Ashwood Court Healthcare Ltd

The Grange 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

This inspection was completed on 6 November 2018 and was unannounced.

The Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is a large detached property. Accommodation is arranged over two floors and a lift is available to assist people to get to the upper floor. The Grange Care Home provides care for up to 28 older people living with dementia, frailty and mobility care needs. There were 11 people living at the service at the time of our inspection.

There was no registered manager at the time of our inspection. However, the manager of a sister service, owned by the same provider, had applied to become the registered manager of The Grange. Their application had been received by CQC and was being processed. Their registration to manage The Grange was intended to be temporary, this was because a new manager for The Grange had been appointed and was receiving mentoring for the role. Once established, the new manager would apply for the registered manager post at The Grange and the manager of the sister service would return to their original service. 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 temporary manager is referred to as the temporary manager and the new manager is referred to as the acting manager in this report. Jointly, they are referred to as the managers.

Our last inspection of this service took place in July 2018. This was a focussed inspection which looked at the key areas of Safe, Effective and Well Led. Each of these areas were rated as Requires Improvement, together with the overall rating of the service. This was because requirements about the administration and storage of some medicines were not always complied with. Recruitment processes were not as thorough as needed because some gaps in employment history were unexplained and some references from previous employers were missing. The service was not suitably well led because a number of checks and audits failed to address shortfalls in the safety and quality of the service provided. We also found the provider had failed to comply with a condition of their registration because they had not made suitable arrangements to have a registered manager in post.

This inspection was completed on 6 November 2018. It was a full inspection which looked at all five key areas of the service. At this inspection we found improvements had been made and the breaches of regulation identified at the last inspection had been met.

The management of people's medicines was safe. Risks had been identified and action had been taken to manage them. Records about people and the care they received were accurate, complete, held securely and easily accessible to staff when they needed them.

There were enough staff to provide the care and support people needed when they wanted it. New staff were recruited safely. Disclosure and Barring Service (DBS) criminal records checks had been completed to make sure staff were suitable for their role. Staff were supported meet people's needs and had completed the training they needed to fulfil their role.

Staff were kind and caring and treated people with dignity and respect. They took time to get to know each person well and provide the care people wanted in the way they preferred. People received the care and support they wanted at the end of their life.

Assessments of people's needs and any risks were completed and care had been planned with them, to meet their needs and preferences and keep them safe. Accidents and incidents were analysed to look for patterns and trends. The temporary manager worked in partnership with the local authority safeguarding and commissioning teams as well as a clinical nurse specialist for older people. The service had acted on their advice to develop the service and improve people's care.

Staff knew the signs of abuse and were confident to raise any concerns they had with the managers or provider. People were not discriminated against and received care tailored to them. A process was in operation to investigate and resolve complaints to people's satisfaction. People had enough to do during the day, including activities to keep them physically and mentally active.

Changes in people's health were identified and people were supported to see health care professionals, including GPs when they needed. People were offered a balanced diet of food they liked, which met any specific dietary or cultural needs and preferences. Staff supported people to be as independent as they wanted at mealtimes.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The managers knew when assessments of people's capacity to make decisions were needed. Information was available to people in a way they understood to help them make decisions and choices. Staff treated people with dignity and gave them privacy. The managers understood their responsibilities under Deprivation of Liberty Safeguards (DoLS) and had applied for authorisations when there was a risk that people may be deprived of their liberty to keep them safe.

Staff felt supported by the managers and were motivated. A member of the management team was always available to provide the support and guidance staff needed. Staff worked together to support people to be as independent as they wanted to be. All the staff we spoke with told us they would be happy for their relatives to live at The Grange and that they were proud to work there. The views of people, their relatives, staff and community professionals were asked for and acted on to continually improve the service.

The service was clean, staff followed infection control processes to protect people from the risk of infection. The building was well maintained, plans were in operation to maintain and improve the environment. People were able to use all areas of the building and grounds.

The managers had informed CQC of significant events that had happened at the service, so we could check that appropriate action had been taken.

Services are required to prominently display their CQC performance rating. The provider had displayed the rating in the entrance hall and on their website.

Further information is in the detailed findings below.

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 received their medicines safely from staff who were trained to do so.

People were protected from the risk of abuse.

Risks to people and the environment were assessed, and staff took action to reduce those risks identified.

There were enough staff available to meet the needs of people, and those new to the service were recruited safely.

People were protected by the prevention and control of infection.

