

West Country Care Limited

Stainsbridge House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service: Stainsbridge House is a care home that was providing personal care to 34 people at the time of the inspection.

People's experience of using this service:

Risks identified had not always been assessed. This included incidents of behaviour that could be verbally or physically challenging.

Not all medicines administered as 'when required' had protocols in place to give staff clear guidance. All other areas of medicine management were observed to be safe.

One staff member had not received an enhanced Disclosure and Barring check before working within the service.

People told us they felt safe. Staff understood their responsibilities around reporting concerns. Safe levels of staffing were observed.

We saw that mental capacity assessments had been completed, but more detail was needed around evidencing how the decision had been discussed with each person.

People told us they liked the food and were able to make choices about what they had to eat.

We observed staff interacting meaningfully with people. They appeared to know people well and anticipated their needs. There were many positive comments about the kindness and caring nature of the staff.

Wellbeing staff were in place to provide opportunities for meaningful engagement for people.

We identified one notification had not been submitted to the Care Quality Commission. This was notification of when a person who was being deprived of their liberty had their legal application approved.

The system for monitoring the quality of the service had improved. However, some areas of the audits needed to include further details of what needed to be checked.

More information is in Detailed Findings below.

Rating at last inspection:

Requires Improvement (report published 15 August 2018).

Why we inspected:

This was a planned inspection based on the rating at the last inspection.

Follow up:

We have told the provider they must take action to improve the service. We will continue to monitor the service and complete a further inspection to assess whether the improvements have been made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our Safe findings below.

Requires Improvement ●

Is the service effective?

The service was effective.

Details are in our Effective findings below.

Good ●

Is the service caring?

The service was caring.

Details are in our Caring findings below.

Good ●

Is the service responsive?

The service was responsive.

Details are in our Responsive findings below.

Good ●

Is the service well-led?

The service was not always well-led

Details are in our Well-Led findings below.

Requires Improvement ●

Stainsbridge House

Detailed findings

Background to this inspection

The inspection:

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:

The inspection team consisted of 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.

Service and service type:

Stainsbridge House is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not currently have a manager registered with the Care Quality Commission. A home manager is in place and manages the day to day running of the service. The director who visits the home on a regular basis, has overall legal responsibility for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

The service did not receive prior notice that this inspection would take place.

What we did:

Before the inspection, we reviewed the information we held about the service and the service provider. We observed and spent time with people to understand their experiences of the care and support they received. We spoke with 15 people living in the home and six relatives.

We looked at records, which included seven people's care and medicines records. We checked recruitment, training and supervision records for four staff. We also looked at a range of records about how the service

was managed. We spoke with the home manager, director and 12 care staff.

After our site visit we contacted external health and social care professionals and relatives to obtain their views about the service.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

RI: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management: Learning lessons when things go wrong

- At our last inspection in June 2018 the home had been in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risk management and documentation to support identified risks was not always managed safely. At this inspection although we saw that further improvements were still needed enough action had been taken to meet this regulation.

- People's care plans reviewed contained risk assessments relating to moving and handling, pressure ulcers, malnutrition and hydration. There was evidence to suggest that action was taken in response to assessments. For example, one person had been assessed as requiring the use of a hoist, sling and the support of two staff when transferring from a bed or chair. Two staff were observed doing this and the correct sling and hoist were used. People who had been assessed as being at risk of developing pressure sores had been provided with air mattresses and those reviewed had been set at an inflation pressure appropriate for the persons weight.

- One person's eating and drinking care plan stated they were at risk of choking, but the risk was not explored or assessed appropriately. The home manager said the care plan was written incorrectly as this person had only experienced choking episodes at home prior to living in the service and were not a risk. The manager confirmed this would be amended correctly. Another person at risk of choking had been seen by external professionals and prescribed a thickener to be added to their drinks. The risk assessment for this person had not been updated to reflect these changes. The manager said this would be actioned.

