Cliffe Vale Residential Home Limited

Cliffe Vale Registered Care Home Limited

Inspection report

228 Bradford Road
Shipley
West Yorkshire
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17 May 2016 and was unannounced.

Cliffe Vale is located close to the centre of Shipley. The home provides personal care to a maximum of 27 people and caters predominantly for older people and people living with dementia. It is a detached property and provides accommodation on three floors, the home does not have a passenger lift, there are a number of stair lifts which provide access to the upper floors.

There were 16 people living at the home when carried out this inspection.

The last inspection was in October 2015. At that time we found the provider was in breach of a number of regulations and the home was placed in special measures. The breaches of regulation were in regard to person centred care, safe care and treatment, safeguarding people from abuse, premises and equipment, complaints, staffing, staff recruitment and governance. We carried out this inspection to check if the required improvements had been made.

The home did not have registered manager in post at the time of the inspection. 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 company secretary was in day to day charge of the home at the time of the inspection. They confirmed it was their intention to appoint a new manager without delay.

People told us they felt the service was safe. Staff had a good understanding of safeguarding and knew how to report any concerns about people's safety and welfare. We found safeguarding concerns were being referred to the local safeguarding team but the Commission was not always being notified about this. The provider acknowledged this as an oversight and assured us it would not happen again.

There were enough staff to meet people's needs. We talked to the provider about the need to review staffing levels as people's needs changed and/or when more people moved into the home. New recruitment procedures were in place to make sure all the required checks were done before new staff started work. Staff training and support had improved and the majority of staff were up to date with training on safe working practices. More training was planned to focus on the needs of people living at the home. Staff supervision was in place but appraisals had not yet taken place.

The home was clean and odour free. The concerns about the environment raised at the last inspection had been addressed. We found more needed to be done to create a more dementia friendly environment to support people's independence, the provider had already identified this as an area for improvement.

Risks to individuals were identified and we saw action was being taken to manage risks. We found people's medicines were managed safely.

Improvements had been made to the way people were supported to meet their nutritional needs. The meal time experience for people had also been improved by creating a designated dining room. People's weights were checked and advice was sought from other health care professionals. Some people who were known to be at risk were having their food and fluid intake recorded. We found the food diaries provided a detailed picture of what people had eaten but the fluid charts were not completed to the same standard.

The home was working in accordance with the Mental Capacity Act which meant people's rights were protected.

People had access to a full range of NHS services. A bedroom had been changed to a treatment room which meant visiting health care professionals had somewhere to discuss peoples care and/or see people in private.

People living in the home, relatives and visiting health care professionals spoke very positively about the attitude and approach of care staff. During the inspection we saw staff supported people in a caring and compassionate way. We found staff knew people well and understood how individuals preferred their care and support to be delivered. The results of a survey carried out by the provider showed us people's relatives were satisfied that they were consulted and involved in decisions about care and treatment. However, this was not fully reflected in people's individual care records.

People's needs were assessed and there were care plans in place. However, they were not always as detailed or person centred as they should be. The provider was taking action to address this.

There were some social activities but this aspect of the service needed to be improved to create a more stimulating and engaging environment for people.

People knew how to make a complaint or raise a concern and we found complaints were dealt with. However, improvements were needed to the way complaints were recorded to make it easier to analyse them and ensure learning was put into practice.

We found there was a positive atmosphere in the home, staff were friendly and confident in their roles and positive about the improvements which had been made. Staff said they felt supported by the provider and felt the improvements which had been made were as a result of a team effort.

There was evidence of audits being done and actions taken to address shortfalls in the service. People living in the home and their relatives had been given an opportunity to share their views of the service and we saw their views had been taken into account. There was an action plan in place for improvements.

The provider was open and transparent about the past difficulties and future challenges. They confirmed they were committed to continuing to improve the quality and safety of the services provided. The company secretary told us they intended to remain actively involved in the day to day running of the home for at least the next 12 months to make sure the service continued to improve.

We found the provider had taken action to address all the breaches of regulations identified at the last inspection. We concluded improvements had been made but they needed to be embedded and sustained to make sure people consistently received safe, effective care which reflected their individual needs and

preferences.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were protected by staff who knew how to recognise and report any concerns about people's safety and welfare.

