Whytecliffe Limited

Arundel Park Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Arundel Park Lodge on 29 November 2016. The inspection was unannounced.
The home provides residential care for up to 30 people. People required support with their personal care and had additional nursing needs including frailty associated with old age and poor mobility. Some people were living with dementia.

Arundel Park Lodge is a detached art deco style property situated in Saltdean. There are two communal lounges and dining room and well-maintained gardens. The home is one of two locations owned and run by Whytecliffe Limited.

As part of this inspection, we checked what action had been taken to address the breach of legal requirements we had identified at our last inspection on 8 September 2015. After our last inspection, the provider wrote to us to say what they would do to meet legal requirements and sent us an action plan detailing how they intended to ensure they met the requirements of the law. At this inspection we found improvements had been made and sustained and the breach previously identified was addressed.

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 and associated regulations about how the service is run.

We saw that regular meetings with residents and their relatives had not taken place. This was a missed opportunity to ask questions, discuss suggestions and address problems or concerns with management. Feedback had been sought from people and their relatives in the 2016 questionnaire. However, residents and relatives meetings had not been held on a regular basis to provide a forum for people to raise concerns and discuss ideas. One person said, "My views have not been asked of before but I think the home is well managed." We have identified this as an area of practice that needs improvement.

Care plans reflected people's assessed level of care needs and care delivery was person specific. For people with specific health problems, there was guidance in place for staff to deliver safe care and treatment. We were told, "[My relative] has dementia and now needs nursing care. They are safe and well looked after here. The home have smoothed the way in the whole process. Mum is safe and happy." There were sufficient suitably qualified and experienced staff to deliver care.

People's medicines were stored safely and in line with legal regulations and people received their medicines as prescribed.

The provider was meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were completed in line with legal requirements. Staff were following the principles of the MCA. Consideration was made of people's ability to make individual decisions for themselves, as required under

the MCA Code of Practice.

People and visitors we spoke with were complimentary about the caring nature of staff. The delivery of care was tailored to individual choice. Care plans had sufficient information on people's likes and dislikes and information about people's lifestyle choices was available for staff. The provision of meaningful activities positively influenced people's well-being. A relative told us, "[Named relative] never wants to come out of their room but they still offer the opportunity and encourage participation. There's a lot going on for those that want it."

People and their relatives were complimentary about the meal service at the home. One person said, "The food and drink I get here is perfect. It's cooked well, tastes nice and a good variety. I do need support to eat and drink as I am unable to hold anything," The dining experience for people was social and enjoyable. People were supported to eat and drink enough to sustain their health and well-being.

Quality assurance systems were in place. Incidents and accidents were recorded and provided an overview so that identified actions could be taken and plans put in place to prevent a re-occurrence.

People were protected by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health. Care plans included all the information about people's health related needs.

Staff were supported within their roles and described an open door management approach. One member of staff said, "The manager and the owner are very approachable. Everybody knows what they are doing."

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

Arundel Park Lodge was safe.

Risk assessments were in place and up to date.

There were enough suitably qualified and experienced staff to meet people's needs.

The management and administration of medicines was safe.

Staff had received training in how to safeguard people from abuse and staff recruitment practices were safe.

Is the service effective?

Good

Arundel Park Lodge was effective.

Staff had received essential training to carry out their roles effectively.

Staff received on-going professional development through regular supervisions and appraisals.

Staff understood the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Arundel Park Lodge was caring.

Care took account of people's individual preferences.

People's dignity was respected.

Staff interacted positively with people. The support people received was provided by staff who were kind and thoughtful.

Is the service responsive?

Good

Arundel Park Lodge was responsive.
Care plans accurately recorded people's likes, dislikes and preferences.

Staff had information that enabled them to provide support in line with people's wishes.

There were meaningful activities for people to participate in groups or individually to meet their social and welfare needs and to prevent isolation.

A complaints policy was in place and people and visitors felt their complaint or concern would be resolved appropriately.

Is the service well-led?

Requires Improvement

Arundel Park Lodge was not consistently well-led.

People and their relatives were not always able to comment on and influence care in the home.

People, relatives and staff spoke positively of the registered manager.

