Larchwood Care Homes (South) Limited

Cams Ridge

Inspection report

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Tel: 01329238156

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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

This inspection took place on 21 and 22 May 2018 and was unannounced. At our last inspection we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management of medicines was not always safe and the stock of controlled medicines indicated medicines were missing. Records relating to people's care were not always up to date and accurate. The provider sent an action plan telling us how they would address these concerns. At this inspection we found improvements had been made and there was no longer a breach.

Cams Ridge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Cams Ridge provides nursing care to older persons. Cams Ridge can accommodate up to 51 people in one adapted building. The home has two floors accessed via stairs or a lift, three communal areas and a large garden where people could choose to spend their time. At the time of the inspection the registered manager told us they had changed some of the bedrooms to make more space for people and Cams Ridge was now able to provide accommodation to 43 people. At the time of the inspection 29 people lived in the home.

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

People were protected against abuse because staff had received training and understood their responsibility to safeguard people. Concerns were reported and investigated.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. Staff were aware of the need to treat people as individuals and ensure care reflected their individual needs. Risks associated with people's needs were assessed and action was taken to reduce these risks. We identified that some of these assessments could be done more promptly when a person first moved into the home and action was taken to address this during the inspection. People were supported to ensure they received adequate nutrition and hydration. Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services. People told us they were always asked for their consent before personal care was provided. Where needed, people's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA).

People and their relatives provided positive feedback about staff. Observations reflected people were comfortable and relaxed in staff's company. People were cared for with kindness and compassion. People's privacy and dignity was respected and they were encouraged to be involved in making decisions about their

care. Staff responded to people's changing needs and ensured a person centred service.

The provider's recruitment process ensured appropriate checks were undertaken to ensure staff suitability to work in the home. People told us they felt staff had the skills and knowledge to care for them. Staff received supervisions and training to help them in their role.

People and their relatives said the home was always clean and well maintained. Equipment was managed in a way that supported people to stay safe and people were supported to maintain good health and had access to appropriate healthcare services.

There was a process in place to deal with any complaints or concerns if they were raised. People told us they knew how to complain and we saw complaints were investigated and outcomes shared with people and staff.

Communication was open and staff felt supported by the registered manager. Staff felt able to raise concerns at any time and were confident these would be addressed. People and their relatives were confident to raise concerns if they needed to and spoke positively about the registered manager's approach. People, their families and staff had the opportunity to become involved in developing the service. The service aimed to ensure good quality care was delivered and there were systems in place to monitor the quality and safety of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected against abuse by staff who understood their responsibility to safeguard people.

Risks associated with people's needs were assessed and action was taken to reduce these risks.

Medicines were managed safely.

The provider's recruitment process ensured appropriate checks were undertaken to ensure staff suitability to work in the home and there were sufficient staff to meet people's needs.

The home was clean, tidy and staff carried out good infection control management.

Is the service effective?

Good

The service was effective.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs.

People told us they were always asked for their consent before personal care was provided. Where needed, people's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA).

Staff received supervisions, appraisals and training to support them in their role.

People were supported to ensure they received adequate nutrition and hydration.

Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

Is the service caring?

Good

The service was caring.

People and their relatives provided positive feedback about staff.

Observations reflected people were comfortable and relaxed in staff's company. People were cared for with kindness and compassion.

People's privacy and dignity was respected and they were encouraged to be involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

Staff responded to people's changing needs and delivered a person centred service.

People were provided with appropriate mental and physical stimulation.

There was a process in place to deal with any complaints or concerns if they were raised. People told us they knew how to complain but had not needed to.

Is the service well-led?

Good

The service was well-led.

Staff felt supported by the registered manager and able to raise concerns at any time. They were confident these would be addressed.

The provider's values were clear and understood by staff. People, their families and staff had the opportunity to become involved in developing the service.

The service aimed to ensure good quality care was delivered and there were systems in place to monitor the quality and safety of the service provided.

Cams Ridge

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 21 and 22 March 2018 and was unannounced.

The inspection team consisted of two inspectors, a specialist nurse advisor and an expert by experience who had experience in caring for older persons. 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 reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. Prior to the inspection, we reviewed information included on the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection. We also received feedback from a health and a social care professional.