The registered manager took steps to ensure lessons were learned when things went wrong.□□

Is the service effective?

Good

The service was effective.

People's rights had been protected by proper use of the Mental Capacity Act (MCA) 2005.

Staff training and supervision was effective in equipping staff with the skills needed for their roles.

People's health was monitored and staff ensured people had access to external healthcare professionals when they needed it.

People received enough to eat and drink and were complimentary about the choice and quality of food provided.
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Is the service caring?

Good

The service was caring.

Staff acted sensitively to protect people's privacy and dignity.

Staff engaged well with people. Staff spoke with people in a caring, dignified and compassionate way.

People were supported to be independent where possible.
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Is the service responsive?

Good

The service was responsive.

The service involved people and their families or advocates in planning and reviewing care.

Care plans were individual and person centred.

There was a variety of activities, functions and outings on offer.

An accessible complaints procedure was in place.□□□□

Is the service well-led?

Good

The service was well-led.

Checks completed on the quality of the service had improved and met the required standards.

People, their relatives and staff shared their views and experiences of the service and these were acted on.

Staff shared the provider's vision of good quality care.

Staff were motivated and led by the temporary and new managers. They had clear roles and responsibilities and were held accountable for their actions.

The managers worked with other agencies to ensure people's needs were met.□

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

We used information the registered persons sent us in the Provider Information Return. This is information we require registered persons to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about. We also invited feedback from the commissioning bodies who contributed to purchasing some of the care provided in the service. We did this so that they could tell us their views about how well the service was meeting people's needs and wishes.

We visited the service on 6 November 2018 and the inspection was unannounced. The inspection team consisted of three inspectors.

We met and spoke with eight people who lived at the service, we observed some people's care in communal areas, the lunchtime meal, medicine administration and activities. We spoke with two people's relatives. We inspected the environment, including the laundry, bathrooms and some of the bedrooms. We spoke with two care staff, housekeeping and kitchen staff as well as the temporary manager, and new manager.

In addition, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us.

During the inspection we reviewed other records. These included staff training and supervision records, four staff recruitment records, nursing staff registrations, medicine records, risk assessments, accidents and incident records, quality audits and policies and procedures.

We displayed a poster in the communal area of the service inviting feedback from people, relatives and staff.

Following this inspection visit, we did not receive any additional feedback.

Good

Is the service safe?

Our findings

People told us they were happy living at The Grange Care Home. Their comments included, "I am happy with my care and support, I am warm and comfortable," and "Staff are kind and patient, they always make sure I have my pills when I need them, I am not in pain." A visitor told us, "Mum looks well and is cheerful, I don't have any concerns about the care she receives. There always seem to be enough staff, I don't see people waiting for help and the call buzzers don't ring for a long time before they are answered."

At our last inspection in July 2018 medicines were not always managed safely. This was because some medicated creams were not stored within a required temperature range. In addition, the positioning of some medicated patches was not changed often enough. This did not meet with the manufactures' instructions and may have caused irritation of people's skin.

At this inspection, people received their medicines safely and when they needed them. Staff had received appropriate training and competency supervision. There were clear protocols in place to make sure people received the right amount of medicines safely and on time. The position of medicines given in the form of stick-on patches was recorded and changed to a new position as required. All medicines were stored securely, in line with current guidance and storage temperatures. Appropriate arrangements were in place for ordering, recording, giving and disposing of prescribed medicines. Clear records were kept showing when and how much medicine had been given. These records were up to date and had no gaps or omissions. Guidance was in place for people who took medicines prescribed 'as and when required' (PRN). Regular medicine audits were carried out by the managers or key staff. This helped to ensure people received their medicines safely. Application of medicated creams were recorded separately and these records were up to date.

At our last inspection recruitment processes were not sufficiently robust. This was because some references needed from previous employment were not held and some gaps in staff employment had not been investigated.

At this inspection, safe recruitment procedures were in place. Staff recruitment records reviewed showed all the relevant checks had been completed before staff began work. These included disclosure and barring service (DBS) checks, evidence of conduct in previous employment and proof of identity. DBS checks information held on police national databases about any convictions, cautions, warnings or reprimands. This helps employers make safer recruitment decisions to help prevent unsuitable people from working with vulnerable groups. Staff were not allowed to start work until these checks had been completed. Staff confirmed there was a robust interview process in place and they had been required to provide all the relevant documentation before they started working for the provider. This helped to ensure staff employed by the service were suitable to work with the people they cared for.