Quality assurance was used to help improve standards

Arundel Park Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We previously carried out a comprehensive inspection at Arundel Park Lodge on 8 & 9 September 2015. At that inspection, we identified areas of practice that needed improvement in relation to the failure to assess, record and mitigate risks to people's health and safety. The home received an overall rating of 'requires improvement' from the comprehensive inspection on 8 & 9 September 2015. This inspection took place on the 29 November 2016 and was unannounced. The inspection team consisted of 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.

Before the inspection, we checked the information that we held about the home and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the home. A notification is information about important events that the service is required to send us by law. We used this information to decide which areas to focus on during our inspection. A Provider Information Return (PIR) was not requested prior to the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

During our inspection, we spoke with six people who used the service and three relatives. We spoke with four care staff, a kitchen assistant, training coordinator, registered nurse, manager and provider.

We reviewed a range of records about people's care and how the home was managed. These included the care plans for five people and the medicine administration (MAR) records. We looked at three staff training, support and employment records. We examined records relating to the management of the home including quality assurance audits, survey feedback and incident reports.

We contacted seven health and social care professionals after the inspection to gain their views of the home.

Good

Is the service safe?

Our findings

Previously, we found the provider had not made suitable arrangement to safely support a person to eat and drink in a safe manner following the guidelines set out by a health care professional. We also found cross infection risks in two areas. Staff did not have the opportunity to wash their hands before leaving the staff bathroom because it lacked a hand basin. We looked at equipment used by people and saw that a commode was rusted and corroded. Therefore, we could not be assured people did not receive care in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider had followed their action plan, the breach had been addressed and the improvements had been sustained. The provider had taken action to ensure that, as far as possible, the risks were addressed. This was because the provider had additional reviews of care plans following any interventions from health care professionals and had introduced additional staff training and recording to reinforce good practice. The bathroom identified without hand wash facilities was no longer used and regular audits of equipment used in the home took place to ensure that all equipment was safe for people to use.

People and their relatives told us that they felt safe. One person told us, "I love living here. Staff are very good, no problems, staff make me feel safe they are always around and I want for nothing." A relative told us, "[My relative] has dementia and now needs nursing care. They are safe and well looked after here. The home have smoothed the way in the whole process. Mum is safe and happy."

People's risk assessments were accurate and provided sufficient guidance to keep people safe. Individual risk assessments were in place and covered areas such as mobility, continence care, falls, nutrition, pressure damage and overall dependency. They looked at identified risks and included a plan for care staff to follow. For example, where there was an assessment of risk of skin damage, documentation reflected what had been done to prevent or mitigate the risk. These included consideration of factors such as recent ill health, deterioration of mobility and incontinence. There was guidance for people that received care in bed and for people who were not independently mobile. These people may be at increased risk of skin breakdown through prolonged sitting in one position and therefore may require regular continence care, such as changes to their position and assistance to access toilet facilities. Risk assessments were updated and protected people from harm.

People were protected by safe moving and handling procedures. Some people were supported to move, for example from a wheelchair to armchair with the support of hoisting equipment. Staff checked that people were prepared to be supported and supported them safely and appropriately. People therefore were protected from harm by use of moving and handling techniques and were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

People received their prescribed medicines safely. A registered nurse described how they completed medication administration records (MAR) and ensured people received their prescribed medicines. MAR were completed and included prescribed creams. Staff followed the provider's medicine policy with regard to medicines given 'as required' (PRN), including medicines prescribed for pain relief. Records completed

included details of why they had been given and recorded the effectiveness of the medicine. There were systems in place to manage the storage, ordering, disposal and practical administration of medicines safely. We saw medicines were given to people individually and staff signed the MAR only when people had taken the medicine. The clinical room was maintained and staff ensured that the room and fridge temperatures were checked daily.

Nurses were responsible for the administration of medicines and did so sensitively and appropriately. People expressed confidence around the administration of their medicines. One person told us, "Nurse does give medicine and pain meds when I need it." A relative said, "[My relative] needs total care and receives it. They have exceeded my expectation in terms of meeting her health needs."