- One person who smoked had a risk assessment in place, but it had not considered the risks around why the person was unable to safely manage their own cigarettes. This person's cigarettes were looked after by staff and it was recorded when the person had one. However, a total of how many cigarettes the person had left was not being kept, which meant it could not be monitored if any were to go missing. The home manager agreed with us this was a potential risk and would be documented going forward.

- At times some people would display behaviours that would be physically or verbally challenging due to underlying health conditions. We saw that there was not a positive behaviour care plan or risk assessment around this to give staff guidance and ensure they responded consistently. Wellbeing care plans were in place and the home manager was in the process of developing these to include more about people's behaviour and any triggers that staff needed to be mindful of.

- Where there had been a behavioural incident staff would complete a record of the incident and the support given during this time. Between the end of January 2019 and March 15, 20 behavioural incidents were recorded. We saw that these were not always completed appropriately. For example, when it referred to the time taken for a person to appear calm again, the entry recorded notes about the other person instead of focusing on who the assessment was for. Inconsistent approaches were often used in response. Sometimes it was recorded medicines had been administered as a first response and at other times interaction was given or the person was left to calm down alone. We saw that the service was working with external professionals to support people at these times, but the recording needed to be developed.
- All incidents and accidents were recorded on a report. The form was detailed and included a section on what could be done to reduce the likelihood of a reoccurrence and what could be changed in practice. A post falls protocol was in place which gave staff guidance on the action to take when a person falls including seeking medical attention for all head injuries. Where a person had experienced a fall, care plans and associated assessments were implemented or reviewed and updated.
- Personal evacuation plans were available, and copies kept in a fire file by the front door. These did not have enough personal detail about the equipment and individual support a person may need in the event of an evacuation. The director told us this would be addressed. Comprehensive environmental risk assessments, including a fire risk assessment had been completed and a contingency plan in the event of the building having to be evacuated was available. Records seen indicated that routine maintenance and safety checks of essential equipment and services were carried out at the required intervals.
- Routine fire safety checks were completed but it was recommended that these all be recorded in the same file for ease of reference. A fire alarm system was fitted, and a variety of fire extinguishers were available throughout the home. Emergency exits were marked and free from obstruction. It was noted that fire action notices were missing from two fire alarm points. The director was informed of this finding.

Systems and processes to safeguard people from the risk of abuse

- People that could understand and answer the question told us they felt safe. All relatives felt their family member was safe. Three relatives told us that there had been occasions when another person living in the home would wander into their relative's room and pick up their belongings. We discussed this with the director and home manager who were aware of the situation and continued to monitor this. We saw one person had been supported to have a key safe on their door, so they could lock their room when they were not in it.
- Staff spoken with confirmed that they had received safeguarding training and were able to state what they would do if they witnessed abuse, including contacting outside agencies such as CQC, the police and local safeguarding team. Those asked felt that abusive practices were not happening at the home. One staff member said that they felt they would be able to report any unsafe practices by other staff and that these would be dealt with by the management.

Staffing and recruitment

- Observations over the two days indicated that there were enough staff to meet people's needs. Call bells were answered promptly, and care needs appeared to be met. Wellbeing and catering staff assisted at mealtimes. The director told us, "We have more settled staff who are better managed, our staff sickness is next to nothing. The level of basic care has improved, and the manager spends most of her time on the

floor."

- Staff felt that there were enough staff during the day and at night. Staff commented, "The staffing levels are better now; there's enough" and "There have been positive changes here. There's more staff, activities have picked up and there is time to do the nice bits, like people's nails."
- We reviewed the recruitment files of four staff. We saw that it was recorded that Disclosure and Barring Service checks (DBS) had been completed, but the number was not always recorded on site. The numbers were instead recorded at an administration office and the director accessed these during our inspection. We saw one staff member did not have an enhanced DBS check completed. The director explained this had been an oversight as the staff member had initially started as a volunteer and only a standard DBS had been requested. The director applied for an enhanced check immediately and the staff member was refrained from working until this was received. We found that one staff member did not have a previous employer reference in place. The director informed us following the inspection that this had been mislaid from the file, but the previous employer had now resent this to the home.

