Vicarage Nursing Home Limited

The Vicarage Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 7 and 9 November 2016 and was unannounced.

The Vicarage Nursing Home provides accommodation with nursing and personal care to a maximum of 52 people. There were 35 people living at the home on the day of our inspection.

There was no registered manager in post at the time of our inspection. The service is required to have a registered manager. During our inspection, we met with the home manager who had applied to become registered manager of the 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.

At our last inspection on 24 February 2016, we found breaches of Regulations of the Health and Social Care 2008 (Regulated Activities) 2014. We gave the service an overall rating of inadequate. These breaches related to the provider's failure to respect people's dignity, provide safe care and treatment, ensure good governance, maintain sufficient staffing levels and display the service's most recent performance rating on their website. The home was placed into special measures, meaning significant improvements were required or further enforcement action could be taken. The provider sent us an action plan setting out the improvements they intended to make.

At this inspection, we found the provider had made significant improvements to the service. However, people still did not always receive safe support from staff to move. Staff also lacked understanding of how to protect people's rights under the Mental Capacity Act 2005. They were also unclear about the purpose and status of any Deprivation of Liberty Safeguards (DoLS) authorisations granted for people living at the home.

Staff understood how to recognise and report abuse. The provider had developed procedures to ensure any concerns about abuse were passed on to the relevant external authorities and investigated. The risks associated with people's care and support needs had been assessed, monitored and plans put in place to manage these. The provider had assessed and organised their staffing requirements in order to safely meet people's care needs. People's medicines were safely managed by the provider.

Staff received ongoing management support to carry out their duties and responsibilities effectively. People had the support they needed to eat and drink safely and comfortably. Their nutritional needs and dietary requirements had been assessed and addressed. People were supported to access healthcare services. Staff played an active role in monitoring people's health and sought prompt professional medical advice and treatment when necessary.

Staff took a caring and compassionate approach towards their work. The involvement of people and their relatives in decision-making was encouraged by the provider. Staff treated people with dignity and respect.

People received personalised care that took into account their needs, interests and preferences. People's relatives knew how to complain about the service. The provider had developed a formal procedure to ensure complaints were dealt with appropriately.

The manager promoted an open and inclusive culture within the service. They provided effective leadership and management of the service. The provider made use of quality assurance systems to assess, monitor and make improvements to the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always receive safe support from staff to move around. The risks to individuals had been assessed, recorded and plans put in place to manage these. There were enough suitable staff to safely meet people's care and support needs. People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Some staff lacked understanding of the MCA and DoLS, and what these meant for their work with people. Staff participated in an ongoing programme of training and refresher training. People had the support they needed from staff to eat and drink, and any associated risks were managed. People were supported to access healthcare services.

Is the service caring?

Good

The service was caring.

Staff adopted a caring and compassionate approach towards their work. The provider actively encouraged the involvement of people and their relatives in decision-making. Staff treated people in a dignified and respectful manner.

Is the service responsive?

Good

The service was responsive.

People received personalised care, based upon their individual needs and preferences. People were supported to pursue their interests and take part in social activities. People's relatives knew how to complain about the service and felt confident about doing so.

Is the service well-led?

Good

The service was well-led.

The provider promoted an open and inclusive culture within the service. The home manager provided effective leadership and management to the service. Staff felt well supported in their job roles. The provider made use of quality assurance systems to drive improvement at the service.	

The Vicarage Nursing 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.

This inspection took place on 7 and 9 November 2016 and was unannounced. The inspection team consisted of two inspectors.

As part of our inspection, we looked at the information we held about the service, including the statutory notifications the home manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also reviewed the report produced by Healthwatch Shropshire in relation to their most recent Enter and View Visit at the service.

During our inspection, we spoke with two people who used the service, nine relatives and a care home liaison from Shropshire Memory Service. We also talked to 15 members of staff, including the home manager, clinical lead nurse, nurses, kitchen manager, trainee care practitioner, nutrition support, activities worker, admin worker and carers.

We looked at three people's care records, medicine records, MCA and DoLS-related records, incident forms, DNACPR forms, a GP visit logbook and records associated with the provider's quality assurance systems

We also 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 talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, the provider was placing people at risk of injury because staff were not adhering to best practice when moving people. The provider told us in their action plan they would complete an individual moving and positioning risk assessment for each person, and address any associated staff training needs.