There were sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. Nursing staff were supported by senior care staff and care assistants. Ancillary staff included teams working in the kitchen, housekeeping and laundry. Staffing numbers were detailed on the rota. The staff ratio reflected positive outcomes for people. For example, people received the level of personal care, including washing, continence care, dressing and oral care required to meet their needs. Staff told us they were busy but made time to give people the individual attention they needed and followed people's individual preference. One staff member said, "I don't think it's a problem here. There are enough staff around usually. We can be busy in the mornings but that's true in any care home". Another staff member said, "We do get time to spend with the residents." A third staff member told us, "I wouldn't have stayed working here if there wasn't time to do anything but run around."

Safeguarding policies and procedures were up to date and provided appropriate reference to the local authority and relevant national guidance. There were notices to guide staff about who to contact if they were concerned about practice. There was a whistle blowing policy. Whistleblowing is when a member of staff reports suspected wrongdoing at work. Staff told us what they would do if they suspected that abuse was occurring at the home. Staff confirmed they had received safeguarding training. They were able to tell us who they would report safeguarding concerns to outside of the home, such as the Local Authority or the Care Quality Commission.

Staff had been recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The provider had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form. Files contained evidence to show where necessary, staff belonged to the relevant professional body. Documentation confirmed that all nurses employed had registration with the nursing midwifery council (NMC) and these were up to date.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. The provider employed a dedicated maintenance worker who carried out day-to-day repairs and staff said these were attended to promptly. Regular checks on equipment such as wheelchairs took place, and these were regularly serviced and maintained. Regular fire alarm tests, water temperature tests and regular fire drills took place to ensure that people and staff knew what action to take in the event of a fire. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. There was a business continuity plan. This instructed staff on what to do in the event of the home not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan. Generic and individual health and safety

risk assessments were in place to make sure staff worked in as safe a way as possible.

Good

Is the service effective?

Our findings

People spoke positively about the home. Comments included, "Staff have the skills and they know their job. They just do it without any hesitation, if something needs to be done they don't wait, it's done," and "The staff here are very good, they are helpful and very friendly." We found staff and management at Arundel Park Lodge provided care that was effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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. We checked whether the provider 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 worked within the principles of the Mental Capacity Act 2005 (MCA). The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. The reference to people's mental capacity in people's care files recorded the steps taken to reach a decision about a person's capacity. Staff told us how certain decisions were made, for example, consenting to the use of photographs and use of continence aids. Consideration was given for those whose mental capacity fluctuated. For example, one person had supporting documentation that explained the reasons why they were on bed rest and considered whether any other option had been considered. Documents held details of, for example, best interests decisions.

The Care Quality Commission is required by law to monitor the use of the Deprivation of Liberty Safeguards (DoLS). 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). We checked whether the home 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 are applied for when people lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager understood their responsibilities under DoLS and submitted applications to the supervisory body, the local authority.

People received the nutrition required to maintain their health. People ate in the dining room or lounge areas where they used a small table or received their meals in their bedrooms. Some people received support to eat their meal from staff as, without the prompt, they were at risk of not eating unless reminded. People in the lounge area who required assistance were given one to one, person centred support with their meal. People told us that the food was good. Comments included, "The food and drink I get here is perfect. It's cooked well, tastes nice and a good variety. I do need support to eat and drink as I am unable to hold anything," and "Tea is always available here and the food is very good."

Food and fluid charts were consistently completed for those identified at risk. Food returned to the kitchen uneaten or partially eaten was monitored. Staff said they noticed if a pattern of poor eating or appetite had developed to inform and assess whether people were receiving adequate nutrition to maintain their health.

Staff assisted people with a variety of care needs, including support to eat and drink. There was plenty of verbal interaction, eye contact and other non-verbal cues to people throughout the mealtime. Care staff members sat by people's side to assist them in a professional and respectful manner.

The provider had ensured that people received suitable and nutritious food and hydration that is adequate to sustain life and good health. The menu demonstrated a wide range of nutritious meals. The kitchen staff had a good understanding of people's dietary needs and preferences. There was information displayed in the kitchen that informed staff who was at risk, the type of diet and what support they required at mealtimes. The kitchen staff told us that they had a list of people's dietary needs and preferences so that people's nutritional needs were known and met on a day-to-day basis. Dietary and fluid requirement updates were included on the staff shift handovers so that they could be familiar with people's up to date dietary and fluid requirements.

