Ivybank Health Care Limited

Ivy Bank Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Ivy bank is a residential care home without nursing for 27 older people most of whom are living with dementia. At the time of this inspection there were 24 people living in the service.

People's experience of using the service and what we found
Most people could not tell us what living in the service was like for them, but we observed them to be relaxed, and comfortable with each other and with staff. Those who were able to and several relatives spoke positively about the service and staff.

The manager and staff had taken steps to address previous breaches in regulations and to implement previous recommendations we had made for improvements to the service.

Quality checks of important aspects of the service were completed regularly. People with the support of relatives were consulted about their care and support which was recorded.

People were provided with accessible information to make choices about their meals activities and to help describe their pain levels when needed. The manager was aware of and taking action so that key information such as safeguarding and complaints was to be provided in easier to read formats.

People and their relatives felt able to approach staff with complaints. There was a need to confirm arrangements with staff about how people's minor complaints were being recorded, acted upon and monitored to ensure these are not overlooked.

People and relatives had discussed preferences about end of life arrangements which had been recorded to ensure people received the care they wanted when they approached the end of their life.

People were safeguarded from the risk of abuse. Care was delivered in a safe manner in accordance with needs and wishes. Staff received induction into their roles and were provided with training to give them the basic knowledge and skills needed to support people safely. There were enough staff to support people's needs, and there was a safe system of recruitment for new staff.

Medicines were managed safely. People were supported to access health appointments and receive medical attention when needed. Accidents and incidents were recorded and acted upon, these were analysed, and lessons learned when things had gone wrong.

Investment in the premises was ongoing. People lived in a clean homely environment where procedures were in place for its maintenance and upkeep. All necessary health and safety checks were made. Equipment including fire safety systems was tested and serviced at regular intervals to ensure it remained safe to use. Personal evacuation plans were in place for people in the event of fire. Staff attended fire

training and drills to understand how to respond in the event of a fire.

People were supported to have maximum choice and control of their lives and care staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice. Policies and procedures informing staff practice were kept updated and cascaded to staff when changes occurred.

People's privacy, dignity and confidentiality was supported through staff practice. People could spend their time how they chose but could occupy themselves by participating in a programme of planned activities facilitated by an activity's person.

People and relatives were kept informed about developments in the service through family meetings. Staff received information about changes through emails, regular staff meetings, the communication book and staff handovers to ensure they worked in accordance with the latest advice and guidance.
People, relatives and health and social care professionals were encouraged to share their views about the service and suggestion for improvement through regular surveys their responses were analysed to inform service improvement. The outcomes of surveys were displayed in the service for people to see how their information informed service development. Staff told us that communication and team work were good and they enjoyed working at the service.

For more details, please read the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating inspection for this service was requires improvement (published 5 December 2018) and there were two breaches of regulation one of which was continued. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found enough improvement had been made and the provider was no longer in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-Led findings below.

Ivy Bank Residential Care Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was conducted by one Inspector.

Service and service type
Ivy Bank is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager who had applied to register with the Care Quality Commission and was awaiting confirmation of their registration. Once registered this means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on the first day. We told them when we would go back for the second day of inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who worked with the service. We used information the registered provider sent us as notifications and enquiries. The provider was asked to complete a provider information

return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection-
We spoke with three care staff including a senior, we also spoke with the Activities co-ordinator, the deputy manager and manager, the maintenance person, one of the housekeeping staff and the registered provider. We met with three people who were able to comment about their experiences of support in the service. We spent time in the communal lounge so we could make observations of care for people who could not tell us about the support they received. We spoke with five relatives.

We reviewed a range of records that included three peoples care plans, risk assessments and medicine records. This helped us to understand how people's care was planned, delivered and reviewed. We also reviewed a range of operational records relating to the management of the service. These included staff recruitment, training supervision and appraisal records, equipment servicing, accidents and incidents. We reviewed the systems and processes used by the manager to assess, monitor and evaluate the service.