Staffing levels continued to be sufficient. Staff worked at a calm pace to support people to get up and ready for their day and supported people when needed throughout the day. Personal care was completed when and in the way people wanted. Staff felt they were not rushed and there was enough time to give people the

support they wanted. People told us they could have a shower or bath each day if they wanted to and were happy with this. The managers routinely reviewed people's needs against the deployment of staff and were confident that staffing was flexible enough to respond to changing needs. Agency staff were occasionally used, they received a familiarisation induction to the service and the tasks they were required to do. Staff spent time with people throughout the inspection. People enjoyed this interaction and told us staffing levels were what they needed to be.

The managers and providers' representative were clear about their responsibility around protecting people from harm and had contacted the local authority safeguarding team where appropriate. Safeguarding and whistleblowing policies and procedures remained in place for staff to follow and staff had received training. Staff could tell us how they would recognise and respond to abuse. They were confident any concerns raised would be taken seriously and investigated by the management team, to ensure people were protected. Staff were aware of the whistle blowing policy and knew they could take concerns to agencies outside of the service if they felt they were not being dealt with properly. One member of staff told us, "We all want our clients to be safe, feel happy and well cared for. None of the staff or managers would tolerate any ill-treatment of the people here."

Care plans and risk assessments had continued to be reviewed and updated. They considered a number of risks including falls, skin integrity and communication. There was clear, specific guidance for staff regarding how to support people who were living with potentially unstable healthcare conditions such as diabetes, coronary heart disease or if they were at increased risk of pressure ulcers. For example, when people were assessed as at risk of their skin breaking down, there were clear steps for staff. Such as what signs and symptoms to look for, or how pressure relieving equipment should be used. Information and guidance from sources such as the NHS had been placed in people's care files and related to specific care plans to provide staff with increased awareness when supporting people. Care plans had been linked to each other, so that staff could look holistically at the person's care.

A system was in place for staff to report any accidents or incidents and discussion with staff confirmed they knew how to do this. The managers had oversight of these records and learning from incidents and accidents was shared at staff and handover meetings. For example, placement of pressure mats to alert staff if a person at risk of falling was trying to mobilise without support of staff.

People were protected from the risk of choking. When staff identified that people may be at risk they referred people to a speech and language therapist. Guidance received about how to prepare meals, such as to mash foods or thicken drinks was used to plan people's care and followed by staff.

People were moved safely. Guidance was provided to staff about the equipment and techniques they should use to move people and we saw staff following this. One person told us, "Staff are very patient, they always make sure I have my wheelchair and help me in and out of it."

The service was clean and people were protected from the risk of the spread of infection. Staff had completed infection control and food hygiene training. The managers had made sure protective equipment such as aprons and gloves were easily available to staff and we saw staff using them during our inspection.

Staff carried out regular health and safety checks on the environment and equipment to make sure it was safe for people to use. Regular checks were carried out on the fire alarms and other fire equipment to make sure they were working properly. The provider's fire risk assessment had been completed and an action plan was in progress to address areas identified as in need of attention. Staff completed regular checks on the water temperatures within the home to ensure people were not put at risk from excessively high

temperatures. Equipment such as the lifts and hoists had been serviced and maintained by the provider.

There was a business continuity plan in place which contained details of how the service should respond in an emergency. Each person had a personal emergency evacuation plan (PEEP), these gave details of the person's physical and communication needs for staff to support them to be evacuated safely.

Policies and procedures on all health and safety related topics were held in a file in the staff office and were easily accessible to all staff. Staff told us they knew where to find the policies.

Good

Is the service effective?

Our findings

People we spoke with told us they felt the service met their needs. Our observation of staff interaction with people confirmed this. One person told us, "The staff ask before helping me, they really are very good." People and visitors were complimentary about the food. One person said, "I am regularly asked for my thoughts about the meals." Another person told us, "We always have good food, a good choice too."

There had been no new admissions to the service since our last inspection. However, the temporary manager showed us an assessment tool they had introduced. This was designed to be used to holistically assess the needs of a person before moving into the service or returning from a stay in hospital. The assessment included consideration of protected characteristics and using people's preferred name, as well as considering their medical needs and what the person is able to do for themselves. This information was used to formulate the person's care plan and support the managers in considering if their needs could be met, or if for example, any additional training or staff would be necessary. Where possible people and their relatives were involved in planning their care delivery.

