Ridgeway Residential Home Partnership

Ridgeway Residential Home

Inspection report

Salcombe Hill Road
Sidmouth
Devon
EX10 8JR

Tel: 01395516205

Date of inspection visit:
04 April 2017
06 April 2017

Date of publication:
11 January 2018

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

The inspection took place on 4 and 6 April 2017 and was unannounced on the first day. Ridgeway Residential Home provides personal care for up to 16 people over retirement age who may be living with dementia or may have a physical disability. It does not provide nursing care. At the time of this inspection there were 12 people living at the service.

We last inspected the service on 18 December 2015 and 5 January 2016 when it was rated as Requires Improvement overall. At that inspection, we found four breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to staff recruitment, people's capacity to give consent, meeting people's social needs and having effective quality assurance and record-keeping systems. The provider had produced an action plan to ensure improvements were made and sustained. At this inspection, we found that improvements had been made across all four areas with all breaches met.

Since the time of the last inspection, a new registered manager had been appointed. They were present on both days of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had high aspirations for improving the service, led by example and was supported by a committed provider. A priority had been set of improving quality assurance systems. Feedback was regularly gained from staff, people using the service and family members. Concerns and complaints were investigated promptly and thoroughly, with learning identified and changes implemented.

Everyone we spoke with recognised that the new manager had effected a significant culture change at the service to promote person-centred, rather than task centred care. This was reflected in a positive and welcoming atmosphere, a sense of team commitment and positive energy within the whole staff group.

People using the service and their family members said they felt safe and that staff supported people in a kind, caring and respectful way. Comments included "I think the quality of care here is very good. I have never heard anyone raise their voice." And "I'm quite impressed with the way they look after people here."

People were protected from potential abuse and harm by staff who understood how to identify safeguarding concerns and what action to take. Everyone living at the service had risks relating to their care assessed, recorded and measures put in place to mitigate risks. Care plans were regularly reviewed and amended as people's needs changed. Medicines were well managed and stored safely.

Staff levels had increased significantly since the time of the previous inspection when a recommendation had been made. They were now sufficient to meet people's needs. The benefit of social activities had been

recognised and was now met with the appointment of an activities coordinator and a visiting physiotherapist. People were able to work in the garden utilising accessible raised beds. The garden had won two national awards from the Britain in Bloom organisation.

Staff described a new feeling of team working and mutual support and were proactive in suggesting changes. They demonstrated commitment and willingness to learn in order to improve the service. The accommodation provided was well furnished and maintained to a good standard with a variety of social areas. The atmosphere in the home was relaxed and happy, with daily activities giving an obvious sense of purpose and contentment. The provider had made changes to some aspects of the building to improve safety with more planned.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, family members and health and social care professionals were involved in "best interest" decision-making.

People were offered a varied and balanced diet and those with special needs relating to nutrition were well supported and closely monitored. Health care needs were met by access to professionals as required. Professionals visiting the service confirmed that staff were providing good quality care and acted on their health care recommendations.

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 were protected from abuse because staff knew how to recognise and report it.

Risks were assessed and actions taken to mitigate them.

Staffing levels were sufficient to meet people's emotional, physical and social needs.

Recruitment practice was well managed. The provider was able to demonstrate staff were suitable to work with vulnerable people.

Medicines management was safe.

Is the service effective?

Good

The service was effective.

People were cared for by staff with the knowledge and skills required to meet people's needs. Staff had regular training and received support through regular supervision and appraisals.

People were supported in making their own decisions wherever possible. Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and demonstrated this in their practice.

People were supported to lead a healthy lifestyle with prompt access to healthcare services.

Is the service caring?

Good

The service was caring.

Staff demonstrated kindness and compassion towards people in their daily care.

Positive relationships were developed and each person's personal preferences and needs were respected.

The atmosphere was warm, friendly and relaxed.

Is the service responsive?

Good

The service was responsive.

People received personalised care from staff who knew about each person's life, personal interests and hobbies.

A varied programme of activities was on offer. People were encouraged to pursue their own interests and retain contacts in the community.

Is the service well-led?

Good

The service was well led.

The registered manager worked closely with the provider alongside a cohesive team of committed and motivated staff.

She had established an open culture which promoted person centred care. The views of people, their families and staff were sought and taken into account in improving the service.

There were systems in place to monitor the quality of the service. A programme of changes and improvements in response to findings was planned and implemented.

Ridgeway Residential Home

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.

