Care Quality Commission

Caring Homes Healthcare Group Limited

Dormy House

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?	Requires Improvement
Is the service well-led?	Good

Overall summary

The inspection took place on 3 February and 10 February 2015 and was unannounced.

Dormy House is a care home with nursing which is registered to accommodate 88 older people, some of whom may require either nursing or specialist care associated with dementia. At the time of the inspection 63 people lived at Dormy House. The service is divided into three units. Surrey unit provides specialist dementia care, Dormy unit provides nursing care and Wentworth which provides mainly residential care.

At our last inspections in January 2014 and February 2014 we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the number of suitably qualified and skilled staff and medicine management. The provider sent us action plans telling us the improvements they were going to make, which would be completed by February 2014 and March 2014 respectively. At this inspection we found improvements had been made.

Summary of findings

The home is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of the inspection there was a registered manager. However, they had taken up another position in the company and were therefore unable to continue as the registered manager. The deputy manager was acting into the manager role and the provider confirmed that recruitment was underway to replace the registered manager as soon as possible.

There were systems in place to manage risks to people and staff were aware of how to keep people safe by reporting concerns promptly through procedures they understood well. The service's fire evacuation procedure did not contain any information relating to how people living in the service were to be supported in the event of a fire. However staff were knowledgeable about the evacuation procedure and regular fire drills were carried out.

Systems and processes were in place to recruit staff who were suitable to work in the service and to protect people against the risk of abuse. There were sufficient numbers of suitably trained and experienced staff to ensure people's needs were met.

People using the service told us they were happy. Relatives also said they were very happy with the support and care provided at the service. People and when appropriate their relatives confirmed they were fully involved in the planning and review of their or their family members care. Although care plans were focussed on the individual and recorded their personal preferences they did not always accurately reflect people's needs.

People told us communication with the service was good and they felt listened to. People and their relatives told us staff treated them with kindness and respect. However, records were not always completed promptly, therefore we could not be sure people who were unable to call for help were checked regularly.

People told us they received their medicines when required and we found the system in place to make sure people received their medicines safely had improved. People received their medicines from suitably trained, qualified and experienced staff.

People who could not make specific decisions for themselves had their legal rights protected. People's support plans showed that when decisions had been made about their care, where they lacked capacity, these had been made in the person's best interests. However we found one example of consent to care and treatment not being sought in line with legislation. After speaking with the acting manager and clinical lead nurse we were assured this was an isolated incident. By the second day of the inspection this had been addressed and decisions were recorded in line with legislation.

The provider was meeting their requirements of the Deprivation of Liberty Safeguards (DoLS). The DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. At the time of this inspection, four applications had been submitted and approved under DoLS for people's freedoms and liberties to be restricted. The acting manager had made a further two applications and told us they were going to review people in line with recent changes to DoLS. This would ensure people's freedoms were not restricted unnecessarily.

People received care and support from staff who had the appropriate skills and knowledge to care for them. New staff received induction, training and support from experienced members of staff. Staff felt supported by the acting manager and said they were listened to if they raised concerns.

The quality of the service was monitored regularly by the provider. Feedback was encouraged from people, visitors and stakeholders and used to improve and make changes to the service. Complaints were recorded, investigated and responded to in line with the provider's policy.

Summary of findings

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. There were no details regarding the supervision or evacuation of people living at the service in the fire evacuation procedure. However staff were knowledgeable about the procedure and regular fire drills were carried out.

Staffing levels were determined according to the needs of people who used the service. People received care from staff who were suitably trained and qualified to meet their needs.

Staff had received training on safeguarding procedures and understood the action to take if they suspected abuse. People received their medicines safely at the required times.

Is the service effective?

Good

The service was effective. People and their relatives were involved in making decisions about their care.

Where people did not have capacity to make decisions, support was sought from family members and healthcare professionals in line with legal requirements and safeguards.

People were offered choices of meals and drinks that met their dietary needs and when necessary people were supported to eat and drink.

Systems were in place that made sure people received timely support from appropriate health care professionals.

Is the service caring?

Good

The service was caring. People were sometimes referred to using inappropriate language. The acting manager was aware of this and was taking action to address it.

People told us their privacy and dignity were protected and staff treated them with kindness.

People told us they were encouraged to maintain independence. Staff knew people well and responded to their individual needs promptly.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans did not always accurately reflect people's needs and records were not always completed promptly. Therefore we could not be assured regular checks were carried out on people who were unable to call for help.

