chef and maintenance person had been appointed. A full-time activities co-ordinator and an administrator had also taken up post. More structured methods of planning and monitoring rosters, providing cover for absence and assigning tasks to staff were being used. Improvements had also been made to care practices, such as making sure medicines rounds were not carried out during mealtimes. Our observations confirmed staffing was better organised, staff were visible on each of the floors and people received timely support. We concluded that the provider was no longer in breach of the relevant regulation.

Care records showed that risks to people's personal safety had been assessed and ways of reducing risks were documented. The measures guided staff on supporting people with aspects of their care including safe moving and handling, use of aids and equipment, prevention of falls and maintaining skin integrity. Any accidents and incidents were appropriately reported and followed up. The registered manager analysed the events monthly to check for any patterns and review the actions taken to prevent reoccurrence.

During our visits we did not see any issues or hazards which could compromise people's safety. Staff followed safe working practices, for instance when supporting people with mobility difficulties. A person who was unwell was spending the day in bed and looked comfortable and well cared for. We saw that the environment was clean, suitably equipped to meet people's needs and well-maintained. Domestic staff worked to cleaning schedules to ensure all areas of the home were cleaned and kept hygienic. A relative told us, "The domestics do a good job." Supplies of disposable gloves and aprons were provided for staff use. Daily checks had also been introduced where care staff were allocated to check people's bedrooms, including bed-linen, clothing storage and that sufficient toiletries were available.

The maintenance person took responsibility for completing a range of regular safety checks. This included the checks of the call system, fire safety, temperatures, window restrictors, internal and external maintenance and any repairs needed. Established arrangements were made with contractors and servicing agreements were in place for the facilities and equipment in the home. There was a business continuity plan that addressed how the service would be operated in emergency circumstances. Each person also had an individual plan detailing the assistance they would require if the home needed to be evacuated.

The service had made suitable arrangements for managing medicines. Medicines were ordered on a monthly basis, delivered by the supplying pharmacy, and stored securely in the home. Team leaders and senior staff in the main took responsibility for administering medicines. They were provided with annual training in the safe handling of medicines and comprehensive assessments to check their competency were also undertaken annually.

People told us they received their medicines at the times they needed them. One person felt they were taking too many medicines and wasn't sure what they were all for. The registered manager assured us they would give an explanation to the person and check if they wanted their doctor to review their medicines

regime. We saw that adjustments had been made to some people's medicines following consultation with their doctors. This included liquid medicines being prescribed and changes to timings of medicines to fit in with people's routines.

Personalised medicines care plans had been devised and each person had a profile that included their preferences for taking medicines. Where applicable, protocols had been drawn up for medicines prescribed to be taken 'as required'. Any allergies and information about the person self-managing certain medicines, for example inhalers, were specified. No medicines were given covertly (disguised in food or drinks).

We saw that medicine administration records were appropriately recorded and no gaps were evident. Staff used codes to record the reasons why any medicines had not been given. Separate records and body maps were in place for patches and topical medicines applied to the skin. Some discrepancies with these records had been highlighted during the latest monthly medicines audit and were being acted upon.

Good

# Is the service effective?

## Our findings

People told us they felt their needs were met by staff who knew what they were doing. One person commented, "If I need any help they are very good and always know what I need or how I like things." Another person said, "I'm a very satisfied customer." Relatives were complimentary about the effectiveness of the care provided. Their comments included, "My mother has thrived here" and "They (staff) pay attention to detail." Another relative, whose family member was in hospital, told us, "She was happy and well cared for. The care here was better."

New staff completed the Care Certificate, a standardised approach to training for new staff working in health and social care, to prepare them for their roles. Thereafter all staff received on-going training that was a mix of classroom-based and e-learning courses. An overview of all training undertaken by the staff team was maintained. This indicated the majority of staff had completed and, where necessary, refreshed mandatory training such as fire safety, moving and handling and infection control.

Other topics provided included training in caring for people with dementia, diabetes awareness, and care planning. The deputy manager had completed a course on pressure ulcer prevention and was due to provide a briefing to cascade best practice to the care staff. Staff could study for nationally recognised diplomas in care and most of the care staff had achieved these qualifications. Training was monitored by the registered manager and regional director to check that staff kept their knowledge updated.

The service aimed to provide staff with six supervisions sessions each year. This process was being adjusted to directly link into appraisals with reviews throughout the year. A forward planned schedule was in place that indicated due dates for supervisions and when sessions had been completed. This confirmed that staff were given regular opportunities to discuss their performance and any training or support they required. The staff we talked with were confident in their roles and happy with the training and support they received. They told us, "We receive regular training by Care UK. I feel we're provided with training that enables us to do our job and meet people's needs". Another staff member said, "I'm the trainer for moving and handling and for new staff when they start here. I'm also one of the risk assessment points of contact at the home. We all receive the right training to be able to meet people's needs and requirements."

