Westlands Care Home Limited

Westlands Retirement Home

Inspection report

Westlands House
Headmoor Lane, Four Marks
Alton
Hampshire
GU34 3EP

Tel: 01420588412
Website: www.westlansa-retirementhome.co.uk

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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

The inspection took place on 18 July 2018 and was unannounced.

Westlands Retirement Home 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. Westlands Retirement Home accommodates up to 51 people some of whom may be living with dementia, across two linked units. On the day of the inspection, 49 people were accommodated.

The service had a registered manager in post. 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.

People were kept safe from the risk of abuse as staff had undertaken relevant training and understood their responsibilities to protect people. Risks to people both as individuals and from their environment had been identified, assessed and managed safely. There were sufficient staff to provide people's care. The provider followed safe staff recruitment practices. People's medicines were safely managed within the service by trained staff who followed good practice guidance. Staff followed infection control guidance to ensure people were kept safe from the risk of acquiring an infection. Learning took place following incidents and processes were in place to identify any trends that needed to be addressed for people.

People's care needs were assessed prior to their admission. The planning of their care considered good practice guidance, to ensure it was effective. Staff were supported in their role through the provision of an induction, on-going training, supervision and professional development. People were supported to eat and drink sufficient amounts for their needs. Risks to people from dehydration and malnutrition were assessed and managed effectively. Processes were in place to promote effective working both within the team and with other services. People were supported to access healthcare professionals as required and staff had undertaken relevant training to support them in recognising promptly if people's health was deteriorating. Parts of the service were being refurbished and enhanced for people's use and enjoyment. 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.

We observed care and support was given to people throughout the day, in a kindly manner. Staff supported people to be involved in making decisions about their care where possible. People were treated with dignity and respect by the staff who provided their care.

People received care that was responsive to their needs. People and their families were involved in their care planning, which reflected their care needs and preferences. Staff had undertaken relevant training to enable them to be responsive to the needs of people whose behaviours could be challenging. People were

provided with daily activities to stimulate them and could have visitors when they wished. People's concerns and complaints had been used to improve the quality of the care provided. Staff had completed training and were undertaking further training to enable them to support people appropriately at the end of their life.

People told us the service was well-led. The new registered manager had fostered a positive culture within the service, with staff feeling pride and commitment to their work. The registered manager had submitted notifications as legally required. People's views on the service were sought and used to improve the service. Processes were in place to assess and monitor the quality of the service provided. The service had good working relationships with local services.

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.

Safeguarding systems, processes and training were in place to keep people safe from the risk of abuse.

Risks to people had been assessed and addressed to ensure their safety.

There were sufficient numbers of suitable staff deployed.

Staff training, processes and guidance were in place to ensure the safe management of people's medicines.

Is the service effective?

Good

The service was effective.

People's needs were assessed and the planning of their care reflected current good practice guidance.

Staff were supported in their role through training and supervision.

People were supported by staff to eat and drink sufficient for their needs.

Staff across the service worked together to deliver effective care and treatment.

People's consent to their care and treatment had been sought and where they could not give their consent legal requirements had been met.

Is the service caring?

Good

The service was caring.

Staff treated people in a kindly and caring manner.

People were supported to express their views and to be actively involved in decisions about their care.

People's privacy, dignity and independence were upheld by staff.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

People were provided with sufficient opportunities for social stimulation.

Processes were in place to enable people to make complaints and their feedback had been used to improve the service.

People were appropriately supported at the end of their life.

Is the service well-led?

Good

The service was well-led.

There a clear vision for the delivery of the service and a positive, person centred culture.

Processes were in place to engage people and their relatives with the service.

Processes were in place to assess and monitor the quality of the service provide and to identify areas for improvement.

The service worked in partnership with other agencies.

Westlands Retirement 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 18 July 2018 and was unannounced. The inspection team included two inspectors 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. The expert by experience had experience of caring for older people.

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 the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

Prior to the inspection we received written feedback about the service from a specialist nurse and three social workers, we also spoke with a pharmacist. During the inspection we spoke with five people and five relatives. We spoke with the registered manager, the deputy manager, five care staff, an activities co-ordinator, housekeeping, laundry and catering staff. We also spoke with a visiting health care professional. We reviewed records which included four people's care plans, three staff recruitment records and five staff supervision records and records relating to the management of the service. We reviewed the staff duty roster for the period 11 June to 18 July 2018.