After the inspection –
We asked the manager to provide additional evidence in respect of staff training which was provided the next day.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has now improved to Good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management

● At our last inspection the provider had failed to robustly assess and record the risks relating to the health safety and welfare of some people regarding the risks to their well being as a result of conditions such as diabetes and epilepsy, or from choking or falls. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Risks from peoples specific care needs around epilepsy, diabetes, choking or falls had since been reviewed. Individual risk assessments and plans of care had been developed for epilepsy, diabetes, choking and falls. These detailed the support people needed and risk reduction measures in place to keep people safe. For example, risk information made clear what to look for if a persons blood glucose level became to high or low and the steps staff should take. For those at risk of choking clear guidance from speech and language informed how risks were mitigated by using pureed foods and thickeners to reduce choking risks. Enough improvement in these areas had been made at this inspection that the provider was no longer in breach of regulation 12.

● People who were able to tell us said they felt safe and happy in the service. Staff were aware of which people required additional support to keep them safe.

● Assessments of the environment's safety had been developed, and Individualised risk assessments specific to people. Risks were clearly set out and mitigated within each person's support plan.

● Risk assessments informed staff of the control measures in place to keep people safe. For example, staff ensured people who remained in bed were repositioned regularly. Appropriate sprays and creams were administered to help keep their skin intact and equipment to reduce the likelihood of pressure ulcers developing was in place.

● People lived in a safe environment. Checks and tests of equipment such as the lift, hoists, electrical items and fire precaution equipment were conducted at regular intervals. A maintenance person provided support for minor repairs. Staff said this worked well.

● Staff were aware of the steps to take when the fire alarm sounded and practiced this on a regular basis through drills. Individual plans of evacuation were in place to inform staff what support each person needed to evacuate the building safely.

Systems and processes to safeguard people from the risk of abuse

● Staff received training to understand and be aware of how to protect people from harm from others. They were able to describe what they understood as different forms of abuse. They knew how they could report their suspicions of abuse to the manager and provider using the whistleblowing or safeguarding procedures. They understood how to escalate their concerns to other outside agencies should these not be addressed by the management team.

● The new manager had introduced a safeguarding quiz to provide a more interactive learning experience

for staff and this was carried out at the last staff meeting. We discussed with the manager that staff were a little unclear about whether incidents between people were considered counted as a safeguarding incident. Although staff were clear these would be reported to the manager as incidents. The manager agreed to revisit this aspect of safeguarding with staff.

Staffing and recruitment

● Previously we had recommended the use of a dependency tool to calculate staffing needs. This had been implemented. There were enough staff to support people. Routines were relaxed and tailored to meet people's specific needs. For example, those who wanted to get up early were supported to do so. Other people liked to take their time and breakfast was served to them when they got up. People's assessed dependency needs were kept under review to ensure people's needs could continue to be met by the numbers of staff deployed.

● Staff records showed there was a safe system of recruitment in place. Staff completed application forms and attended for interview. Their suitability was thoroughly checked in accordance with the requirements of legislation including obtaining references, confirming their identity and completing a criminal record check.

Using medicines safely

● Only staff who had completed medicines training administered medicines to people. Staff medicines training was kept updated and administering staff competencies observed and checked annually. An audit of medicines management was conducted to ensure all aspects were managed safely.,

● Appropriate systems were in place for the ordering, receipt, storage and disposal of medicines. A daily record was made of medication room and medication fridge temperatures.

● Medication records were completed appropriately with no omissions in recording. Handwritten entries made by staff were signed and dated. Protocols were in place to inform and guide staff about administration of 'as and when' prescribed medicines.

Preventing and controlling infection

● The home was clean, housekeeping staff worked to cleaning schedules to maintain individual rooms and communal areas.

● Staff were observed using gloves and aprons. Supplies of these were noted around the service

● An odour was detected in two small areas. Cleaning staff told us that the carpet cleaner had been unavailable this was returned during inspection and the two areas cleaned thoroughly. We discussed with the manager and provider whether consideration needed to be given to providing alternative flooring in areas of heavier soiling in consultation with people and their relatives.