There were enough staff available and checks were done before new staff started work to make sure they were suitable to work in a care setting.

People's medicines were managed safely.

The home was clean, odour free and risks to people's safety were identified and managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service was working in accordance with the requirements of the Mental Capacity Act which helped to make sure people's rights were protected and promoted.

People were supported to have an adequate dietary intake and their preferences were catered for. Some improvements were needed to the way people's fluid intake was monitored.

People had access to a full range of NHS services.

Improvements had been made to the way staff were trained and supported. Further improvements were planned to make sure staff were fully supported to meet the needs of people living at the home.

Is the service caring?

Good

The service was caring.

People's privacy, dignity and confidentiality were respected.

People were supported by staff who were caring and compassionate.

Staff knew about people's individual likes, dislikes and preferences.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed and we observed staff knew how people liked their care and support to be delivered. The home was in the process of improving people's care plans to support the consistent delivery of person centred care.

There were some activities but more needed to be done to support people to spend their time meaningfully.

People knew how to make a complaint and their complaints and/or concerns were acted on. The recording of complaints needed to improve so that lessons could be learned and improvements made as a result of complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The home did not have a registered manager.

Improvements had been made to all aspects of the service. Systems had been put in place to make sure the provider could continue to monitor and assess the quality and safety of the service provided. These changes need to be sustained to make sure people consistently experience care which is safe, effective and responsive to their individual needs and preferences.

Cliffe Vale Registered Care Home Limited

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 took place on 17 May 2016 and was unannounced.

The inspection was carried out by two inspectors 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. In this case their area of experience was services for older people and people living with dementia.

During the inspection we spoke with six people who lived at the home, four relatives, three care workers, the cook, the senior support worker and the company secretary who was in day to day charge of the home. We looked at five people's care records, medication records and other records relating to the management of the home such as duty rotas, staff files, training records, maintenance records and service reports, surveys, audits and meeting notes.

We observed people being cared for and supported in the communal areas and observed the meal service at breakfast and lunch. We looked around the home at a selection of bedrooms, bathrooms, toilets and the communal rooms.

Before we visited the home we looked at the information we had about the service which included notifications they had sent us. We contacted the Local Authority safeguarding and contracts and commissioning departments to ask for their views on the service.

On this occasion we did not ask the provider to complete a Provider Information Return. 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.

Requires Improvement

Is the service safe?

Our findings

People living at the home and relatives told us they felt Cliffe Vale provided a safe environment. One person who lived at the home told us, "They (the staff) come in during the night to see if you're alright." A relative said, "I absolutely feel mum is safe here, there's never been a question about that." Another relative told us, "It's very good, I have never had any complaints and there's no neglect here. I feel he's safe here, the girls are so patient and nice, staff numbers are good."

The care staff we spoke with demonstrated a good understanding of protecting vulnerable adults. They told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact, for example the local safeguarding team or the Care Quality Commission (CQC). Staff were confident they knew how to raise any concerns even if these related to colleagues. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the management team knowing they would be taken seriously.

We found the provider was referring safeguarding concerns to the Local Authority safeguarding team. However, they were not always sending notifications about these incidents to the Commission. This was discussed with the company secretary who acknowledged it was an oversight on their part. They provided an assurance that in future notifications to the Commission would be made at the same time as referrals were made to the Local Authority.

At the last inspection we had concerns about the safety and cleanliness of the environment. During this inspection we carried out a tour of the premises. We found the home was clean and there were no unpleasant odours. A relative we spoke with said, "The cleaning is better."

We inspected a selection of bedrooms, bathrooms, toilets and various communal living spaces. We saw radiators throughout the home were covered. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We found all floor coverings were appropriate to the environment in which they were used. All floor coverings were of good quality and properly fitted thus ensuring no trip hazards existed. We inspected records of the stair-lift, gas safety, electrical installations and fire detection systems and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested and carried confirmation of the test and the date it was carried out. A record of on-going maintenance assured us the home remained free from hazards and minor repairs were promptly attended to.