Using medicines safely

- At our last inspection in June 2018 the home had been in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines were not always managed safely. At this inspection we saw that action had been taken to meet this regulation.
- Medicines were stored appropriately and securely. Senior care assistants who had undertaken medicine management training were responsible for the administration of medicines. Following training, staff undertook three supervised medicine rounds in order to check their competency. Training updates were undertaken annually but did not currently involve a competency assessment. The director stated that this would be introduced.
- We observed two senior care assistants on two medicine rounds. They demonstrated an awareness of the needs and preferences of the people they administered the medicines to and their practice was seen to be safe. Medicine records (MAR) were pre-printed by the pharmacy and contained details of any allergies people had. Where handwritten amendments or additions were seen, these had been signed by two staff members. There were no gaps seen on the MAR sheets reviewed. Individual protocols for the use of 'when required' (PRN) medicines were available in some, but not all cases. There were missing protocols on five of the MAR 's reviewed.
- There was a system in place for the recording of prescribed topical medicines, such as creams and lotions. Those seen had been fully completed and included body charts detailing areas of application. Evidence indicated that appropriate action was taken in response to medication errors. One staff member had reported their own error. They had been suspended from administering medicines and were currently awaiting retraining and competency assessments.

Preventing and controlling infection

- Communal areas of the home appeared clean and tidy, apart from the second floor at times during the day. Some relatives commented on the odour. One relative said "I worry about the cleanliness. It could do with a deep clean, the bedroom floor is sometimes sticky, and bins are dirty." We saw on one occasion staff left a person's bedroom after supporting with personal care and had not removed their gloves before

accessing other areas of the home. Cleaning records indicated that people's rooms were 'deep cleaned' each month and communal areas were subject to a monthly cleaning audit. Infection control was included as part of mandatory staff training.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance

- At our last inspection in June 2018 the home had been in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a lack of understanding around the appropriate process to follow for people who lacked capacity. At this inspection although we saw that further improvements were still needed enough action had been taken to meet this regulation.
- The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.
- We saw that mental capacity assessments had been completed, but more detail was needed around evidencing how the decision had been discussed with each person. The home manager told us they understood this was needed and was starting to review them all. We saw an example of one which included a lot more detail on how the person was supported to communicate and given information.
- Records of best interest decisions relating to administration of covert medicines were seen. These included capacity assessments and had been signed by a manager, a staff member, the persons GP, pharmacist and an advocate.
- People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made for everyone living in the home and the majority were still awaiting approval by the authorising body.
- We spoke with the director about the keypad restriction to the lift. People who could retain the code were given this. We saw that a lift protocol was now in place which recognised that the keypad restricted the movement of some people but that the risks to safety outweighed the compromise. The director said there had been incidents of people becoming distressed from going in the lift but not being able to use it correctly and going up and down and becoming disorientated. There were also examples of people having altercations with other people when going on to another floor and the measures in place allowed staff to monitor this and support accordingly. These restrictions around the lift however had not been recorded in people's care plans, capacity assessments or DoLS. The home manager said this would be addressed.

Adapting service, design, decoration to meet people's needs

- The home was over three floors with communal lounge, dining and bathroom spaces on each floor. One relative said they had chosen the home because, "There seemed to be plenty of room to walk around, have a bit of freedom and a lovely garden." The bedrooms we observed were personalised and relatives had also been involved in this. People were able to walk around on each floor, but access to the lift was restricted by a keypad. Stairgates were at the bottom of accessible stairs, although these were not always securely fastened and were easy to open and/or leave open. We raised this with staff to consider alternative measures to ensure people remained safe.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- A research based, nationally recognised assessment tool (Waterlow) was used to assess people's risk of developing pressure ulcers. For those reviewed, appropriate equipment, such as pressure relief mattresses, and repositioning support was in place in response to assessments. It was noted that there was an effective skin care regime for those people at risk of developing pressure ulcers which involved the regular application of topical creams.
- Where people were susceptible to urinary tract infections, NHS guidelines entitled 'Management of UTI's for elderly patients residing in care homes' were seen alongside the person's medicine administration records. There was evidence in one case that these guidelines had been followed and the person had been seen by their GP and appropriate treatment prescribed. A visiting healthcare professional stated that training had been provided by the community nursing team in relation to pressure area care and the management of urinary tract infections.
- A research-based assessment tool for malnutrition (MUST) was used. Where people had been assessed as being at risk, records and observation during the inspection indicated that nutritional supplements were provided, and that people were offered regular meals and snacks and encouraged to eat. Records indicated that two people reviewed, who were at risk of malnutrition and who required the support of staff to eat, had gained weight.