The inspection took place on 4 and 6 April 2017 and was unannounced on the first day. The inspection team consisted of one adult social care inspector 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. They had specific expertise in care of the elderly and dementia care.

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 from the PIR, previous inspection reports, and any notifications received. A notification is information about important events, which the provider is required to tell us about by law.

As part of the inspection, we spoke with the registered manager, the registered provider, five care staff, the cook, three visitors, and seven people who were using the service. We looked at a range of records including four care plans in depth and three in part to check specific aspects of care, three recruitment files, staff duty rosters covering a three-week period, staff training records, medicine administration records (MAR) and records relating to the management of the service, including accident and incident records. We also looked at quality monitoring information such as health and safety checks, cleaning schedules and audits.

We contacted four health and social care professionals with knowledge of the service and received a response from three. We undertook formal observation of a medicines administration round and informal observation of activities sessions, mealtimes, a staff handover meeting and a "coffee chat" involving the registered manager and three staff.

Good

Is the service safe?

Our findings

At the previous inspection in January 2016, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to recruitment. We also made two recommendations, one in relation to staffing levels and one in relation to management of medicines. The provider sent us an action plan detailing the actions they would take to ensure improvements were made. At this inspection, we found improvements had been made in all the above areas and the breach had been met.

Each of the recruitment files we looked at contained all the necessary information to ensure safe recruitment of staff. This included a completed application form with full employment history, two satisfactory references, photographic ID and a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helps employers make safer recruiting decisions to ensure people were not exposed to staff barred from working with vulnerable adults. Records confirmed staff members were entitled to work in the UK.

At the last inspection, we found that medicines were stored securely, but records of fridge and room temperatures were not being regularly audited. At this inspection, we found that temperatures were now being included as part of a new weekly general medicines check carried out by the registered manager. However, the check for the week of inspection showed that the room temperature had exceeded the recommended level of 25°C by 1° for the first five days, that is, before the check, which was due on the seventh day. On investigation, the provider checked the wall mounted thermostat and found it had been accidentally lowered thus preventing the fan from operating. On the first day of the inspection, the provider readjusted the thermostat which caused the fan to operate effectively once again. They also removed shelving to create better airflow and purchased and installed a new fridge. On the second day of inspection, all was fully functioning and room temperatures were back to safe levels.

People required different levels of support when taking their medicines, from prompting through to administration. Where clients were supported with their medicines, they were managed in a safe way. Where people were assisted in taking their medicines this was done in a caring way. Arrangements were in place with the local pharmacy to have people's medicines dispensed in a blister pack. This is where the pharmacy organises people's medicines into separately sections/packets, each marked with the day and time of day when different tablets should be taken. There were effective systems in place for the receipt and disposal of medicines. The local pharmacy undertook regular audits of medicines and systems and had confirmed safe practice.

Staff responsible for medicines administration had received medicine training and had received competency assessments to ensure they were competent to carry out medicines administration. The registered manager checked medicine adminstration records (MAR) each month to ensure they had been administered correctly. Examples were given of areas for improvement and the action taken as a result. The registered manager offered one-to-one supervision and support to the staff involved when any shortcomings were found. Medication errors and incidents were also discussed in staff team meetings to inform better practice. There had been no errors which affected the safety of people living at the service.

One person described how staff supported them with their medicines, "I get my pills in a pot. They do my eye drops."

At the previous inspection, we received mixed feedback about whether there were always enough staff on duty. Since then staff hours had been increased by 23 hours per week. Rather than moving staff from the local "sister" home run by the same partnership, the provider now used an agency to cover staff shortages. The aspiration was only to use the same staff each time from the agency in order to maintain continuity for people.

Staffing levels at the service were assessed on a regular basis. The registered manager used her own version of a dependency tool based on one from the Royal College of Nursing (RCN) in order to determine need and to adjust staffing levels in accordance with people's care needs. In addition, new posts had been created such as an activities coordinator and an additional cleaner, as well as a weekend cook. We checked the staff rosters and found that they tallied with staff who were actually on duty.

People living at the service now felt there were sufficient numbers of staff. One person said "(there are) Plenty of staff. I don't demand much, but there are plenty of staff. They are very nice."

People were all aware of the call bell system and how to use it. We observed bells were readily to hand in people's rooms. People appreciated the prompt response rate to call bells. One person commented "When I have occasion to get help they are here immediately.". She gave an example of a bee coming in through her window the previous week. Another person said, "If I have to ring in the middle of the night they are here in a second. I think it's lovely.". A third person described the response rate as "medium to good response."