At this inspection, we found people had this risk assessment in place, and staff moving and handling training had been updated. However, we saw two members of staff use an inappropriate lifting technique to help a person move from their wheelchair to an armchair. The use of this technique put both the person and the staff involved at risk of injury. It also contradicted the guidelines in the individual's moving and positioning risk assessment. We spoke with the staff members involved who confirmed they had completed moving and handling training, but did not understand the risks associated with the lifting technique used. We reported our concerns to the home manager, who took immediate action to prevent further use of this unsafe moving and handling technique.

People's relatives were confident their family members were cared for safely. One relative told us, "I can leave here at night and not have to worry that they (family member) are not being looked after." The home manager told us they encouraged people and their relatives to voice any concerns they may have about the safety and wellbeing of anyone living at the home. People's relatives confirmed that they would not hesitate to raise any such concerns with the home manager or another senior member of staff. One relative told us, "If I have any concerns, I always consult with the person in charge. They always give me good responses."

The staff we spoke with understood the different forms and potential signs of abuse. They gave examples of the kinds of things that would give them cause for concern in protecting people from abuse. These included marked changes in a person's mood or behaviour, loss of appetite or any unexplained bruising. Staff understood the need to report any abuse to the home manager or another senior member of staff without delay. The provider had procedures in place to ensure any allegations of abuse were reported to the appropriate external authorities and thoroughly investigated. Our records showed the provider had previously made external notifications in line with these procedures.

At our last inspection, staff also did not always understand the risks associated with people's care needs, or have the necessary skills to meet these needs. The provider told us in their action plan about a range of measures they intended to put into place to address this These included minimising the use of agency staffing, improving staff handover and ensuring staff had regular one-to-one meetings with their line manager. Handover is the means by which staff leaving duty pass on important information to those arriving on shift.

At this inspection, we found staff understood the risks to individuals, and their role in keeping people and themselves safe. The provider had assessed and recorded the risks involved in meeting people's care needs. They had put plans in place to manage these risks, that were kept under regular review by the individual's named nurse. These plans covered important aspects of keeping the person safe, including managing

behaviour issues, the prevention of pressure sores and minimising the risk of falls. People's relatives told us the provider had encouraged them to be involved in decisions about keeping their family members safe.

At our last inspection, the provider had not always investigated or acted upon incidents involving people, in order to reduce the risk of reoccurrence. At this inspection, staff told us they consistently recorded and reported incidents or accidents involving people who lived at the home. We saw that the home manager used these reports to identify causes and trends, and to take action to reduce the risk of things happening again.

At the last inspection, the provider needed to make improvements to the way in which staff were deployed and supported people. At this inspection, people's relatives, and staff themselves, told us there had been a significant improvement in the staffing arrangements at the home over recent months. One relative told us, on the subject of the staffing levels, "They are about right now. There was a large use of agency before, but that's now disappeared." Another relative said, "They (the provider) got rid of all the agency staff and brought in more staff that seem competent." A member of staff said, "It (the home) is a lot calmer. We're not rushing around, because we've got more staff now."

The home manager explained that the provider had reviewed and increased staffing levels, based up people's individual care and support needs. Agency staff were only used when needed, to improve continuity of care. The provider had undertaken a recruitment drive to attract the new staff required. Before starting employment, all prospective staff members underwent checks to ensure they were suitable to work with people. These checks consisted of an enhanced Disclosure and Barring Service (DBS) check and employment references. The DBS helps employers to make safer recruitment decisions.

The home manager described how they took into account the skills and experience of staff when planning the staff duty rotas. During our inspection, we saw that there were enough staff available, on both of the home's floors, to readily meet people's needs and any requests for assistance. Staff in the communal areas did not appear rushed or overwhelmed. Staff made regular, recorded checks on people who were cared for in their beds. People had calls bells within reach to request any additional support.