Staff completed assessments of people's ongoing needs using recognised tools. These included Waterlow assessments (to assess the risk of people developing pressure wounds or skin breakdown) and a malnutrition universal screening tool to identify people at risk of losing weight. Specialist mattresses and cushions were used to help support people who were at risk of developing pressure wounds. Following assessment, clear guidance was put in place for staff, for example, what setting a person's pressure relieving mattress should be at or what equipment they may use. There was evidence of regular review to ensure people's changing needs were responded to.

People were supported to live healthier lives with access to healthcare services and ongoing support. Records confirmed that people had received all the help they needed to see their doctor and other healthcare professionals such as specialist nurses, dentists, opticians and dietitians. Timely referrals had been made to speech and language therapy (SaLT). Care records now contained clear guidance for staff to follow. The temporary manager informed us they were in the process of implementing hospital passports for people to take with them should they need to be admitted to hospital. Currently they took the front sheet of their care plan and medicine administration records. This information was also shared for anyone moving out of the service to another service.

Mandatory training such as infection control, safeguarding and moving and handling people had been delivered and was up to date. People received care from staff who had received training appropriate to their role and to people's needs. Staff completed an induction when they started working at the service. This included working with experienced staff to learn about people's choices and preferences. New staff were mentored and their competency in each area of their role was assessed and signed off by their mentor or the managers.

All staff received regular supervision and an annual appraisal. They had opportunity to give their feedback and reflect on their performance as well as receive comments from the managers. Staff told us they felt

supported by the managers and people told us they had confidence in the staff who cared for them.

People's consent to care and treatment had been formally asked. Verbal consent was sought by staff for day-to-day matters, like asking permission to go into people's bedrooms or when giving people medicines. Some people lacked mental capacity to make some decisions and, in these cases, a mental capacity assessment had been made. These were necessary to comply with the principles of the Mental Capacity Act 2005 (MCA).

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 with appropriate legal authority. 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 authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

DoLS authorisations had been applied for when appropriate and at the time of our inspection were either being processed or were authorised by the local authority. People were supported to make decisions, such as choices about what to wear and how to spend their time. Staff told us that if people were unable to make simple decisions, they would use what they knew about their likes and dislikes to decide. When decisions had been made in people's best interests these were recorded and involved staff, relatives and professionals that knew the person well.

People were supported to maintain a balanced diet. Individual needs had been assessed and preferences recorded. The menu was displayed in large print in the dining room and showed that there was a choice of dishes served at each meal. People were asked their choices prior to the meal and the meals we saw served at lunchtime were attractively presented. We observed staff were attentive to people's needs, for example, one person commented, "Dinner is nice, but a lack of red wine!" A member of staff told them they would go and get a glass for them, which they did immediately. When meals were served, staff told each person what was on their plate, offered a selection of condiments and a choice of drinks.

During the lunchtime meal we heard the staff and cook discussing individual's meals. They knew each person's preferences, like and dislikes and spoke about people's appetites and how to arrange the plates for some people to make it more appetising. For example, one person wanted a very small portion for their main meal and dessert. Staff made sure that the person had what they asked for on their plate.

There was a relaxed atmosphere during lunch, staff offered to put on some background music, but this was declined. Throughout the meal we heard people chatting amongst themselves and with staff. A choice of desserts were served from a sweet trolley and people were asked their opinion on their meal in order to offer feedback to the cook. Discussion with the cook found they were aware of how to fortify food for people and any adaptations to make for people living with diabetes. There was a list of people's preferences and allergies available for staff in the kitchen. The cook had met with a dietician recently to discuss fortifying food and no issues were raised at this meeting.

Good

Is the service caring?

Our findings

People felt well supported by the staff, describing them as warm, friendly and accommodating of their requests and support needs.

Staff spoke with people with courtesy and kindness and it was clear that relationships of trust had been built. For example; one person needed a lot of reassurance at different points during the inspection. Staff responded to this with compassion and patience on every occasion and made time to stop and comfort them and distract them from their anxieties with a cup of tea and a chat. Another person did not want any of their lunch. Staff arranged for several different meal options to be brought and offered to the person. Staff spoke to this person with care and consideration and tried to gently persuade them to try something to eat.

There was a clear person centred culture at the service and a commitment to supporting people to express their views, feelings and maintain their independence. Staff knew about people's background, their preferences, likes and dislikes and supported people in a way that they preferred. One visitor told us, "I am completely satisfied with the support my relative receives, I really don't think the staff could try any harder to make sure she is happy."

