Park Homes (UK) Limited

Claremont Care Home

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?	Good

Summary of findings

Overall summary

Claremont Care Home is situated in Farsley, between Leeds and Bradford. The service is registered to provide nursing care and accommodation to up to 63 older people. The service also provides care and support to people who are approaching the end of their lives. At the time of the inspection, there were 52 people at the service, with two people in hospital. The majority of people who used the service were living with dementia.

This comprehensive inspection took place over two days on 13 and 29 June 2017. At the last inspection in June 2016, the service required improvement to become Safe, Effective and Responsive. At this inspection we found the required improvements had been made.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe at the service. Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns. There were appropriate systems in place to make sure that people were supported to take medicines safely and as prescribed. Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were a sufficient number of staff on duty to make sure people's needs were met. Recruitment procedures made sure that staff had the required skills and were of suitable character and background.

Staff were supported by a comprehensive training programme to help them carry out their roles effectively. Staff were led by an open and accessible management team. There were opportunities for staff to participate in service developments through supervision and team meetings.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS are put in place to protect people where their freedom of movement is restricted. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were provided with sufficient amounts of food and drink. Where people required support with eating or drinking, this was appropriately provided and took into account people's likes, dislikes and preferences.

People told us staff were caring and that their privacy and dignity were respected. Care plans showed that people and their relatives were involved in decisions and individual preferences were taken into account. Care plans gave clear directions to staff about the support people required to have their needs met. People

were supported to maintain their health and had access to health services if needed.

People received good care at the end of their lives. Staff were well trained in this area and sensitive to the needs of people, their friends and relatives.

People's needs were regularly reviewed and appropriate changes were made to the support they received. People had opportunities to make comments about the service and how it could be improved upon.

The manager had good oversight of the service and was well known tom people who used the service. They had made improvements at the service since they started in post. There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified.

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.

There was safe management of medicines which protected people against the associated risks.

Staff used safeguarding procedures in order to protect people from harm.

Risks to people had been assessed and plans put in place to keep risks to a minimum.

There were sufficient numbers of staff to meet people's needs. Recruitment procedures made sure that staff were of suitable character and background.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills necessary to carry out their roles effectively.

Staff understood the requirements of the Mental Capacity Act 2005. Relevant legislative requirements were followed where people's freedom of movement was restricted.

People were supported to maintain good health and were supported to access relevant services such as a doctor or other professionals as needed.

People were provided with sufficient amounts of freshly cooked food, drink and snacks.

Is the service caring?

Good

The service was caring.

People told us that they were looked after by caring staff.

People were treated with dignity and respect whilst being supported with personal care.

People were supported to make everyday choices and decisions.

People at their end of life were provided with good support which was sensitive to their needs and those of their loved ones.

Is the service responsive?

Good

The service was responsive.

People received care which was responsive to their needs. Care and support plans were up to date, regularly reviewed and reflected people's current needs and preferences.

People could take part in a range of activities.

People knew how to make a complaint or compliment about the service.

Is the service well-led?

Good

The service was well-led.

The manager had good oversight of the service and had plans in place to make continuous improvements.

There was a positive, caring culture at the service.

There were systems in place to look at the quality of the service provided and action was taken where shortfalls were identified.

There were opportunities for people to feed back their views about the service.

Claremont 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 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 13 and 29 June 2017 and was unannounced on the first day. The inspection was carried out by one adult social care inspector, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of supporting someone living with dementia. The specialist advisor was a registered nurse.

Before the inspection, we reviewed the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We sought feedback from Leeds County Council social services, Leeds Clinical Commissioning Group and Healthwatch, prior to the inspection.

During the inspection, we looked around the premises and spent time with people in their rooms and in communal areas. We looked at records which related to people's individual care. We looked at five people's care planning documentation and other records associated with running a care service. This included recruitment records, the staff rota, notifications and records of meetings.

We spoke with eight people who received a service and six relatives. We met with the registered manager, eight members of care staff, an activity coordinator and a chef. Because not everyone who used the service was able to talk with us, we used a Short Observational Framework for Inspection (SOFI) tool. This involved a period of time spent observing care practice and interactions.

Good

Is the service safe?

Our findings

At our last comprehensive inspection published in June 2016, we found the service required improvement to become safe. The environment had not been made safe to protect people from potential risks. We identified this as a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection the provider submitted an action plan telling us the action they would take to make the required improvement.