During the inspection we spoke with seven people who lived at home and four visitors. We observed the care and support people received in the shared areas of the home. We spoke with the registered manager and the deputy manager. We spoke with 10 staff, including nurses, care staff, ancillary staff, activity staff and administration staff. We also spoke to an external health care professional during the inspection.

We looked at the care plans and associated records of eight people, medicines administration records for six people, staff duty rotas, six staff recruitment records and supervision records. We looked at staff training records, records of complaints, accidents and incidents, policies and procedures, safeguarding and quality assurance records.

Good

Is the service safe?

Our findings

People and their relatives told us they were safe at the Cams Ridge. One person said "Yes I think they do (provide safe care) – they have a system that ensures that every resident is checked hourly, I do feel safe and confident" and a relative told us "I am delighted with the care here, I think the staff are marvellous and the new manager is doing a great job".

At the last inspection we found the management of medicines was not always safe. Medicines were not always administered appropriately. We were unable to check stock in the medicine trolleys but we were concerned that the stock of morphine sulphate for one person did not match the records. The time homely remedies were given and the dose were not always recorded. This was a breach of Regulation 12 of the Health and Social Care Act 2014. We issued a requirement notice and the provider was required to send us an action plan telling us what they would do to ensure this improved. At this inspection we found improvements had been made although the recording of cream applications needed to be consistently completed.

People could be confident their medicines were safely managed. Since the last inspection the manager told us they had changed the medicines system and no longer used the electronic medicines system as this had not been effective. People told us they received their medicines as they needed them. Medicines were stored safely in locked trolleys, rooms and fridges. Staff checked the temperature of medicines storage daily to ensure this would not impact on the medicines' effectiveness. The administration of medicines followed guidance from the Royal Pharmaceutical Society. Staff did not leave the medicines trolley unlocked when unsupervised. Staff checked the records before administering the medicines and then signed for these once the person had taken them. We looked at the Medicines Administration Records (MARs) for six people living at the home and found no gaps in these records. All MARs contained a front sheet with a recent photograph for identification purposes, all except one medicines care plan contained relevant information. The need of the persons whose plan was out of date, had very recently changed and staff took action to address this when we raised it. Creams, dressings and lotions were labelled with the name of the person who used them and safely stored. Care staff were required to sign records confirming when they had applied a person's creams but they did not always consistently do this. We found several gaps in the recording of cream administration for three people. The registered manager was aware of the need for care staff to do this and had been working with them to improve their recording. This needed more time to be fully embedded.

People were protected against abuse. Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. Staff recognised their responsibilities and duty of care to raise safeguarding concerns when they suspected an incident or event that may constitute abuse. Staff said they were confident to do so and felt that the manager would take prompt action to address any concerns related to people. Records were held when referrals had been made to the local authority and incidents were investigated and appropriate action was taken.

Incidents and accidents were recorded and audited monthly by the registered manager. These audits looked for patterns and trends as well as recording any individual action that had been taken for people.

This information was inputted onto the provider's electronic system to enable senior management to monitor the service, identify trends and ensure action was taken. This meant risks to people from incidents were monitored and action was taken to address safety issues and prevent a reoccurrence.

People could be confident they were supported by staff who understood their needs. Any risks associated with people's needs were assessed and plans developed to reduce the risks, although the need to undertake some assessments when a person was admitted to the home needed to be quicker. For example, for one person, we saw a pre admission assessment had been completed before they moved into the home which identified the persons needs and potential risks to them. On discussion with staff they all had a very good understanding of this person's needs and the risks associated with these. Equipment to reduce the risks for this person were in place. The person said they were happy with the care they received and felt staff were supporting them well. They said they were "making the most of being looked after". More detailed risk assessments needed to be completed and staff were aware of these. We discussed with the registered manager the need to undertake these in a more timely manner which they took immediate action to address.