A focused inspection of this service was last completed on 5 February 2018 to check upon the actions the providers had taken to meet the breaches found at our previous inspection completed on 12, 13 and 14 July

2017. We found the provider had taken the relevant actions to meet legal requirements.

Good

Is the service safe?

Our findings

People overall told us the service was safe. Their comments included, "Residents are well looked after and if there was anything wrong I would let you know." "It's clean everywhere." "The medication round comes regularly." "I can't see any risks" and "Any incident, we get a phone call." Some people expressed the view they would like to have seen more staff, the provider had also identified this need, which they were addressing for people.

Staff had undertaken safeguarding training and had access to relevant policies, procedures and telephone numbers. Notices were displayed around the service to inform people and staff about what safeguarding meant for their information. Staff spoken with could demonstrate their understanding of what they should do if they suspected a person had experienced abuse and how to raise concerns outside of the service if required. One staff member said, "I would let the manager know if I saw something [abusive behaviour by staff.] I know they would do something but if I had to I could call you [CQC.]" The registered manager understood their duty to report any safeguarding concerns to the local authority and had done so. They had completed investigations where instructed to by the local authority following safeguarding alerts raised and taken relevant actions to keep people safe. Feedback on the outcome of safeguarding investigations was provided to staff at the staff shift handover and during their supervisions.

Risks to people had been assessed, identified and addressed in relation to various aspects of their care. These included for example: skin care, falls, moving and handling, nutrition, choking and challenging behaviours. Staff took a positive approach to risk assessments to support people's rights and independence. Risk assessments considered the benefits to people of taking the risk and their strengths in addition to the factors that needed to be managed for the person's safety. Where risks were identified, guidance was provided for staff which they followed and understood. For example, staff could tell us how individuals were supported to re-position in bed if they had reduced mobility and how the risks of people falling were managed. People were provided with the correct equipment to keep them safe, such as pressure relieving equipment which was checked regularly. We saw staff ensured people had their call bells placed within easy reach, so they could call for assistance if required. Staff had undertaken moving and handling training and were observed to transfer people safely.

The provider had a business continuity plan to ensure the safe running of the service in the face of a critical event such as bad weather. Relevant safety checks had been completed in relation to fire, electrical, gas, water and equipment safety. The registered manager had identified that a fireplace was a risk to people's safety and we saw it was being removed as part of the refurbishment that was underway in one of the lounges. The environment was safe for people.

People's levels of care needs were individually assessed. The registered manager then used this information with the staffing dependency tool to calculate the number of staff required. Staffing was flexible and was due to be increased from 23 July 2018, to include one extra member of care staff during the day. The provider's call bell audits showed for the past two months almost all call bells had been answered within a four-minute period, and most much sooner. A staff member said, "We do use agency but it's always the

same one and usually the same staff so it's not too bad. We do have time to spend with the residents." There were sufficient numbers of senior staff on shifts to lead the team and allocate work. There were sufficient staff who knew people to provide their care.

Appropriate checks were undertaken before staff began work. Staff files showed criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation including full employment histories, professional and character references, immigration status and interview notes in staff files. Applicants were asked questions applicable to the role they were applying for, such as safeguarding and their understanding of the Mental Capacity Act 2005. A record was maintained of when staff's DBS checks needed to be renewed to ensure they were checked and updated regularly. The provider followed safe recruitment practices.

Staff who administered people's medicines had undertaken relevant training. Staff had their medicines competency assessed annually and the provider acted when deemed necessary. For example, one staff member underwent re-training after making an error during a medicines administration round, to ensure they could administer people's medicines safely.

People's medicines were stored safely at the correct temperature including those medicines which required a higher level of security. Thickeners used to thicken people's drinks were stored safely, to prevent their accidental ingestion.

The administration of medicines followed current guidance. Staff did not leave the medicines trolley unlocked when unsupervised and signed people's medicine administration records (MAR's) only when the person had taken their medicine. There were no gaps in people's MAR's.

Where people took medicines 'as needed' (PRN), protocols were in place; they outlined how, when and why they should be taken and included maximum doses over a 24-hour period. People at risk of experiencing pain who could not express this verbally were frequently assessed using a formal tool, to ensure their pain was identified and managed.

