# Eastlands Health Care Limited

# Eastlands

## Inspection report

Kingfisher Way
Sutton In Ashfield
Nottinghamshire
NG17 4BR

Tel: 01623528960

Date of inspection visit:
27 June 2017

Date of publication:
09 August 2017

## Ratings

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

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

# Summary of findings

## Overall summary

We carried out an unannounced inspection of the service on 27 June 2017. Eastlands provides accommodation for up to 20 people who require nursing and personal care services. On the day of our inspection 17 people were using the service with one of those attending for a short period of respite.

On the day of our inspection there was not a registered manager in place and there had not been for a period of six weeks. An application had not yet been submitted for a new registered manager, although we were assured by a representative of the provider that recruitment was on-going. 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. We will continue to monitor the recruitment and application process and will address any further delays with the provider.

During our previous inspection on 8 September 2016 we identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the safe management of people's medicines. During this inspection we checked to see whether improvements had been made and we found they had. We did find one omission in a person's medicine administration records; however stock levels suggested the person had received their medicines. Other areas of safe medicine management such as; storage, administration and timely ordering were now managed effectively.

Staff could identify the potential signs of abuse and knew who to report any concerns to. Risks to people's safety were continually assessed and reviewed. There were enough staff to keep people safe and to meet their needs.

The principles of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards, had, on the whole been followed when decisions were made about people's care.

People were supported by staff who completed an induction prior to commencing their role. Staff training had taken place, with refresher courses booked for the staff that needed them. Staff felt supported by the manager.

People were supported to maintain good health in relation to their food and drink. People's day to day health needs were met by staff and referrals to relevant health services were made where needed.

Staff were kind and caring and provided people with dignified, respectful and compassionate care and support. Staff were knowledgeable about people's needs and listened to and acted upon their views. People's privacy and dignity were maintained. People were involved with decisions made about their care and were encouraged to lead as independent a life as possible. People were provided with information about how they could access independent advocates, although this information needed to be placed in a

more accessible part of home. People's friends and relatives were able to visit whenever they wanted to.

People were encouraged to take part in activities, as well as following their own hobbies and interests. Two activities coordinators were in place to support people with this. People living at the home had detailed person centred care plans in place which contained their preferences and likes and dislikes. Staff were knowledgeable about people's preferences. Some care plan documentation required archiving to ensure all records available for staff were reflective of people's current health needs. People were provided with the information they needed if they wished to make a complaint and relatives felt their complaint would be acted on.

A registered manager was not in place at the time of the inspection. This had led to some complaints received by relatives not being responded to in a timely manner. The current manager was respected and well-liked by all. People were invited to regular reviews with their key workers to discuss their needs and were encouraged to provide feedback about the quality of the service. Quality assurance processes were in place to ensure people and others were safe in the home.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People's medicines were now managed safely.

Staff could identify the potential signs of abuse and knew who to report any concerns to.

Risks to people's safety were continually assessed and reviewed.

There were enough staff to keep people safe and to meet their needs.

### Is the service effective?

Good

The service was effective

The principles of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards, had, in the majority of cases, been followed when decisions were made about people's care.

People were supported by staff who completed an induction prior to commencing their role. Staff training had taken place, with refresher courses booked for the staff that needed them. Staff felt supported by the manager.

People were supported to maintain good health in relation to their food and drink.

People's day to day health needs were met by staff and referrals to relevant health services were made where needed.

### Is the service caring?

Good

The service was caring.

Staff were kind and caring and provided people with dignified, respectful and compassionate care and support.

Staff were knowledgeable about people's needs and listened to and acted upon their views. People's privacy and dignity were maintained.

People were involved with decisions made about their care and were encouraged to lead as independent a life as possible.

People were provided with information about how they could access independent advocates, although this information needed to be placed in a more accessible part of home.

People's friends and relatives were able to visit whenever they wanted to.

## Is the service responsive?

Good

The service was responsive.

People were encouraged to take part in activities, as well as following their own hobbies and interests.

People living at the home had detailed person centred care plans in place which contained their preferences and likes and dislikes. Staff were knowledgeable about people's preferences.

People were provided with the information they needed if they wished to make a complaint and relatives felt their complaint would be acted on.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A registered manager was not in place at the time of the inspection. This had led to some complaints received by relatives not being responded to in a timely manner.

