Lifestyle Care Management Ltd

Blenheim Care Centre

Inspection report

Ickenham Road
Ruislip
Middlesex
HA4 7DP

Tel: 01895622167
Website: www.lifestylecare.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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection was carried out on 26, 27 and 28 April 2016 and the first day was unannounced. This was the first inspection under the current registration with the Care Quality Commission.

Blenheim Care Centre provides accommodation for a maximum of 64 people. The service has three floors and accommodates people in single rooms each with en suite facilities. The ground floor provides general nursing care for up to 12 older people and 8 people with physical disabilities. The first floor provides personal care for up to 22 older people with dementia care needs. The second floor provides nursing care for up to 22 older people with dementia care needs. Each floor has communal dining, sitting rooms and bathing facilities. At the time of inspection there were 57 people using the service.

The service is required to have a registered manager and there was 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.

The majority of care records were up to date and reflected people's needs, however we did identify some shortfalls with completion and updating of documents. This had already been identified by the registered manager and action was being taken to address this.

People and relatives expressed their satisfaction with the care and support being provided.

Systems were in place to safeguard people from the risk of abuse.

Risk assessments were in place for identified areas of risk to minimise them. Maintenance and servicing of the premises and equipment took place to maintain a safe environment.

Staff recruitment procedures were in place and being followed. There were enough staff on duty to meet people's needs.

The provider made suitable arrangements to ensure service users were protected against the risks associated with the inappropriate treatment of medicines.

Staff worked well as a team and received training to provide them with the skills and knowledge to care for people effectively.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff acted in people's best interests to ensure their freedom was not unduly restricted.

People's nutritional needs were assessed and monitored. People's dietary needs and preferences were being met.

People's healthcare needs were monitored and they were referred to the GP and other healthcare professionals if needed.

People and where appropriate their representatives were involved with making choices about care needs. Staff respected people's choices and treated them with dignity and respect.

Staff had a good understanding of the individual care and support people needed and provided this in a gentle, caring and calm manner.

People and relatives were confident to raise any complaints and systems were in place to record and investigate these.

The manager was approachable and had the qualifications and skills to manage the service effectively.

Meetings for relatives and people took place and action was taken to address points raised. Staff meetings took place and individual supervisions were being progressed to identify staff development needs.

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 and relatives felt people were kept safe at the service. The provider had appropriate arrangements in place to safeguard people against the risk of abuse.

Risk assessments were in place for identified areas of risk to minimise them. Maintenance and servicing of the premises and equipment took place to maintain a safe environment.

Staff recruitment procedures were in place and being followed. There were enough staff on duty to meet people's needs.

The provider made suitable arrangements to ensure people using the service were protected against the risks associated with the inappropriate treatment of medicines.

Is the service effective?

Good

The service was effective. Staff worked well as a team and received training to provide them with the skills and knowledge to care for people effectively.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff acted in people's best interests to ensure their freedom was not unduly restricted.

People's nutritional needs were assessed and monitored. People's dietary needs and preferences were being met.

People's healthcare needs were monitored and they were referred to the GP and other healthcare professionals if needed.

Is the service caring?

Good

The service was caring. People and where appropriate their representatives were involved with making choices about care needs. Staff respected people's choices and treated them with dignity and respect.

Staff had a good understanding of the individual care and

support people needed and provided this in a gentle, caring and calm manner.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. The majority of care records were up to date and accurately reflected people's changing needs. Some information was found to be out of date or incomplete and needed reviewing. The registered manager had identified this and work was ongoing to bring the care records up to date.

People and relatives were confident to raise any complaints and systems were in place to record and investigate these.

Is the service well-led?

Good

The service was well-led. The registered manager was approachable and was managing the service effectively.

Meetings for relatives and people took place and action was taken to address points raised. Staff meetings were held and individual supervisions were being progressed to identify staff development needs.

Systems were in place to monitor the quality of the service and areas for improvements were identified and addressed. Work in this area was ongoing, with environmental improvements being planned for the service.

Blenheim Care Centre

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.

This inspection took place on 26, 27 and 28 April 2016 and the first day of inspection was unannounced. Before the inspection we reviewed the information we held about the service including notifications and information received from the local authority. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

The inspection team consisted of three inspectors including a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience of working with older people and of care services.