At this inspection, we found improvements had been made and the registered provider was no longer in breach of Regulations.

People and their relatives told us that they felt safe. One person told us, "Yep, I always feel safe here. There is nothing not to feel safe for". Comments from relatives included, "Overall, we are all happy with dad's care. He is safe, happy and well looked after", "Mum has no mobility so they have to hoist her into and out of chairs and her wheelchair. They are very careful when they are doing this. I felt happy enough to go away on holiday for three weeks and knew she would be in good hands" and "I feel happy leaving mum here. She seems to like it. She can't speak to tell me, but I would know if she didn't. I am happy that she is safe here".

We looked at the environment and the checks that took place to make sure it was safe. At the last inspection, we found that some windows did not have suitable restrictors on to prevent accidents. At this inspection, appropriate window restrictors were in place. Communal areas and corridors were kept free from avoidable clutter and no hazards were identified.

The manager took steps to make sure the environment was kept safe. An environmental risk assessment and fire risk assessment had been completed recently. This helped to protect the health and safety of people who used the service, staff and visitors. The fire alarm system was regularly checked to make sure it operated effectively and there were up to date inspection reports for electrical wiring and gas safety. Weekly checks were carried out on vital equipment, such as call bells, hoists and bed rails. During the inspection we noted that all areas of the service were kept clean and free from unpleasant odours. We found no concerns with regard to infection control.

Records showed that people had personal emergency evacuation plans. This meant that staff were aware of the level of support people required should the building need to be evacuated in an emergency.

There were up to date safeguarding policies and procedures in place which detailed the action to be taken where abuse or harm was suspected. Staff had received training in keeping people safe, and they told us they were confident about identifying and responding to any concerns about people's safety or well-being.

Records showed that any incidents or accidents were logged and appropriate action taken in response. Lessons were learnt from incidents. For example, there was a record of a hoist tipping over while moving a person who used the service. Following the incident, the hoist was re-inspected and an occupational therapist was asked to come out to assess and observe moving and handling practice. They found no issues

but advised that the room space needed changes. The person subsequently moved rooms in order that care could be provided safely.

Accident reports went to the manager to review and assess if further action was required. The manager produced a monthly overview of all incidents, which helped them to identify any themes or trends. Any serious incidents or concerns had been reported to other authorities, such as the Care Quality Commission (CQC) or the local safeguarding team, as necessary.

There was a robust system in place to make sure new staff had the right qualities to care for older people. We reviewed staff recruitment files and saw that applicants had completed an application form which was discussed at interview. References were sought prior to employment and checks were carried out on each applicant's suitability for the position. A criminal background check was provided by the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about criminal records. The manager also monitored the registration of nurses to make sure they remained fit to practice. This helped to ensure people who used the service were protected from individuals who had been identified as unsuitable to work with vulnerable people.

There were sufficient numbers of staff to meet people's needs and keep them safe. The manager told us they had a full staff team and did not use agency staff, except for one person's additional one to one support. This meant the staff team was consistent and familiar to people who used the service. The rota showed that two nurses were on duty at all times. There were also two care coordinators who between them carried out checks, audits and care plan reviews. Care staff were supported by ancillary team, including domestics, cooks and maintenance personnel. The manager explained they used a dependency tool to check staffing levels and updated this weekly because people's needs often changed.

We checked the systems in place to ensure people received their medicines safely. Each person's medication administration record (MAR) had a photograph of the person to help make sure medicines were given correctly. MARs showed that medicines had been administered as prescribed.

There was suitable guidance in place which identified when and in what circumstances 'as required' medicines should be administered. When topical creams were applied, the site of application was included on a body map so that staff were clear about where it was needed. In the majority of cases, the reason for administering 'as required' medicines was recorded.

We checked the systems in place for the safe storage of drugs liable to misuse, called controlled drugs. We saw they were stored securely and a controlled drugs register was in place. We completed a random check of stock against the registered and found the record to be accurate. No one at the service received their medicines covertly. This is a method of administration which is used if someone refuses necessary medicines and has their medicine crushed and added to food or fluid.

All medicines were stored securely and safely. The temperatures of the medicines room and refrigerator, used for the storage of medication, were recorded daily to ensure medicines were kept at the correct temperature.