Summary of findings

People's views were listened to and acted upon. There was a system to manage complaints and people felt confident to make a complaint if necessary.

People's preferences were recorded and staff were provided with information to enable them to meet people's wishes.

People had things of interest to occupy them and a programme of activities was provided.

Is the service well-led?

Good

The service was well-led. Staff, relatives and professionals found the acting manager approachable and open.

People and their relatives were asked for their views on the service and they felt confident to approach the registered manager with concerns.

Thorough and effective processes were in place to monitor the quality of the service and audits identified improvements required.

Dormy 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out by two inspectors on 3 February 2015 and one inspector on 10 February 2015. The inspection was unannounced.

Before the inspection visit we looked at previous inspection reports and action plans the provider had sent us. We checked notifications we had received. Notifications are sent to the Care Quality Commission to inform us of events relating to the service.

During the inspection we spoke with six members of care staff, four registered nurses, a maintenance worker, an activity assistant, a healthcare professional, the clinical nurse lead and the acting manager. We observed people taking part in a variety of activities, observed a meal time activity on all units and attended the shift handover on Surrey unit. We reviewed nine people's care plans, six staff files, staff duty rotas and a selection of policies and procedures relating to the management of the service.

Good

Is the service safe?

Our findings

At an inspection of this service in January 2014 we found there was a risk that staffing levels were insufficient to safeguard the health, safety and welfare of people who use the service. We also found that systems designed to assess staffing requirements were not used to allocate staffing numbers. During this inspection we found improvements had been made and people's dependency levels were monitored monthly using a specific tool to calculate the number of care hours required. Using this tool and the guidelines produced by the Royal College of Nursing the provider was able to define the number of staff required to meet people's health, safety and welfare needs. The acting manager confirmed that staffing levels were kept under review and they had clear guidance to follow if they required additional staff. For example, one person required one to one support, an agency staff had been employed to provide consistent care for this person and to ensure regular staff remained available to continue to meet the needs of other people.

During the inspection our observations indicated there were sufficient staff to meet people's needs. Call bells were answered promptly and records confirmed that audits were carried out to ensure people were able to summon attention when required. These audits showed calls were mostly answered in less than 2 minutes. People we spoke with gave mixed answers when asked if there were enough staff. One person said, "Sometimes there's not enough but it's generally alright." Another person said, "Sometimes at night you have to wait longer as it can be busy." Other people told us they thought there were sufficient staff and they never had to wait very long for help. Relatives of people said there were enough staff and one commented, "a lot more carers now, (and) more stability." Staff also had mixed views, one said they felt the staffing levels were, "OK" and added "we need that level because of the size of the building." Another felt the levels were, "fine" and confirmed that the levels on the day of the inspection were consistent with the levels normally on duty. However, one nurse told us they felt there was not enough staff and thought care workers often felt, "stretched." This was not reflected in the comments from the care workers that we spoke with. We reviewed the staff duty rotas and saw minimum staffing levels had been maintained throughout the period from 10 January 2015 to 6 February 2015.

When we inspected this service in February 2014 we found people were not always protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place to manage people's medicines. At this inspection we found the provider had made improvements and people received their medicines safely.

Appropriate arrangements were in place to obtain medicines which were delivered by a community pharmacy. Medicines were stored safely either in locked medicines trollies chained to walls or dedicated locked medicines rooms. Each medicine room contained appropriate storage for all medicines including lockable refrigerators and lockable cupboards. A balance check of one medicine was carried out and found to be correct. Daily temperature checks were recorded for refrigerators and other areas used for storage of medicines. During the inspection a senior staff member completed an audit on medicines administration records (MAR) and told us this was carried out on a regular basis. Records confirmed this and the acting manager told us audits were also completed by the community pharmacist. An audit was due to take place in the near future and following the inspection the acting manager informed us the date for this audit had been arranged for 3 March 2015.

Information was recorded to ensure the safe administration of medicines. For example, some people were prescribed medicines to be taken when required (PRN). There was clear guidance available for staff to follow when administering these medicines. The guidance included signs that staff should look for to indicate a person may require the medicine and the dosage to be given. This information helped to ensure people who were unable to ask for the medicines themselves, received the medicines when they were required.