The care records we looked at showed people were supported to maintain their independence. There were risk assessments which identified risks and the control measures to mitigate risk. The balance between people's safety and their freedom was well managed. For example, we saw one person was at high risk of malnourishment. Whilst the person was able to eat independently the care plans instructed staff to observe the person through meal-times providing prompts where necessary. We observed the instructions were carried out. We also saw records existed to chart the effectiveness of staff actions. These records included the use of a food diary and two-weekly weighing. We saw another person had been assessed at being at risk

of falls. The care plan identified the situations and locations where falls were most likely to occur. We saw instructions to care staff stated they must ensure footwear was appropriate and well-fitting and movement around the home must be with the aid of a Zimmer frame. At lunch-time we saw a care worker ensured the person's slippers were correctly fitted and the Zimmer frame was used to walk to the dining room. Our observations showed the service operated effective risk management systems.

Our observations throughout the day showed there were enough staff on duty to make sure people were safe and received the care and support they needed in a timely way. This was confirmed by the duty rotas and by our conversations with staff. One care worker told us, "Whilst sometimes staff may ring in sick we are usually well staffed; when staff ring in sick the manager will always put care ahead of administration and help us." In addition to care staff the home had separate staff for cleaning, catering and maintenance.

We talked with the company secretary about the importance of continuing to review staffing numbers and skill mix as people's needs changed and more people moved into the home.

At the last inspection we had concerns about the safety of the recruitment procedures. The provider had put new policies and procedures in place to address these concerns. The provider had only recruited one new member of staff since the last inspection. We looked at their staff file and found all the required checks had been done including a criminal records check with the Disclosure and Barring Service (DBS). This helped to protect people from the risk of being cared for by staff who are unsuitable to work in a care home.

We observed the administration of medicines by a senior care worker. Our observations and discussion with the care worker demonstrated medicines were administered by competent staff. For example, the care worker had a good understanding of each person's medicines, knowing why they were prescribed and the common side-effects. The care worker was particularly knowledgeable about which medicines had to be administered before and after food. None of the people living in the home had the capacity to administer their own medicines.

We found medicines were stored and administered safely. There were appropriate storage facilities including secure controlled drugs storage. Medicine administration records (MAR) had been completed accurately and there were no unexplained gaps. All creams and liquid preparation were labelled with a recorded opening date. We saw basic 'as necessary' (PRN) protocols existed however these fell below an acceptable standard. There was no guidance for staff when variable doses of medicines could be administered and no minimum time between doses. Discussions with the management team assured us these shortfalls would be addressed. Allergies or intolerances to medicines were clearly annotated on each person's medicine records and the monitored dosing system cards.

We saw medicines had been reviewed regularly by GP's either as a consequence of a GP visit or at the request of care staff. For example, one person was found to have difficulty swallowing tablets and the senior care worker had suggested changing to a liquid preparation.

The administration of medicines was underpinned by a medicines policy which referred to the National Institute for Health and Care Excellence (NICE) guidance on the management of medicines in care homes. We carried out an audit of five medicines supplied in individual boxes and found all medicines were accurately accounted for. Whilst no controlled medicines were in use at the time of the inspection the drug register showed records were correctly recorded and signed by two people. We saw evidence of monthly audits of medicine administration showing outcomes similar to our observations. We saw the outcomes of the audits were acted upon recording actions taken. The audits demonstrated a reflective approach to improving quality.

Requires Improvement

Is the service effective?

Our findings

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 so that they can 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 saw two people were subject to DoLS authorisations and in both cases there were conditions attached. Our discussions with the management team showed the conditions were known and were being met. The company secretary told us a further ten people required some restrictions to be in place to keep them safe and as such authorisations for DoLS had been submitted but were awaiting a response.

We found that while bed-rails were not used at the home senior care staff and the company secretary showed they had sufficient knowledge to use them correctly if the need arose.

Most people who lived in the home were not able to choose what care or treatment they received. The company secretary and senior care staff had a clear understanding of the MCA and how to make sure people who did not have the mental capacity to make their own decisions had their legal rights protected.

From our discussion with staff, people using the service and the care records we found that people's consent was sought and was appropriately used to deliver care. In addition we observed staff seeking consent to help people with their needs. When people were not able to verbally communicate effectively we saw staff accurately interpreting body language to ensure people's best interests were being met.

We found some people had 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders in place. These had been completed by relevant clinicians. There was evidence of involving family members in the decision. Staff we spoke with had an accurate knowledge of which people had DNACPR arrangements in place.

