Finchworth Limited

Dinsdale Lodge Care Home

Inspection report

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Date of inspection visit:
29 September 2016

Date of publication:
05 December 2016

Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 29 September and was unannounced. This meant the registered provider did not know we were coming. We last inspected Dinsdale Lodge in April 2016 and found the registered provider had breached a number of regulations we inspected against.

We identified multiple concerns in respect of the safe care and treatment of people using the service. The registered provider failed to follow instructions and advice from other health care professionals. People's health and nutritional needs were not being met in a safe manner. The registered provider did not ensure staff received appropriate training and development to enable them to carry out the duties they were employed to perform. The registered manager failed to ensure people were protected from the risk of financial abuse. Care records did not reflect people's needs and preferences. People were not treated with dignity and respect. People's confidential information was not held securely. Health and safety requirements in relation to water temperatures had not been addressed. The registered provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and failed to ensure that people received appropriate care and support.

We undertook this comprehensive inspection to check that the registered provider now met legal requirements. During this inspection we found the registered provider had implemented actions and some improvements had been made.

Dinsdale Lodge is a care home with accommodation for up to 28 people who require personal care, some of whom are living with dementia. At the time of our inspection 16 people were receiving a service. The service was no longer providing accommodation for people who required nursing care.

The service did not have 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 registered provider had employed a manager who had submitted an application to be the registered manager for Dinsdale Lodge. The application was being processed at the time of the inspection. Staff gave positive feedback about the manager and the improvements in the home.

We reviewed the development plan introduced by the registered provider to ensure all the concerns we found in the previous inspection were addressed and quality was monitored. We found the registered provider had made progress against the development plan to ensure people were safe, but it was too early to assess the effectiveness of the audit process in driving continuous improvement.

Systems and processes were in place to manage safeguarding alerts, accidents and incidents. The registered provider had records of monthly analysis, investigations and lessons learnt. Statutory notifications had been submitted to the Care Quality Commission (CQC) appropriately. People's monies were being kept in a locked safe with measures to audit monies coming in and out of the home. We found financial records had been completed accurately. Office doors were secure and had been fitted with key pads for entry.

We found people's medicines were being managed safely. The registered provider ensured competency checks were completed for staff who had responsibility for administering medicines. Care workers had completed training in safeguarding, moving and handling, fire safety, food safety and care plan training. Some staff had not completed training for epilepsy and medicine management however this had been booked.

Care plans and risk assessments contained information about people's care needs, these were reviewed on a regular basis. We found two care plans which required updating. We found advice and recommendations from health care professionals were being acted on. For example, speech and language and district nurses. Due to care plans being recently amended and in some cases rewritten following review, it was too early to assess how responsive the service would be regarding changes in need and the impact on people.

Health and safety certificates and risk assessments were in place. For example, testing of water temperature, gas safety certificate and fire checks. People had up to date personal emergency evacuation plans (PEEPs) in place to support safe evacuation in the event of an emergency.

We found the registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and any conditions on authorisations to deprive a person of their liberty were being met. Staff had an understanding of the MCA and how this applied to the people they supported.

Information on advocacy and how to complain was available for people and visitors. The registered provider had developed a specific document to enable people with communication needs to complain.

The registered provider had a robust and thorough recruitment system. We found checks had been made with the disclosure and barring service, (DBS) these were carried out before they were employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people.

We observed caring interactions between staff and people. People were given time and were not hurried in any way. We found staff respected people's privacy and dignity.

People's nutritional needs were assessed and met. We observed meals were appetising and well presented. The service provided a varied and health menu choice for people.

We found the registered provider had updated some areas in the home, radiator covers were being replaced and some bedrooms had been deep cleaned. The stair carpet was worn and in need of attention. Some bedrooms were in need of redecoration along with paintwork requiring repainting.

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

The registered provider had safeguarding procedures in place to keep people safe.

Processes were in place to ensure people's medicines were managed safely. Staff responsible for administration of medicines had their competencies checked to ensure they were safe to do so.

The registered provider had a robust and thorough recruitment process in place.

Is the service effective?

Good

The service was effective

Staff had completed essential training.