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 found the service worked within the principles of the MCA and trained staff to understand the implications for their practice. Best interest decisions relating to specific areas of care had been made following completion of mental capacity assessments. The service had also established where people had

appointed representatives with power of attorney, to enable them to be involved in decisions about the person's care. In practice, we observed that staff were mindful of seeking permission before providing support, asking for example, "Is it alright if I.." and "Would you like me to help you with…" Many of the people living the home had DoLS in place. There was a well-organised system for making applications, keeping checks on authorisations and expiry dates, and guidance for staff to follow.

We checked the action taken in response to the breach in legal requirements about meeting people's nutritional needs that we had found at our last inspection. Systems continued to be in place for assessing and care planning people's nutritional needs and risks. Advice was sought when needed from dietitians and weights and food/fluid intake was monitored. Night duty staff now totalled fluids over the 24 hour period to check if target amounts had been met.

A new chef had been appointed and the home had been given a five star food hygiene rating by the local authority. Menus were adapted seasonally and people's preferences were taken into account. The chef attended workshops at a local university that kept them updated with catering techniques and ideas for new dishes. They reported there was good communication with staff and information about people's specific dietary requirements was held in the kitchen. Staff were aware of individual dietary needs, telling us, for example, about a person whose appetite fluctuated and nutritional drinks they had to supplement their diet.

People we talked with gave positive feedback about the food provided. Comments included, "The food is lovely" and "The chef is marvellous. He'll make you anything you want, within reason." A relative told us, "The meals always look nice and my mother enjoys them." Another relative described how staff had spent considerable time encouraging and supporting their family member to take drinks. Two people said they would like to be offered cold drinks as options when tea and coffee were served during the drinks rounds. We noted jugs of cold drinks were made available around the home and that biscuits, pastries and cakes were served between meals.

We observed mealtimes were now more organised. All care staff concentrated on helping serve the meal and assisting people with eating and drinking. Specialist crockery was used to support people in eating independently. Thickened drinks and food of different textures were provided for people who had difficulties with swallowing. The menu was followed, choices were offered, and there were no undue delays in people being given food and drinks. We concluded that the provider was no longer in breach of the relevant regulation.

Appropriate arrangements were made for people to access a range of health care professionals to help meet their physical and mental health needs. Doctors from a local practice visited the home weekly to review their patients. There was regular input from the district nurses, a specialist behaviour team and an older person's specialist nurse. Information was gathered about each person's medical history and all contact with external professionals was documented. Where applicable, emergency health care plans and decisions about resuscitation were in place to ensure staff were guided about people's wishes for their future care and treatment.

During our visit we talked with a senior worker who was going to a local hospital to reassess a person who was due to return to the home. They told us this was always carried out whenever the home was informed about discharge, to review if the service would still be able to meet the person's needs.

A visiting health care professional told us they received timely referrals from the service. They described staff as having a good understanding of people's needs and said they often pre-empted when an underlying

physical condition might be affecting a person's mental health or behaviour. They told us staff acted on their advice, contacted them between visits and praised the way they had worked with a person who had complex needs.

Good

# Is the service caring?

## Our findings

People living at the home and their relatives spoke positively about their relationships with staff and their caring nature. They told us, "The staff are just amazing. [Name] is very happy and is always smiling. We often find the staff in their room just having a chat and this makes us very happy", "The staff are excellent here", "They have real compassion for the residents", "There's a lovely atmosphere. All the staff are approachable. You can ask them anything and they always listen to what you have to say" and "I'm very happy. My mother gets good care." A visiting professional said they found staff to be attentive and felt they demonstrated genuine warmth towards the people they cared for.

We noted an improved level of information about the service was now displayed for people and their visitors to refer to. This included the guide to the service, dates of resident and relative meetings, leaflets about care standards and methods of providing feedback about the service. There were noticeboards dedicated to information about the menus, social activities, events and outings. The registered manager told us they were looking at having a safeguarding noticeboard with information that would raise people's awareness of their rights and how to report any concerns. Additional information about forthcoming festive events was also displayed around the home.

Most relatives confirmed they were consulted and contributed to decisions about their family member's care. One relative said, "I've been fully involved in the care planning." Some people received support from Independent Mental Capacity Advocates. Care plans detailed where Deprivation of Liberty Safeguards were in place and who needed to be involved in decisions made on the person's behalf.

Methods were in place for people and their relatives to give their views about the service in general, including meetings and completing surveys. We saw a relative had given high praise about the care that staff provided in a survey, commenting "I know how they care for [name]. They get down on their knees to his level and chat with him. They hug the residents and make them feel special, needed and wanted. They really care for them." We met this relative who told us, "The home has exceeded my expectations." The survey findings and the management's response were on display, informing people about how their comments had influenced the service.