The provider had policies and procedures in place to safeguard people from abuse. Safeguarding training was part of the mandatory training programme. Staff were able to describe the principles of safeguarding and knew how to implement the procedures if they witnessed abuse or poor practice or had an allegation of abuse reported to them. However, the training matrix appeared to show that some members of staff had not had a recent update to safeguarding training. The registered manager agreed to speak to the external trainer regarding updating the list.

People living at the service said they felt safe. Comments included; "I feel safe here, and they are so kind and considerate." We observed that people appeared happy and contented and the atmosphere was very relaxed.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Staff ensured they always acted in accordance with these plans. For example, where people had difficulty with walking, their needs had been assessed and suitable mobility aids provided. One person told us; "I can't walk, I use the stand aid with a member of staff." The person said they felt safe when this was happening, because the staff were on hand to help them.

We observed that other action had been taken to minimise risks. For example, one person had a padded mat on the floor alongside their bed to minimise risk from falling. Records were kept of people who had falls as part of the accident and incident reporting system. The registered manager told us that senior careworkers checked everyone's risk assessment monthly and used the information to improve the service. For example, they found that the same two people were involved in all the falls recorded and so requested further medical assessment to ascertain the reason and provide amended treatment. The registered manager had undertaken an audit of Treatment Escalation Plans for everyone living at the service in order

to update them. The intention was to continue this annually.

A new tool called 'comfort rounding' was being introduced for people who were identified as being at risk of falling, of dehydration or isolation in order to ensure a safe environment. By undertaking hourly checks on people who were not able to leave their rooms, this enhanced observation would enable any change of needs or deterioration in a person's condition to be observed and treated promptly, thereby improving health and safety.

Personal Emergency Evacuation Plans (PEEPs) were in place with information about the support each individual would need in the event of an emergency evacuation of the building. This demonstrated the service had plans and procedures in place to keep people safe in such an emergency. On the first day of the inspection we observed the registered manager implementing the incident procedure from first reporting of a potentially unsafe procedure to successful resolution and conclusion. Learning outcomes were identified for discussion at the next staff meeting. This demonstrated that the system put in place was being used in an effective way to keep people safe.

Good

Is the service effective?

Our findings

At the previous inspection in January 2016 we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to mental capacity assessments. The provider sent us an action plan detailing the actions they would take to ensure improvements were made. At this inspection we found improvements had been made and the breach had been met.

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.

At this inspection we found that care plans all had completed mental capacity assessments.
People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager demonstrated a thorough understanding of the MCA and of the DoLS process. We were told that applications for authorisation had been made for two people who had been assessed as lacking capacity to make certain decisions. Authorisation was awaited. This meant that the service was acting to protect people's legal rights.

One person wanted to make a life changing decision. The registered manager organised a best interests meeting which was attended by the following professionals: social worker, GP, solicitor (who had financial Power of Attorney), panel chair, police support officer, as well as a recreational representative, a minute taker, and the person's sister and brother-in-law. The outcome of the meeting was that it was decided there was a need to gather further information, hold another meeting and formulate an action plan which could involve a best interest decision if required.

Most staff had received training relating to the MCA and DoLS. All those who interviewed were able to demonstrate they understood the principles and practice.The training matrix showed some gaps where staff needed training in this topic. Additional training was planned to address this. However, staff were clear on the need to gain consent, one of them said, "you just give choice every time you meet them." Another staff member commented, "we like to treat people like family … We always listen to what they prefer." Staff confirmed that they were receiving regular training, supervision and appraisal.

People living at the service confirmed that they were always asked to give their consent to personal care. One person said, "Yes, they ask me if they can do anything for me." Another person said, "Mostly I do it myself. I don't need much help. They knock on the door."

People were supported by staff who had received a range of training to develop the skills and knowledge

they needed to meet people's needs. New staff undertook "shadowing" of experienced staff to help them become familiar with people's individual needs. They then undertook induction training which followed the Skills for Care Certificate. Training was delivered by an external professional trainer who was responsible for a rolling programme of mandatory courses. We viewed the training records for staff which confirmed staff received training on a range of subjects. Mandatory training completed by staff included manual lifting and handling, infection control, safeguarding, mental capacity, health safety, dignity respect and choice and equality and diversity. Of the current staff group of 14, nine had an NVQ diploma at level 2 or above in Health and Social Care. It was a requirement of the new manager for all senior staff to have gained the level 3 diploma.