Guidance was also available for staff to use when people required their medication to be administered covertly. Covert administration involves putting medicines in food or drink when it is considered to be in the best interests of a person. Records for two people showed a mental capacity assessment (MCA) had been completed and a risk assessment carried out before a best interest decision had been made and recorded. Guidance for staff was in line with legislation and indicated the person must always be offered their medicines in the least restrictive way before covert administration was considered. At the previous

Good

Is the service safe?

inspection it had been noted that people's allergies were not always recorded consistently. This had been addressed and allergies were now recorded accurately on the MAR charts and this information matched that documented in people's care files.

We reviewed a copy of the service's fire evacuation plan on display. It indicated that staff were to leave the building in the event of a fire. However, there were no details regarding the supervision or evacuation of people living at the service. This was discussed with the acting manager who said people would be evacuated to the nearest safe area. This was not reflected in the procedure on display. Staff were able to describe the procedure to follow in the event of a fire and records showed regular fire drills were carried out both during the day and night. The provider had an emergency contingency plan which gave clear instructions for staff to follow in the event of emergencies, for example, fire, flood or loss of utilities. However some of the essential contact details had not been completed in the plan. We raised this with the acting manager and by the second day of the inspection these details had been fully completed.

The recruitment procedures for the service included completion of Disclosure and Barring Service (DBS) checks. A DBS check allows an employer to check if an applicant has any criminal convictions which would prevent them from working with vulnerable people. Other recruitment checks carried out included seeking information from employers with regard to an applicant's previous performance and behaviour in employment. Additionally a full employment history was taken from applicants and any gaps explained. However, in one staff file we found this had not been completed and there was no record of a DBS check being carried out. Following the inspection the acting manager sent us a record to show the DBS had been completed prior to the member of staff starting to work at the service. They also confirmed gaps in the employment history had been explained and the information recorded. A check was carried out for members of staff who were registered healthcare professionals to ensure they remained on the professional register.

People told us they felt safe at Dormy House. One person said, "I feel very safe. I am very happy here, my carers are wonderful" another said, "they are all very kind, yes I feel safe here." Relatives of people living at the service also expressed the view that they felt their family members were safe. Guidance about safeguarding vulnerable people was available to staff and displayed in key areas of the service for staff to refer to. This included information on whistleblowing and informed staff of contact details they could use if they had concerns that a person was being abused. Staff were able to tell us what they would do if they witnessed any abuse and understood the reporting procedures. One staff member told us they were happy with the way people were treated in the service and added, "I've never seen anything to worry me." Staff told us they received training in safeguarding people and records confirmed this was refreshed on an annual basis.

Investigations into accidents, incidents and safeguarding concerns were carried out thoroughly. Action plans were drawn up to help staff to learn from what had happened. For example, a medicines error had resulted in disciplinary action being taken and a discussion with all staff who administer medicines. Staff who administer medicines then had their competency rechecked. Weekly reports of all accidents and incident s were sent to the provider's head office where they were monitored for trends.

The home was well maintained and regular checks were carried out to ensure safety. The need for remedial work was routinely assessed and the staff could request maintenance work to be undertaken. Three staff were employed to manage the day to day maintenance of the service and a list of approved contractors was available for any work that required more defined skills and out of hours emergencies. Staff told us work was usually completed promptly. Fire safety equipment was regularly tested to ensure it was in working order and other checks including those made on equipment used to move and position people were carried out according to relevant policy and legislation.

Good

Is the service effective?

Our findings

Staff received training in the Mental Capacity Act 2005 (MCA) and understood the need to assess people's capacity to make decisions. The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

We reviewed the care files of two people who lacked mental capacity. The first had a Do Not Resuscitate (DNR) order in their records. This had been signed by the GP and discussed with the person's welfare attorney. There was a letter of confirmation on file from the welfare attorney regarding the decision and an advanced care plan had been put into place. It was clear from the records the attorney had authority to make this decision. On another occasion the welfare attorney had felt unable to make a best interests decision for the person. The service had organised an independent mental capacity advocate to visit. A mental capacity assessment was carried out and the best interests decision recorded in line with legislation. The second person's care file had two DNR orders. One had been completed whilst the person was in hospital the other by the GP and a nurse when the person moved to Dormy House. There was no record of this decision being discussed with the person or their next of kin. We raised this with the clinical nurse lead who said the discussion had taken place with the person's next of kin but agreed it had not been recorded. On the second day of the inspection a record of the discussion was in the person's care file and an advanced care plan in place.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were being met. The DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. The acting manager was aware of the legal requirements in relation to DoLS. Four people had DoLS authorisations and a further two applications had been made. The Appropriate records were in place and the authorisations were reviewed in line with legislation and guidance. The acting manager informed us that they were reviewing people using the service in line with recent changes to DoLS. This was to ensure people's freedoms were not restricted unnecessarily.