Staff monitored people's medicines where required to ensure concentrations of the medicine in the person were safely maintained. This was done either through blood tests or by monitoring the person themselves, for example, the glucose levels of those living with diabetes. There was clear guidance for staff concerning the safe management of people taking other types of high risk medicines such as anticoagulants, used to prevent people's blood clotting.

Some people could manage their medicines independently. Their ability to do so had been assessed and safe storage facilities made available. Where people received their medicines covertly, without their knowledge, mental capacity assessments had been carried out and meetings held with relevant parties, to determine whether this was in the person's best interests. GPs and pharmacists had been consulted during this process, as legally required.

The service was observed to be clean and there was adequate provision of housekeeping staff. Some walls required redecoration, and this was underway. The carpet in one of the lounges was due to be replaced the weekend following the inspection, as part of this room's refurbishment. The registered manager told us that several other carpets in people's bedrooms were also due for replacement as part of the refurbishment programme.

Staff had undertaken infection control and food hygiene training. Staff wore the personal protective equipment provided. Bathrooms and toilets were visibly clean, and soap and paper towels were available for people to clean their hands. Processes were in place to ensure the safe handling of laundry.

In the kitchen staff followed daily cleaning rotas, in addition to taking fridge and freezer temperatures and temperature recordings for the food prepared. The kitchen had been inspected by the local environmental health team on 25 June 2018 and rated as five, which meant hygiene standards were very good. People's meals were prepared in safely in a clean environment.

People's care plans contained guidance for staff about what they should report to senior staff, such as risks to people's skin integrity. When incidents occurred such as falls, staff followed guidance and used the local 'post falls' protocol to monitor people. People's weights were monitored, and any significant weight loss was reported to the person's GP. A form was completed following any incidents and these were collated and reviewed both to identify if any further actions were required and to identify any trends. Staff were informed of any changes to people's care because of incidents and could tell us of the actions taken following a person's fall to promote their safety. Incidents were analysed and reviewed to identify any learning points.

Good

Is the service effective?

Our findings

People felt the service was effective. Their comments included, "I can ring up the surgery. I go to community hospital now. They [the home] can also arrange it for me and volunteer drivers collect me." "The chef is very good, offers me choice all the time." "There isn't a no-go area in this home."

The registered manager or the deputy manager completed people's pre-admission assessments, to assure themselves the service was suitable to meet the person's needs. We saw they obtained copies of relevant assessments from other agencies to inform their assessment and a social worker confirmed information they had provided about a person was considered in the person's care planning. People's needs were thoroughly assessed prior to their offer of accommodation.

Staff used recognised tools to assess people's care needs, such as 'The Braden Tool' to assess people's risk of developing a pressure ulcer and the Malnutrition Universal Screening Tool which is used to assess people's risk of becoming malnourished. The service assessed people's risk of dehydration using a recognised tool called 'GULP.' They also used local guidance such as the local authority 'post falls' protocol to monitor people's welfare after a fall and the local authority's mental capacity 'toolkit.' This helped staff to assess people's mental capacity and to clearly document best interest consultations and decisions. In addition, staff were provided with information leaflets and good practice guidance. For example, in relation to issues such as urinary tract infections and continence management.

All staff received an induction to their role and shadowed more experienced staff to understand what was expected of them. Staff who were new to care were required to meet the requirements of the 'Care Certificate', which familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life. A staff member told us, "I didn't go onto the floor alone until my induction and training was done and I'd shadowed other staff."

Staff could access on-going training in subjects relevant to the care needs of the people they supported in a variety of settings, including on-line, one to one and classroom learning. Ten of the 24 permanent care staff held a professional qualification in social care.

We saw all staff, including ancillary staff had received regular supervisions and an annual appraisal in line with the provider's policy. Staff were happy with this process, one said, "It's very open and honest; I can get things off my chest." Staff were happy with the training opportunities on offer and the support provided. One staff member said, "There is something every month. We can talk about it in supervision and then it's arranged."

The chef was provided with information about people's dietary needs and requirements upon their admission to the service. These included their likes, dislikes, cultural and religious food requirements. Provision was made for people with diabetes for example, with fresh fruit and yoghurts provided as alternative choices for pudding.

The menu was based on a four-week rotation. People chose from the menu on the day. There was a choice of freshly cooked meals. People were offered an alternative to the menu if they wished and could request food items of their choice.

We observed meal times were a pleasant experience for people. Staff supported those who required assistance and as there were two lunch sittings, one for each side of the service, meals were not rushed.