People were supported to maintain important relationships. Relatives told us there were no restrictions on the times they could visit, they were always made welcome and invited to events. Staff recognised people's visiting relatives and greeted them in a friendly manner and offered them drinks. Visitors told us they could speak to people in private if they wished and gave positive comments about how well staff communicated with them, telling us how staff contacted them if they had any concerns about their family members.

People received discreet assistance, which allowed them to stay independent with some tasks. For example, people told us about the support they received with personal care and how staff only did what they wanted them to rather than trying to take over. One person told us, "The staff are always kind, friendly and patient with me."

Staff were attentive. They observed and listened to what people were saying. They picked up on communication cues such as use of arms and hands to communicate yes or no and facial expressions and body posture which may indicate discomfort. Staff knew people well and were easily able to hold a conversation with them. People responded well to staff and we saw staff interacting with people in a way that demonstrated they understood their individual needs and had a good rapport with them. Staff talked about and treated people in a respectful manner and, where possible, ensured they were involved in conversations.

Staff described how they supported people with their personal care, whilst respecting their privacy and dignity. This included explaining to people what they were doing before they carried out each personal care task. When people had to attend health care appointments, they were supported by staff that knew them well, and would be able to help health care professionals understand their needs. People were moving freely around the home, moving between their own private space and communal areas at ease. Staff knocked on

people's doors before entering. Doors were closed when people were in bathrooms and toilets. People were given discreet support with their personal care.

People's care plans told us how their religious needs would be met if they indicated they wished to practice. People were supported to be involved in decisions about their care. When people could make complex decisions the care plan was agreed with them. Staff were guided by their choices and respected their decisions. Some people signed their care plans to confirm they agreed with them.

People's information was kept securely and well organised. Staff were aware of the need for confidentiality and meetings were held in private.

Good

Is the service responsive?

Our findings

People were supported to have their needs met by a staff team who knew them well. One person told us "The staff help me just how I like it," and, talking about support needed for personal care, another person commented, "Someone will always make sure it's done for me as I do sometimes need a bit of help." A visitor told us, "I can't fault the home in any way, there is nothing that needs changing about mum's care."

Each person had a care plan covering all aspects of their care and support, including details about people's choices and preferences. Within care plans were life histories, guidance on communication and personal risk assessments. In addition, there was guidance describing how the staff should support the person with various needs, including what they could and could not do for themselves, what they needed help with and how to support them. Care plans contained information and guidance on people's likes and dislikes around food, drinks and activities. For example, they documented what time people liked to get up and go to bed and what toiletries a person liked, to help staff be sure they supported people in the way they preferred. Easy to use pain assessment charts had been introduced, designed to support people and staff in identifying pain when people could not verbally express their pain. The scale used a range of faces with different expressions and colours.

When people needed support with moving and handling there was information about the type of sling they needed and how staff should support them effectively. Health plans detailed people's health care needs and involvement of any health care professionals. Each person had a healthcare plan, which gave healthcare professionals details on how to best support the person in healthcare settings if needed, such as if the person needed a stay in hospital. Care plans were regularly reviewed and reflected the care and support given to people during the inspection. At the beginning of each shift, a handover provided staff with information about the care and support people had received as well as any concerns about them. This was recorded on a handover sheet.

There were a range of activities available to support people to remain both physically and mentally active. People enjoyed taking part in a sing along session which took place during our inspection. Other activities included keep fit, music for health, quizzes, visiting musicians, memories with music and wildlife talks. A Christmas show was planned for early December and people and visitors told us national events, such as the Royal wedding, the Queen's birthday, Wimbledon and other sports events were celebrated. During the inspection, staff encouraged people to join in with activities as much as they could. People smiled, laughed and sang during the activities. A planner in the lounge informed people which activities were taking place and when.

Although nobody was receiving end of life care, staff were aware of the importance of supporting people at the end of their lives. People were asked about their end of life wishes and these were recorded. Some people had declined to discuss their wishes, and this was respected, but where expressed, staff were aware of people's cultural and spiritual needs regarding their end of life wishes. Staff liaised with the GP and other health professionals to ensure people's needs were met and made sure that pain relief medicine was available when people needed it.

Staff understood the importance of promoting equality and diversity. People could meet their spiritual needs by attending a regular religious ceremony if they wished to do so. People were supported by staff to maintain their personal relationships. This was based on staff understanding who was important to the person, their life history, their cultural background, life choices and sexual orientation.