Staff support: induction, training, skills and experience

- Staff spoken with confirmed that they had received training in mandatory and other relevant subjects. A record of staff training was reviewed which showed that staff received mandatory training including fire safety, moving and handling, diversity and equality, dementia and person-centred care. Some staff had and were in the process of achieving diploma's in health and welfare.
- A staff member confirmed that they had received supervision and support from their line manager, which had included working with them whilst delivering personal care in order to check their competency and practice. Supervision records seen indicated that staff had begun to receive an appraisal review every four months.
- The induction record of a new staff member indicated that they had received initial mandatory training, information relating to the home and spent time shadowing more experienced members of the team. One staff member confirmed, "The induction was good, I went around the building and information about fire safety was given, I did a lot of online training and shadowing."

Supporting people to eat and drink enough to maintain a balanced diet

- People told us they liked the food and were able to make choices about what they had to eat. We observed that where needed, people had the support of an individual staff member and were not rushed. The meals appeared well cooked, nutritious and the portions were generous. One relative told us, "My relative loves the food here, if you suggest a change then the chef will try new food to coax her to eat." People were shown options on each plate, so they could decide what they preferred at the time of their meal.
- The director told us they had recently identified that the gap between morning coffee and lunch was too short and this had been increased to ensure people ate their meals, which was working well. The chef was passionate about their role and we observed the chef joined people all over the home to see how the food was being received, also helping them to eat where needed. The chef told us, "We have a tasting day where I make fresh new dishes to taste and see what people like. Food is the main thing for them, it makes them smile."
- Staff were responsive to people's dietary needs, for example offering a milkshake made from the chocolate mousse when one person couldn't manage it in the original form. All dietary needs were recorded and records kept of food and storage temperatures and cleaning checks. The home had in place a five-star rating for food hygiene standards.

Supporting people to live healthier lives, access healthcare services and support: Staff working with other agencies to provide consistent, effective, timely care

- Records seen indicated that people had access to a range of healthcare professionals including GP's, community nursing services, community mental health teams, speech and language therapists and hospital specialists. A GP from a local surgery visited the home twice weekly. A resident 'first glance sheet' was in place, which contained important information, including if people had a Do Not Attempt Resuscitation order and if the person was on any monitoring charts.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- We observed staff interacting meaningfully with people. They appeared to know people well and anticipated their needs. One person said, "Staff are nice, I like living here." One relative said, "It's clear staff have been briefed about individual care needs for my relative, the regulars as well as agency." People had information in their room which explained what support the person needed and what was important to them such as preferring to have the door open. This relative said, "I am confident that staff know what they are doing."
- There were many positive comments about the kindness and caring nature of the staff. One relative said, "There has been an enormous improvement in the last six months and a noticeable change in staff attitude, you get a welcome when you arrive. The manager has worked extremely hard and the atmosphere and interaction is positive when we visit." Another relative commented, "The care is done with kindness, sensitivity, dignity, privacy." One person said, "It's like home."
- Staff were seen to be compassionate towards people who appeared relaxed in their company. This included not just the care staff but other staff roles within the home. One relative said, "I can tell my mother is happy and well cared for, by her mood and demeanour, she is stable, cheery and affectionate when I visit." One staff commented, "It's a nice relaxed atmosphere, it feels homely and not institutionalised."