We observed a nurse administering medicines to people who used the service. They spoke to people in a polite and dignified manner, explaining what was happening with patience and kindness. Records confirmed that staff had received appropriate medicines training. This included a practical observation of competence as part of their training updates.

Good

Is the service effective?

Our findings

At our last comprehensive inspection published in June 2016, we found the service required improvement to become effective. Staff did not receive appropriate supervision and there was a lack of detail in care plans about people's capacity to consent. We identified this as a breach of Regulations 18 and 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection, the provider submitted an action plan telling us the action they would take to make the required improvement.

At this inspection we found improvements had been made and the registered provider was no longer in breach of Regulations.

The staff we spoke with told us they felt supported in their roles and there was good teamwork. Comments included, "I really enjoy it here. I did induction training before I worked on the floor. I feel supported. I want to do nursing and [Manager] said she will help" and "I get supervision and I'm encouraged to speak freely. The rota is worked around my caring responsibilities". A relative told us, "Most of the carers are really lovely and they deserve a medal".

Staff received a formal, planned supervision (one to one meeting with a manager), four times a year. The manager said they often had informal chats with staff, either to check that they were okay or because the member of staff wanted to talk about something. Each member of staff had a supervision agreement which included sections such as, 'What I will contribute' and 'What I want from a supervisor'. Supervision records showed that some meetings were used to discuss a particular practice area whilst others were about staff development and needs. All staff had an appraisal planned in the year. Appraisals were an opportunity to reflect on the past year and discuss future goals and staff development.

Staff told us they got the training they needed to maintain competence and for their own professional development. Staff had received training in key areas such as safeguarding and moving and handling. Training was regularly updated so that staff were aware of current good practice. Staff had completed training in dementia awareness although one member of staff told us they thought more training was needed. The manager confirmed that staff knew about dementia but said they wanted to do more in this area. They added that an external 'Memory Team' would be coming in to do some presentations.

The manager told us that three care staff had been trained as nurses since working at the service. They explained, "It helps that they used to be carers. They have stayed with us and are very loyal. I take pride on staff achievements".

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). 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.

The manager told us they had made improvements to MCA information in care plans following advice from an Independent Mental Health Advocate (IMCA). There was evidence in care plans that people's capacity was considered when decisions needed to be made. Capacity assessments were in place where needed, for example, for the use of bedrails. The assessments were well evidenced and gave clear reasoning. Where people lacked capacity to make a decision, a 'best interests' meeting had been held with relatives and any professionals involved in the decision. This was confirmed by a visiting doctor, who said, "We do have best interest meetings when we need to".

The manager showed us a spreadsheet which they used to monitor DoLS applications and authorisations. This showed that 14 had been approved and 33 were waiting for approval, either as a renewal or a new application. This demonstrated that the provider was following legal requirements.

The manager and staff were aware of the importance of consent and understood the MCA and DoLS procedures. Staff had received training in this topic to support their understanding.

We observed the lunchtime experience in two of the units. The atmosphere was relaxed and pleasant. Tables were nicely laid with tablecloths, serviettes and condiments. Staff offered assistance and encouragement where needed and took time to support people at their own pace. Meals looked appetising and people were offered an alternative if they wanted.

People told us they enjoyed the food. Comments included, "I like what I get to eat" and "I actually prefer my own food as I'm a fussy eater. But the food here is good". A relative told us, "Dad wasn't eating at all when he came in here, but he enjoys his food now". A member of staff described how they felt mealtimes had improved since last year. They explained, "We have more time to spend with the residents now. To deliver the food on time and to assist with eating and chatting with them. The residents are much happier now they have a laugh and interact with us".

The cook told us they closely monitored people's food requirements. In the kitchen a chart showed each person and their type of diet as well as important information about food and drink requirements, for example, the use of fluid thickener. The cook said, "If there is a new resident a senior carer informs the kitchen. Residents will say if they like or don't like something. Food is discussed in team meetings and resident meetings". We noted that mealtimes were 'protected'. This meant that professionals were advised not to visit, so that people could enjoy meals undisturbed.

For those people at nutritional risk, a professionally recognised assessment tool was used to monitor weight loss and prompt appropriate action. Where risks had been identified, a referral was made to a relevant professional such as a dietician. People at risk had food and fluid charts in place and care plans specified the recommended daily amounts. In dining areas, we noted a chart which had photographs of different glasses and the amount of fluid they each contained. This made sure that fluid charts were completed accurately.