At our last inspection, the provider had not always managed people's medicines safely. They told us in their action plan about their intention to introduce a new electronic barcode system to help them better manage people's medicines and minimise medication errors. At this inspection, we saw the provider had implemented this new system, and trained staff in its use. A nurse demonstrated to us how the new system helped them monitor stock levels and order the right medicines. The provider had also developed written protocols to help the nurses recognise when people should be offered "when required" medicines. The nurses confirmed that they made use of these protocols. We looked at the arrangements for storing people's medicines and observed how staff administered medicines to people. The systems and procedures in place reflected good practice, and were designed to ensure people received their medicines safely.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we were not assured that the training provided gave staff the skills and knowledge needed to meet people's dementia-related needs. The home manager had since updated the dementia training of the majority of the staff team. They had a training plan in place for the remainder of staff to complete this training as soon as possible. Some of the staff we spoke with described the insights this training had given them into how to better support people living with dementia. The provider also worked closely with the local memory service in supporting people with dementia.

During our inspection, we spoke with the care home liaison from the local memory service, who attended a weekly multi-disciplinary meeting at the home along with the local GP. The care home liaison praised the level of knowledge staff had about dementia, and their readiness to seek any additional advice from the team. They gave an example of how staff's insight into the symptoms and forms of dementia had led to one person getting the correct diagnosis and treatment.

Staff attended regular one-to-one meetings with a senior member of staff to address any additional support needs they may have. Staff told us these meetings gave them a valuable opportunity to talk about any problems affecting their work, receive feedback and request any additional training. One staff member explained, "They ask about what training I want and how I'm feeling. They also say how well I'm working." Outside of these meetings, staff had access to an on-call manager, at all times, for any urgent guidance and support needed.

People's relatives felt that staff had the necessary skills and knowledge to meet their family members' needs and to communicate with them. One person told us, "They (staff) are all good at everything." A relative said, "They (provider) have got their own staff who are extremely well trained and vigilant. The whole of the staffing now is of an excellent standard."

Before starting work at the home, all new members of staff underwent an induction with the provider. During this period, staff completed required training, worked alongside more experienced colleagues and got to know the people they would be supporting. Staff spoke positively about the degree to which their induction had prepared them for their new job roles. One staff member told us, "I shadowed until I felt confident in what I needed to know."

After completing their induction, staff participated in an ongoing programme of training and refresher training. The home manager explained that this programme was based upon both required training and people's individual care needs. Staff spoke positively about the increase in their training over recent months, and felt it gave them what they needed to know to. One staff member described how their infection control training had reminded them of the importance of regular hand-washing. Staff felt able to request additional training from the home manager, where necessary. The home manager described how they maintained strong links with the local memory service, safeguarding team and infection control nurses for guidance on best practice to inform staff training.

At our last inspection, we found that people cared for in their bedrooms did not always have drinks within their reach. We did not identify any concerns of this nature during this inspection. Staff carried out hourly "corridor checks" to ensure people in their bedrooms had access to fluids. Fluid charts were completed to track how much individuals had drunk. Any concerns about individual's fluid intake were discussed at handover. The provider had created a new post for a nutritional support person who had the specific responsibility of checking that food and fluid charts had been consistently completed each day.

People's relatives praised the quality of the food and drink served at the home. One relative told us, "I join [person's name] every lunchtime and have lunch with them. The food is excellent; I'm thinking of moving in!" Another relative said, "The food is very good. There is always tea and biscuits coming round and staff are welcoming. I've got no quibbles there." The provider encouraged people to have a balanced, healthy diet. The kitchen manager described how they had worked with a registered nutritional therapist to promote healthy eating within the home.

Staff spoke with people, monitored their response to particular foods and drew upon the knowledge of their relatives to understand their food-related likes and dislikes. The kitchen manager explained, "We talk about people's preferences at some relatives' meetings. When we are planning a new menu, we also put a box out for relatives and carers to put their ideas in." The mealtimes we observed were unrushed and relaxed affairs. Staff asked people what they wanted to eat. One person was having difficulty in choosing which dessert they wanted after their lunch. The activities worker told this person, "I'll bring you one of each and you can pick". There was plenty of staff support available for individuals who needed physical assistance to eat and drink. Some people had their food served in a particular consistency or made use of eating aids, based upon their individual needs. Staff checked people had access to drinks as they ate their meal.