The current manager was respected and well-liked by all.

People were invited to regular reviews with their key workers to discuss their needs and were encouraged to provide feedback about the quality of the service.

Quality assurance processes were in place to ensure people and others were safe in the home.

# Eastlands

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

This comprehensive inspection was carried out on the 27 June 2017 by one inspector and a specialist advisor, who was a nurse.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about. Information that had been sent to us by other agencies was also considered prior to the inspection. This included the local authority who commissioned services from the provider.

Due to the people living at the home having varying communication needs we were only able to speak with one person living at the service. We undertook observations throughout the day to help us to gain the views of people who used the service and spoke with two visiting relatives. We also spoke with the chef, two nurses, a member of the care staff, an activities coordinator, the administrator, the manager and a representative of the provider. We also spoke with one visiting health and social care professionals.

We looked at care records relating to seven people living at the home as well as medicine records for all others. We reviewed other records relevant to the running of the service such as, staff recruitment records, quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Good

# Is the service safe?

## Our findings

During our inspection on 8 September 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities). This was in relation to the management of people's medicines. We found people's medicines were not always managed safely. Processes for the timely ordering of people's medicines were not effective. We also identified discrepancies in the stock levels of some medicines and people's medicine administration records were not always appropriately completed. Guidance for the administration of 'as needed' medicines was in place, although a review of the administration of these medicines was needed to ensure they were administered appropriately.

During this inspection we checked to see whether improvements had been made and found they had.

A relative told us they were happy with the way their family member's medicines were managed at the home.

People's medicine administration records (MAR) contained a photograph of them to reduce the risk of medicines being administered to the wrong person. Additionally, details of people's allergies were also recorded to reduce the risk of them experiencing avoidable harm. We saw the way people liked to take their medicines had also been recorded. We observed a member of staff administer people's medicines. They did so safely and patiently.

In each of the MAR that we looked at we saw the majority of these had been completed correctly showing when a person had taken or refused to take their medicines. We did find one example where a person's records did not state whether they had received their medicines, but when we checked the levels of stock for this person, we found the correct amount was in place. This would indicate the person received their medicine.

When people received 'as needed' medicines, protocols for the safe administration of these were in place. As needed medicines are not given at set times of the day and are only administered if a person is showing signs that the medicines are needed, such as an increase in pain or agitation.

People's medicines were stored safely in locked cabinets within a locked room. Regular checks of the temperature of the room, cupboard and fridges where the medicines were stored were carried out. These were completed to ensure the effectiveness of people's medicines was not affected by temperatures that were too hot or too cold. We found the temperatures recorded were within safe limits.

Records showed that staff who administered medicines had received the appropriate training. The manager told us staff competency was regularly assessed to ensure medicines were administered safely and in line with current best practice guidelines.

The person and visiting relatives we spoke with did not raise any concerns with us about their or their family member's safety at the home. Processes were in place to reduce the risk of people experiencing avoidable

harm. Staff were trained to identify and to report incidents which could cause people harm. Staff spoken with could explain who they reported concerns to both internally and to external agencies such as the local safeguarding team or the CQC. A safeguarding policy was in place and records showed this was adhered to by care staff and the manager.

Information about how to reduce the risk of injury and harm was available in people's care plans. Where risks to people's health and safety had been identified prior to admission, detailed risk assessments were in place to help support each person without unnecessarily restricting their freedom. We saw adjustments such as the use of bedrails or sensor mats had been made to further support people safely. Other risk assessments such as people's ability to access the community safely, nutrition, managing seizures and medicines were also in place. These assessments were regularly reviewed. Care staff spoken with were aware of people's needs and the support they required to reduce risk.

Regular assessments of the environment people lived in were conducted to ensure that people were safe. Equipment used to support people such as wheelchairs and specially adapted baths were regularly serviced by external professionals. Gas installations, fire safety and prevention equipment and the home's lift were also regularly serviced to ensure the risk to people's safety was reduced. People had individualised personal emergency evacuation plans (PEEP) in place that enabled staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner. These were regularly reviewed to ensure they met people's current needs.

Processes were in place to ensure that when an accident or incident had occurred at the home, they were investigated thoroughly and where needed, preventative measures were put in place to reduce the risk of reoccurrence. The number of accidents and incidents was closely monitored by the manager and where trends had been identified action had been taken. This had, on occasion, resulted in referrals to external health and social care professionals for further advice and guidance.