● The laundry was well equipped, but the environment was tired and in need of upgrading, which was planned. Soiled laundry was handled safely with appropriate separation of soiled and normal laundry.

Learning lessons when things go wrong

● All incidents and accidents involving people in the service were recorded and acted upon to ensure they remained safe. The manager analysed all incidents and accidents looking for any possible trends or patterns. Action was taken to minimise the risk of further similar occurrences.

● The manager and staff reflected on incidents and accidents and how they could have managed them differently. For example, one person who could not have side rails because of their dementia but had not previously been shown to be at risk of falling out of bed. Fell from their bed and hit their head on a piece of furniture. As a result, the bed was lowered a mat was installed when the person was in bed, so they would be safer if they fell and furniture was moved to minimise the likelihood of similar incidents.

● Relevant risk assessments and care plans were reviewed to assess whether risk reduction measures in place remained effective or required strengthening.

Good

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.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has improved to Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience

- New staff received an induction to the service. Induction involved learning about the policies and procedures that guided staff practice. New staff gained an understanding of the routines of the service and learned about the people they would be supporting. This involved working alongside more experienced staff as an extra until they felt confident. New staff completed a probationary period and the skills for care certificate if new to care. New staff also completed a mandatory programme of training. This provided them with the basic knowledge and skills needed to support people safely .
- There was an established programme of training that staff were required to update at regular intervals. Staff were observed to be supporting people safely. The absence of a manager however, had meant training updates had not happened and were overdue. The manager was addressing this shortfall with several training course dates booked. We will check this on our next inspection.
- Staff told us that they felt better supported with the new manager in post who they thought was acting to improve things, and who they found approachable. Staff had not received regular supervision while there was no manager. The manager had commenced these for staff and a schedule had been developed to plan supervisions at 6-8 weekly intervals. Annual appraisals were being held for those staff in post long enough to qualify.

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

- Assessments informed the development of individualised care and risk plans. We had previously identified one person was without a care plan despite being resident for some months. The new manager ensured everyone had an electronic care plan in place and the system showed this to be the case.
- People's admission to the service was planned and their needs assessed prior to admission to ensure these could be met. These provided staff with the guidance and information they needed to understand people's day to day support needs. This information was reviewed at regular intervals or sooner if there were changes in needs
- Assessments gathered information from people and professionals. These covered people's personal care, communication, personal history, and any associated risks. These also considered lifestyle choices and what support a person may need from staff. This enabled people to be treated in a person centred way. Transition to the service was arranged at a pace to suit the person..

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

- Some people had special dietary needs, these were documented in their care plans and were well understood by both kitchen and care staff. For example, one person would only drink hot chocolate.

Concerns about this had been discussed with relevant health professionals. Whilst not ideal, staff reinforced the hot chocolate with milk and cream to give added nutritional value as advised.

● A person assessed by the Speech and language team (SALT) was at risk of choking, this was documented in the care plan. Staff followed the advice from SALT on how to provide the right consistency of food. Food was pureed. Staff used thickeners in drinks to minimise the risk of the person choking.

● People could eat where they preferred. Some people liked to sit together on a large table. Smaller tables were set aside for those who preferred to eat alone or in a smaller group. Mealtimes were relaxed. Those who needed assistance received this in a patient and compassionate manner from staff. Staff sat at eye level and engaged with people they were supporting with their meal to encourage them to eat.

● Pictorial menus were used to help people make decisions about what they wanted to eat. People enjoyed their food and were supported to eat independently through the provision of plate guards, adapted cutlery, and drinking beakers.

● Food and fluid intake were monitored for everyone with close attention given to those deemed to be more at risk of not maintaining a good diet.

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

● Previously we had identified that parts of the service were tired and in need of redecoration. The premises were undergoing a redecoration and upgrading programme to provide décor that was more soothing and calming for people living with dementia.

● A small enclosed courtyard in the centre of the service was being updated to provide a safe space for people to sit out in the open air. A first-floor balcony which was kept locked was also going to offer similar outlet once made safe and relevant risk measures in place.