Staff told us that they had completed various training to make sure they had the skills and knowledge to provide the support people needed. One staff member said, "Yes, there is training which we do regularly. If you need it, you can do it". Another staff member told us, "There is quite a lot of training. It's very good". The training coordinator ensured relevant training was available, reviewed and updated. Training records indicated that fundamental training was up to date for all staff in, for example, fire training, food hygiene, Control of Substances Hazardous to Health, (COSHH), health and safety. Specific training, such as end of life care, dementia, wound care and nutrition had been undertaken or updated to ensure best practice was followed by all staff to ensure person centred care was effective. Staff supported people who lived with dementia with sensitivity, as observed by the interaction when supporting and managing some behaviours that challenged the service.

Systems to support and develop staff were in place through regular individual meetings with the registered manager or identified supervisor. These meetings gave staff the opportunity to discuss their own developmental needs as well as any concerns or issues they may have. Mechanisms were in place for supporting staff in relation to their roles and responsibilities. Staff commented that if they had any worries they could approach the provider or registered manager for advice or guidance. One member of staff said, "Yes we have one to ones. They're very good and the manager is very supportive". Another staff member told us, "Yes that happens regularly. I can speak to the manager anytime though really." Appraisals for staff meant that they were supported to undertake further training to develop their skills, such as through undertaking the health and social care diploma.

People received effective on-going healthcare support from external health professionals. People commented they regularly saw the GP, chiropodist and optician. Visiting relatives felt staff were effective in responding to people's changing needs. Staff had referred people to the tissue viability nurse (TVN) and speech and language therapist as required. A healthcare professional told us, "It's a good home." Another said, "When we assessed and reviewed the resident we met with [the registered manager], the nurse in charge, two carers and the residents wife. Within this meeting, we found the team to be transparent, caring and motivated to work out the best approaches that could assist the resident."

Good

Is the service caring?

Our findings

People were supported with kindness and compassion. They told us caring relationships were developed with staff who supported them and that they were well cared for and treated with respect and dignity and had their independence promoted. One person told us, "I have unquestioning confidence in the staff skills, they are really nice people with happy and smiling faces." A relative said, "Care is top of the list and that is good. They [staff] take time to talk to [my relative], they are friendly and it is obvious to me that staff are patient and caring."

Individual needs were considered and met and this positively affected people's wellbeing. Staff focussed on people's comfort and gave appropriate care, treatment or support. For example, some people living with dementia found it difficult to initiate contact and staff were careful to give time and attention throughout the day. Staff responded to people appropriately and in a caring manner. Staff included people in their chatter and included them as partners in the conversation. Staff talked to people and made sure they were in their field of vision to include them. People responded to the focused attention in a positive manner and this provided reassurance. People and their relatives spoke positively of care staff and communication, comments included, "The staff here are all nice and I am respected and comfortable with all of them."

People were treated with dignity and respect. People's preferences for personal care were recorded and followed for each person. For example, records showed people received personal care, which included taking a bath or a shower when they wanted it. People's personal hygiene needs were being met. Continence care was offered regularly. People appeared well, for example, their nails were painted by choice for some of the women, and their clothing was clean, pressed and reflected their personality and choice. This impacted positively on the individuals' dignity.

Staff were confident when they spoke about how they promoted people's rights to privacy and dignity. They told us they always shut curtains and doors when assisting people with personal care and made sure people were covered when having a wash, bath or shower. For example, one member of staff told us they always covered the lower part of a person if they were washing the top. Staff told us it was important to tell people what they were doing when they were preparing to provide personal care. For example, staff discretely adjusted a person's clothing in the lounge while talking with them and telling them the reason for the intervention, and ensured the individual's dignity was maintained. One person said, "I use a walking frame for support, staff are very caring they help me with showering, comb my hair, we talk together and they are so friendly."