People and their relatives did not raise any significant concerns about the number of staff available to support them or their family members. However one relative did say, "Staffing is ok but they are stretched at the weekend." The staff we spoke felt there were generally enough staff on duty to meet people's needs. A member of staff told us they felt another person would be helpful, however, they also said, "Staffing is a lot better than it was. It works better now." The nurses told us they felt their workload was busy but manageable with the number of people currently using the service. One said, "You just need to be organised," whilst another said as long as there was a good team leader on duty, it made all the difference.

The manager explained how the number of staff assigned to support people safely and to meet their needs was calculated. A dependency assessment tool was in place and this corresponded to the number of staff showing on the staff rota and the number of staff working on the day of the inspection. The manager told us the nursing hours were soon to increase due to a new deputy manager being recruited. They told us the deputy manager would provide additional support to the nurses working at the home and would offer valuable support during busier periods.

During this inspection we observed staff delivering care and support in a calm and unhurried manner. People were not left unattended for long periods of time. When people requested the support of staff, this was provided immediately. Busier periods such as meal times were well organised, with enough staff available to support people.

Safe recruitment procedures were in place. Checks on staff suitability to carry out their role before they commenced work were carried out. This included checks to establish whether a potential member of staff

had a criminal record, whether they had sufficient references and proof of identity. This reduced the risk of people receiving care and support from unsuitable staff.

The manager told us they had a dedicated and flexible team of staff who covered shifts when others were sick or on annual leave. This, they told us, meant there was no requirement to use agency staff which meant people received a consistent level of care and support from staff who knew and understood them well.

Good

# Is the service effective?

## Our findings

The person we spoke with told us staff understood how to support them and did so effectively. Relatives also spoke positively about the way staff supported their family members.

Staff received an induction, which for new staff included the completion of the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers. An on-going, detailed training programme was also in place which provided staff with the skills needed to be able to support people effectively. Records showed that staff had been given training in how to support people safely and where refresher training was needed, in areas such as the safe moving and handling of people and safeguarding of adults, training courses had been booked for those staff that needed it. The staff we spoke with felt well trained and felt the frequency and quality of the training had improved. One staff member said, "Previously I had been asking for training but nothing happened, but recently we have had a lot of training." Another staff member said, "The manager is listening and booking training for us."

There was an on-going supervision programme in place which enabled the manager to review staff performance and to address any areas of concern with the staff. This was also an opportunity for staff to discuss their role and any areas for development. Staff were also encouraged to complete a recognised external qualification in health and social care to further enhance their skills. The staff we spoke with felt supported by the manager. One member of staff said, "If you want to know anything the nurses and management are very knowledgeable and will help you out."

Individual care records contained detailed guidance for staff that enabled them to communicate effectively with people who used the service. We observed staff communicate with people patiently and with respect and empathy. Guidance was also in place for staff to support people who may present behaviours that may challenge others. We saw people respond positively to the way staff supported them throughout the inspection. The approach of staff led to a calm atmosphere within the home.

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. We checked whether the service was working within the principles of the MCA.

All of the care records we looked at contained assessments of people's capacity to make decisions in a wide variety of areas. These included people's ability to manage their own medicines and whether bedrails were needed to keep them safe when they were in bed. These were reviewed regularly. We noted the majority of these contained detailed descriptions of the agreed decisions taken, with input from relatives and healthcare professionals where needed. A small number of these assessments did require further detail about the specific decision being made for each person. We noted on occasions the documentation was not always decision specific and covered too broad an area. However, we were reassured by the manager that

decisions were always taken in people's best interest and they would carry out a review of all MCA paperwork to ensure they were all completed in line with the principles of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We looked at the documentation for two people who had a DoLS in place and found staff adhered to the terms of the authorisation..

Staff displayed a good knowledge of MCA and DoLS and were able to give good examples of its application. Observations of staff showed that they always asked for people's consent before carrying out care or support tasks and explained what they were doing and why.

The person we spoke with was positive about the food provided for them at the home. They told us there was always a choice of two main meals and if they did not like either of them staff would offer them an alternative. They also told us meals were planned with them the day before, there was plenty to eat and the quality of the food was good. A relative said, "They [staff] do some good dishes." They also told us that due to their family member being unable to communicate their preferences staff had involved them by seeking information about their food and drink preferences. The relative welcomed this and liked being able to choose food they knew their family member would like.