The registered manager said they had made a priority of improving the attitude and approach of staff and had made some new appointments. They said that although staff were well trained, "I found there was poor morale…when I'm recruiting I choose the people I'd want to look after me and mine."

We found that the manager was leading by example, being an experienced nurse, who worked alongside staff on some shifts. We observed her taking time to calm an anxious person who was calling out by stroking their hands, whereupon they immediately quietened. On another occasion the registered manager was seen giving individual attention using tactile toys to a person who was unable to communicate verbally. All this was a way of demonstrating how person centred care applied to practice.

Staff supervision happened on a daily ad hoc basis (as the manager said, "I'm observing them all the time informally") as well as on a more formal one-to-one basis and in team meetings and daily "coffee chats". This was a new method of getting together with staff every day at coffee time to discuss issues arising and learning how to do things better. The registered manager used these daily informal chats to instil the ethos of the service as follows "do unto others as you would have done to yourself… I always say to my staff, try and walk in their shoes. My mantra is that our residents do not live in our workplace, we work in their home."

People's dietary needs and preferences were known and recorded. There was a book in the kitchen that listed residents' likes and dislikes. All residents preferences were in the book each on a separate page with details of allergies or special conditions such as diabetes. A laminated weekly menu was placed in each person's room so they could make meal choices. People were offered alternatives such as a lighter meal or a salad. Staff said that since (manager) arrived they had been able to get new kitchen equipment when needed, and that there were more choices on the menu. They reinforced the importance of choice, saying "We like to do what they (people living at the service) would like."

People living at the service and visitors were positive about the food provided. One person said, "The food is just brought to me. The staff tell me what is for supper and breakfast, and if I don't like it they get me something else. The food is very good. I know what is coming and they would suggest something else if it wasn't something I like. I can't stop eating because the food is so nice." Another person commented that the food was "Excellent, everything. They say what's on and if I don't like anything I can say. I can request ice cream, or whatever." Efforts had been made to provide people from different ethnic groups with culturally appropriate food.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People gave the following examples of how responsive staff were when they had experienced health issues. One person said "I tell them and they see to it. I haven't had to call my GP. I have a hearing aid but I use the headphones for the radio and TV. They have brought the phone to me…I see the chiropodist and hairdresser". Another person said, "Sunday I was sick. The staff dealt with it for me. I was told not to eat that night, I just had toast." People described

appointments with local health specialists and with other relevant services as follows; "I never feel ill here." "I was at an optician a few months ago. I don't have hearing aids." And "The GP comes if I'm not very well."

Good

Is the service caring?

Our findings

It was evident that staff had developed good relationships with people. People looked happy, were smiling and relaxed with staff and we saw people laughing and sharing a joke with staff.

People using the service, their relatives and professionals were universally positive about the quality of care provided by the staff team. One person said, "They are all very friendly, very kind. Any one of them. (The manager) is exceptionally nice, very kind and considerate." Other comments from people living at the service included the following "They are so kind here, they will get me anything I want." And "If I can't hear they repeat it for me. They have wonderful patience. They always say 'Good morning, (name)', they are very, very kind." And "They asked if it was okay to be called by my first name, and asked how did I want to be called."

People were treated with kindness and compassion in their day-to-day care. Staff asked people if they would like help before offering assistance, for example, with eating lunch. We observed someone who was very distressed about being moved. She was crying out in apparent alarm, but was very quickly calmed down by staff stroking her hands. This person was unable to communicate verbally and staff had discovered that she responded well to touch. In addition, they had given the person a range of tactile objects which were placed on a small table within her reach to hold and feel so that she could distract herself and gain some comfort.

Staff were all able to describe a particular individual's interests, likes and dislikes and seemed to take great pleasure in meeting people's needs in very personal ways. A specific example was of a person who used to have a pet who sat on their lap. They lost their pet when they moved into residential care. Staff described how they helped the person to regain that sense of comfort which they missed by placing something similarly soft but heavy, like a large cushion, on their lap.

People were able to choose whether they socialised and had their meals in their room or in the communal dining room. One person chose to stay in their room all the time. The room had lovely views across the valley and there was an outside patio area with patio furniture which was accessible by French windows. The person treated this as a self-contained suite and expressed great contentment with their accommodation and the care provided to them within it. Her family were able to visit whenever they wished and all meals were served within the room. As the person was hearing impaired, staff had provided her with headphones to plug into her radio and television. They were delighted to have this because they said it helped them not to feel embarrassed about having the volume of the television turned up which might disturb other people. Although they had been invited to join in social activities, they always declined and expressed great contentment with their private room. This shows that people were respecting an individual's choice when and with whom to socialise.