Some people received their nutrition through a tube into their stomach, called a percutaneous endoscopic gastrostomy (PEG). We looked at the care plan for one person who was fed in this way. There was very detailed information about how this was carried out as well as clear instructions for cleaning and maintenance of the tube and PEG site.

People were supported to maintain their health and had access to health services as needed. One relative told us, "Mum has not been poorly here. I am really happy about that. Where she was before she had constant water and chest infections and was hospitalised on more than one occasion". Care plans contained clear information about peoples' health and nursing needs. These showed that the service made effective use of advice and support from other professionals when required. A visiting doctor told us, "There had been some problems here, but our Practice joined the 'enhanced care home scheme'. So we now visit two to three times a week as a routine, and more often if necessary. I ask the staff to call me even if I am off duty, and if I can, I will come in and support them".

The manager explained further about the enhanced care home scheme in Leeds, which the service had recently joined, and said, "We can tap into resources directly, such as a dietician or physiotherapist. We don't have to go through the doctor for a referral". This meant that there was a more effective process for managing health concerns.

Some people were at risk of skin breakdown which could cause pressure sores. Where this was the case, there was clear information in care plans about how to manage the condition. Wound care treatment was well documented and showed the involvement of a tissue viability nurse.

The manager talked about the successes the service had had in rehabilitating people to return home, even though this was not expected. They told us, "We always see the potential in people. Never stop trying. We work in partnership as a team. The physio has made a lot of progress with people. The enhanced scheme is really good. I have seen staff working with [Name]. Initially he was using a wheelchair with assistance of a walking frame. Now he is independent with a frame. He uses the wheelchair a lot less. We hope to have him using only a stick".

We spoke with another person, who described how they had been supported with their rehabilitation. They explained, "If it wasn't for the staff here I would still be bed-bound. They have encouraged me and helped me. I was stuck in a bed all the time, couldn't speak, use my arms or legs or do anything for myself. Now I can talk, do everything for myself and almost walk. I didn't think I would ever do these things again".

Good

Is the service caring?

Our findings

People gave positive feedback about the service. Comments included, "It's very nice here they look after us well", "I like living here" and "I have been here a few years and always enjoyed it". A relative told us, "The staff are absolutely fine as far as we are concerned and dad gets along with all of them. He has settled in well. He has a lovely room and he seems very happy here".

The staff we spoke with also felt they provided a caring service. One member of staff told us, "Staff are very caring and compassionate. Families are complementary". Another staff member said, "We reassure people. Keep their dignity and respect them. We know how to be caring and understanding. We keep peoples dignity, such as making sure doors are shut".

We spent time in the communal areas of the home. There was a friendly, positive atmosphere throughout our visit. We saw that people's requests for assistance were answered promptly and politely. Throughout the visit, the interactions we observed between staff and people who used the service were warm, supportive and encouraging. Staff approached people in a sensitive way and engaged people in conversation, which was meaningful and relevant to them.

When people required support, staff explained what they were doing. For example we observed staff using equipment to hoist people from chairs to wheelchairs. This was all carried out with care and attention and staff told people what they were doing in order to reassure them. In the afternoon of our second day, we observed one person who was quite distressed in the lounge. A member of staff sat with the person to reassure them and held their hand. They were aware of the reasons that the person became distressed and tried to comfort them. The situation was managed calmly and sensitively.

We observed staff treated people with respect and dignity. They made sure that any personal care was carried out behind closed doors in order to maintain people's privacy. Staff knocked on peoples' doors before entering and spoke with people in a dignified manner, explaining what they needed to do. We noted that staff took time to listen to what people said so that they were included in any discussions.

People were encouraged to make decisions about what they wanted to do during the day. We saw that people were free to go where they wanted in each unit. One person liked to stay around the main reception area and enjoyed meeting visitors. This person used to sing on stage and we observed staff encouraged the person to sing songs, which they clearly enjoyed. Care plans stressed the importance of including people in decisions and gave clear guidance about how to do this. For example, "Please approach me from the front, make eye contact with me, say my name and speak in a calm voice. I would like you to talk first, pause, touch my hand second and continue to talk to me. This way it gives me a sense of being non threatening".