There was a lift to the first floor to aid accessibility around the building.

● People were provided with the equipment required to support their mobility and care needs. The service was accessible with ramps and a lift to the first floor to aid accessibility around the building.

● A 'virtual assistant' system had been provided so that people and staff could ask it to play different music tracks. Staff were aware of what music people liked and requested this for them. People were seen to enjoy the music played.

● There were enough communal toilets and bathrooms and many people had ensuite facilities in their rooms. There was some signage denoting toilets and bathrooms and the manager has ideas for developing this further.

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

● Relatives told us that staff referred people if they had concerns about their health. Staff supported people to appointments if relatives were unable to do so. Relatives thought that staff kept them informed about changes in their family members health needs.

● Records showed that staff were making appropriate contact with health professionals to access appointments and health care advice and support. A visiting community nurse told us that they had no concerns about the service. They told us that staff used the community nurse service responsibly, and referrals received from the service were appropriate. Staff understood how to monitor people's health needs and take appropriate action.

● Staff had received training and understood how to provide basic support around catheter care for one person admitted to the service from hospital. A referral to the community nurse team had been made to support this. Staff were changing drainage bags, monitoring for signs of infection and recording fluid inputs and outputs. The manager agreed to look at how fluid output recording on the new electronic system could be enhanced to alert staff if inputs and outputs were too low.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorizations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Where possible people were supported to make everyday decisions for themselves. For example, people were supported to choose what they wanted to eat or drink. What clothes they wanted to wear, and how they wanted to spend their time each day.
● For those people lacking capacity to make some more important decisions for themselves the manager ensured decisions were undertaken in their best interest. Relatives and social care and health professionals were consulted where necessary to help this process.
● Where capacity assessments indicated restrictions needed to be implemented for peoples own safety, an application was made to obtain appropriate DoLS authorisation to do this. Arrangements existed for any conditions on authorised applications to be implemented. This ensured people's legal rights were respected.

Good

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.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- A few people were able to tell us how much they enjoyed living at the home and were happy with the support staff gave them. They said they were consulted about their care by staff. Relatives spoke positively about the care their family members received. One told us "staff are very lovely, good with people."
- Initial assessment identified if people required support around equality and diversity issues and this would inform their care plan. The manager and staff understood the importance of respecting people's lifestyle choices. Policy and procedure guided staff in how to provide a caring environment that promoted equality and diversity. This could include for example provide staff support to help people meet their spiritual needs met.
- All staff including housekeeping and kitchen staff were observed to demonstrate compassionate attitudes towards people with spontaneous expressions and acts of kindness We saw staff stopping to talk and chat with people as they were going about their duties. Staff took time to kneel to be at eye level to find out how people were.
- Staff were seen to be alert to people's needs. For example, we observed a staff member chatting to one person whilst directing a walking stick away pointed by another person trying to get their attention. Staff were alert to people's whereabouts and requests for comfort or support. A staff member said about someone expressing very anxious behaviour "she is a very cuddly person, she likes it and it can distract her."

Promoting people's privacy, dignity and independence

- Staff protected people's dignity and supported them to maintain their appearance. Staff assisted people to dress appropriately. They ensured people's clothes were clean and their hair washed and brushed in a neat style. A relative said " it's the only place he has been where his clothes look good and he is always shaved."
- Staff supported people to maintain their independence. Staff enabled people to do things for themselves such as undertaking some of their personal care. Staff were on hand if the person needed staff support.
- Staff respected and upheld people's privacy. They gave people space to spend time away from others but were observed to check on people to make sure they were ok. Personal care was undertaken discreetly, and staff ensured doors were closed and people were covered up.

Supporting people to express their views and be involved in making decisions about their care

- Staff supported people where possible to be involved in making every day decisions for themselves. For example, choosing whether to participate in activities or not, choosing when they wanted to spend time alone.