We saw involvement from external health care professionals such as speech and language therapy and district nurses.

Staff had an understanding of the Mental Capacity Act 2015 and how this impacted on their role supporting people.

Is the service caring?

Good

The service was caring.

Staff were kind and patient with people, and respected their privacy and dignity whilst promoting independence.

People and relatives told us they found the staff to be caring.

Information about advocacy was available for people and visitors.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found some information in relation to people's care was not recorded appropriately.

Care plans had been reviewed and updated or rewritten to include people's preferences.

Information on complaints was available for people and visitors. Information was also available in different formats to support communication needs.

Is the service well-led?

Requires Improvement

The service was not always well led.

Development plans and quality monitoring had been introduced but it was too early to assess the effectiveness in driving continuous improvement.

The registered provider had employed a manager who had submitted an application to become the registered manager.

Staff gave positive feedback about the manager.

Dinsdale Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 29 September 2016 and was unannounced. This meant the registered provider did not know we were coming.

The inspection was carried out by two adult social care inspectors and an expert by experience.

Before the inspection we reviewed other information we held about the service and the registered provider. This included previous inspection reports and statutory notifications we had received from the registered provider. Notifications are changes, event or incidents the registered provider is legally obliged to send to the Care Quality Commission (CQC) in a timely manner. We also contacted the local Healthwatch, the local authority commissioners for the service, the local authority safeguarding team and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with 10 people who lived at Dinsdale Lodge. We spoke with the registered provider, manager, deputy manager, four care workers, the activities coordinator and two catering staff, who were all on duty during the inspection. We also spoke with 10 people who were using the service, six relatives, four who were visiting at the time.

We spent time observing care delivery at various times throughout the day, including the breakfast and lunchtime experience in the dining room.

We looked around the home and viewed a range of records about people's care and how the home was

managed. These included the care records of three people, the recruitment records of two staff, training records, nine people's medicine records and records in relation to the management of the service.

Good

Our findings

When we last inspected the home we found the home was not safe and the registered provider had breached regulations 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The registered provider had failed investigate safeguarding incidents or to submit statutory notifications to the CQC in relation to safeguarding incidents.

Effective systems were not in place for the safe keeping of people's personal money. The business continuity plan and personal emergency evacuation plans did not contain up to date information for staff to follow in the case of an emergency.

Individual risk assessments were generic and did not contain specific risks to people. Staff administering medicines had not had their competencies checked to carry out this process safely.

Health and safety checks in relation to water temperatures had not been actioned. There were no effective system in place to monitor accidents and incidents. The environment was in need of some refurbishment, radiator covers were loose and worn.

During this inspection we found the registered provider had made improvements to the systems and processes in place to manage safeguarding alerts. We found records of monthly analysis, investigations and lessons learnt, these were disseminated to staff in team meetings and supervisions. We saw statutory notifications had been submitted to CQC appropriately as well as submitting information to the local authority safeguarding team.

The finance policy had been reviewed and amended. We reviewed financial records and found all withdrawals or deposits of people's monies had been dated and signed by two staff members as per the policy. The safe key was held by the manager or the person in charge. Key codes pads were fitted to the office door to prevent unauthorised access.

The registered provider had an up to date business continuity plan which contained contact details for staff guidance should an emergency situation arise. People had personal emergency evacuation plans (PEEPs) in place to support the safe evacuation of people in the event of an emergency. The manager advised these were updated whenever there was a change in need.

We found individual risk assessments were completed for people using the service based upon their specific

needs. For example, moving and handling assessments contained the type of sling to be used with the mobile hoist.

Since the last inspection the registered provider has had all boiler cylinders replaced, weekly water temperatures were completed for scald risk. An outside contractor was responsible for the management of Legionella and had carried out the required checks, records were in place.

We reviewed accident and incident records. We saw the information was detailed and included what happened, the injury and action taken following the incident. The manager investigated all accidents and incidents. We saw that the system looked at patterns and themes. For example, one person had experienced two falls, so was referred to the falls clinic.

Since the last inspection we found staff that who were responsible for administering medicines had their competency to administer medicines checked. Records were available to demonstrate their competency. The deputy manager told us, "Training was updated and we have had our competency checks done, the manager is really good."