People's relatives felt their family members had the support they needed to eat and drink safely and comfortably. We saw that the provider had assessed, monitored and recorded people's nutritional needs and their special dietary requirements. Plans had been put in place to manage these needs, with specialist input from the local speech and language team therapy team or dietician, where appropriate. The staff we spoke with demonstrated an understanding of the practical support people needed to eat and drink. The handover sheet given to all staff at the start of their shift contained important information about the support each person needed from staff at mealtimes. The kitchen manager praised the good communication maintained between kitchen staff and senior care staff. This ongoing dialogue ensured they had accurate and up-to-date information about people's dietary requirements. The kitchen manager explained, "We have great communication when a new resident comes in. We get forewarning about any special dietary needs, any input from the speech and language therapy team or food allergies."

We looked at how the provider protected people's rights under the Mental Capacity Act 2005. The 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 our last inspection, we saw that staff did not always seek people's consent before carrying out care tasks. During this inspection, some staff still lacked understanding of people's rights under the MCA, and what this meant for their day-to-day work with people. Not all staff had received training to help them understand their responsibilities in this area.

People living at the home were due to receive their annual flu vaccinations. A number of people lacked the mental capacity to decide whether or not to have this treatment. Although there was some evidence of

discussion with people's relatives, the provider had not arranged best interests meetings to reach a decision about flu vaccination for those who lacked capacity. We saw other best interests decisions were referred to in people's care plans. However, the home manager was unable to locate the records of these best interests meetings. We were not assured that best interest meetings were being appropriately conducted and recorded, in the event that people were unable to make a particular decision for themselves.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had assessed each person's individual care and support arrangements and had made DoLS applications on this basis. A number of these applications had been authorised, without any conditions, whilst others were still being processed by the relevant funding authorities. The home manager was aware of the current status of each person's DoLS application. However, there was still some confusion amongst staff about the purpose of DoLS and which of the people living at the home had a current DoLS authorisation in place. Staff were unaware of who was being lawfully deprived of their liberty, and any conditions that must be complied with for this to continue.

We discussed staff's lack of understanding in relation to the MCA and DoLS with the home manager. They told us they would provide additional training and support in this area to increase staff awareness.

We saw that decisions about whether cardiopulmonary resuscitation (CPR) should be attempted with individuals had been made by the appropriate healthcare professionals and clearly documented. Some people had appointed another person to make decisions about their health and welfare, or their property and financial affairs. In these instances, the provider had retained written evidence of the attorney's right to act on the individual's behalf.

People's relatives felt staff played an important role in monitoring their family members' health, and that staff were quick to respond to any health concerns. One relative told us, "When [person's name] fell, they (staff) called the ambulance straightaway. They deal very promptly with any medical emergencies and monitor the medical conditions of the residents." Another relative said, "[Person's name] was quite poorly with a viral infection. Staff were very attentive, and they didn't hesitate to get the doctor in." The home manager explained that they worked with a range of healthcare professionals, including people's GP, the district nurses, and the visiting optician and chiropodist, to ensure that people's day-to-day health needs were met.

Good

Is the service caring?

Our findings

At our last inspection, we found the provider had not ensured people's dignity was respected at all times. Staff did not always have enough time to spend with people. People did not always receive an appropriate response from staff to their requests for assistance. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, we found that staff had the time to stop and chat to people, both in between and during care tasks. Staff were not rushed or overstretched. For example, we saw two people sat chatting with care staff in the home's main lounge as they flicked through books and magazines. We did not see any occasions on which people had to wait unduly to have their needs or requests met by staff.

People's relatives felt staff cared for their family members with dignity and respect, and that they understood people's rights. One relative told us, "They take the residents to the toilet at regular times. They don't make a big song and dance about it; they're all treated with great dignity." We saw that staff took the time to offer people aprons to protect their clothing at mealtimes. The staff we spoke with understood the importance of treating people in a dignified and respectful manner. They gave examples of the practical steps they took each day to protect people's privacy and dignity. These included respecting people's wishes, protecting their modesty during personal care tasks and knocking on people's bedroom doors before entering.

People's relatives told us staff took a caring approach towards their work. They felt staff had taken the time to get to know and establish a rapport with their family members. One relative told us, "They (staff) really show an understanding and caring nature far above what you'd expect. They form loving and professional relationships with the residents." Another relative said, "They (staff) are very friendly and have a good banter and rapport with [person's name]. I genuinely feel that staff think the world of the clients."