● Most people had relatives, legal representatives, friends or care managers from their funding authority to help them with making decisions. These people helped them express their views and preferences. The manager was aware of advocacy services if there was someone without representatives who needed help with decision making.
● Peoples personal information was kept safe. Any written documentation was secured within the office in locked cabinets. Most people's care records were now electronic. All electronic records were password protected, with each staff member having their own personal computer login to access records.

Good

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has improved to Good: This meant people's needs were met through good organisation and delivery.

End of life care and support

- The new manager had made progress in seeking feedback from people and their relatives about personal wishes and preferences should people become gravely unwell.
- At the time of our inspection visit no one was receiving end of life care. The manager was still to add peoples end of life preferences to the care plan to ensure their wishes were respected. The manager agreed to take action to ensure this information was added to care plans to inform staff and enable them to provide support that offered people a dignified and pain free death.
- Staff were aware of those people who had 'not for resuscitation' forms in place. A quick colour coded reference was available to inform staff in an emergency so that they carried out peoples advanced decisions.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Progress had been made to provide people with some information in pictorial formats. The manager understood that further work was needed to ensure that other key information about making a complaint or safeguarding also needed to be provided in easier to read formats and was taking action to address this.
- Most people had lost the ability to understand written information due to their increased needs. Therefore pictorial or sensory formats were important to help them understand the world around them. For example, visual prompts were used to enable people to describe their pain levels or make food choices each day. Pictures were used to inform people about the activities on offer. Staff photographs were displayed to help people recognise the faces of the staff that supported them.
- The manager explained that people's individual communication needs were assessed prior to their admission. This helped staff understand how people best received information.

Improving care quality in response to complaints or concerns

- Relatives and people who could, told us that they felt able to approach staff with any concerns they might have. They felt listened to and said any issues they had were resolved quickly. Staff also said they dealt with minor issues immediately. However, no record was kept of the minor concerns raised so these could be monitored. The manager agreed to look at how this could be better evidenced.
- A complaints record was maintained that detailed complaints received, investigations conducted and their outcome, and whether complaints were resolved satisfactorily. The manager told us, and records

showed that no complaints had been received since the new manager had taken up post. Those preceding this period had been closed.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Previously we had identified that care plans were not always being updated and reviewed. This had improved and the new manager had ensured everyone received an monthly review or sooner if needs changed.

● People, their relatives and relevant health care professionals had been consulted about the care people needed and their preferences. This was recorded in people's care plan records which were regularly reviewed by a senior staff member. Relatives said they were consulted when peoples support, and health needs changed. An annual review afforded relatives the opportunity to comment on the care plan overall.

● We had previously identified that there were issues with the electronic care plan system that led to inconsistencies in the way information was documented. This was not evident at inspection staff were still learning about the system they were using. Information was personalised but the amount of detail that could be added on the new system was word limited at present. The manager agreed to consult with the programme support to see how this could be improved.

● We observed that people were receiving care that was responsive to their specific needs. For example, assistance with eating their meals. Mobilising around the service and being reminded to use their walking aids. Staff managing people's anxieties using personalised de-escalation techniques.

● People when they were in their rooms were provided with call bells. Not everyone was able to use these appropriately. Alarm mats were used therefore to alert staff to people who may be at risk if they mobilised independently, this helped ensure they were given the required support to keep them safe.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Previously we made a recommendation regarding the provision of activities. An activities co-ordinator had since been employed. A programme of activities was displayed with pictorial prompts to help people understand. During inspection we observed a bingo session that people enjoyed because there were small prizes to win. We also observed painting, and individual -1-1 time spent by the co-ordinator with people. Entertainers were booked to come in at intervals each month. Events were organised so that relatives could come and join in. Relatives were pleased with the amount of activities now offered and spoke positively about the activities co-ordinators contribution

● People spent their day as they wished, and they were free to relax in their bedroom or whenever they wanted. For example, one person who preferred their own company said they sometimes went out with the activity's person for a coffee in the town which they enjoyed.

● A virtual assistant enabled people to call out music choices if they wished. We saw staff request music on several occasions that people would know from their past. From people's expressions, smiles and their singing we saw these were good familiar choices that showed staff knew people well. We observed people joining in to sing with staff and several people swaying to music in seated or standing positions.