During the inspection we viewed a variety of records including eight care records, some in detail and some to look at specific areas of care, the medicine supplies and medicines administration record charts for 18 people, seven staff recruitment files, risk assessments for safe working practices, servicing and maintenance records for equipment and the premises, complaints records, audit and monitoring reports and policies and procedures.

We used the Short Observational Framework for Inspection (SOFI) during the lunchtime on the first floor. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the mealtime experience for people and interaction between people using the service and staff on all floors.

The service submitted a provider information return (PIR) and this was viewed and information used to inform this report in conjunction with our findings at the inspection. We spoke with eight people using the service, nine relatives, the registered manager, the deputy manager, four registered nurses, one team leader, four care staff, the activities coordinator, one chef and two domestic staff including the housekeeper. We also spoke with a visiting social worker and the optician. Following the inspection we requested feedback

from healthcare professionals including the GP and members of the Community Adult Rehabilitation Service. We received feedback from the GP and also from the Team Leader of the rehabilitation service with input from five healthcare professionals in the team.

Good

Is the service safe?

Our findings

We asked people and their relatives if they felt safe at the service. Comments included, "Yes I feel safe in this building." "Yes my [relative] is safer in here than anywhere else." "My [relative] is safe here, the staff know her and myself very well, which allowed her to settled very well with staff and other residents." We asked staff about keeping people safe and comments from them included, "Have clear pathways in the home and proper lighting. Monitor people in their rooms – we check them hourly. Always have enough staff on to check on people and respond to their alarms" and "I have to look after my chemicals and can't leave them out at all. Residents are mobile – I have to lock chemicals away all the time. I have to put equipment back in the cupboard and lock it."

People were being protected from the risk of abuse. Policies and procedures for safeguarding and whistleblowing were in place and contact numbers for reporting safeguarding concerns were on display in the service. We asked staff what they understood about safeguarding and whistleblowing and feedback included, "It's where if something is wrong, that's where safeguarding comes in. Like if there is a bruise. I would tell my nurse and then someone in charge or the manager. If the manager does nothing I would go above her. Whistle-blowing is going to the CQC or the local council." Staff told us they had received training in safeguarding and were able to describe the different types and possible signs of abuse. Staff knew how to report safeguarding concerns and said they would inform the senior person on duty in the first instance and report to the registered manager. Staff understood whistleblowing procedures and knew the outside agencies they could contact to report concerns including the Care Quality Commission and the local authority. They also knew they could contact the police in an emergency situation.

Risks were being assessed so they were identified and action could be taken to keep people safe. Individual risk assessments had been carried out and recorded in each person's care records. These included assessments for the risk of developing pressure sores, risk of malnutrition, falls risk and any risks associated with use of equipment, for example, using a wheelchair. These were updated monthly so the information was kept up to date. Risk assessments for premises, equipment and safe working practices were in place and had last been reviewed in June 2015. Risk assessment documents for the new provider were available and the registered manager said she would use these to review and update the risk assessments.

Staff were able to tell us the action they would take in an emergency. One told us, "Inform a senior about the incident. Leave the person in their position. Take instructions from the senior who would call the GP if injuries are minor. We would check the person's condition to see if their condition was serious or they had moderate injuries. If moderate, call Raid Response and if serious call 999." They also told us they read the risk assessments and found them helpful to provide them with the information to minimise risks. Comments included, "I have read the risk assessments. I know what they contain" and "We need to have some risk assessments – they are helpful." Accidents and incidents were recorded and reviewed each month to look for any trends, for example, the time of day they occurred. The registered manager said she if she identified a trend she would take action to address it, for example by reviewed staffing and procedures at specific times.

The fire risk assessment had last been completed in February 2016 and the registered manager explained

the provider was to address areas of the fire protection system that had been identified for action. An evacuation plan for fire safety was available and identified the method of evacuation for individuals so this information was available to the emergency services. There was a business continuity plan in place and this had last been updated in December 2015. This included contact details for key members of staff and of alternative services that could be accessed to provide shelter for people should an evacuation of the premises be necessary.

Servicing and maintenance records had been completed and we saw systems and equipment including gas appliances, hoists, fire safety equipment and lifts were being serviced at required intervals. The lifts had been out of order for a prolonged time at the end of 2015 due to awaiting parts for repairs to be carried out and the registered manager had put a contingency plan in place to minimise disruption in the service. During the inspection the fire detectors were being checked by the maintenance company and these were done every six months to ensure they were in good working order. We observed staff using equipment including hoists and wheelchairs safely, speaking with people and reassuring them when using equipment to move them within the service.