For other people we saw there were risk assessments and associated care plans in place to give the guidance to staff that they would need to provide safe care. These included risks associated with health conditions such as epilepsy, diabetes and mental health. In addition assessments were reviewed regularly of the level of risk to people in relation to mobility, falls, skin integrity and choking. Where a risk was present, this risk was incorporated into people's care plans which gave guidance to staff about the action they should take to not only reduce the risk from occurring but to manage them if they did occur. Staff knowledge of people was good and they were able to describe certain health conditions, what they would monitor for and the action they would take. Where risks presented for people staff took action to involve other professionals to ensure they were receiving effective care and treatment.

Equipment was managed in a way that supported people to stay safe. Regular maintenance checks took place of equipment, such as hoists and lifts. Window restrictors were in place where these were required. Where it had been assessed that a person required the use of bed rails, staff ensured that protective bumpers were also in place to prevent any injuries. The bed rails were checked regularly by staff to ensure they were safe and working correctly. Personal Emergency Evacuation Plans (PEEPs) were in place which outlined how people could be removed or kept safe in the event of an emergency, such as fire or flood.

Throughout our visit we saw the home was clean. We did not detect any malodours. All areas, both communal and clinical, were clean and tidy. There were ample hand hygiene stations throughout the home. All hand basins contained hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff received training in infection control. Infection control audits were completed to monitor the cleanliness of the service. There was adequate provision of personal protective equipment (PPE) for staff, such as aprons and gloves, which we observed were used appropriately.

Recruitment records showed that appropriate checks had been carried out before staff began work. Candidates were required to complete an application form and were subject to an interview. Following a successful interview, recruitment checks were carried out to help ensure only suitable staff were employed, including reference requests and Disclosure and Barring Service (DBS) checks. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Registered nurses professional registration was checked. Staff confirmed they did not start work until all recruitment checks had taken place. Occasionally, agency workers were used and the service held records regarding their character and fitness to work.

Some people expressed concerns about staffing levels and said they felt there were times when they had to wait extended periods of time for staff to answer calls bells, whereas others told us staff were very responsive to their calls. Our observations demonstrated staff responded promptly to people's requests, we were not concerned about the staffing levels. One person said "The staff and service here are excellent, I am presently bed bound from a stroke. The staff are good humoured and kind – they are also responsive, I only have to press the bell and they are here". Staff felt they had enough staff to meet people's needs but that it could be difficult if there was staff sickness. However, they did say this was always covered and very rarely would they use agency staff. The provider and registered manager used a dependency tool to assess staffing levels in the home to ensure they met the needs of people. This was undertaken monthly or as and when a need changed. The last completed analysis showed more staff being used than the dependency tool suggested was needed. The registered manager told us they ensured two registered nurses throughout the day and one at night; five care staff in the morning, four in the afternoon and three overnight. In addition to nurses and care staff, the provider also employed kitchen and domestic staff to work each day and activities staff who worked 60 hours a week, five days a week. The registered manager worked five days a week, administration staff were available five days a week and at times the deputy manager was on duty in addition to the two nurses. Rotas reflected this level of staffing.

Good

Is the service effective?

Our findings

People told us they felt staff were knowledgeable of their needs and were well trained to support them. They felt listened to and spoke positively about the food. People told us they were always asked for their permission before personal care was provided. One relative also told us "The staff certainly are well trained, we know they are often on courses. My [relative] is really well looked after here, they treat [them] with dignity and respect – we have no complaints".

At the last inspection we rated this question as good and at this inspection this remained good.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. People told us they and their relatives were involved in making decisions about coming to Cams Ridge. They also said they met someone from the home before they moved in. The preadmission assessment process identified the areas of support people needed in relation to their health, their social needs and their personal needs.

Staff were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. The provider had numerous policies in place to ensure that people's human rights and equality and diversity needs were met, including sexuality and relationships. They provided staff with training in dignity and respect, person centred care and equality and diversity to aid staff's understanding. The registered manager was clear that discrimination would not be tolerated and was confident any human rights or equality needs people had would be met.

The registered manager told us the provider used evidence based guidelines to support practice and employed a clinical quality manager to support this. We saw nationally recognised tools were in place and used to assess the risks of skin breakdown and malnutrition. Staff were required to undertake annual medicine competency assessments in line with good practice guidance.

New staff received an induction and were required to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Staff were encouraged to further develop their skills and knowledge by completing vocational qualifications in health and social care.