Some refurbishment had taken place, radiators covers were in the process of being replaced and were part of the remedial work plan. The stair carpet was worn and in need of attention. We discussed this with the registered provider who advised the refurbishment of the home was something that will be looked at, the emphasis had been on establishing good care for people as first priority.

People told us they were happy in the service. One person told us, "I think of this as my home." Another person told us, "I am absolutely safe here, look at how well they look after everyone. Relatives told us they felt their family members were looked after properly. One relative told us, "[family member] does appear to be looked after." Another commented that they had had sleepless nights when their family member was in another home, but not this one.

We looked at staff recruitment records. These showed checks had been made with the disclosure and barring service (DBS). DBS checks were carried out before staff members were employed to confirm whether they had a criminal record and were barred from working with vulnerable people. References had been obtained and completed application forms, employment history and proof of identification was on file.

Staff had completed safeguarding training and had a clear understanding of safeguarding and whistleblowing procedures. We asked staff what action they would take if they felt or suspected someone was being abused. One care worker told us, "I would report anything to the manager." The care worker gave examples of how a person's behaviour may change, such as becoming withdrawn or emotional if they were being subjected to abuse.

Medicines were stored securely in a locked cupboard in the dedicated medicines room. There was also a fridge available if the service needed to store medicines that required cool storage. Records confirmed that temperatures were checked and recorded daily. Each person had a new monthly Medicine Administration Record (MAR) in place. These gave clear instructions on what medicine people were prescribed, the dosage and timings. We reviewed the MARs of four people and found these were completed correctly with no gaps or inaccuracies. As the MARs were relatively new we reviewed five people's previous records to ensure these were completed correctly. Where people required topical medicines separate charts were in place for staff to sign when topical applications were administered. We reviewed two topical charts and found these were completed correctly. One relative told us, "[Family member] does not have a lot of medicines, but what she needs she gets." We asked people if they received their medicines on time. One person told us, "Yes I seem

to." Two other people indicated yes.

We observed the deputy manager administering medicine to three people. People were approached sensitively and the medicine was administered safely. The deputy manager spoke gently with people, providing reassurance and encouragement. Medicine administration records (MAR's) were completed after each medicine was given. This meant accurate records were made as people accepted or refused their medicine. Regular audit checks of medication administration records and checks of stock were carried out. This meant that there was a system in place to promptly identify medicine errors and ensure that people received their medicines as prescribed.

We asked if people thought there were enough staff on duty. One person told us, "Yes I think so." Another person said, "There is always plenty of staff about, they are good girls." From observations of responses to call bells, these were answered quite quickly. We reviewed the current week's rota and recent weekly rotas. The service had enough staff on duty, depending on people's assessed support needs and activities for the day. The registered provider used a dependency tool to ascertain the correct amount of staff to meet people's needs. There was a high ratio of staff to people on the day of the inspection.

We noted checks were in place to ensure the safety and security of the home. We found all records were completed and up to date. For example, regular assessments for fire alarms, water temperatures and gas safety.

Good

Our findings

When we last inspected the home we found the home was not effective and the registered provider had breached regulations 11,14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation2014. Care workers and qualified nurses had not received appropriate training to ensure people received safe and effective care. This included training in managing medicines and appropriate training in relation to specific clinical care needs people had, such as epilepsy, diabetes, swallowing problems, skin integrity issues and learning disabilities. This meant people were at risk of receiving inappropriate care as untrained staff were providing some people's care. We found care workers had not received regular supervision and an annual appraisal. Nurses had not received clinical supervision or reviews of their competency.

The registered provider had not always provided a nutritional balanced diet as fresh vegetables or fruit were not regularly being offered as part of the meals. Some people gave negative feedback about the limited meal choices available. We also found people were not always offered the support and encouragement they needed to ensure they had enough to eat.

Where people lacked capacity some decisions had been made without following the requirements of the Mental Capacity Act 2015.