People received effective care and support from staff who were well trained. Staff had received an induction when they began work at the home. This included a two week training programme called a 'care certificate' which incorporated all the elements of the common induction standards as well as more specific skills such as taking observations and managing catheter care. New staff also spent time working alongside experienced members of staff. They were allocated a 'buddy', that is a member of staff who supports a new care worker until they feel confident. This helped new staff to gain the knowledge needed to support people effectively. A briefing document called 'Am I being me?' was also used to support staff in recognising signs and symptoms that indicate that something may be wrong.

Staff told us they felt they had received sufficient training. They told us they had received training in mandatory subjects and also areas related more specifically to the care needs of the people they looked after. For example, end of life care, percutaneous endoscopic gastrostomy feeding (PEG) and continence. The acting manager showed us a training workbook called 'Living in my world' which had been recently introduced for all staff working in the service including ancillary staff. This was designed to inform and develop staff knowledge about living with dementia. Records confirmed training was refreshed and there was a system in place to identify when training was required. The provider had established an e-learning centre called 'ecademy' which was accessible to all staff to help in the development of their knowledge and skills. Members of staff who held professional qualifications confirmed they were given the opportunity to continue their development in order to meet the requirements of their professional registration.

Staff told us and records confirmed they had regular individual meetings with their line manager to discuss their progress, opportunities for further training and matters relating to the provision of care to people living at the service. Staff said they felt supported and could speak with senior staff if they needed advice or guidance. Staff meetings were held regularly and provided opportunities for staff to express their views as well as discuss ways to improve the service. The minutes of staff meetings showed discussions took place with regard to topics such as, safeguarding, refurbishment of Dormy House and the introduction or review of policies.

People were supported to eat and drink and maintain a healthy diet. During the inspection we observed there were snacks available in the lounge areas between meals. Staff

Good

Is the service effective?

spent time ensuring people had drinks, biscuits, sandwiches and fruit throughout the day. We observed lunchtime in both the Dormy/Wentworth unit and the Surrey Unit. Staff assisting people to eat sat at the same level as the person. They took their time and did not rush the person. Staff spoke with people and gave encouragement throughout the meal. One member of staff ensured that a person with swallowing difficulties had their drink thickened and gave the person time to swallow what they had before proceeding. Staff told us about the people who were at high risk of poor nutrition. People had their weight recorded weekly or monthly depending on their identified risk. Nutritional risk assessments had been carried out and people's weight was recorded appropriately.

Menus containing photographs of meals were displayed in all dining areas. People were assisted to select their choice and other options were available if they did not want anything from the main menu. One person told us, "I can have sandwiches or a poached egg if I don't like what's on offer." One relative told us they felt the food was, "a bit institutional" however, another told us they thought there was plenty of choice and the food was "very good." Special diets were catered for and the chef was aware of people's individual needs. For example, a list was maintained in the kitchen of those people with medical conditions such as allergies and diabetes.

People's healthcare needs were met and they were able to see healthcare professionals when they wished. People told us that the GP visited regularly and staff told us they had a good relationship with the GP practice. The acting manager informed us that the service had been selected to take part in a pilot scheme which would increase the access they have to GPs as part of the winter pressure service. Records showed people had seen healthcare professionals in response to changing needs and management of existing conditions. Referrals had been made to specialist health care professionals for example, mental health professionals, dieticians and occupational therapists. People had also seen dentists, opticians and chiropodists. The service had a physiotherapy room where people could receive individualised therapy sessions.

The service had made specific adaptations for people living with dementia. For example people's names and room numbers were clearly displayed in bright colours on their bedroom doors. Each room had a small alcove where photographs and personal items could be displayed and some areas had contrasting flooring to aid orientation.

Good

Is the service caring?

Our findings

People were not always treated with respect and dignity. Some staff were heard to refer to people as, "good boy" or "good girl" and people who needed assistance to eat and drink were referred to as "feeders." The acting manager told us they had identified an issue regarding staff using inappropriate language. This was being addressed through one to one meetings with individual staff members and a dignity champion had been introduced. Other staff spoke respectfully to people and were polite in their approach. People were treated with kindness and staff responded quickly to people's needs. For example one person called for assistance to move their position while in the lounge area. A care worker responded immediately and gave the assistance required.