Concerns and complaints had been documented and responded to appropriately. The provider had a complaints process in place, which advised people on how to escalate their complaint if they wanted to take their complaint further. The complaints process was available in the entrance of the service. Complaints we reviewed had been resolved to the complainant's satisfaction, and steps put into place to try to minimise the risk of the event reoccurring.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The provider had looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. They provided information in picture form such as menus and meeting minutes, along with an easy read document about what providers/health and social care services must do to support people.

Good

Is the service well-led?

Our findings

At our last inspection the service had not been well-led. We found a breach of Regulation 33 of the Registration Regulations and 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to comply with a condition of the registration; the service had not had a registered manager since April 2017 and the provider had failed to assess, monitor and mitigate risks to the quality of the service and to individuals using the service.

At this inspection, we found improvements had been made. A new manager had been appointed to the service. They were mentored by the registered manager of a sister service, owned by the provider, to ensure they received all the support they required to transition into their new role. In the interim, the established manager of the sister service had applied as registered manager of The Grange. This fulfilled the condition of registration that a registered manager must be in post.

Checks and audits of the service had improved and each of the breaches in regulation identified during the last inspection were met. The provider had commissioned a consultant to complete regular audits of the service and report back any findings during monthly governance meetings with both managers and the provider. Action plans had been created to address issues identified at our last inspection and progress was documented and visible throughout the service.

The managers had completed a range of checks and audits to ensure staff were providing safe, effective compassionate care. Medicines had been checked weekly, and regular checks had been completed on the environment. A recent HR audit identified shortfalls in historic recruitment files of staff. The managers had worked with staff to address these shortfalls and they had been discussed and resolved during staff meetings. The temporary manager told us this audit had proved so successful, they had implemented it at the provider's other service.

The managers had formed positive working relationships with healthcare professionals to benefit the people living at the service. Staff had formed good relationships with district nurses, the GP and dentists visiting the service. The managers had a good working relationship with commissioners and had booked for staff to attend training with the CCG. For example, the service had signed staff up to receive training to become dignity champions through skills for care. Skills for Care is an independent registered charity working with adult social care employers. It sets the standards and qualifications to equip social care workers with the skills and knowledge needed to deliver high quality care to people who use services and carers.

People, relatives and staff told us of improvements in the culture of the service since the new manager started, supported by the temporary manager. One member of staff told us "The leadership has improved greatly. The way it is run is better. It's not chaotic anymore, I used to come in in the morning and it was manic. Since the new manager came it's been brilliant it's really good." We observed people to be happy, smiling and at ease in staff company. The temporary manager told us staff were working better as a team since our last inspection and communicating better, which has had a positive impact on the people living at

the service.

Both the temporary manager and the new manager told us they were well supported by the provider. The provider's two homes were working closely together and supporting the induction of the new manager. Both managers received support from a consultant employed by the provider. A deputy manager had been recruited and was awaiting their start date at the service.

The provider had sought feedback from relatives in the form of a questionnaire. The results of the questionnaires had been collated by the provider and returned to the managers to review and implement any changes. The managers told us their plans to display the results of the questionnaires within the service, along with the action taken to address any feedback. We reviewed the results of the questionnaire which were mostly positive. The managers were able to show us how concerns raised in the questionnaire had been responded to. For example, one relative commented that there was not always enough staff with the correct skills to look after their loved one. The managers planned to address this during the resident and relative meeting, providing assurance about staffing numbers, and discussing the training provided for staff.

Regular resident and relative's meetings were scheduled to give people and their relatives the opportunity to discuss the service. During the meeting people were given updates on staff recruitment and changes as well as what was working well in the service, and what staff were working on improving.

Feedback from people living at the service was due to be sent out and had been made available in a format accessible to everyone. The provider had also created questionnaires to be sent to healthcare professionals for their feedback.

Staff meetings were scheduled regularly and included discussion of any accidents and incidents over that period of time, as well as a review and update of the service progress. The manager took this time to refresh staff knowledge on key topics and use the meeting as a learning opportunity. For example, one meeting was used as an opportunity to review the documentation on file for each staff member to ensure it met the required standard.

The new manager told us they kept their skills up to date by receiving good practice guidance from NICE and CQC, as well as ensuring they kept their training up to date. Both managers belonged to a registered managers forum and used this as a tool to develop good practice.

The managers had notified the Care Quality Commission of important events as required. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the managers had conspicuously displayed their rating in the service and the provider had displayed the service's rating on their website. The managers were also aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support.