People's independence was promoted. For example, people had access to a call bell to summon assistance. A relative told us their experience, "We do hear call bells but staff always seem to respond quickly if the bell is ringing." The registered manager and staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do what they wanted throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their

day. Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "We give people choice. We know who wants to get up early but sometimes someone surprises us and wants a change and if they decide they don't want to, we respect that." Relatives told us they were pleased with the care their family member received. They told us staff had taken time to get to know their family member and had created a file, which included their personal preferences. Relatives told us staff kept them informed of any ill health, consultations, incidents or accidents. People were able to maintain relationships with those who mattered to them. They said they were able to visit at any time and were made to feel welcome. One relative said, "I can absolutely visit at any time and there's always a friendly word of welcome and a cup of tea. I often stay for lunch on a Sunday."

Good

Is the service responsive?

Our findings

People and their relatives told us they were happy with the standard of care provided and that it met their individual needs. People had access to a range of activities and could choose what they wanted to do. One person told us, "I do take part in any activities, it's no good just sitting around in a chair feeling sorry for myself. I take life as it comes; I used to love knitting but not so much anymore as my eyes are not what they were. I do not do any outside activities though most weekends I spend with the family, especially special occasions". A relative said, "Sometimes there are quizzes and there have been outings".

Care plans and daily records were clear and comprehensive and staff were knowledgeable about the care people required. This helped ensure people received appropriate care and treatment. For example, some people were potentially at risk of developing pressure damage and contributing factors were recorded such as incontinence, immobility and risk of infection. Preventative measures were recorded to meet this need and staff recorded action taken when they noted skin changes or signs of physical health changes that may affect their skin.

People's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner. Care plans contained personal information, which recorded details about people and their lives. Care plans contained life histories that had been completed with the assistance of relatives where it was available and gave a picture of each person's life and preferences. Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care.

Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans also contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. For example, we noted one person's evening medicines were given early at the person's request, after having consulted their GP. The registered manager told us that a significant amount of work had taken place on developing people's care plans and staff ensured that they read them in order to know more about people they were caring for. We spoke with staff who confirmed this and gave us examples of people's individual personalities and character traits that were reflected in peoples' care plans. One member of staff described how they supported a person to live well with dementia, they said, "We know that [named person] does not like having their hands touched for an extended period of time. We respect that." Another added, "We get to know the residents and what they like. I take the time to chat and get to know the residents, they are lovely".

There was a designated member of staff to arrange activities and occupation for people. They had recently visited another care home, rated as Outstanding by the Care Quality Commission, in order to gain an insight into how to help facilitate and maintain ideas for future provision. Group activities were undertaken in the communal areas of the home and in addition to group activities, one to one time was devoted to people who were unable or did not wish to participate in group activities. The activity coordinator told us this was

done to prevent people from becoming socially isolated. The home had opened a 'tea room' in the garden, equipped with a red post box. A person with an interest in gardening had benefited from the construction of a raised flower bed in which they had planted a collection of herbs and flowers. The registered manager told us this was to help orientate people living with dementia to place. People also had engagement outside the home with the wider community, such as trips to local pubs and restaurants. The activities coordinator produced personal profiles for each person and these were used to generate ideas for activities and interaction. A relative told us, "[Named relative] never wants to come out of their room but they still offer the opportunity and encourage participation. There's a lot going on for those that want it."

Meetings with people were not held to gather people's ideas, personal choices and preferences on how to spend their leisure time. We asked how activities were decided upon and how much input came from people themselves, especially as there were no regular resident's meetings. We were told people were approached individually and their opinions and preferences were gathered one to one. We asked if there was enough time to undertake the role effectively, especially in the light of it being part-time. We were told care staff also contributed to the provision of meaningful activities and occupations and the staff we spoke with confirmed this.

The provider's complaint procedure operated effectively. People and relatives were aware of how to make a complaint and all felt they would be listened to if they raised any issues. A complaints procedure was in place to record and address issues with a detailed response. The complaints procedure was displayed in the home. People we spoke with told us they had not needed to complain and that any minor issues were dealt with informally. One person told us, "No complaints since living here and I do speak my mind." Another person said, "If I had a complaint I would tell the manager but I have no reason to, it's like a hotel living here." The relative of one person said, "I raised an issue. It was dealt with promptly and [registered manager] took the trouble to respond to my concerns immediately."