● Relatives told us they were always made welcome and were invited to attend family meetings or other events. People were supported by staff to maintain links and relationships with the important people in their lives. A relative had been recruited to help with the development of a monthly newsletter for people and other relatives.

Good

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.

At the last inspection this key question was rated as Requires improvements. At this inspection this key question has improved to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Continuous learning and improving care; Working in partnership with others

- At our last inspection on 17 October 2018 there was breach of regulation 12 regarding mitigating risks to keep people safe. There was also a continued breach of Regulation 17 Good Governance. This was due to some audits not having been completed. One person had been without a care plan. Recommendations from an external consultant regarding implementation of specialist care and risk information for conditions such as diabetes and epilepsy had not been implemented. We also made a recommendation in regard to the need for improved stimulation and activity for people. At this inspection we saw improvements in all these areas. The new manager demonstrated drive and determination to improve overall compliance.
- Quality checks were being completed at intervals dependent on the area monitored for example health and safety and medicines were monitored both weekly and monthly. Care plans and risk information were reviewed monthly or sooner if changes occurred. Learning from incidents and accidents informed staff practice.
- Relatives were happy with the way the service was now run. A relative told us "Things have certainly changed for the better since [Name] took over, things are more organised, it runs smoother, there have been improvements to decoration and menus.
- The registered manager accessed websites for guidance and updates such as the provider website operated by CQC, and the National Institute for Health and Care Excellence (NICE) website. They were aware of local manager forums arranged by the local commissioning teams and intended to attend these to network and share good practice.
- Staff were kept updated with changes to policies and procedures, these were cascaded to them through email and discussed at staff meetings. The provider used an external service that provided the service with policy updates; these were adapted to suit the service needs. Staff were required to read updates to understand how changes could impact on their support of people.
- The new manager was building effective relationships with relative's, care managers, and health and social care professionals. A health care professional told us "We try and work together." These relationships helped people to receive 'joined up' support and ensured their needs continued to be met.

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

- The new manager had been appointed since the last inspection and been in post for only five months. They had made an application to register with CQC and this was being progressed.
- Previously staff had been unclear about who was leading the service. At this inspection there was a clear management and staff structure; staff understood the lines of accountability.

● The previous inspection rating was displayed clearly. The service does not have an individual website at this time.
● The registered manager understood the regulatory requirements to report notifiable events and had done so when these had occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●There was a kind relaxed and compassionate culture in the service, staff told us how they loved working in the service. People's needs, and the delivery of person-centred support were central to the culture of the service, staff learned about the values of the service through their induction.
● People's care was planned, monitored and reviewed regularly with them. What people wanted was the priority. Relatives and staff spoke positively about the impact of the new manager on improvements to the service. One said the manager was 'all for the people.'
● The registered manager understood their responsibilities under the duty of candour requirement. This requires that the registered persons and staff are honest and open with people and their representatives when something has gone wrong.
●The manager analysed all accidents and incidents for trends and patterns that may require reviews of support plans and risk assessments. They were therefore able to determine if any accidents or incidents were required to be reported to CQC under the duty of candour requirement.
● Staff understood the arrangements for seeking out of hours management support if they needed advice and guidance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People, relatives and health and social care professionals who knew the service were invited to give feedback about the service in regular surveys carried out several times each year. The manager analysed these to inform areas for service improvement. Analysis of what the service did well and needed to improve on was clearly displayed in the service. One relative survey comment said "I don't think you would get any better dedicated staff. They are worth their weight in gold."
• Family meetings were held for relatives and people using the service to attend. These meetings gave people and relatives opportunities to express their views, be made aware of planned service developments and make their own suggestions for additional changes and improvements.
● Staff meetings were held regularly. Staff said they felt able to bring suggestions and issues to the meetings for discussion. Staff thought that communication was good and improving with the new manager in post. Staff said they were kept well informed of important changes in various ways such as staff handover meetings, staff communication book, staff email, and staff meetings.