We observed people attending the 'breakfast club' which was a social occasion. Staff offered them a choice of a cooked breakfast and assisted people who required support to eat. There was a relaxed atmosphere and staff were attentive to people's needs whilst chatting with them and involving people in choices wherever possible.

Nutritional risk assessments were completed and reviewed monthly and nutritional care plans were developed. These contained details of the each person's support needs, any special nutritional requirements and food preferences. A dietary notification sheet was completed to provide further details about people's dietary requirements and food preferences. Staff were knowledgeable about foods which should be avoided for individual people due to intolerances or allergies.

We spoke with the chef and they told us they used fresh food and vegetables and had a weekly order with a local supplier. They said a 'residents' forum' was used to obtain feedback from people on the food and whether they would like to add anything to the menu. There was a four weekly, season appropriate, rotating menu, and a choice of two main meals and a vegetarian option were served daily. At the time of the inspection one person using the service was a vegan and we were told the chef discussed what they would like to eat on a daily basis.

People's weight was monitored monthly or weekly depending on their level of nutritional risk. When a person started to lose weight, staff identified this and referred the person to a dietician. As a result their nutritional needs were reviewed and staff followed the dietician's advice by providing nutritional supplements.

A person we spoke with and two relatives told us staff were alert to changes in their or family members' day to day health needs. One person told us staff recognised when they were feeling unwell and ensured they were reviewed by their GP or emergency medical assistance when necessary.

People's care records contained examples of the involvement of a range of specialist services such as an epilepsy nurse specialist, tissue viability nurse, optician, dietician and speech and language therapist.

Records showed advice from a physiotherapist had been acted on with clear goals and objectives in place to support the person's needs. Should people require treatment at a hospital, information was available to go with them to inform hospital staff to be aware of each person's individual health needs. This reduced the risk of people receiving treatment that was not appropriate to their needs.

A visiting professional spoke positively about the staff. They told us staff shared enough information with them to enable them to tailor the time they visited to the person's preferences and needs. They said staff were available to support the person when needed.

Good

# Is the service caring?

## Our findings

The person we spoke with and visiting relatives on the whole spoke positively about the staff. They thought they were kind, caring and helpful. One person said, "They [staff] are very good. They are nice, helpful and pleasant." One person told us staff were caring although some staff appeared to have more empathy and understanding of their situation than others. The relatives were pleased with the approach of staff, with two telling us they had no concerns at all. One relative said, "The more mature staff in particular are very good, although some of the younger ones are very good too."

Staff were respectful of people's care needs and spoke discreetly when discussing sensitive issues. For example, we saw a conversation taking place following training from a healthcare specialist. The staff were discussing the most appropriate way to incorporate their learning into supporting the person in a way that would be the most dignified for the person. This showed a great empathy and understanding for this person's individual needs.

We saw warm and friendly interactions between people and staff. Although staff were busy at times, they always ensured people were responded to quickly, worked with a smile and spoke respectfully and compassionately at all times. We saw a 'code of respect' was in place which informed people how they should expect to be treated by staff and what to do if they felt staff were falling short of this code.

People were supported by staff who had a good understanding of what was important to them. People's life history and past achievements were recorded that enabled staff to have a good understanding of the person and what was important to them. Staff we spoke with demonstrated a good understanding of people's character and treated everyone as individuals. They were aware of people's likes and dislikes and how this would affect the care they provided.

People were encouraged to make decisions about their care and support needs and where able, were regularly asked for their views in case they wanted to make changes. People were supported to achieve their goals and an achievements board was in place to celebrate people's success. These ranged from day to day tasks such as making a cup of team for themselves and others, achieving goals in relation to their hobbies or interests or goals such as meeting rehabilitation targets. The manager was particularly proud of this board and told us people enjoyed seeing their and other's success being openly celebrated.

People's care records showed their religious and cultural needs had been discussed with them and support was in place from staff if they wished to incorporate these into their life. The manager told us no person currently had any requirements in this area but immediate support would be provided if needed.

Information was available for people about how they could access and receive support from an independent advocate to make decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care. However we did note this information was only available in the reception of the home which people were unlikely to regularly access. The manager told us they would display this in a more

accessible place within the home.