Staff felt the training opportunities on offer for them were positive and helpful in their role. They told us they were encouraged and supported to undertake additional qualifications in health and social care. The registered manager told us that there had been some changes to the way in which training was delivered. Staff were required to undertake some training face to face. For other courses and refreshers eLearning was in place. The provider had recently introduced an app that staff could download on their mobile devices meaning they could access and undertake their training anywhere. Staff spoke very positively of this and said this enabled them to keep up to date in a more flexible way. The provider ensured training met the needs of staff and the people being supported. They ensured staff had access to training in safeguarding,

Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DoLS), care planning and record keeping, using bed rails and moving and handling. Additional training was also available including end of life care, diabetes, epilepsy and courses to support registered nurses to maintain their skills.

Staff told us they were receiving one to one supervisions and found these helpful. Records showed staff members had received individual supervision where their views and opinions were sought and any areas for improvement were addressed. The registered manager confirmed that appraisals had been completed last year and had been booked for this year.

People described the food as 'excellent' with plenty of choice that met their individual needs. One person told us how the chef spoke to them every day to ask what they wanted to eat as they had numerous allergies. Another told us how the chef prepared them a separate menu as they were vegetarian. People were offered a choice of two main meals and alternatives if they did not want what was on the menu.

People's nutritional risk and weights were monitored regularly. Action was taken should any significant change be noted, including increasing the frequency of monitoring their weight and involving the GP. This information was shared with kitchen staff who were aware of the need to fortify foods. Staff were knowledgeable about people's differing dietary requirements. Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. Care plans had been developed to guide staff on people's nutritional needs. We observed people being given the correct consistently of meals. Observations reflected people were given appropriate support to eat their meals.

Handovers between staff took place to ensure they were kept up to date about everyone's needs. The registered manager felt they had developed good working relationships with other professionals to enable clear communication about people's needs. People told us they had access to healthcare. The home had a local arrangement in place with a GP practice who provided a weekly visit to the service to review any people who needed this or whom the nursing staff felt would benefit from a GP visit. Records demonstrated that people were supported to access appropriate healthcare services. People's records confirmed they had regular appointments with health professionals, such as chiropodists, GPs, mental health nurses and speech and language therapists.

People were cared for in an environment where adaptations had been made to meet their needs. Doors had been widened to enable access to everyone. Signage was in place to assist orientation. Rooms were laid out to enable people to understand the purpose of the room. For example, the dining room looked like a dining room with tables laid with cutlery and condiments at meal times. People were able to personalise their rooms. The environment was regularly checked for safety and maintenance issues.

People we spoke with said they were asked for their consent. Two people who were using bed rails but had not signed any consent forms told us the staff had spoken to them about using these and they had agreed to this support. We observed staff asking people's permission throughout the inspection before they provided care.

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.

Staff understood the importance of always assuming a person can make their own decisions. They sought

permission from people before providing support and supported them to make decisions. All except one member of staff we spoke with understood that if a person was deemed to lack capacity they needed to ensure best interest decisions were made. Mental capacity assessments had been completed where needed and were detailed within care plans.

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 2005. The authorisation 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 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Only one person had an authorised DoLS in the service and the registered manager explained that a further three applications had been submitted. Staff and the registered manager understood their responsibilities with DoLS and had received training from the provider.

Good

Is the service caring?

Our findings

People and their relatives provided positive feedback about staff. One relative said "I am satisfied my sister gets the help and care she needs, and the staff are all very kind, I do love to see them give her a hug and a kiss". A second relative said "The staff are exceptional. They are so kind, they have a thorough understanding of her needs. She is kept clean and comfortable at all times, and is treated with kindness and compassion". One person told us "The staff are all very patient with me, and let me do things my way" and another said "The staff are always very kind to me".

At the last inspection we rated this question as good and at this inspection this remained good.

Observations reflected people were comfortable and relaxed in staff's company. Staff spoke with people with kindness and warmth and engaged positively throughout our visit, laughing and joking with them. We heard good natured banter between people and staff showing they knew people well. People were clearly relaxed and comfortable in the company of staff. We found the atmosphere in the service was warm and friendly with staff observed to give individual attention to people when needed. The registered manager told us how they were encouraging staff to nominate themselves as dignity champions who would receive additional training to support other staff.