At the last inspection in October 2015 we had concerns people were not being supported properly to meet their nutritional needs. During this inspection we found improvements had been made. During the morning we observed people having breakfast and saw they were offered a cooked breakfast in addition to a choice of cereals, porridge and toast.

During the morning we saw people were offered tea or coffee and biscuits. We also saw a jug of orange juice was put on a table in each lounge. However there were no glasses and we didn't actually see anyone being offered a drink of juice, we also noticed there wasn't a choice of juice.

We saw one of the lounges had been converted to a dining room and at lunch time staff encouraged people to go to the dining for their meal. This gave people the opportunity to have a change of environment and to experience the social aspects of meal times. We observed the lunchtime meal being served in the dining room. We saw people sat at tables which were nicely laid and each had condiments and drinks for people to access. Staff appropriately supported people who needed assistance to cut up their food, or who needed assistance to eat their meal. We saw staff were using appropriate cutlery to ensure food could be consumed easily. Staff were patient and people were given time to eat their meals. Staff demonstrated they knew each person's needs and preferences in terms of food and drink.

We asked people what they thought about the food. One person said, "The food is first class and we can have whatever we want." Another person said, "I like it, the food's not too bad and the staff are nice girls."

In the care records we saw nutritional risk assessments had been completed which identified if the person was at risk of fluid imbalance or malnutrition and reflected the level of support they required for eating and drinking. Additionally, records showed peoples weights were being monitored as described in their care plans. A relative told us, "He did lose weight when he first came in, but he's putting it back on now. I feel he's safe and he's had less TIA's since he's been here."

To protect people from the risks of receiving inadequate nutrition and fluids, staff recorded and monitored people's daily intake in food diaries and fluid charts. We found the food diaries were well completed and gave a clear picture of what people had eaten. However, the fluid charts were not all completed to the same standard. This was discussed with the company secretary who assured us they would deal with it.

We spoke with the cook and they were able to tell us about people's individual dietary needs and preferences. They had a list to help them make sure people's dietary needs were not overlooked. For example, the cook knew who needed a diabetic diet and who needed their food fortified. The family of one person who lived at the home liked to bring food for their relative and help them to eat. The home facilitated this by heating up the food when they were ready to support the person. We spoke with the relative who said, "This fits the bill. 99.9% of the time it meets mum's needs. They get the extras right here. I can bring in food from home, they'll warm it up and we'll share feeding mum."

During the inspection we looked at five people's care records. These showed people had access to appropriate professionals such as GPs, dentists, chiropodists, district nurses and speech and language therapists. However, one relative we spoke with told us, "We've asked for a dentist for mum, but it's taking a long time". Whilst we saw an array of healthcare professional visited the service we saw little input from dieticians. We saw the cook enriched foods with saturated fats such as butter, cream and cheese yet many people were prescribed statins to reduce cholesterol levels which could be produced by consuming saturated fats. The company secretary assured us they would seek suitable advice to address the matter.

During our inspection we witnessed district and specialist nurses delivering specialist care and advice. We had the opportunity to speak with three visiting health care professionals who all told us they had no concerns about the home. They said staff were quick to refer any concerns and followed the advice given. One of the health care professionals said they had seen a lot of improvements in the last six months and felt the management team had "turned it around".

During the inspection we found the environment was not particularly supportive of people living with dementia. For example, there was a lack of pictorial signage to help people find their way around independently. However, we found the management team and staff had already identified this as an area for improvement and were exploring ways of creating a more dementia friendly environment.

At the last inspection we were concerned staff were not receiving the training and support they needed to carry out their roles and responsibilities effectively. The company secretary told us they had concentrated on making sure all staff were up to date with mandatory training on safe working practices such as fire safety, moving and handling, food safety, safeguarding and first aid. This was confirmed by the training records and our discussions with staff. Further training was planned and the company secretary had identified a need for training on dementia care. They were in the process of trying to find a suitable training provider for this at the time of the inspection.

The provider had put a supervision plan in place and all the staff had attended one supervision meeting. Going forward supervisions were planned to be carried out at two to three monthly intervals. The company secretary said all staff would have an annual appraisal but at the time of the inspection this had not been implemented as priority had been given to supervisions. We concluded the provider was taking appropriate action to implement an effective system of staff training and support but there was still work to be done in this area.