During this inspection we found the registered provider had made improvements to ensure people received effective care from trained and competent staff. We viewed the registered provider's training matrix which confirmed essential training for care workers was up to date. This included safeguarding, moving and handling, fire safety, food safety and care plan training. Care workers were still in the process of completing training in relation to specific health conditions, such as diabetes, swallowing difficulties and epilepsy. For example, all care workers were booked onto epilepsy training during September and October 2016. This meant staff had been provided with the relevant information they needed to develop their knowledge of providing appropriate care for people using the service.

Care workers confirmed they were well supported whilst working at the home. One care worker said, "I have brilliant support, my boss is lovely. I am learning every day." Another care worker commented, "[New manager] is fantastic, I have learnt a lot from [manager]. The staff are supportive as well." They went on to tell us, "I am really well supported, I can go to [manager] anytime. I don't just have to wait for supervision. [Manager] is really approachable that way." Records confirmed care workers had received two one to one supervisions and an appraisal since April 2016. This meant care workers had opportunities to discuss their

training and development needs with their line manager.

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 so that they can 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). 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."

DoLS authorisations had been agreed for six people using the service. The registered provider kept a record of whether any specific restrictions were in place and the date the authorisation was valid until. Care workers knew about MCA and gave examples of decisions which had been made in people's best interests. They also described how they supported people with making choices and decisions. One care worker told us, "Some people have capacity assessments. Most people can answer simple questions." They went on to say they had used prompt cards to help people make choices.

We observed the mealtime experience at breakfast and lunch during the inspection. People were supported into the dining room by staff who then supported them to sit at the table. Staff were patient and people were not hurried. A choice of hot or cold drinks were offered as soon as they were comfortably seated. The food looked and smelt appetising, jugs of water were available on each table, flavoured with cucumber. Staff supported people with eating and drinking where needed. The kitchen assistant knew what people had pre-ordered.

One care worker led on the mealtime experience. They told us they were "based in the dining room" and "offered prompts to people who needed it". This meant a care worker was available to offer support if people required it. We saw this happen throughout the morning. For example, when people came into the dining room for breakfast which was available at whatever time people chose to get up each morning. One care worker told us, "People have breakfast as and when they get up." For example, we overheard one care worker ordering a sausage sandwich for one person who had woken up after the main breakfast had finished.

We observed staff prompted one person, who was at risk of dehydration, to regularly drink sips of squash. We saw this happen during our morning observation in the communal lounge and over lunch. The person responded positively and therefore received regular fluids. Where people were at risk of poor nutrition, accurate records were kept of their nutritional intake. This included care workers recording the amount people ate and drank so that they could check whether people were getting enough to meet their nutritional needs. People were also weighed each month to check they weren't losing significant amounts of weight.

Since our last inspection a wide range of health professionals had been providing support and treatment to people at the home, as well as advice and guidance to the staff team. This included GPs, community nurses, specialist nurses, speech and language therapists and dieticians. One care worker commented, "We work a lot with district nurses, we can access them straightaway."

The deputy manager told us, "We have district nurses come into the home and we regularly have the GP

visit. We have the handover so I would know if someone has not been well and may need a visit."

Good

Our findings

When we last inspected the home we found the home was not always caring and the registered provider had breached regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Staff did not always acknowledge people's preferences regarding their personal hygiene needs. People were not supported appropriately at meal times and staff failed to offer encouragement when people made no attempt to drink.

We found people were left unattended despite asking for support. The culture in the home was based on tasks rather than personalised care.

During this inspection we found the registered provider had made improvements to ensure the service was caring. Staff had completed training courses to cover dignity, equality and diversity. The registered provider had introduced meal time champions to oversee the mealtime experience of people. Reviews of care plans have taken place to ensure people's preferences were recorded. Staff attended handovers where personalised care was discussed at the start of shift.

We observed staff displayed a caring, kind and compassionate attitude towards people and visitors. We observed many positive interactions throughout the inspection and staff clearly knew people well.

We asked people and relatives if they found staff to be caring. One person told us, "Oh yes, very kind and they've just bought me biscuits." Another person told us, "Very nice, yes, very nice." One person, who had communication needs, gave a thumbs up sign. One relative told us, "Absolutely, [family member] wouldn't be alive now if it was not for her care." Another relative told us, "It certainly seems to be to us."