People were relaxed and calm when being supported by care staff. We observed how staff gave reassurance to people when assisting them. For example, one person was hoisted into a chair from a wheelchair. Care workers spoke to the person and explained what they were going to do and how they would do it. They involved the person by encouraging them to hold their arms in a certain way and asked the person to tell them when they were ready to move. Staff acknowledged people when they entered a room and engaged people in conversations about things they knew they were interested in. One person particularly enjoyed using an activity board which contained activities related to the person's past life. Staff spoke with the person about this activity and engaged them in talking about their past. Staff took their time and never hurried people when assisting them and communicated throughout the time they were with people.

People said staff respected their privacy and dignity. They said that curtains and doors were closed when they received personal care, their choice was respected and they felt staff knew them and their preferences well. Staff knocked on doors before entering rooms and spoke discreetly to people when asking would they like to use the bathroom. People told us they were happy living at Dormy House. One person said, "I think this is the best place I've ever been" and another person told us, "staff are kind and always willing to help, I am helped to stay independent here." Relatives also said they were happy with the care provided to their family members. One commented, "his personal carer is an angel" and another told us, "this is the best home in the area."

People were cared for by staff who knew them well. Staff told us what people liked to do, the type of thing that may upset someone and people's individual care needs. These details matched those recorded in people's individual care files. Staff applied their knowledge in the way they provided care for people during the inspection. For example, when one person became anxious a nurse approached them and spoke to them quietly about what was upsetting them. From what the person said the nurse recognised it was something from their past working life. The nurse gave reassurance and suggested an activity the person enjoyed to help them move away from the thoughts that were distressing them. A health care professional visiting the service during the inspection told us, "Things are definitely on the way up, improving no end. There are stable staff who are considerate and very good."

People told us they were involved in decisions and planning about their own care and when appropriate relatives had also been involved. One person said they had been fully involved in planning their care. They had chosen their room, and told us they had brought items that made it feel like home. Another person had been supported to maintain their cultural and spiritual beliefs. A relative told us their family member wanted to maintain their independence but is prone to falls. With the support of the service they have assessed the risk of falling and agreed a level of acceptance. They said, "they tell me every time if [name] falls. They don't alarm me; just tell me of any injuries." People and/or their relatives had been able to discuss their wishes in relation to how they would like to be cared for at the end of their life. Where advanced decisions had been made they were recorded.

People and their relatives told us they were able to visit at any time and could spend time with their family member in private if they wished. An area of the home had been designed as a coffee shop where people could spend time with their relatives in an informal setting enjoying coffee, with biscuits or cakes. Other areas such as the lounge and dining rooms were also available for people to spend time with their visitors. Relatives told us they were made to feel welcome and they were listened to by staff and the acting manager.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed prior to them moving into the home. People's care plans were focussed on the individual and recorded information about their past lives, how they liked things done and what their personal preferences were. They were reviewed regularly on a monthly basis and amendments made when changes occurred. However, care plans did not always accurately reflect people's needs. For example, one person's care plan indicated they required an airflow mattress and a 'spenco' cushion. This was not in line with the findings or recommendations of the tissue viability assessment that had been carried out and the equipment was not used. However, this had not placed the person at risk. Another person's care plan stated they required two hourly position changes to prevent pressure damage occurring to their skin. The records showed infrequent position changes had been recorded. We spoke with the clinical nurse lead who informed us the person could move independently in bed. This was not reflected in the care plan but had not put the person at risk.

Where people were unable to use a call bell their care plans stated a regular check was carried out to ensure their wellbeing. However, records were not always completed promptly to reflect these checks had been conducted. For example, one person required half hourly checks. Their chart had not been completed for over two hours when we reviewed it. We later saw it had been completed retrospectively for all the checks that should have been carried out. We could not be assured that checks had been conducted at the appropriate times or how long this person may have been unable to attract staff attention. People who were able to use call bells were responded to quickly. People said they mostly received help promptly and did not have to wait. One person commented that occasionally at night staff forgot to leave the call bell in reach. However, they told us, "I am very good at shouting for help and they come."