Employment checks were carried out to ensure only suitable staff were employed at the service. Staff told us about the recruitment process they went through before starting work at the service. We saw completed application forms included employment histories and any gaps in employment had been discussed at interview and the reasons for these identified and recorded. Pre-employment checks had been carried out, including references from previous employers, a Disclosure and Barring Service (DBS) check, proof of identity and evidence of people's right to work in the UK and medical questionnaires had been completed. The files also contained a photograph of the member of staff. The registered manager obtained confirmation that employment checks had been carried out for any agency staff before they worked at the service. There were enough staff on duty to meet people's needs and where necessary agency staff were employed to cover staff shortages. We saw staff were available to provide the care and support people needed and call bells were answered promptly.

We checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and were stored securely in a locked medicines trolley (within a locked room). This assured us that medicines were available at the point of need. When the medicines trolleys were not in use, they were secured to the walls in an appropriate manner. Current fridge temperatures were taken each day, including minimum and maximum temperatures. During the inspection and observing past records, the fridge temperature was found to be in the appropriate range of 2-8° centigrade. This evidenced that medicines requiring refrigeration were stored at appropriate temperatures.

People received their medicines as prescribed, including controlled drugs. We looked at 18 MAR charts and found no gaps in the recording of medicines administered, which provided a level of assurance that people using the service were receiving their medicines safely, consistently and as prescribed.

We spoke with one person who reported that they received their medicines in a timely and correct manner. Running balances were kept for medicines that were not dispensed in the monitored dosage system. This meant that staff were aware when a medicine was due to run out and could make arrangements to order more. Where a variable dose of a medicine was prescribed, for example one or two paracetamol tablets, we saw a record of the actual number of dose units administered to the client. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this, in line with national guidance.

Medicines were administered by Nurses that had been trained in medicines administration. We observed a

medicines round and found that staff had a caring attitude towards the administration of medicines for people. Also, we saw that staff wore a protective tabard to ensure that they were not disturbed during the medicines round. Medicines to be disposed were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs were appropriately stored in accordance with legal requirements, with weekly audits of quantities done by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour was not controlled by excessive or inappropriate use of medicines. For example, we saw 15 PRN forms for pain-relief or laxative medicines. There were mostly appropriate, up to date protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit. Where four protocols were not in place, they were completed at the time of the inspection.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the supplying pharmacy and on behalf of the provider, including safe storage of medicines, room and fridge temperatures and stock quantities on a daily basis. When asked, the deputy manager stated that no medicines incidents/ near misses had been reported recently. However, they demonstrated the correct process verbally of what to do should an incident/near miss arise in the future, including who to contact. This was in-line with the provider's policy.

The deputy manager confirmed they were happy with the arrangement with the supplying community pharmacy and GP, and felt they received good support with regards to the training of nursing and senior care staff regarding high risk medicines such as warfarin and medicines reviews. This was evidenced by checking the record of several medicines reviews that had been carried out within the last six months. The deputy manager was in charge of medicines management and had completed a National Vocational Qualification level 3 in the subject.

Good

Is the service effective?

Our findings

Staff received training to provide them with the skills and knowledge to care for people effectively. Staff said the majority of training was done via online learning modules, with practical sessions for topics such as moving and positioning. The service had provided two laptops so staff could access the online training if they so wished, and could also access it from home. Staff had to gain 100% in the online training test for each module and if they did not then they had to repeat the training to ensure they had understood it. Training staff had undertaken included fire safety, first aid awareness, dementia awareness, diet and nutrition and moving and positioning. Staff felt the training was good and were able to describe elements that they had found particularly interesting, demonstrating they had retained the information.

Staff confirmed they had received induction training and had shadowed experienced members of staff when they first worked at the service. They felt the induction process was appropriate to meet their needs. The registered manager had a supervision calendar and had allocated the supervisions to appropriate senior staff in each department so these could be carried out. We saw supervisions had been taking place and staff confirmed this. The registered manager was clear that further work was being done to ensure all staff received regular supervisions. Staff said if a gap in their knowledge was identified then a supervision session was carried out there and then to discuss the situation and refresh their knowledge. We observed staff had a good knowledge of people's needs and how to meet these effectively.