Staff showed concern for people's dignity and privacy. For example, one person had remained in bed during the morning, but then got up wearing only a night dress and moved towards her open bedroom door. A member of staff engaged with her in a sensitive and caring way and persuaded the person to put some more

clothes on before leaving her room, thus protecting her dignity. People living at the service confirmed that privacy and dignity was respected. "I just take it that they have a job to do. They knock on the door and always ask permission."

People's bedrooms were personalised and decorated to their taste with family photographs and pictures. One person had a series of picture hooks on the wall without pictures. The registered manager explained that pictures had been removed by a relative whilst the room was being decorated and had not yet been returned but that she would follow this up.

Good

Is the service responsive?

Our findings

At the previous inspection in January 2016 we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to activities provided for people. The provider sent us an action plan detailing the actions they would take to ensure improvements were made. At this inspection we found improvements had been made and the breach was met.

A key change was the appointment of an activities coordinator. A range of new activities, such as a weekly exercise class, had been put in place, all designed to improve outcomes for people's well-being. A physiotherapist attended weekly on a Tuesday for one hour and had been coming since September. Staff helped him if more people wanted to participate and the session was then held in the sitting room. We observed an exercise session which was held with five residents in the dining room. Most of the exercises were done whilst seated, but there was a short while when those who were able to stand supported by the table, did specific exercises in that position.

The physiotherapist was very gentle and encouraging throughout, and one person new to the sessions joined in a little at the beginning and then watched. The physiotherapist engaged with each person individually as well as with the whole group collectively. For example, one more physically able person went with the physiotherapist to the stairs to do a short exercise while the others were having a short break. We later saw this person practicing for a few moments on their own after lunch.

One visitor confirmed these changes saying, "(name of registered manager) has put in new things… People are now doing drawing, gardening and exercise classes."

Raised vegetable beds at waist height had been built within the garden. People living at the service had participated in growing a range of herb and salad plants from seed. We saw pots labelled with individual's names containing small plants which were going to be planted out in the garden. The service had won two awards from the Britain in Bloom organisation for the quality of its garden. Plans were in place for further developments, including a sensory garden. The garden was accessible from the main lounge and we saw people taking real pleasure in enjoying the sunshine and outside environment with staff.

One visiting professional said, "the residents here are more engaged than elsewhere… They love listening to Vera Lynn."
An activities board in the hall showed upcoming events, and an Easter display, including an Easter Bonnet. We later observed an activity session where people were making their own individual Easter bonnets. Future planned events included an evening of National Specialty suppers for residents and their families, supported by the various careworkers' nationalities (e.g. Polish, Indian, Danish, Phillipino) The objective was for careworkers to introduce people living at the service to food from their own culture as a way of promoting ethnic diversity.

People were encouraged to practice their religion either by attending local church services or a Holy Communion which had been arranged to take place within the service. One person said, "I go to the Parish

church and All Saints, and (café) and the charity shop."

People received personalised care and support based on their care plan. Each person had a plan which described their preferences; mental capacity, specific health needs and staff were knowledgeable about each person. The service used a sheet entitled "All about Me" as part of the admission process to find out people's likes and dislikes in order to enable truly personalised care to be given. We saw that these had been filled in with a high level of detail by people or their families. Everyone we spoke with confirmed that they had been asked about their likes and dislikes, family history, interests and hobbies. One person said, "I wrote it all down for them and they kept it for their own records.". Other people commented as follows "My daughter has power of attorney. I don't know how they know my dislikes and preferences. I can't say there is anything I dislike." and ""They know what I like. I feel able to tell them."

The provider had a complaints procedure and people said they knew how to make a complaint if necessary. For the most part they said they would do this by talking to the registered manager. One person said, "I would talk to (manager) because she's very gentle, kind and easy to talk to." Another's person said they would take any complaint "To (name of manager). But there is no complaint to make."

The complaints procedure was on display in the hallway in a conspicuous place.
When a complaint was raised with CQC by a relative, the manager sent a prompt and very detailed response describing all actions taken. This was supported by relevant documentary evidence which showed that a thorough investigation had been undertaken. A health and social care professional who also knew the family confirmed that staff at the service had worked hard to resolve the issues.

People living at the service and their families confirmed that they were asked to give their views and to raise any concerns by means of regular meetings. "A couple of months ago, and we were asked our views and so on." It involved all of the staff and residents. "They did ask my wife but she was not available. There have probably been two meetings since I have been here. It would be good if they could have regular sessions." The registered manager confirmed that regular meetings would continue.