Good

Is the service caring?

Our findings

We asked people if they thought the service was caring. One person who lived at the home said, "I've known them all my life and I'm happy with them." Another person said, "They treat you alright if you ask for anything. The staff are very nice, all my washing and ironing gets done and put in my room." and a third person said, "The staff are good, I'm alright."

One relative said, "It's a very friendly, loveable home, the girls are so patient." Another relative said, "Overall the girls are great and really do care for mum, which is what is most important."

We also spoke with a relative of a person who had needed hospital care recently. They said, "The hospital was great for [name] immediate needs but I felt much better when [name] was back at Cliffe Vale."

One person's relatives said the staff were not always as attentive to detail as they would like. For example, they said they often forgot to top up the water in the flowers in their relative's bedroom.

We observed the relationships between staff and people living at the home were warm, yet professional. The staff were very caring, responded appropriately to individual situations and demonstrate empathy. For example, in one lounge we saw a person who lived at the home was becoming a little anxious and not responsive to a request from care staff. The person was clearly becoming increasingly less happy. The care worker responded by temporarily withdrawing from the situation and calling on another care worker who 'mediated' and the desired outcome was achieved. In another example, we saw a person's clothes had become dishevelled and staff acted promptly and discretely to maintain their dignity.

We observed people were well groomed and looked cared for. For example, we saw the men had been supported to shave and people's fingernails were clean.

Later in the morning we observed a care worker very sensitively administer medication to a person. They explained everything that was happening while all the time talking encouragingly and demonstrating real warmth. The person did not have English as a first language and the care worker had clearly worked to develop some appropriate language skills and prayed with this devout person. The person's relative was also present and from our observations it was evident this was not an infrequent show of individual care. In the same person's room we saw there was list on the wall of frequently used words and phrases in their mother tongue to help staff communicate with them.

We spoke with three care staff to gauge their understanding of people's needs and past history. They had good knowledge of each person and spoke about people in a compassionate, caring way. At the last inspection we were concerned that the bathing arrangements meant people did not have a proper choice about when and where they wanted to have a bath. We found this had been dealt with and there were no longer set 'bath days'.

People's privacy was respected and all personal care was provided in private. We saw staff knocking on

bedrooms doors and waiting for a response before entering. At the last inspection we found people's privacy was being compromised because visiting health care professionals were using individual's bedrooms to carry out consultations with different people. The provider had addressed this by creating a treatment room where such consultations could take place.

At lunch time we saw people were provided with suitably adapted cutlery to help them maintain their independence while eating.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful and compassionate way. For example, we asked a member of care staff about the deterioration in the mental health status of one person. Their response was with the use of well-chosen sensitive words to describe sometimes challenging behaviours.

We asked the company secretary and the senior support worker if there was anyone living in the home that did not have any near relatives or friends. They told us one person, who had an outstanding DoLS application, was currently without independent advice. However, they said they hoped an independent mental capacity advocate (IMCA) would be appointed. They also told us about a situation in the recent past when they had obtained the services of lay advocacy for a person who lived at the home. This showed us the provider understood the importance of making sure the views of people who used the service were taken into account.

Requires Improvement

Is the service responsive?

Our findings

All the people we spoke with expressed their general satisfaction with the care provided. One relative said, "Mum's well looked after in every respect." A second relative said, "I'm more relieved and stress free now Mum's in here." A third relative said, "It's improved, at first it was brill, then we had quite a few issues, but we've raised them and they're resolved. They're lovely with mum, can't fault them, they care for her, do her nails, little walks out etc." A fourth relative told us, "They bath or shower him; he's always in clean clothes and the food's good."

We saw people's needs were assessed before they moved in. This helped to make sure the home would be able to meet their needs. People had individual care plans in place to show staff how they should be supported to meet their needs. The company secretary told us they had identified the care plans were not as detailed or person centred as they needed to be and they were working to improve this. They told us they were being supported by the Local Authority to improve their care documentation. When we looked at the care plans our findings supported this view; the care plans were adequate but did not support the consistent delivery of person-centred care. For example in one person's care plan we found that although there was information about helping them with their day to day personal hygiene there was no information about their bathing preferences.