We sat lots of positive, caring interactions between staff and people living at the home. People were relaxed in their home environment and at ease in speaking to or requesting help from staff. Staff responded to people in a warm and respectful manner, and took interest in what people had to say to them. Staff encouraged good communication with people through, for example, maintaining eye contact and getting down to people's eye level. Staff talked about the people they supported with warmth and affection, and demonstrated concern if they were distressed. One staff member described how they offered reassurance to an individual who became anxious whenever their spouse had to leave following their visits to the home. They assured this person that their partner would get home safely and would visit them again in the near future.

The staff we spoke with demonstrated that they knew the people they supported well. They were able to tell us about people's individual interests and preferences. One staff member told us a particular individual liked to hear their doorbell tune play as staff entered their bedroom. We later saw this person singing along to this tune with the staff member in question, as they supported the individual in their bedroom.

People's relatives told us the provider encouraged their involvement in care planning and any decision-making affecting their family members. One relative told us, "When [person's name] had a fall, I had discussions with the nurses and manager about the best ways to minimise the risks to them." This person went onto say that these discussions had resulted in the introduction of a new personal safety alarm for their family member. People's relatives felt the provider kept them informed and updated about any changes in their family members' health or wellbeing. One relative explained, "If there are any concerns or [person's name] has been unsettled, they come straight to me." People's relatives told us the provider was willing to listen to, and would, where possible, act upon any suggestions or ideas that may benefit their family members.

The provider had put systems in place to support people and their relatives to express their views about the care and support provided. These included the allocation of a key worker to each of the people living at the home. A key worker is someone who acts as a focal point for people and their relatives, ensuring people's individual requirements are met. The provider also invited people and their relatives to six-monthly care reviews, to review what had been achieved in the last six months and make plans for the coming period. Relatives meetings were held at the home every six weeks, to give people's relatives a further opportunity to have their say and receive updates from the home manager on the progress of the service. People's relatives told us these meetings were beneficial to them, and helped them feel involved. On this subject, one relative said, "The communication is now a lot better. It's a chance to air our views and [home manager] keeps us up to date with what's going on." The home manager indicated that no one living at the home required the support of an advocate, at present, to have their voice heard on important issues or decisions. They would, however, help people access local advocacy services as necessary.

Good

Is the service responsive?

Our findings

At our last inspection, we found that people did not always receive personalised care and support. Staff lacked awareness of people's individual needs and preferences, or did not have the necessary time to take these into account. People were not always supported by staff to take part in social activities. Due to the pressure upon staffing, the provider's activities workers were often required to assist with personal care tasks, as opposed to engaging people in activities. In addition, the care plans that staff worked from did not always contain accurate and up-to-date information about people's needs.

During this inspection, people's relatives told us the care and support staff provided took into account their family members' needs and what was important to them. They felt involved in the decision-making and care planning that shaped the care delivered. We saw that people's care plans contained information about people's individual care needs and preferences, and provided staff with guidance on how to meet these. The relevant named nurse and key worker kept each individual's care plans under regular review, to ensure this information remained accurate and up to date. The staff we spoke with demonstrated a good understanding of people's individual needs and how they preferred to be supported. They told that through talking to people, reading their care plans and learning from people's relatives and their more experienced colleagues, they got to know how each individual liked things to be done. One staff member explained, "We look at their care plan and CareDocs (a computer-based care planning system). You can get an in-depth view of people's lives. I also do quite a lot of talking with people and their families to get to know them well."

The provider had developed procedures to ensure information about any changes in people's needs was quickly shared with the staff team. Staff felt communication within the service was good. They told us they were kept up to date about people's needs, and the risks to themselves and others. These procedures included daily "stand-up meetings", during which key senior members of staff discussed any changes in people's health, wellbeing or behaviour. Daily handovers also took place between shifts, following which staff were given a written handover summary.

People's relatives felt their family members were supported to spend time doing things they found interesting and enjoyable. One relative said, "Given the needs and abilities of the residents, they (staff) put on an appropriate programme of activities. They also drill down to the individual level, and put on individual activities." The changes the provider had made to their staffing arrangements meant that activities workers and coordinators now had the time to engage people in both one-to-one and group activities. People were offered a varied programme of activities, which took into account their personal backgrounds, interests and preferences. This included visiting groups and entertainers, arts and crafts sessions, acts of worship, group games and the use of sensory items and memory boxes. Memory boxes are a resource used to help people recall and talk about people and events from their past. Where possible, people were also supported to get out and about, for example, by visiting local pubs and garden centres. During our inspection, we saw people engaged in a range of one-to-one and group activities, such as jigsaws, sensory sessions, nail care and sing-alongs.