Good

Is the service well-led?

Our findings

At the time of the previous inspection the management role was being shared between a senior carer and the registered manager of another service within the same partnership. A new registered manager had been in post since June 2016.

On day one of the inspection we found that the provider had not displayed the ratings from the previous inspection. However, by the end of the first day this was displayed in a conspicuous place as required .

People, relatives and professionals told us that the service was well led and that the new manager had brought about a culture change. The registered manager told us she wanted to promote an ethos of "focusing on a person centred approach…recognising the nuances of the individual personalities [of people living here] so that we think about the person, rather than a diagnosis." She had a clear vision about how to achieve that and had made significant changes by bringing in new systems, new activities, new attitudes and new staff. This included an awareness of the need to recognise diversity, equality and human rights.The registered manager said she felt well supported in these aspirations by the provider.

This new ethos was reflected in changes made to job descriptions. For example, that of the cook had been changed from 'To ensure the provision of an efficient catering operation' to the following: 'To ensure the provision of nutritious food and fluids that reflect dietary wishes and needs (of people using the service).' This meant that staff were clear that the main purpose of their roles was to provide person centred rather than task centred care.

Staff were encouraged to implement new ideas and take ownership of them. For example, the cook had created a checklist of all areas which required cleaning, then developed this into a regular cleaning schedule which detailed exactly what to use, what to wear and how often to carry out the cleaning. This was created for the benefit of all staff to maintain high standards of cleanliness within the home.

The registered manager had moved the office down into the conservatory from upstairs, set up a new staff noticeboard there and kept copies of policies and procedures in a folder for staff to read. This meant that urgent and important topics, along with new information, could more readily be brought to the attention of staff. The location of the conservatory, (which was alongside the open plan sitting room and dining area and led onto the garden), enabled the registered manager to observe daily interactions between staff and people living at the service and provide informal supervision and support as required. We saw that it also enabled visitors to have better access to the registered manager. This meant they could raise queries about people's care more easily and promptly. Confidentiality was maintained by closing the interconnecting glass door.

The registered manager had instituted a new daily "coffee chat", also held in the conservatory. This gave an informal opportunity to staff to discuss all matters relevant to improving care delivered at the service. It also helped to create a team culture. All staff confirmed a new feeling of team working and mutual support. We observed one such session where staff clearly felt comfortable asking questions and making suggestions

within the group about how to improve people's care.

Staff said they appreciated this additional informal support and described the impact of this culture change on them as follows; "I feel very comfortable working here because (name) is a very good manager, she is very supportive, she also respects us… It's really important… whatever you are not sure about you know where to go for help." Another said, "We are now working as a team… It's really good… we share our duties between ourselves… we all help each other.". One other member of staff said they felt comfortable raising issues with the registered manager because "You can talk to her…you know she'll listen."

Staff also commented on an improvement in the recording, especially of care plans and personal histories. One of them said, "It's a very big difference now. Care plans were not being reviewed… but now they are."

The impact on people living at the service was that they benefited from interacting with more motivated staff and from having frequent assessments of their needs. One person living at the service said, "She has made a lot of improvements since she has taken over. It's a more methodical system, I think she is a very trained, qualified and experienced lady."

A visiting professional observed "Staff are very engaged with (registered manager) …there seems to be a lot of respect shown to staff."

We found a robust quality assurance process had been put in place. This included audits of areas such as medicines, accidents and incidents, premises and equipment, complaints and care plans. Information was analysed in order to identify themes and patterns and to decide on action to take to improve the service. Findings were then discussed with staff during individual supervision sessions and staff team meetings. Actions to be taken, including any new procedures, were written up and placed in a folder for the staff team to read and then sign to confirm that they had understood. The registered manager checked the file regularly and said "we have to prove to ourselves that we are doing all we can (to improve the service)."

Some new audits had been brought in since the time of the last inspection, such as an annual audit of treatment escalation plans (TEP) and an environmental audit. Meetings were held and questionnaires circulated to people living at the home and their families at six monthly intervals. The aim was to seek opinions on what was working well and what could be improved at the service. One suggestion was for adapted transport to be provided to enable people to go on outings. The registered manager confirmed this was now under consideration.

A local quality improvement expert had been invited to advise on quality assurance matters and had confirmed that all areas were being covered. The registered manager was described as being "very engaged …very well organised … definitely wanting to learn how to do things better ."