The staff we talked with knew people well, understood their diverse needs and were able to give clear accounts of the ways individuals preferred to be supported. Routines were flexible and people made everyday choices such as what time they got up and where they spent their time. Choices of food and drinks were offered and people could choose where they took their meals. Some people said they preferred to have their meals in their bedrooms and this was accommodated.

People told us they felt respected and that their privacy and dignity were promoted. They gave examples of staff always asking permission before entering their rooms or giving support and ensuring doors and curtains were closed when they were being assisted with personal care. We observed this in practice when a staff member knocked on a person's door and politely asked if they could come in. The person initially said to wait and they did so until being told they could enter. Door hangers were also used which informed

others when a room was occupied by a person being assisted with personal care and was not to be disturbed.

We observed lots of engagement and a good rapport between staff and people living at the home. Staff treated people respectfully. For example, we saw two care staff interacting with a person who was unable to communicate verbally. They talked with the person, saying, "It's lunchtime, are you ready to go for lunch?" and "Is it okay if we help you up and into your chair?" The staff then gently supported them into their wheelchair, explaining what they were doing, and continued to chat to the person as they made their way to the dining room.

In another instance we observed the deputy manager patiently listening to a person as they talked about their past experiences. They acknowledged the person's feelings and showed interest in their memories of important events that had happened during their lifetime.

The deputy manager was a 'dementia champion' and led on promoting best practice and delivering training to staff. The regional director told us the provider's dementia strategy was in the process of being implemented in the home. This recognised the importance of having information about each person's individuality and work was underway putting together life story books, with input from families. More emphasis had been placed on enhancing social stimulation and the activities co-ordinator was undertaking further training in activities which were beneficial for people with dementia-related conditions.

As part of the dementia strategy, mealtimes were being monitored to check that people had a dignified dining experience. Pictorial menus were planned to be introduced to help people make choices. We gave feedback to the management on our mealtime observations to follow up. This included napkins not properly protecting people's clothing from spillages, condiments not always being available, and to review the use of weekly, as opposed to daily menus being displayed.

The management assured us that, as previously recommended, more efforts were being made to create a dementia-friendly environment. This included resources being made available from the beginning of 2017 for the provision of rummage/memory boxes and creating themed areas of interest in communal spaces.

Good

# Is the service responsive?

## Our findings

People and their relatives told us they felt the service was responsive to their needs. For example, one person said the registered manager had arranged for wireless internet in their bedroom to enable them to use their IPad. A relative commented, "The manager is absolutely great here. When my family member's sight worsened they found it very difficult to see where the toilet was in the bathroom as it was all white. The manager gave us a colour chart and suggested we chose a colour that would stand out to help and this was arranged and painted the next day. We were extremely happy with the results and grateful for this personal touch." Another relative said, "I've seen that the staff always respond quickly to situations and whenever anybody uses the call system." A visiting professional told us they found the service "flexible and accommodating".

Care records showed that information had been obtained about people's backgrounds and lifestyles. Each person had their needs and dependency level regularly assessed and personalised care plans were in place for meeting needs. The care plans addressed all aspects of personal care, maintaining safety, physical and mental health, medicines, communication and social needs. They were recorded in sufficient detail, specifying the person's routines during the day and at night, and the extent of support that staff needed to provide.

Care plans were evaluated, usually on a monthly basis and other records were adapted in response to changes. For instance, a staff member told us, "I always update the risk assessment when someone has had a fall." Six monthly reviews of care, involving the person and their representatives, had lapsed, however dates had been arranged to bring these meetings up to date.

Staff completed a range of care records that monitored each person's on-going welfare and accounted for the care provided. These included, for example, completing food and fluid charts and logging any behavioural incidents that had occurred. Handovers took place between shift changes, ensuring staff were kept informed about any changes in people's well-being.

At our last inspection we had made a recommendation about the provision of activities as these had been limited. The majority of people and their relatives told us this was an area that had significantly improved and praised the commitment of the activities co-ordinator. They told us, "There's a real buzz about the place now", "Every time I come in there is something going on" and "The activities person has really made a difference and is so enthusiastic. There's plenty to entertain the residents. One of the staff even comes in to play the guitar on their day off."

Other people's comments included, "There is adequate activities here. I tend to do my own thing and my family visit a lot and take me out" and "I really like the view from my room, I love to people watch." Another person explained they weren't able to do a great deal due to mobility difficulties. They said, "The activities manager always comes to get me and takes me to any of the activities I wish to join in with. He brings me back to my room as well. He is very nice and very good like that." One person told us they were generally happy sitting in their room but at times felt isolated and would like staff to pop in for a chat. A relative also

said there could be more going on at weekends.