A programme of activities was provided and details were displayed throughout the service for people to refer to. Some people had copies of the activity timetable in their rooms. The programme included a physical exercise activity which staff had undertaken specific training to provide. Other activities included music for health, arts and crafts, quizzes, games and manicures. People were encouraged to join in the activities of their choice. However, we saw if people did not wish to take part this was respected. When asked about attending activities, one person said, "it's not my cup of tea, but I'm not forced to go." Individual activities were provided for people who were either unable or unwilling to leave their room. One relative spoke about an activity assistant and said, "[name] is excellent" and then described the individualised interaction [name] provided for her father.

Holy communion was provided each week for those who wished to receive it and other spiritual and religious needs were provided for on an individual basis. The acting manager told us the activity programme was being developed further and the recent purchase of a minibus would allow people to enjoy outings and trips away from the service. They also told us of plans to develop a sensory room. A hairdressing salon was available in the service and appointments were arranged for people whenever they wished.

People told us and records confirmed that meetings were held for people living in the service and their relatives to express their views about how the service was run. One person said, "I don't really go to them, I don't have any complaints." Another person said they went to the meetings and added, "If there is something in my room that needs doing, I am able to bring it up and it's done." On Surrey unit where many people are living with dementia a large pictorial communication tree was displayed. People were encouraged to express their views with support from care staff then attach them to the tree for others to see and share.

There was a complaints procedure and information on how to make a complaint was displayed. Everyone told us they were aware of how to make a complaint but said they had not needed to do so. People and relatives said they were confident they would be listened to and things would be put right as soon as possible if they needed to raise a concern. For example, a relative told us they had been concerned their relative could not reach their call bell when sitting in their armchair. They had requested a bell with a longer lead and this had been installed. Where a complaint had been raised the records confirmed an investigation took place and action had been taken.

Good

Is the service well-led?

Our findings

There was a registered manager in post. On the first day of the inspection the registered manager was on leave, however, on the second day of the inspection we were told they had taken up another role in the company and therefore would no longer be the registered manager for the service. The provider had taken steps to ensure the service had managerial cover. The deputy manager was acting into the role of manager and had support from the provider's regional manager. The recruitment process had begun to replace the registered manager.

One person working in the home commented that they felt "morale was a bit low" due to the changes in management. They said, "[Name] the acting manager is good. She is so busy, but she listens." Other staff told us they thought there had been a lot of improvements and they felt the acting manager was open and listened to their views. A senior care worker felt the new management team have had a good impact on the service. They said, "Things are getting done. Leadership has improved; they are not afraid to roll their sleeves up and help you, train you and support you." Staff were aware of the values and aims of the service. One care worker said, "we aim to keep people comfortable, safe and happy, I believe this." Most staff felt well supported and said they could seek advice at any time. They did not have to wait for an arranged meeting to be able to voice their opinions or seek guidance.

People said the acting manager was approachable and told us they were always available if they needed to speak with them. We observed people and their relatives approaching the acting manager and speaking with them on a variety of topics ranging from new equipment to the proposed development of a new care service in the local area. The acting manager was open and welcoming to the people and relatives she spoke with. She gave appropriate reassurances and noted concerns people had. Relatives told us they would have no hesitation in talking about anything with the acting manager. They said they were happy with the communication they received from the service. One relative said, "It's had its ups and downs but since [acting manager] has come it's fantastic."

Links to the community were maintained through activities organised with the local schools, cheese and wine evenings, an annual fete and connections with the local golf course. The management team at the golf course have an on-going working relationship with the service such as donating prizes for raffles and tombolas. The acting manager plans to develop this relationship further and had arranged a meeting to discuss future plans. With the recent purchase of a minibus people were now able to maintain links to the community by taking part in trips away from the home such as outings to the seaside and other places of interest.

A robust programme of audits was completed by the acting manager and provider. Monitoring of the premises, equipment, accidents and incidents enabled them to have a clear picture of the service at all times. Audits were completed to assess the quality of the service and to enable appropriate action to be taken. For example, food and fluid intake charts had been identified as not always being completed promptly. The acting manager and clinical lead nurse had addressed this during staff meetings and one to one meetings with nurses and care workers. The provider monitored the service and identified trends using a monthly management and risk report. An action plan was drawn up for any areas where shortfalls were identified.

The registered manager took part in continuing professional development to ensure their knowledge and skills remained up to date. They received regular information from authorities such as the Health and Safety Executive and the Local Authority Safeguarding Board. They also made use of information and guidance available from professional bodies including the Care Quality Commission.