The home manager was a visible presence on the floor for people and staff and was able to monitor the service in this way. The home manager told us, "I like to be on the floor more, so I see what is going on." We observed the manager was caring to people and took time to reassure and spend time talking with or helping people mobilise around the home.

Supporting people to express their views and be involved in making decisions about their care: Respecting and promoting people's privacy, dignity and independence

- We observed that staff communicated well with people and were mindful to seek permission when offering support. People were encouraged to go to the dining table for meals or given the choice to eat in the sitting room, or their own room. People confirmed they could get up and go to bed when they wished. One relative told us, "My relative has always been very mobile but recently has been less able. The staff have responded to this and helped my relative to stay independent where they can."
- The service recognised the importance of respecting people's human rights and diversity and staff

received training around this. The director told us, "We support people as individuals and they are entitled to their own lives and beliefs and we support where we can. The staff are made up of a diverse team and get on well."

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- At our last inspection in June 2018 the home had been in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans lacked detail and person-centred information. At this inspection we saw that action had been taken to meet this regulation.
- Peoples care plans were based on assessments of needs that included communication, eating and drinking, mobility, night support and dementia. There had been an improvement in their clarity and accessibility since the previous inspection. One person who was living with dementia had a care plan in place relating to this, which included a detailed life history. One healthcare professional stated that they felt there had been an improvement in care planning saying, "It's better now, much clearer." They felt staff responded to people's healthcare needs when required saying, "They know when to call us, they're good."
- Plans seen contained information specific for the person. For example, "I am unable to communicate; I often grind my teeth and when you see me doing this, please encourage me with a drink" and "I like to join in with activities, although sometimes I can only observe, I am very aware of what is going on around me." The provider used an electronic care record system and a room folder contained assessments and daily records.
- One person who was susceptible to urinary tract infections had a care plan in place which described the symptoms they may display, and the actions required during these times. Where one person had sustained weight loss, they had been promptly referred to their GP and nutritional supplements had been supplied. Records of nutritional intake indicated that staff were encouraging the person to eat and that the nutritional supplements had been given.
- Where positional changes were indicated, records showed that these were mainly carried out at the required intervals. In two cases where four hourly positional changes were required it was noted that the person had remained in their chair for a longer period. However, they did not have any pressure damage. The recommended targets for people's fluid intake were not recorded. This meant staff did not have a guideline to know how much a person should be drinking. We raised this with the home manager to action. We saw that people were offered drinks and these were refreshed regularly throughout the day.
- We saw that care plans were reviewed regularly, and any changes recorded. One relative told us they now felt much more included in their relative's life and part of the decision-making. They commented, "We get feedback without having to ask for it, we feel like to the staff our relative is a person and that they have a relationship with her. She's not just a task and we feel we are included in that relationship."

- An activity programme was in place providing opportunities for people to participate in a variety of events. This included cooking, music and movement and one to one time for people who preferred to spend time in their bedrooms. The wellbeing staff were aware of people's hobbies and interests. For example, we observed one staff member reading from the bible to a person in their room, which was on their list of interests. Another staff member organised a small poetry reading on the middle floor with three people who liked poetry.

- Staff noticed when potential issues might arise and provided distraction and interaction with activities or conversation. We observed during a Jenga activity one person became upset. Staff engaged the person with a set of music headphones and dancing and after a while they re-joined the group.

Improving care quality in response to complaints or concerns

- A complaints folder recorded any formal concerns people raised. These had been managed appropriately in line with the provider's policy but did not always record if the complainant had been satisfied with the actions that had been taken. The home manager would hold one to one meetings with staff following events to discuss issues and agree outcomes going forward.

- There were lots of comments raised to us about missing laundry items and items being found either in rooms of or with other people wearing. Most relatives said that when they raised concerns of this nature they were dealt with, although it had continued. We raised this again with the home manager to address.