People were encouraged to express their views and to make their own choices. Staff understood the importance of respecting people's choice. They told us how they ensured that people were able to retain their independence by making their own choices. This was evident in many aspects of their care; for example supporting people to choose the clothes they wished to wear, where they wanted to eat their meals, and how they wanted to spend their time. We observed staff offering choices throughout the day. People told us they felt staff respected their decisions and we observed this. For example, some people chose to spend time in their bedrooms and staff visited them at regular intervals to identify if they needed any support.

Care plans and risk assessments were reviewed regularly by staff and people and their relatives told us they were involved in the development of their care plans. One person told us "At the outset I was consulted about my care plan, I have a copy of it here, and I am asked about updates to it every six months".

Resident and relative meetings took place and minutes of these reflected people's involvement in discussions about the environment and their care. For example, we saw that at one meeting a person had raised a concern about a lack of equipment meaning they sometimes had to wait for support. The registered manager had assured people this was being addressed and we saw this matter had been resolved at the time of the inspection.

People and their relatives described staff who respected people's privacy and dignity. We observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff told us the action they took to ensure people's privacy and dignity was respected when supporting them with personal care.

Good

Is the service responsive?

Our findings

People and their relatives told us they felt Cams Ridge staff responded to their needs and requests. One person told us "So far the staff have reacted to anything I have asked of them, they are proactive. I came here from the [another service], my hair had not been washed for weeks and my nails were long, they simply dealt with it for me, I felt so much better". A relative told us "[Staff] are responsive and she gets all the help we could wish for her". Another relative said "[The person] recently got a chest infection, the doctor was immediately called and the matter was dealt with, I think she is safe and they know what they are doing".

At the last inspection we found that inaccurate and impersonalised care plans for some people meant there was a risk staff may not have the information needed to support people in the way they needed and wanted. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and the provider was required to send us an action plan telling us what they would do to ensure this improved. At this inspection, we found that records had improved although further work was needed to ensure these improvements were consistent and fully embedded. The registered manager was fully aware of this and was addressing this through regular auditing and discussion with staff.

People told us that staff knew them well and this was apparent throughout our discussion with staff about people. Staff were aware of people's histories, their likes and dislikes. Whilst not everyone knew if they had a care plan, they said staff listened to them and knew what they needed. One person told us how they were always asked what they preferred.

The initial assessment process identified the person's needs, wants and wishes. From this information care plans were then developed based on the information gathered from the person, their relatives and other professionals. In addition to care plans, we also saw one person had an overall 'mini' care plan. This was very detailed and person centred. It provided sufficient information to aid staff in caring for the person and included information about the person's life history and social/activity wishes. Another person's care records contained an isolation risk assessment which contained details including 'bed is positioned to enable [person] to look out of the window so [person] can see the birds and wildlife that frequent the garden'. It also included the type of music they liked and we observed this playing in their room.

The Accessible Information Standard was introduced in August 2016 and applies to people using the service who have information or communication needs relating to a disability, impairment or sensory loss. It covers the needs of people who are blind, deaf, and/or who have a learning disability. It also covers people who have aphasia, autism or a mental health condition which affects their ability to communicate. Information was not always provided to people in a variety of ways which would give them the best opportunity to understand it and be able to contribute. Policies and information on display were in written text only. The registered manager told us they were aware of the Accessible Information Standard. People had communication care plans in place and could request alternative formats for information if required. The registered manager told us they would ensure that the need for alternative communication informed the assessment process and was not subject to request only.

It was evident that staff responded to people's needs as they changed or new issues arose. For example, one person had expressed a wish to hurt themselves. Additional support had been implemented following a risk assessment. The person's GP had been involved and the staff had liaised with the family.