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 (DoLS).

Staff understood the importance of acting in people's best interests and we saw they asked people about their care and support and listened to what they had to say. One relative told us, "Staff always have the interests of the people at heart." The service had a keypad security system in place and the codes were displayed on butterflies up above the keypads, so people who were able to read and understand the numbers could use the keypads for themselves. We saw people moving freely around the units and when someone asked to 'go home' staff were attentive and used appropriate distraction tactics to divert their attention and occupy them.

Mental capacity assessments and best interest decision documents were seen in people's care records. Some needed to be fully completed to include input from the GP and people's representatives and staff were addressing this at the time of inspection. Where DoLS authorisations were required for people, applications were being made. At the time of inspection 20 had been submitted to the local authority DoLS teams and one standard authorisation had been received. Where people had been assessed for DoLS authorisations, evidence of this was included in the multi-disciplinary team visit records and the outcomes

were being awaited.

Some care files contained completed 'do not attempt resuscitation' (DNAR) forms at the front of the file and we saw the official forms and had been completed and authorised by the GP. Discussion with the person, if they had capacity, or, where appropriate, with their representative was recorded to evidence that this had been discussed and a joint decision reached.

People and relatives were happy with the food provision, and comments included, "The food here is very nice and there are choices" and "My [relative] has a choice when choosing her meal." Care plans for eating and drinking included people's preferences, the type of meal they needed, for example, a pureed diet, feeding a person via a tube or a normal diet, and the support they required. Food and fluid charts were completed to monitor people's intake and staff knew to report if people had any problems with eating. People were weighed on a monthly basis and the malnutrition universal screening tool assessment (MUST) was used to monitor people's nutritional status. People were referred to the dietitian or speech and language therapist if any concerns around weight loss or eating difficulties were identified and their input and instructions were recorded and were being followed.

The service had a four week menu and this was balanced and provided choices for people. We spoke with one of the chefs who told us the menus had recently been reviewed and they were in the process of being updated. We saw people had been asked about their meal choices and the menu choice forms had been completed clearly so the catering staff knew what each person wanted and the type of meal they required, for example, a pureed or soft diet. The chef told us about the meals provided to meet people's different needs including those for religious and cultural reasons. Staff were available to support and assist people with their meals and ensured people received meals that met their nutritional needs.

People's healthcare needs were being identified and met. If people required input from healthcare professionals this was arranged. The GP visited each week and more often if there were concerns about a person's health. Visits from the GP had been documented and there was evidence of visits from other healthcare professionals including optician, tissue viability nurse, diabetic specialist nurse, podiatrist and physiotherapist. Healthcare professionals confirmed people were referred to them appropriately and staff were available when they visited to provide any support and assistance needed, so they could carry out their role effectively with people. They commented that the permanent staff were knowledgeable about people's needs and implemented any changes in care that were required.

Good

Is the service caring?

Our findings

People and relatives were happy with the care being provided at the service. Comments included, "Staff are very caring and have always been very good with my [relative]." "Yes, staff are caring and compassionate." "The care is very good, very nice." "They are very kind and all the carers are very nice." "Staff are caring and always want to help and always want to do a good job. They work as a lovely team and take on board any matters relating to [relative]. The cleaners are very good and do a perfect job." "My overall feeling about this place is that my [relative] has been very well cared for and I'm very happy about it" and "Staff are kind, compassionate and treat me very well."

We asked staff what was important to them when caring for people. Comments included, "Elderly people need emotional support as much as food and drink. If you give this people are happy and delighted. We put individual needs in care plans and we ensure we know what these are. I have read the care plans for everybody I have cared for". "Yes, I would be happy for a friend or relative to be here. Yes, the carers are doing a fantastic job". All the staff we asked said they would be happy to have a relative of theirs living at the service and were happy with the standard of care.

We observed staff interacting with people in a kind and caring way, listening to what they had to say, showing patience and supporting people in an encouraging and gentle manner. People's cultural and religious wishes and beliefs were identified in the care plans. Representatives from the Church of England and Roman Catholic Churches visited the service and each month there was a Christian church service, with the dates for the year displayed so people knew when they were. We asked staff about other religions and staff knew these and told us that families were involved with ensuring people attended their place of worship, for example, the temple. We saw staff also ensured people received appropriate meals to meet their religious and cultural needs.