Staff described how they supported people whilst at the same time maintaining their dignity and respect. This included ensuring doors were closed, explaining to people what was happening, seeking their consent. Staff told us they aimed to keep people as independent as possible. They said they offered prompts to encourage people to do as much for themselves as they could.

We observed care workers supported people to meet their choices and preferences. For example, we observed the activity co-ordinator supporting one person to set up Skype so they could keep in touch with a family member who lived abroad. Other people were supported to use 'twiddle muffs' to meet their sensory needs. 'Twiddlemuffs' are knitted woollen mittens with ribbons, buttons and fabric attached especially designed for people living with dementia. Care workers said information about people's preferences was

included in their care plans. They also said each person had a poster on their wall which detailed their likes and dislikes. This was useful as a quick reminder for care workers to refer to.

One person had an appointment the next day so would miss the fish and chips which were on the menu and a favourite meal of theirs. Staff acted and fish and chips were bought from the local fish and chip shop. This meant that staff were mindful of the person's wishes and showed a caring nature.

We observed staff stopping to have a word with people who were sitting in the reception area as they passed. One person told us, "I like to sit here, they all stop and have a chat, I get a cuppa when I want one they are good like that." We saw communication between staff and people took many forms such as appropriate touch, gestures and facial expressions. There was lots of laughter in the home, staff were having a joke with people in an appropriate manner.

Staff used moving and assisting equipment in a dignified manner, people were supported with eating and drinking using prompts at a pace appropriate to them. We observed one member of staff supporting a person to have a snack and a drink in the communal area, taking time to make sure the person's mouth was empty before telling them there was another piece of food ready if they were. Personal care was attended to discreetly and clothing changed to maintain dignity. Staff explained to people what they were going to do before they acted and gained consent either verbally or by gestures.

The service had information available to people and visitors regarding advocacy.

The communal areas were homely, with pictures and ornaments on display. Lounge areas had a range of seating, with small tables for people to have personal effects close by. Bedrooms were personalised with photographs, pictures and ornaments brought from home. Staff were respectful of people's belongings and ensured people had their important items with them during the day.

Requires Improvement

Our findings

When we last inspected the home we found the home was not responsive and the registered provider had breached regulations 9, 12 and 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We found care records did not reflect people's current needs. Staff were not following people's care plans in relation to specific interventions relating to skin integrity, oral care and nutrition. Records relating to food and fluid intake were not being reviewed appropriately.

We found the service failed to support people to access health care, hospital appointments had been missed. Referrals to other health care services were not followed up in a timely manner.

The registered provider did not have a suitable format to enable people with communication needs to make a complaint.

During this inspection we found the registered provider had made some improvements to people's care records. We reviewed care plans and found these were specific to people and reflected their assessed needs. Care plans and risk assessments were reviewed regularly and updated when necessary. We did find one care plan which made reference to a specific document, when we could not locate the document we spoke to the manager who advised the document had been removed. The manager acted immediately and amended the care plan. Another care plan contained interventions for staff but records did not indicate these were always happening. Again the manager acted immediately and amended the care plan to reflect the actual support staff were delivering which was meeting the person's assessed need.

The registered provider had new documentation in place which staff completed throughout their shift. We found records demonstrated staff had supported people with positional changes, nutritional intake and personal care. The deputy manager told us, "We review these every day to check they are being completed correctly and to see if there are any changes."

We observed the morning handover. The senior care worker gave a detailed account of the support people had received during the night. Concerns were raised with the deputy manager regarding people's health needs so the appropriate health care professional could be accessed. People's care records showed regular intervention from other health care professionals. For example, speech and language therapist and occupation therapy.

The registered provider had a process in place to ensure people attended hospital appointments. When new

appointments were received or follow up appointments made we found these were recorded in the diary immediately.

Staff were able to discuss people's care needs and had an understanding of personalised care. One care worker told us, "We always give choice. We have a couple who like to stay up late and one who gets up really early. If they are up late I always make them a drink and extra toast." Another care worker told us, "[Person] has come on leaps and bounds. I put myself in their shoes and explain each step bit by bit, it's so much better for [person] now."