People's nutritional and fluid requirements had been assessed, to identify those at risk from malnutrition or dehydration. Staff were knowledgeable about people's needs. They were aware of the special diets some people were on and the implications if certain diets, such as soft or pureed food for those with swallowing difficulties were not followed. The deputy manager could tell us about a person they had identified as being at risk from malnutrition through their monitoring and the actions they had taken, to ensure the person received the support they required.

Staff promoted the use of a hydration drink with people, to encourage them to drink. There were also 'hydration stations' for people to help themselves to drinks. Staff understood the importance of monitoring the food and fluid intake of those at risk and records demonstrated they had done so. Staff had guidance about people's individual fluid requirements to ensure they knew when to alert healthcare services if the person was not drinking sufficient for their needs.

Processes were in place to enable effective communication within the staff team. These included staff handovers and walkie talkies for staff to communicate on the floor. Information was also shared through a 'communication book' which provided updates about people's care and there were daily catch ups between senior staff on the floor and management. Staff were provided with a range of protocols to guide them on what action to take in what situation, for example, if a person became unwell, to ensure consistency of approach across the staff team. Records demonstrated that when staff identified risks to people through their monitoring they had taken prompt action to refer people to relevant professionals for guidance. If people needed to go to hospital then there was a transfer form in the person's file ready to be sent with them, which provided essential information, for example, if the person had any sensory impairment, or communication needs that the hospital would need to be made aware of.

People had health care logs which demonstrated people had contact with a wide variety of healthcare professionals to address their physical and mental health care needs in addition to their social care needs. People were visited regularly by GP's, the chiropodist, dentists and opticians. Staff had recently undertaken training in a recognised system to enable them to more effectively identify if people were deteriorating and required referral to healthcare services.

A programme of refurbishment was underway. One of the lounges was in the process of being re-decorated, with a new carpet and new furniture for people. The layout of this part of the service was also being changed, to provide an additional 'quiet' lounge for people to use. As part of the refurbishment additional signage was about to be displayed for people to orientate themselves. There was a large secure garden and further work was due to be undertaken to make it more appealing for people to use, with the provision of a pagoda and increased colour.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. 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 were being met.

Staff had undertaken relevant training and understood the application of the MCA as it applied to their role. One staff member told us, "We assume everyone has [mental] capacity unless we can prove otherwise." Another said, "Someone without mental capacity, they might not be able to make big decisions, but what they wear or what they want to eat, it's up to them." Staff understood that mental capacity was decision specific and assisted people to make the decisions they could.

Mental Capacity Act 2005 assessments and best interest decisions involving relevant parties had been completed for specific decisions a person could not make for themselves. Where appropriate Deprivation of Liberty Safeguards applications had been made for people who could not consent to their care and restrictions placed upon their liberty. These were correctly underpinned by a MCA assessment to demonstrate how this decision had been reached.

Good

Is the service caring?

Our findings

People told us the service was caring. Their feedback included, "They are all very nice. They treat me well." "Staff are friendly. They would do anything for you." "All of the staff are always interacting." "They all know me. They always listen to me" and "They knock before entering. I have got nothing against this place."

We observed care and support was given to people throughout the inspection in a kindly manner. Staff were sensitive to people's moods and signs of distress and responded promptly and reassured people. Staff understood how to interact with people, bending down to their level and maintaining eye contact as they spoke with them, gently. Staff spoke respectfully to people. A person told us they had experienced discrimination in other settings due to their disability but they had not experienced this since they moved to this service. We asked staff if they thought the home was a caring place. One staff member told us, "Yes, I've worked here for years and I wouldn't stay if it wasn't caring."

Professionals confirmed they had observed staff to be kind and caring towards people. The registered manager told us they also monitored the quality of staff's interactions with people through their daily 'walks of the floor,' observations and quality assurance processes.

Staff were provided with information about people's background and life histories, which they used to understand people. Staff knew people's preferred term of address and what they liked to eat and drink. There was information for staff about how to communicate with people, for example, if staff needed to use 'closed' questions to enable the person to understand what was being asked.

People were supported to express their views and to be actively involved in decisions about their care. Staff were informed of people's diagnosis and what this meant for them in relation to communicating and making their wishes known. For example, if a person was living with dementia, it was noted the extent to which they could make their needs and wishes known and what could cause them frustration. If a person could not make decisions about an area of their life such as what they wanted to eat, this was documented. We observed staff constantly tried to involve people in making decisions wherever possible. They asked people their view rather than just 'doing' things for them, such as cutting up their meal without asking. Although the service was separated into two parts, people could exercise choice about where they spent their time. Some people therefore lived on one side of the service but chose to spend a lot of their time in the lounge on the other side, which staff supported.