We talked to staff about how people's cultural backgrounds and needs were supported. One member of staff explained, "We have a mixed staff culture which means we can often communicate better with people. For example, we had an Asian resident and I was able to speak with them in their own language". Another member of staff said that management respected the cultural needs of people and staff, adding that they

got time off for Eid (a religious festival).

The service provided good support for people who were approaching the end of their lives. Staff had received training in end of life and palliative care. They were knowledgeable about the emotional impact this could have on people, their loved ones and staff. One member of staff told us, "I have had in-depth training in end of life and palliative care. I like to give support to people. The last two weeks of someone's life are vital. All the staff took time to sit with one gentleman recently, who was on palliative care. We let relatives know if they want to stay we can accommodate them". This was confirmed by the manager, who said, "We support relatives with palliative care. We offer meals and beds if it helps".

The manager told us they had good support from the local doctor and the service had access to a local hospice who provided a 'nurse hospice advisor'. They added that staff had received training in end of life and palliative care, which this was confirmed by the records we viewed. The manager told us, "I had a meeting last week with a palliative care lead nurse. I am going to put together learning packages, such as end of life, bereavement and appropriate boundaries". Nurses had been trained and assessed to use syringe drivers, which are used to provide pain relief during end of life care and treatment.

We looked at some of the feedback sent to the service from relatives, regarding end of life care. One relative had said, "Every single member of staff that I met went out of their way to not only provide a professional and caring service, but to do so with kindness, friendliness and compassion". Another relative had written, "It really helped us to cope a little better".

Good

Is the service responsive?

Our findings

At our last comprehensive inspection published in June 2016, we found the service required improvement to become responsive. The assessment of need or the designing of care was not carried to ensure people's care and support needs were been met. We identified this as a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection, the provider submitted an action plan telling us the action they would take to make the required improvement.

At this inspection, we found improvements had been made and the registered provider was no longer in breach of Regulations.

Prior to admission, people had an assessment of their needs to make sure the service was able to support them. We spoke with the relative of one person who had been recently admitted. They told us about the process and said, "The transition from home to here went smoothly on the whole. The staff are very supportive to me. I didn't want to leave for the first week and they allowed me to stay. Now I go home feeling that Dad is safe here". We noted that where people were admitted to the service at short notice, information was available for staff so the person's needs were known and could be met. For example, for one person admitted the previous night, there was a full care plan in place, including a pre-admission form and dependency assessment.

People received person-centred care which was responsive to their needs. Person-centred care is about treating people as individuals and providing care and support which takes account of their likes, dislikes and preferences. We reviewed people's records and saw they were detailed and focussed on their individual needs.

The care plans we looked at were up to date and reviewed as necessary. Areas covered included health, nutrition, mobility, personal care and medicines. There was a clear picture of each person's needs and how they were to be met. People and relatives confirmed they were asked to contribute to assessments and reviews and this was evidenced in care plans. Comments from relatives included, "We are involved in the care plans and reviews for mum, and our suggestions are listened to", "I feel fully informed and I am involved in my dad's care plan every step of the way" and "I have seen the care plan and was involved in what was written".

Each person's care plan gave details of their preferences for care and support, as well as likes and dislikes in general. There was information about people's life history, although this was sometimes brief and lacking in detail. Some people had a chart inside their room which gave a 'pen picture' overview of their needs, preferences and interests. The manager told us they were in the process of doing this with everyone, working in conjunction with the Alzheimer's Society. The information gave staff a useful insight into the background of people so they had a better idea of their personality and experiences.

We spoke with the activity co-ordinator about the range of activities available to people who used the service. They told us, "We do our best to keep the residents happy and active. We play bingo, do baking, craft

with salt dough, have movie days, singers come in and we have pamper days. Some people go shopping. We have animals in, such as 'pat' dogs and a donkey. We were trying to plan a day to the seaside, but decided to bring Blackpool here. We will have a seaside theme with a beach and barbecue".

People and relatives confirmed there was a range of activities. Comments from relatives included, "Mum has been taken to the local pub for lunch with other residents. She plays dominos and bingo and has her hair done every week" and "Mum has really improved. She never used to come out of her room. She has even been out to the pub now". One person who used the service told us, "I do what I want to do really. I can chill out, watch TV, read and do anything I want to do. I sit outside most days. I like to do that".

A visiting professional told us about the activities they had witnessed and said, "They recently arranged for a donkey to come in. It was amazing! The residents just loved it. They also had two greyhounds as pet stroking dogs, which was good for the residents. They have sing-songs which the residents join in with, and there are residents with dementia who are taken to the pub with staff for a half, which I approve of".