Notices by bedroom doors with names helped people to recognise where their room was. Bedrooms were personalised with people's possessions and we saw several rooms that were very homely and reflected people's lives and interests. People's preferences and routines were recorded in the care plans, including their preferred term of address, any preferences for the gender of the staff providing personal care and preferred waking and retiring times. Staff confirmed they read the care plans, respected people's wishes and they demonstrated a good understanding of people's preferences.

We observed the lunchtime meal on each floor. Staff were available to provide the support and assistance people needed. Lunch was served in a calm and orderly manner and people did not have to wait long before they were served. People were asked about their meal choice before it was served. A member of staff sat with a person who became distressed and successfully reassured them so that they became temporarily oriented to time and place and calm enough to eat their meal. People could choose where they ate their meals, either in the dining room, the sitting room or in their bedrooms and their choices were respected. The mealtime was unhurried and people who were eating very slowly were gently encouraged and offered help to eat.

People were being treated with dignity and their privacy was respected. Staff knocked on bedroom doors before entering and ensured that bedroom doors were closed when delivering personal care, with a 'do not disturb' notice placed on the door. People were supported to get up when they were ready to do so and staff were very clear that it was people's choice as to when they wanted to get up and go to bed and these were to be respected. People looked content, cared for and were well dressed and there was a good atmosphere in the service.

Requires Improvement

Is the service responsive?

Our findings

Staff responded to people's changing needs to ensure they were met. People and relatives were comfortable at the service and felt their needs were being met. Comments included, "The staff, nurses and managers are very friendly and make me welcome when I visit my [relative]" and "They are very kind and respond quickly if there are any issues." Comments from staff around meeting people's changing needs included, "I couldn't ask for better carers to work with" and "It is very important to understand people's needs."

Care plans did not always reflect people's current care needs. The service was in the process of changing over the care records to the current provider's documentation. The majority of the care plans we viewed were up to date and reflected people's needs and how these were to be met. They covered each aspect of people's care and staff demonstrated they had a good understanding of people's needs. However, for one person the care records had not been reviewed since December 2015. We saw that the person's condition had improved significantly but this was not reflected in the care plans and associated assessments. Staff were able to tell us about the person, were up to date with the changes in their care needs and continued to encourage them to make progress.

In two other care plans on the new documentation some sections were incomplete, for example, information about family involvement and religious and cultural needs, and incomplete best interest and mental capacity assessment documents. The registered manager had identified improvements were needed with care records in her own action plan for the service. They said this would continue to be addressed with the staff concerned to ensure care records were updated in a timely way.

Staff understood the importance of caring for people's skin and pressure areas. They were able to tell us about the care people needed to help minimise the risk of pressure sores. Where people had wounds, wound care documentation was comprehensive, up to date and reflected the current condition of each wound. If specialist advice on a wound was needed then people were referred to the tissue viability nurse specialist and their advice was recorded so staff were aware of any changes in treatment. Some people had specialist equipment to assist them with communicating, for example hearing aids and other hearing devices. These were in place and we saw staff communicating well with people and making sure they had been understood.

Care records included a section entitled 'My Life Story' and this provided a good picture of the person, their families, hobbies and interests and previous occupation. Staff knew about people's lives and could engage with them on topics that they were interested in. One told us, "We use care plans. We ask the person about their interests. We read the care plans. We have a section called "My Story of My Life" which is for care assistants to use so we know what people like." There was a weekly activities programme in place and this was up to date. We saw activities taking place on each day of inspection and these were led by the activities coordinator and also some care staff on each floor. A record of the activities people took part in was kept in people's files and this included if people had engaged and enjoyed the activity, to help ensure their needs were being met. We asked people if they were able to take part in hobbies they enjoyed. One person said,

"Yes, I read a lot and staff allow me to read all sorts and at any time."

Copies of the complaints procedure was in each person's room, so they and their visitors had access to this if they had any concerns. Comments from people and relatives included, "The care is fine, I can't complain at all. They do a very difficult job" and "I've never had any concerns." We asked staff what they would do if someone wanted to complain and comments included, "Yes, there is a complaints process. People can put it in writing. They can talk to the Home Manager, take it to Head Office or speak to CQC. Actually, they can escalate to CQC if needed" and "I would speak to a senior and report it and ask the person to speak to a senior." We viewed the complaints file. There had been four complaints in 2016 and these had been recorded, investigated and responded to, demonstrating concerns and complaints were taken seriously and addressed.