During our visits we observed various activities were advertised and took place, including a choir practice session which many people participated in. The activities co-ordinator approached people in their rooms to ask if they wanted to join in the 'gentlemen's club' where the men got together to play dominoes, cards and have drinks and snacks. There was an activities room that was well-equipped with materials, a social budget was provided and we saw some relatives had brought in donations for tombola's and raffles to help with fundraising.

The activities co-ordinator told us they were supported in their efforts by the registered manager and received training appropriate to their role. They showed us how they planned activities each month and said they were doing more with smaller groups of people with support from other staff. New ideas had been introduced such as virtual reality reminiscence and 'timeslip', a means of using photographs to stimulate imagination and encourage conversation. The home had acquired two pet rabbits and had visits from another pet therapy service.

Good links had been forged with the community including coffee mornings, churches and activity sessions with the 'Memory Trust', a local organisation that promoted creative activities. A regular feature of these sessions was 'Feel Good Fridays', held at the venue or in the home, which relatives could also join in with. The activities co-ordinator told us this entailed crafts, games and other activities specially designed for people with cognitive impairments. Overall, we found there was now a much improved level of stimulation provided for people living at the home.

Relatives told us they were made to feel welcome when visiting, though some commented on having to wait at times to be let into the home, as the entry code was withheld for security reasons. Most relatives told us they felt able to raise any queries or concerns with the staff or management and were happy with the way these were handled. One relative commented, "They keep me well-informed and if anything happens they're straight on the phone. I've never had any complaints." Another said, "I'd speak to the manager if there was anything I was unhappy with and feel certain she'd deal with it."

Some relatives brought problems with the laundry and other matters to our attention which they felt had not been fully resolved. We relayed these to the registered manager who gave us explanations about historical issues and assurance of further communication with relatives.

The complaints procedure was made available to people and their representatives. Two complaints had been made in the last year which we saw were taken seriously and appropriately investigated. A number of compliments, in the form of letters and cards, had been also been received that gave thanks and praise for the service provided to people.

Good

# Is the service well-led?

## Our findings

The home had an experienced registered manager. They understood their registration requirements and ensured the Care Quality Commission (CQC) was kept notified of events or changes affecting the service.

Many of the people and relatives we talked with spoke highly of the registered manager and the way the home was run. Their comments included, "I am happy with the staff and the manager. I feel my relative is in a good place and that they do a great job running things here. The service is well-led and managed"; "The manager is very good and approachable. The home is well-run and I've often recommended and praised it to others" and "If I ever have a problem with anything I just speak to the manager and my problem is resolved pretty quickly. I feel the home is managed well." A visiting professional also told us, "The manager always has time for us to go over people's care."

The registered manager continued to be supported in their role by the deputy manager, a structure of senior staff and had regular visits and contact with the regional director. Team leaders and senior care workers were designated to lead shifts, supervising staff and the care provided to people on each unit. Revised handovers had been introduced with more detail and accountability, ensuring staff confirmed they had completed certain tasks.

There was good morale amongst the staff team, with many commenting to us about how they enjoyed their roles and derived satisfaction from their work. Staff described good leadership in the home and felt well supported. We saw that monthly staff meetings were held with corporate, employment and care items on the agenda. For example, at recent meetings there had been debate including about the provider's staff forum and surveys, health and safety, learning from a serious incident, training and adhering to policies and procedures. The minutes stated action points, included briefings on care-related topics and also provided links for staff to further reading.

The registered manager told us they aimed to work inclusively with people and their relatives, though found there was limited attendance at resident and relative meetings. They had written to relatives earlier in the year about the planned redecoration of one of the units and held a meeting with them to get their suggestions. The registered manager said they maintained an open door policy and often met with visitors informally or on request, at a time that was convenient for them. They were considering developing a newsletter to relay information about what was happening in the home and having holders for information in people's bedrooms. Satisfaction surveys had also been conducted and the findings were displayed in the home, set out in a 'you said, we did' format that explained the actions taken in response to comments.

We found there were systematic methods for assessing and monitoring the quality of the service. A new computer programme was now being used to keep checks on occupancy, rostering of staff, and to highlight issues in the daily running of the service to the registered manager for follow up or delegation. This was accessed by the regional director and clinical governance team, enabling them to be kept appraised of people's care and the operation of the service. The registered manager submitted monthly reports to the regional director, informing them about significant care related issues including safeguarding alerts,

hospital admissions, infections, incidence of pressure damage and, where applicable, actions taken in response.

Spot checks of staff performance and people's care, including during the night, continued to be routinely carried out. Various internal audits were conducted to review standards such as medicines arrangements, care plans and safety in the environment. An extensive quality review based on the CQC's five key questions had been completed. From this, and other audits, there was a 'live' service improvement plan which was monitored at least monthly to ensure any improvements needed were acted upon.

The management told us about their vision for the future of the service. Planned developments included assigning staff lead roles for different areas of care, supported by further training, further enhancing communication and working towards fully embedding the provider's 'dementia strategy' in the home.