Staff were observed to treat people with dignity and respect throughout the inspection. People's care plans instructed staff on how to uphold people's dignity as an individual. For example, the signals one person might use to indicate their need for the bathroom were noted. We observed staff knocked before they entered people's bedrooms. Staff ensure people's personal care was provided in private.

People were supported to maintain their independence. Their care plans reflected what they could do for themselves, or if they required verbal prompts from staff to commence tasks, such as washing their hands.

Good

Is the service responsive?

Our findings

People and their relatives told us they had seen their care plan. Their comments included, "I have seen lots of plans given to me" and "Yes, I have seen my [loved ones] care plan." People felt there were sufficient activities and that their loved ones could visit at will. Their feedback included, "They ask me to go downstairs," "I can go out if I want to" and "You can have visitors any time you want." People felt able to make complaints. A person told us there had been an issue with the water temperature, when we checked this with the registered manager we found this had been addressed.

People had personalised care plans that reflected them as an individual in terms of their care needs and preferences about how they wanted their care to be provided. People and their families were asked to complete 'Life histories' for people and the Alzheimer Society's 'This is me' document where relevant to enable staff to understand people's personal history. A health care professional confirmed that staff had established a person's wishes when they were admitted and that the guidance in their care plan had been followed by staff. People's care plans were then reviewed by staff monthly to ensure they remained current. People and their relatives were welcome to attend these reviews as they wished.

People had a 'micro' care plan in their notes which was easily accessible to staff. This contained a 'snapshot' of all the information staff needed to be aware of to provide the person's care. This was particularly useful for new or agency staff, as it provided an overview of each person's care needs.

Staff had undertaken relevant training to enable them to respond to people's behaviours which could be more challenging. There was clear guidance for staff in people's care plans if the person was likely to find certain aspects of care provision more challenging and how they should respond. We observed staff followed the guidance provided for a person and remained calm as they supported them with a transfer.

Staff had noted and took account of people's spiritual needs. We saw they had researched what was important to people of different faiths, in relation to both practising their religion and their end of life wishes. There was a monthly church service held for people to attend if they wished.

The service ensured that people had access to the information they needed in a way they could understand it and are complying with the Accessible Information Standard. 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.

People's care plans noted if the person had a disability or sensory loss and how this impacted upon how they needed information to be provided. For example, if a person wore glasses then it was noted they needed them and that they should be cleaned. One person could understand most information, but it was noted staff may need to use pictures to explain information to them if required. There was a pictorial complaints policy and the registered manager had just obtained a pictorial menu as part of the refurbishment which was to be displayed shortly. This will support people living with dementia or those with a cognitive impairment to make choices about what meal they would like. Yellow signage was displayed to

assist people living with dementia to orientate themselves.

There was a daily activity schedule providing a range of activities and external entertainers attended the service. The activity coordinator told us there was a range of activities which changed according to people's needs. They said, "If people get fed up we come with something else." The schedule included for example, sing alongs, board games, one to ones, keep fit, massage, films, gardening, baking, and flower arranging. People were provided with a range of activities to stimulate them.

The complaints procedure was available for all to view in the communal areas. It contained information about how and to whom people and their representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. The staff we spoke with were clear about their responsibilities in the management of complaints.

There were three formal complaints in 2018; two concerned the environment and one the quality of care. All had been managed in a timely and satisfactory manner and resolved to the complainants' satisfaction, in line with the provider's policy. We saw improvements were underway in respect of the environment. People's concerns and complaints had been used to improve the quality of the care provided.

People and their relatives had been consulted about the person's end of life care wishes and where people were not ready to have these discussions this had been noted for staff's guidance. People's end of life care plans noted what was important to them and we saw staff followed the guidance provided. Where relevant, people had a do not attempt cardiopulmonary resuscitation document, this was prominently placed in their file, to ensure staff were aware.

There was an end of life policy for staff to follow and guidance on the changes to expect in people at the end of their life. There was an 'after passing checklist' for staff to document the care provided to the deceased. Nine staff had undertaken end of life training and further staff were undergoing the 'Six Steps Programme' with a local hospice. This is a programme of learning for care home staff to develop their awareness and knowledge of end of life care. People were appropriately supported at the end of their life.