We saw people were supported to be as independent as they wanted to be. People who had difficulties with mobilising independently were encouraged to do as much for themselves as possible. Staff support was always available when needed. People's care records clearly described the level of support needed to enable people to carry out tasks independently. Staff were knowledgeable about people's individual needs in relation to this.

People told us they felt staff treated them with dignity and respect. Staff gave us examples of how they ensured people's dignity was maintained at all times. They told us they knocked on people's doors before entering and ensured they covered them as much as possible when providing personal care, ensuring they always closed the door and the curtains. We observed this during the inspection. We noted staff had signed up to a 'dignity in care' pledge, aimed at ensuring all people were treated with dignity at all times.

People's privacy was respected within the home. There was sufficient private space throughout the home if people wished to be alone, or to spend time with family and friends. People's care records on the whole were handled respectfully and were locked away when not in use. We did note one occasion where a person's daily record had been left in a communal area and could pose a risk to the person's privacy. We raised this with a member of staff who removed the documents immediately.

The manager told us that people's relatives and friends were able to visit them without any unnecessary restriction. We observed and spoke with relatives visiting during the inspection who confirmed this.

Good

# Is the service responsive?

## Our findings

People were supported to do things they wanted and to follow the hobbies and interests that were important to them. Care records contained a social activities support plan and staff recorded the activities people had participated in. For example, we saw a person had recently attended the home's 'breakfast club', attended a film afternoon and attended a performance by a magician at the home. On the day of the inspection a weekly 'breakfast club' took place with a cooked breakfast and a quiz. People from both floors of the service participated. We saw a planned schedule of weekly activities displayed on the wall of a communal area. There were activities planned for within the service each day, such as pamper sessions, a crafts group, baking and a games day.

Activities outside of the home also took place. Staff told us people had the opportunity to access the local community and mentioned going out to the cinema, bowling, and shopping. However, the person we talked with said they did not get out as frequently as they would like.

There were two full time activities coordinators who worked across the weekday and weekends ensuring people received support with their interests seven days a week. They told us that when people were admitted to the home they talked with them and their families about things they liked to do and a schedule of activities was put in place based on their interests. They told us they provided people with a wide range of activities that people had expressed an interest in attending. They mentioned barbeques, afternoon tea in the garden, gardening and watching classic movies. Several people were also going on holiday together later in the summer. The activities coordinators told us they felt the activities had improved a lot since our last inspection although they felt there was still room for improvement.

Personalised care records were in place for each person living at the home. Each care record contained a summary of people's needs and key contacts for relatives and professionals involved in their care. People's preferences for their personal care needs, the time they wished to go to bed and to get up each day and the food and drink they preferred were just some of the examples of the personalised care provided for people.

Each person's care records provided information about their preferences in relation to their care and a good level of detail was in place in relation to individualised support they required. Health care plans provided information on how to manage each person's health needs and when to seek specialist or medical advice. For example, a person had a specific health condition that required regular monitoring. A clear process for nursing staff to follow was in place, with detailed records completed by the nursing staff which showed the support the person had received and how their condition was progressing. We also saw when people were at risk of developing, or currently had a pressure ulcer or other skin lesions, care plans were in place and the progress of wound healing was assessed regularly.

We did note that one person received nutritional intake via percutaneous endoscopic gastrostomy (PEG). This is a medical procedure in which a tube is passed into a patient's stomach when oral intake is not possible. We noted this was on the whole provided sufficiently however the records used to record the tube retraction and rotation were not always recorded in the daily records of care. When we discussed this with

the manager they told us they used to use a record sheet specifically for this and would re-introduce it immediately.

People's care records contained a range of assessments and care planning documents that enabled staff to respond to people's changing needs. Prior to people coming to live at the home we saw pre-admission assessments had been carried out to ensure their needs could be met by the staff.

Detailed care planning records were in place. In some cases, these records had not been archived when people's needs had changed and although an up to date care plan was in place, there was a risk that this could confuse staff if they viewed the incorrect document. We raised this with the manager and they agreed with our observations. They told us a new care planning system was due to be introduced which would significantly decrease the amount of records within people's care plans.

People were cared for by staff who had a good understanding of their care needs and ensured that the care was provided at the right time; for example, when administering medicines and personal care. We saw that staff communicated well with each other and people using the service to ensure that everyone received the care and support they required. Staff we spoke with had a thorough understanding of people's needs and told us they found the care plans contained useful information.