However, we observed staff knew about people's individual needs and knew how best to support them. For example, we observed one person who lived in the home was unsettled due to a recent bereavement. The staff dealt with this in a very patient and sensitive way, supporting the person and not challenging their slightly changed behaviour.

The relatives we spoke with told us they were supported to contribute to the planning and in some cases the delivery of care. This view was supported by the results of a recent survey carried out by the provider which showed people's relatives were satisfied with consultation and involvement in making decisions about care and treatment. However, we found this was not always documented in people's individual care records.

We saw people were supported to keep in touch with their family and friends. For example, there were no restrictions on visiting. In another example we saw arrangements had been made for staff to accompany one of the people who lived at the home to their grandson's wedding during the summer.

Although there was a list of activities displayed the people we spoke with and staff did not comment much on aspect of care other than to mention visiting entertainers. The company secretary told us they had temporarily suspending the regular activities programme and care staff were responsible for organising and delivering this aspect of care. We saw some individual examples of people being supported in leisure activities. For example, we saw one person being asked if they wanted to go with staff to hang out some washing and we saw another person was regularly accompanied on walks to the local shops. However, this aspect of the service needs more attention to make sure people have opportunities for social interaction, occupation and engagement which has been shown to enhance people's sense of wellbeing.

There was a complaints procedure in place. The people we spoke with told us they knew how to raise concerns and said any issues they had raised had been dealt with. The company secretary showed us the complaints records which confirmed people's complaints were being dealt with. However, the way complaints were recorded needed to be improved to enable effective audit, analysis and learning to take place.

Requires Improvement

Is the service well-led?

Our findings

The home did not have a registered manager in post. Although the manager was still registered with the Commission they had been off work for some time and resigned from their post in May 2016. The company secretary was in day to day to charge of the home. The company secretary was open and transparent about the past difficulties and future challenges. They confirmed they were in the process of recruiting a new manager and stated it was their intention to remain actively involved in the day to day running of the home for at least the next 12 months to make sure the service continued to improve.

We found the atmosphere was warm, friendly and welcoming. The management team had generated a positive culture, this was evident by the way different grades of care staff worked well together, understood their respective roles, supported each other and showed initiative. It was further evident in the feedback from visiting health care professionals who told us they staff were always welcoming and eager to take on board suggestions for improvements.

The staff with whom we spoke with gave us a competent account of what they would do if they were worried by anything or witnessed bad practice. We spoke with three members of care staff one of whom told us, "If I saw anything of concern I would report it to the senior on duty or the manager." The other member of said, "I have every confidence in the management team but I would not hesitate to get in touch with you [CQC] if I thought things were not being treated seriously enough."

The provider had a service improvement plan which they were working through systematically to address all the requirements following the last inspection. In addition, they had implemented systems to audit the quality and safety of the services provided and identify for themselves others areas where improvements were needed.

We saw auditing was a common feature of the service. We saw audits were reflective and were being used to improve quality. For example since our last inspection the service had asked all relatives for their opinion of the service. The questionnaire directly related to our last report and sought to make improvements with their consent and approval. We saw a questionnaire had also been sent to all people receiving care. This was in pictorial format to help people understand the question being asked. From our findings on this inspection it was clear the outcome of the questionnaires had contributed to the improvements made.

We also saw the responses from relatives stated they were involved in care planning and were aware of the contents of their relatives care plans. Both relatives and people receiving care commented they were involved in care planning which was reflective of people's needs rather than the needs of the service. Comments recorded in the responses included; "Staff are very loving and caring", "I am always dealt with in a professional way by the senior staff and manager" , "I marvel at the way staff interact with residents" and "I feel care is delivered in a way my [relative] wants." Whilst our original understanding of care planning suggested care was not person-centred, comments by relatives and people who used the service suggested otherwise. However, as mentioned previously in the responsive section of this report this was not evidenced in people's individual care records.

Staff told us staff meetings were a regular feature of the service. They told us the agenda comprised of items from both the management and individual members of staff. Staff told us management were keen to hear of their views and took note of their suggestions for improving care. Staff told us the meeting following our last visit was positive with no hint of a blame culture. Staff told us improvements in the service were as a result of a team effort.

Overall, we found the home was more organised, for example, all the records we requested were readily available.