End of life care and support

- People had end of life care plans in place, which recorded peoples wishes regarding resuscitation and treatment, and whether they wished to remain in the home. It was stated that nobody was receiving end of life care at the time of the inspection. Two relatives told us that they had been involved in care planning around end of life plans and said the staff had been very kind in this process.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

RI: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At our last inspection in June 2018 the home had been in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because quality monitoring of the service did not provide a clear rationale of what this attributed to the overall picture of the service. At this inspection, although we saw that further improvements were still needed, enough action had been taken to meet this regulation.
- We identified that one notification had not been submitted to the Care Quality Commission. This was notification of when a person who was being deprived of their liberty had their legal application approved. The home manager said this was an oversight and would be sent.
- The system for monitoring the quality of the service had improved. We saw that audits were completed monthly in areas of infection control, medicines, care plans and safeguarding. The director took sample audits during visits and reviewed what the manager had completed.
- We saw that areas of the medicine audits could be enhanced such as checking medicine counts and expiry dates. The last audit had been completed in March 2019. We saw that a risk assessment for March 2019 had not picked up that some risk assessments had not been put in place and stated there were no concerns.
- The home manager did not currently have a working action plan in place. The director discussed areas for improvement on visits to the home and kept notes of this and sent weekly updates to the manager. We reviewed these and saw areas including weights, staff appraisals and care plans had been included to address.
- We saw that other audits had identified areas to be worked on. For example, the director had changed to auditing incidents monthly, due to an increase in falls. A training audit had identified that staff wanted more face to face training and this was in progress. The home manager told us they felt well supported by higher management and could approach them when needed.
- Staff were able to attend regular meetings and be kept up to date with events happening within the service. We saw that where events had happened these were shared with staff as a learning opportunity.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- A registered manager was not in place. A home manager had applied to be registered and the first application had been refused by the Care Quality Commission. The director told us further training in leadership and management had been sourced for this manager. An application to register again had been made prior to this inspection.
- Staff confirmed they had seen positive improvements since the last inspection and felt more settled now. Comments included, "Things are a lot better, the managers are good, but everybody has made a difference", "I am proud of how the home has come to a better standard. We've come on leaps and bounds." Staff did raise that whilst the manager was supportive, they felt they still needed to find their confidence as an effective leader. All staff members spoken with said that they felt they could approach the director with any concerns they might have, and that action would be taken.
- Relatives spoke positively about the management of the home and improvements they had seen. One relative said "The home is well managed now, [manager name] has worked very hard and been extremely supportive. We would not have got that support from the previous manager." Another relative said, "I wouldn't have recommended this home before but now we would." One health and social care professional told us that they felt the home had improved over the last year saying, "It's more settled and there is more continuity. The manager is good and see's what is happening." They added that they felt the manager, "Has worked very hard to improve the home. It's much more organised, staff morale is better and they're more relaxed."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Relatives said in the past there had been relatives' meetings. Several relatives suggested that communication off site could be improved, for example a newsletter to update would be useful. Relatives told us they would like to know about staff changes, menus, plans for the home and garden and a chance to engage. We observed that the staff photo board needed updating.
- People, their relatives and staff were given the opportunity to provide feedback on the service through a feedback survey. The results would then be summarised, and any actions set to be addressed. We saw that sometimes the uptake to complete these was poor, but the responses received were mostly positive. There was not yet a pictorial format survey in place which some people in the home would benefit from.

Continuous learning and improving care

- The service had worked to improve the service people received and we saw action had been taken to meet areas of concern from the last inspection. The director told us, "Our residents with dementia are becoming physically frailer and managing their mental and physical health care is a challenge. We therefore strive for better communication with health care professionals, staff will have to become stronger clinically and we continue to work with families."
- The service was focusing on increasing knowledge around Dementia within the home. Staff had now taken on roles of wellbeing and focus had been given to activities for people. Some staff had been put forward to start a Dementia diploma and the director said, "We recognise that senior staff need to increase

their awareness in Dementia and be forward thinking."

Working in partnership with others

- The service encouraged links with the local community. A communion practice would be available weekly for people and the school choir had also visited. The home had some regular volunteers who came and spent time with people.