Kitchen staff had an understanding of people's specific diets. The cook explained in detail the different types of diet and textures catered for along with choices. We observed cakes and snacks they had prepared for people living with diabetes. The cook told us, "It's important that everyone is able to have a piece of cake so I make special ones." This meant that the registered provider was responding to people's specific dietary needs.

We found the registered provider had systems and processes in place to support people with communication needs to make a complaint. The activity coordinator had worked with one person and developed a format specifically using hand gestures.

We spent time with the activities coordinator and observed general enthusiasm about the activities, people were very aware of what was on offer in the home. We asked people if they enjoyed the activities. One person told us, "I am dressing up for the Halloween party, and there will be a singer." Another person gave a 'thumbs up' gesture. We saw good interaction between the activities coordinator and people whilst doing things in the home. The range of activities included armchair exercises, indoor bowls and crosswords. We observed people using electronic devices for storing music and photographs with support from staff. One person was enjoying knitting and others were doing crosswords and puzzles. People could have a cup of tea or coffee if they wanted, and the feeling was one of inclusion. There was lots of chatter between people, it was evident from people's body language and facial expressions that they enjoyed the activities.

Requires Improvement

Our findings

When we last inspected the service we found the home was not well-led and the registered provider had breached regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The registered manager had not checked qualified nurse's registration with the Nursing and Midwifery Council (NMC) and had not submitted some required statutory notification. The registered manager did not take ownership for developing the home or ensuring the cleanliness and safety of the home environment. Quality assurance systems were not always effective in identifying issues and to demonstrate any improvements and actions were monitored.

The registered manager had not followed the registered provider's financial policy regarding the recording of withdrawal of monies from people's funds and confidential records were not kept securely.

Accurate records were not always maintained, such as when people had chosen not to follow the advice of health professionals.

Following our last inspection the registered provider had developed an extensive development plan to ensure all the concerns we found were addressed and dealt with. During this inspection we found the registered provider had made progress against this development plan to ensure people were safe and received the care they needed. These included a range of actions to improve the quality of people's care plans, staffing levels, health and safety, nutrition and communication. Of the 78 actions identified in the development plan four were still outstanding. These were to complete some training such as epilepsy and medicines management and to complete the redecoration programme throughout the home.

Although the registered provider had a quality assurance system in place, this was in its infancy, it was difficult to gauge the impact on sustainability and continuous improvement. More time is needed for the service to determine the system is robust in driving quality.

During the last inspection the registered manager left their employment and had de-registered as the manager with the Care Quality Commission. A new manager had been appointed and had applied to register as the registered manager for the home. The CQC is currently considering this application.

Care workers gave us positive feedback about the new manager and the improvements made since their appointment to the role. One care worker commented, "There has been a lot of a good improvement. Staff are supported more, residents are happier. The place is more lively, staff are interacting with residents more,

it is more person-centred. Safety checks are done now and things are reported straightaway." Another staff member said, "The home is happy at the moment and calm." Statutory notifications had been submitted regularly since the last inspection.

Senior care workers were carrying out daily and weekly checks of the home. Each day care workers checked water temperatures, the home was free from clutter, cleanliness and menus were correct. Weekly checks included bathing records, weights, a random check of five care plans and maintenance. From viewing previous records we saw where areas were not up to the expected standards action had been taken. For example, moving specialist equipment out of communal areas and speaking with the relevant care workers.

Incidents and accident were logged and investigated. Falls in the home were monitored to identify any trends and patterns. For example, where people had fallen for two consecutive months a referral was made to a specialist falls team.

People, relatives and professionals had been asked to complete questionnaires to gather feedback about the quality of people's care. Most of the feedback was positive. For example, one relative had complimented the home for activities, looking at ways to improve and the welcoming atmosphere. Where a minority of people had expressed any unhappiness this was dealt with on an individual basis. For example, one person said their clothes had been mislaid when they went to the laundry. The manager had spoken with person and located the missing items. Changes had also been made to the labelling procedure for the laundry. Feedback from questionnaires were analysed each month. Trends had been identified from problems with the laundry service and improvements were requested to the garden area.