The person living at the home and the relatives we spoke with told us they had not needed to make a formal complaint, but felt it would be acted on if they did. A relative said, "I would go and see the manager. I have never done it but that's what I would do."

A complaints procedure was in place which informed people and their relatives of how to make a complaint and how they should expect it to be managed and responded to.

Requires Improvement

# Is the service well-led?

## Our findings

A registered manager had not been in place for six weeks at the home at the time of the inspection. We spoke with the manager and representative of the provider during the inspection and established that whilst recruitment was on-going, an application for a registered manager had not yet been submitted to the CQC. We were advised the previous registered manager had left with little notice and therefore they were urgently seeking a full time replacement. The current manager, although experienced in the role, told us they would not be applying for the permanent position and would be returning to their previous role within the provider group once a full time registered manager was in post. It was acknowledged by the representative of the provider that the recruitment of a full time registered manager was urgent and was being prioritised.

We did note that during the period when the previous registered manager was unavailable, records showed that responses to some complaints, received by relatives of people living at the home, were not always responded to in line with the provider's complaints policy. The policy stated responses should have been received by the complainant within 28 days. We found three examples where due to the lack of a registered manager in place this had not happened, with all responses taking over 40 days with no explanation why there had been a delay. The current manager told us this had now been rectified and acknowledged the period of uncertainty over the management of the home had resulted in some complaints not be addressed as quickly as they should have been.

Following our previous inspection, we noted the rating for that inspection was on display in the main reception of the home. The provider operated in an open and transparent way ensuring people living at the home, relatives, visitors and healthcare professionals were aware of the home's current CQC rating and where appropriate the areas they needed to improve.

The manager had a clear understanding of their role and responsibilities until a new registered manager was appointed. They had processes in place that ensured the CQC and other agencies, such as the local authority safeguarding team were notified of any issues that could affect the running of the service or people who used the service.

Staff and relatives welcomed the approach of the current manager and felt they had improved the home. A relative described them as "nice" although they were concerned that the appointment was not permanent and another manager would be in place. They went on to say, "They seem to change managers quite a bit." Staff spoken with were positive about the current manager and their leadership style. One staff member said, "She is one of the first managers here to listen to you and act on what you say straight away." Another said, "She's brilliant. In a short period of time the feel of the home has totally changed; the atmosphere is different." They went on to say the manager was firm but very approachable. Staff also felt able to contribute to the development of the service and their opinions were valued. One staff member told us they had been asked to write down their ideas for improvement and the manager told them they would consider all the ideas and consider the changes which could be made.

People living at the home were also supported to give their views. Quarterly review meetings were held with

their key workers and with relatives invited where appropriate. This was an opportunity to raise any concerns they may have and to discuss changes that they wished to be made to their care and support provision. Records showed action plans were in place and reviewed that ensured any agreed changes were implemented.

A detailed auditing and review process was in place that identified areas for improvement before they impacted on people's health and welfare. An external consultancy was used to carry out detailed audits to inform the manager and the provider of areas that were operating effectively and areas that required improving. In addition to the external audits, monthly provider compliance reviews were carried out, with areas for improvement highlighted to the manager and action plans put in place, with timescales agreed to carry out the required improvements. Other audits such as the environment; care plans and medicines were completed by the manager and where appropriate the heads of department. These heads, such as the cook, nurse in charge and senior care staff carried out regular reviews in their own departments and reported back daily to the manager. The manager told us and records confirmed that daily heads of department meetings were also held to agree any immediate actions and to delegate responsibility for their completion to other staff within the home. The manager told us they felt the current auditing process was effective in highlighting areas of improvement and reduced the risk to people's health and welfare.

The manager told us they tried to ensure there was an open and transparent approach throughout the home. They told us people, relatives, staff and visitors were welcome to discuss anything with them and they would always try to address any concerns raised. Results of internal audits were made available for all to view along with a 'You said, we did' board which highlighted the things people had recently asked for and what action had been taken. An 'easy read' service user guide was also available for people living at home which explained how they should expect to be treated by staff and what to do if the quality of the service they received dropped below the expected level.

People were supported by staff who had an understanding of the whistleblowing process and there was a whistleblowing policy in place. Whistleblowers are employees, who become aware of inappropriate activities taking place in a business either through witnessing the behaviour or being told about it.