Requires Improvement

Is the service well-led?

Our findings

Staff told us they felt supported and could approach the registered manager with any concerns or questions. One member of staff told us, "The manager and the owner are very approachable. Everybody knows what they are doing." Another member of staff added, "I like to work with people and it's a good team here." However, we found Arundel Park Lodge was not well led in one area.

People and their relatives were not actively involved in developing the home. As part of their governance, providers must seek and act on feedback from people using the service, those acting on their behalf, staff and stakeholders, so that they can continually evaluate the home and drive improvement. Providers must ensure that improvements should be made without delay once they are identified. The provider told us one of the organisational core values was to have an open and transparent service. Friends and relatives meetings were planned and surveys were conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views. Feedback we received from relatives stated they felt the management at the home was approachable and the provider told us that people had opportunities to give feedback about staff and the home individually. However, we received the following feedback about the home from people who told us their views were not actively sought and that residents meetings did not take place. We were told, "My views have not been asked of before but I think the home is well managed," and, "I have not shared my views and experience no one has asked."

There were systems and processes in place to consult with people and relatives through satisfaction surveys. This year's satisfaction questionnaire had been sent out in October to four people and 25 relatives and to date three responses had been received. The registered manager told us, "We listen to the people and my door is always open." The registered manager and provider confirmed that they were aware of the issues with regard to communication and a 'residents and relatives' meeting had been arranged to meet this need. However, we have identified this as an area of practice that needs improvement.

A wide range of audits were carried out to monitor the quality of the home. Monthly checks were made of areas of the home, such as medicines, infection control and the safety of the premises to ensure that people were safe. The results of which were analysed in order to determine trends and introduce preventative measures. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered. The registered manager met with the provider to give regular feedback of progress. Accidents and incidents were reported, monitored and patterns were analysed, so appropriate measures could be put in place when needed.

The registered manager and provider demonstrated strong values and a desire to ensure best practice throughout the home. There was a positive culture that encouraged staff to also strive for improvement. People were placed at the heart of the home and the registered manager placed emphasis on continuous improvement in all aspects of their care. The provider was proud of the achievements of the home and told us, "The home has a good reputation in the area and we want to work to continue to maintain our position." A member of staff said, "This place is in my blood, it's such a lovely place to work. I think that helps to make

it a nice place to live." Staff spoke positively of the culture and how they all worked together as a team, they spoke highly of the registered manager and the provider who enabled this and one said, "The manager and the owner are very approachable. Everybody knows what they are doing." Staff told us they felt well supported by the registered manager and described their open door management approach. The manager and provider acknowledged the importance of the culture of the home. They told us they were working to ensure good practice was maintained to make sure care remained person centred and regulations were met.

The registered manager provided clear leadership for staff. They were actively involved and present on the floor of the home and kept themselves informed of the on-going care and treatment provided to people through handover and staff meetings. They were also seen to provide positive feedback and encouragement to staff working in the home. The registered manager shared updates and learning with staff to ensure all staff were kept informed to changes to care practice. For example, staff were informed when people were referred to healthcare professionals and communication with staff reminded them of their responsibility to read updated care plans and ensure appropriate support was in place.

Mechanisms were in place for the registered manager to keep up to date with changes in policy, legislation and best practice. The registered manager and the provider were able to meet and share practice learning with managers from other services. Up to date nursing and care information was also made available for staff, including guidance around moving and handling techniques, updates from the nursing and midwifery council (NMC) and the care of people with dementia. We saw that the registered manager also liaised regularly with the provider in order to share information and learning around local issues and best practice in care delivery, and learning was cascaded down to staff. The provider had fostered links with a local school to provide experience for those students considering a care in social care or nursing, We noted the following feedback from the school, 'Your help and support with the recent work experience was truly amazing. [Named student] has gained so much knowledge about the world of work and this has been due to your commitment to the programme.'

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was also aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and sets out specific guidelines providers must follow if things go wrong with care and treatment.