The manager described how they involved the local community and said, "We have good relationships with the community. Some children from the local school come in to do baking with people, a local choir visits and shops and pubs donate prizes. We often make use of the pub!".

Visitors and relatives were encouraged to visit at any time. The visitors we spoke with told us they were made to feel welcome by staff when they arrived at the service.

The people and relatives we spoke with knew how to complain and who to go to if they had a concern. Comments from relatives included, "I have no complaints at all" and "We don't have any complaints, but if we had, we would talk to the staff or [Manager's name]". There was information on how to complain displayed on noticeboards. This included details of other relevant contacts, such as CQC and social services.

We looked at the record of complaints received over the last year. Each complaint was clearly recorded, together with a summary of the action taken, response and closure date. All complaints had been responded to in writing or through a meeting with the complainant.

Good

Is the service well-led?

Our findings

The manager had been registered with the CQC for nearly a year. They acknowledged that there had been some problems at the service when they first started, but felt that practice had improved.

The manager spoke knowledgeably about the service and had a clear understanding of regulatory requirements. We found the manager had a good awareness of each person's needs. They were able to respond to our questions about individual people's care and support promptly and without reference to records. They were aware of areas of practice that could be improved and had taken action to make changes since starting at the service. For example, improving care plans and teamwork.

People who used the service and relatives made positive comments about the management of the service. One person told us, "This home is well run and [Manager's name] is always approachable". A visiting professional commented, "The manager is very enthusiastic and so am I, so I always find if it comes from the top, things cascade down and do improve. The manager is great and I do enjoy coming here."

Staff recognised that there had been improvements over the last year. Feedback included, "[Manager's name] is amazing", "I think it has improved a lot" and "A lot of improvements have been made. A lot of changes. The home has come a long way". Several staff raised the booking and authorisation of annual leave as an issue during the course of the inspection. We received feedback that leave was granted inconsistently. One member of staff said, "We never get holidays agreed even if we put them in 12 months in advance. We can't carry days over and we don't get paid for them". We raised this with the manager who told us that annual leave was approved by head office who prioritised the effective running of the service when considering requests. The manager was aware that there had been problems with the system and told us that changes were being implemented so that leave would be allocated fairly.

Throughout the inspection, we observed the manager engaging with staff and people who used the service. It was clear that people were familiar with the manager and enjoyed her company. The manager spoke about their role and said, "I am very approachable and have a good rapport with staff. Relatives comment that they see me on the floor. I make sure I see all the residents every day. I try to meet with relatives when they visit. I love the home and the people. Any chance to change someone's life for the better is what drives me".

The registered manager spoke passionately about their aims and ideas for the service. These included improving resident meetings to make them more interesting and engaging, such as combining a meeting with a cheese and wine evening. A sustainability improvement plan was in place, which the manager updated each month. This covered areas such as infection control, accidents, dignity, documentation and staffing and considered how to maintain and improve standards. There were also plans to improve the environment, detailed in a comprehensive refurbishment plan, which included new flooring and decorating.

There were weekly team meetings and head of department meetings. These gave the staff team opportunities to share ideas and be involved in service developments. A staff survey was carried out in

March 2017 and this included a summary, together with conclusions about how to make changes, for example, improving the annual leave system.

There were systems in place to monitor and review care practices in the service. The registered provider carried out a formal monitoring visit every few months. The manager told us that the provider visited three days in the previous week. After the visit an action plan was put in place to make sure any shortfalls identified were rectified. We asked the manager about the support received by the registered provider and they told us, "I think they are good to work for. They have always been fair. [Provider's name] came three days last week. I get the support I need".

Management staff carried out audits for different areas of practice. These included audits of care plans, medicines management and infection control. Audits clearly identified if there were any actions needed to make improvements and showed when these had been completed. We noted that all the records we looked at were well maintained, ordered, and kept up to date. Confidential records were kept securely as necessary.

People who used the service and relatives were given opportunities to feed back their views and make suggestions about the service. There were resident and relative meetings every three months. The manager also spoke with people and visitors when possible, throughout the day. Visitors told us they knew the manager and that she was often visible in the service. One relative commented about how they were involved and said, "We come to the residents meetings where we get updates on things like the renovations and health and safety type things".