People's relatives told us they knew how to raise a complaint about their family members' care and support,

if they needed to. With the provider's support, people's relatives had produced a general information booklet for all residents and relatives that explained how to complain, amongst other useful information about the service. On the subject of this booklet, a relative said, "It makes it perfectly clear that if you have any problems you go to the nurse who is responsible for dealing with them. If I had any concerns that they were not dealt with properly, I would go to the manager." Another relative said, "I would always approach the nurses. I have confidence they would act on things. I have a good rapport with them and feel they'd listen." People's relatives had confidence the provider would take their complaints seriously and act upon these. A relative explained, "If I want to raise something, they will hold up their hand and apologise. They will act upon what we say." Another relative described how concerns raised about the condition of their family member's bedroom had resulted in it being redecorated. The provider had a formal complaints procedure to ensure that all complaints were dealt with properly. The home manager shared with us the details of the most recent complaint received. We saw that the complainant had received a written response to their complaint, and that action had been taken to address the concerns raised.

Good

Is the service well-led?

Our findings

At our last inspection, we found that the provider had not made use of appropriate systems to assess and monitor the quality of the care and support provided. As a result, the risks associated with continued poor staff practice and not been addressed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan setting how they intended to address the shortfalls in quality. We saw evidence of these improvements in, for example, the level and nature of the staff support people had available to them and the safe management of people's medicines.

The provider had developed and implemented a range of quality assurance systems to assess and monitor the quality of the service provided, on an ongoing basis. These included regular audits by the provider's quality compliance manager, monthly health and safety checks by the maintenance officer, regular audits of medicine records and daily checks on people's care records. The nurses and trainee care practitioners were responsible for monitoring staff working practices on a day-to-day basis, and addressing any issues or concerns with individual staff members. In addition, the home manager told us they carried out unannounced spot checks on weekends, and worked occasional night shifts, to ensure staff were working as expected during these periods.

The home manager told us about the improvements resulting from the quality assurance systems in use. We saw evidence of their impact during our inspection. The home manager recognised the need to keep themselves up to date with current best practice in order to measure the quality of the service provided. They had, for example, worked closely with the local infection control nurses, who had helped them to develop staff cleaning schedules and set up an infection control resource folder for the service.

People's relatives and the staff we spoke with described an open and inclusive culture within the service. They felt involved in the service, and listened to by the provider. One relative told us, "I think they do have an open culture; quite a few of my suggestions have been adopted. [Home manager] is very receptive to ideas and suggestions for improvement coming from the relatives." A staff member said, "It's very good here - our opinions matter." People's relatives told us that the provider had been open with them about the shortfalls identified during our last inspection of the service. One relative said, "The manager kept us (relatives) informed about what was wrong with the home; they haven't hid anything. I feel they've turned a corner."

People's relatives and staff found the home manager approachable and prepared to act upon their concerns, ideas and suggestions. A staff member said, "I'm pleased that we can bring things up with [home manager]. She will listen, and things will be done about what we say." Staff told us they felt able to challenge decisions and working practices, if necessary. The provider had developed a whistleblowing procedure, and staff told us they would follow this.

Staff told us the home manager provided effective leadership and management of the service. One staff member said, "[Home manager] is not just a manager, she is a leader." Staff felt well supported by the home

manager, who they described as "straight-talking", "motivated", "on the ball" and "encouraging". Staff spoke positively about the renewed sense of teamwork amongst staff, and the improved communication within the service. They were clear about what was expected of their job roles, and had a sense of shared purpose with the home manager.

The home manager had a clear understanding of the duties and responsibilities associated with their position. Our records showed that they had previously submitted statutory notifications to us in accordance with these. The home manager told us the provider gave them the necessary support and resources to drive improvement at the service. They keep their own knowledge up to date by, amongst other things, attending events run by the local authority, participating in weekly multi-disciplinary meetings at the home and working collaboratively with external agencies, teams and professionals.