Good

Is the service well-led?

Our findings

The registered manager had been in post since July 2015. She had experience of managing a smaller service and of being a deputy manager in a medium sized service. We received positive feedback from relatives about the registered manager and senior staff at the service. Comments included, "The manager is aware of any changes in the building, and the new management is adjusting to any problems and deal with them promptly. For example, in the past there was problem with the lift, they have ordered repairs and the lift is working properly at present." "The manager is very approachable, likes to hear feedback and will take action, where necessary. They encourage me to make my views known to the management, about the care and treatment delivered in the care home" and "The manager gets stuck in and gets involved."

Staff told us the registered manager was approachable and supportive. Comments included, "I'm happy here, good teamwork and the managers are supportive." "The manager is a very supportive lady. I made a mistake and she said not to worry and that she is there to support me and she told me I can do it and to be strong." "The manager here is OK. She is good – she looks after residents well. For the residents she is good and for staff too. She wants to know if there is something wrong – she cares." "The manager is nice. Senior staff make me feel good about working here. Everybody is friendly. I have no problems working here." "The manager is very professional to my knowledge and is a good listener. She is so supportive. She did a proper handover to me. She is the most professional manager I have had. I like her work ethic – she puts everything in writing, for example complaints and takes action. She doesn't listen to hearsay" and "Before the manager came in, it was not as good. She makes you feel you are here for the residents and to meet their needs. She brought in this approach and leads this way. She brought in lots of training."

The provider had compliance officers who carried out quality monitoring visits. There had been three visits carried out in 2016 and we saw that action had been taken to implement improvements, for example, improvements with medicines management, staff training and completing Deprivation of Liberty Safeguards (DoLS) applications. It was clear the registered manager was working hard to make improvements at the service and the compliance officer had identified that some additional input from the provider would assist the registered manager in this endeavour.

The registered manager had an action plan she had drawn up in August 2015 and reviewed in April 2016. This had taken into account recommendations made in the local authority monitoring reports and the findings of the last Care Quality Commission inspection report under the previous provider. There was also an action plan for the recruitment of permanent staff for the service and was saw progress had been made with the areas for improvement under both action plans. During the inspection that the management team were responsive to any points we raised, for example, immediate action to ensure all medicine protocols were in place and showing that care plan improvements had been identified and were ongoing.

The maintenance person carried out health and safety checks, for example, monthly hot water outlet temperatures and weekly fire alarm checks, nurse call system checks and cleaning and disinfecting shower heads. If any issues were identified they were addressed. Other checks completed included monthly monitoring of care matters, for example, monitoring of skin tears, pressure sores and invasive devices such

as catheters and feeding tubes so action could be taken to identify any issues and address them. During our tour of the service we saw there were areas in need of redecoration and refurbishment, for example, marked and faded carpets and rooms needing redecoration. The registered manager told us the provider had recently carried out a full audit of the environment and she was awaiting the action plan with timescales for redecoration and refurbishment of the service.

The majority of staff said they received supervision regularly from senior staff. We saw there was a diary for supervisions and these were being progressed with staff. Staff also told us that any practice or training issues that were identified were discussed immediately rather than waiting for a scheduled supervision session, so they could be addressed without delay. The registered manager she said she would be planning and progressing annual appraisals for all staff. We saw the deputy manager carried out observations to assess staff learning from aspects of training they had undertaken, so staff progress was being monitored.

Daily flash meetings for heads of department and units took place to discuss any issues and regular staff meetings and quarterly health and safety meetings were held, to discuss relevant issues so action could be taken to address them. Meetings were also held for relatives and we saw where any action was taken to address any issues this was fed back at the next meeting to keep people up to date. The provider had a diary of events to include regular surveys on different topics for people, relatives and staff. The most recent of these had been a laundry survey and the results were being collated so any issues could be addressed.

The registered manager said she kept up to date with good practice by accessing articles of interest on the internet and in nursing publications. She also attended provider forum meetings at the local authority and company managers meetings. Policies and procedures were comprehensive and covered each aspect of the service. The provider kept them under regular review to reflect any changes, for example, in legislation and good practice guidance, to keep the information available to staff current. Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.