Good

Is the service well-led?

Our findings

People told us the service was well-led. They knew who the registered manager was and who to take any issues to. Professionals reported they had seen a significant improvement in the management of the service since the appointment of the new registered manager.

The provider's objectives to provide high quality personalised care and to respect people's rights, were clearly set out in their statement of purpose. The registered manager told us staff learnt about the provider's purpose during their induction and this was reinforced on an on-going basis through the staff supervision process.

There was a registered manager in post as legally required. They were supported in their role by the providers and the deputy manager with whom they worked closely and senior staff. The registered manager understood their legal responsibilities and ensured notifications were submitted to the Care Quality Commission following incidents as required. There was clear guidance and protocols in place for staff to follow and they were informed of new or updated policies.

The leadership of the service by the registered manager was both clear and visible. They were experienced and had used their skills and knowledge to lead the service well. Since their appointment they had documented a total of 73 changes or improvements to the service they had introduced. These included for example, new care plans, micro care plans, re-decoration, creating a 'quiet' lounge' on the green wing, increasing domestic and maintenance staff and the introduction of an additional staff member from 07:00 to 10:00 to increase staffing during people's breakfast time. People had benefited from their strength of leadership and the changes they had introduced.

The registered manager told us there was now a good person-centred culture amongst the staff team. There had been a focus on improving the culture of the service, with the provision of new staff uniforms, identity badges and the upgrading of the environment, to give staff a sense of pride and commitment to their work. Staff told us, "I think the care is much better. Since [registered manager] has started things have really taken off" and "They've made a big difference." The registered manager monitored the culture of the service during their daily walk arounds of the service and spoke with staff regularly at the staff meetings about the need to promote a positive team culture for people. There was honesty and transparency within the service and people's families were kept informed of any incident that impacted upon their loved one.

People were asked for their views at reviews of their care, residents meetings and the annual survey. People were asked at the last residents meeting held on 2 May 2018 their ideas for celebrating the royal wedding. In June 2018 there had been an informal consultation with people about their favourite foods and the chef now completed food surveys with people. People, their relatives and staff had been asked to complete an annual survey in April 2018. The results showed overall a good degree of satisfaction with the service. People did express that they would like to see more staff and refurbishment both of which were underway to improve the service for people. The results of the survey were displayed along with a 'You said, we did' poster so they could see the actions taken in response to their feedback.

The service also engaged with the local community. A garden party was held recently for people and their families. The church visited monthly and local schools were invited in to sing.

Processes were in place to assess and monitor the quality of the service provided. Audits and analysis of service data was completed by staff, the registered manager, the providers and external professionals such as their dispensing pharmacist.

Medicines audits were conducted both weekly and monthly, they looked at aspects of medicines management, such as ordering and disposal. There was also an annual medicines audit by the provider's dispensing pharmacist which was last undertaken on 19 June 2018, this had not identified any areas of concern.

There was a monthly analysis of incidents and falls. This identified not only the details of the incident and the actions taken to prevent re-occurrence, but any underlying trends which needed to be addressed for people. The registered manager had told us that the level of falls people had experienced had dropped and this was supported by the evidence from both their falls analysis and feedback from a healthcare professional who told us that calls to the ambulance service had fallen.

The registered manager had an audit schedule for the year, to ensure a range of aspects of the service were audited. It encompassed audits of areas such as: dignity, consent, care, nutrition, working with others, safeguarding, infection control medicines, premises, equipment, staff files, staffing, supporting workers, complaints and records. We saw that when issues were identified through the audit processes, actions were taken. For example, the safeguarding audit identified the need to revise the guidance on people's finances for their safety and this had been completed. The infection control audit of 18 April 2018 identified that not all staff could be seen washing their hands prior to entering the kitchen so an urgent message went out to all staff to remind them of the importance of this. In addition, the providers now completed an audit of the service to satisfy themselves of the quality of the service provided.

The service had good working relationships with local services such as the older person's mental health team, social services teams, and G.P practices. They also worked with specialists such as the speech and language therapy service, the pharmacy and a local hospice to access relevant training. They engaged with the local specialist nurse and accessed the training opportunities provided by them for example, on the National Early Warning Score a system which improves the detection and response to clinical deterioration in adults, to improve the care they provided.