At the last inspection we made a recommendation that the registered person seek guidance and advice from a reputable source about meaningful activity provision in care homes. Whilst the registered manager was unable to tell us if advice had been sourced, they did tell us the number of hours of activity provision had increased in the home. In addition to this, staff had linked in with local schools and football clubs. People had attended a party with the local school and the registered manager was aiming for lunch time clubs to be set up. People told us activities were available if they wanted to access them. One person said "There is always something going on, although I think the person who organises the events is not in today. That said, I am going to have communion this morning, the lady comes in from St Peter's Fareham, she comes to my room every week". During our visit we observed ball games, a quiz and flower arranging whilst one resident was washing up with a carer.

The provider had a policy and arrangements in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided. All of the people we spoke with told us they knew how to complain and were confident to speak to both staff and the registered manager. The registered manager told us that when concerns were raised they dealt with them in line with the provider's policy. Records reflected complaints were investigated and the outcome and learning shared with the person and staff.

At the time of the inspection the registered manager and a nurse told us training had been provided in end of life care. We were told one person was receiving palliative care but was not at the end of their life. A care plan was in place which had been created with the person. Medication to reduce any anxiety when the person reached the end of their life had also been prescribed. Staff were able to tell us about what they would need to consider and how they would engage with other health professionals to ensure people received the appropriate support at the end of their life. The registered manager was developing the end of life care planning processes further.

Good

Is the service well-led?

Our findings

Since our last inspection a new manager had been appointed and had registered with CQC. 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People spoke positively about the new registered manager and felt that Cams Ridge was managed well. One person said "I would talk directly to the manager, she is here all the time. I have never had to complain and I don't expect to" and a second person said "I am confident that if I raised any constructive suggestion it would be welcome. There is an atmosphere of 'can do'. They have a professional system of control that is reassuring". A relative told us "I am delighted with everything about the place; that must tell you something about the way the place is run. There is a kind of light touch efficiency, they have a systems approach that seems to work".

The registered manager understood the importance of valuing and involving staff and we could see this approach had worked and staff clearly felt involved and committed to the service. Two staff told us how the manager's door was always open now and it no longer felt like "Them and us". Staff said they felt very well supported and described the registered manager as approachable. Staff consistently told us the registered manager had really made a difference to the home, in a positive way. There was open communication about the service, people and staff were encouraged to engage and contribute ideas. Staff told us they were able to make any suggestions and were always listened to and this was evident in the meeting minutes we reviewed.

People, relatives, and visiting health and social care professionals were asked their views in relation to the quality of care on a regular basis. An annual survey was carried out with people, visitors and staff. The registered manager told us they were waiting for the results of these. However, the provider had also installed an immediate electronic feedback system that anyone could use at any time and that alerted the registered manager to feedback immediately. Of the two emails responses we reviewed, the quality of care was rated as 10 out of 10. The registered manager told us they planned to introduce a "You said, we did" board to share with people their feedback and the action taken. The provider also had a system in place to recognise achievements and improvements in services. Cams Ridge had recently won an internal award for 'Best Presentation' and as such had been nominated for the regional competition.

The registered manager engaged with other agencies and the local community. We saw positive working relationships with the local authority, clinical commissioning group, district nurses, GP's and other health professionals. In addition, the registered manager had made links with local schools and a football club to build community engagement which they said they wanted to build on further.

A number of local auditing systems including medicines audits, infection control audits, health and safety audits, care plan audits as well as other clinical audits such as weights and wounds were carried out. These

were all completed by either the registered manager or delegated to appropriate staff for completion. Clinical governance information was then entered onto the provider's central electronic system which enabled the senior management team to consider trends, patterns and any support the home may need. A central home development plan was in place which included any actions identified as a result of audits. For example, we saw entries included the need to ensure all care records were up to date and individualised which the care plan audits completed by the registered manager had identified. Target dates for completion were included and the status was monitored. The regional manager also completed monthly audits and the provider's quality team undertook annual impact audits. The last impact audit recognised the improvement made in the service since the previous audit. The areas we found within our inspection that required improvement were mostly related to record keeping and had no impact on people. The audits had identified the need for these improvements; the registered manager and staff were aware of these and working hard to ensure all records were updated.

The registered manager was aware of other areas that they wanted to monitor more closely. For example, they had requested a new call bell system be implemented to enable them to more closely monitor staff response times to people and use this information to analyse the staffing levels needed. They said the provider had agreed to budget for this change next year.