Denestar Limited

Ivanhoe Residential

Inspection report

Ivanhoe Care Home
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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 unannounced inspection was carried out on 28 June and 3 July 2018.

Ivanhoe Residential provides residential care for up to 26 older people, some of whom may be living with dementia. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. At the time of this inspection 20 people were living at the service.

The management of the home had changed since our last inspection. The new manager had registered with the CQC in June 2018. A registered manager is a person who has registered with the CQC 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.

At our last inspection in February 2016, we rated the service as good overall. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People received their medicines safely and on time from staff who were trained to manage medicines safely. Risks associated with people's care and support were assessed, reviewed and managed well. People were protected from the risk of infection, and staff understood the importance of infection prevention and control.

People told us they felt safe. Support staff were able to confidently explain the process for reporting any suspected abuse. Staff and people told us they felt happy to raise any concerns they had.

There were enough suitably recruited and trained staff on duty to provide people with safe care and support when they needed it. Staff felt supported in their role and received regular supervisions.
We found 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's needs were assessed and staff and other healthcare professionals worked together to ensure good outcomes for people. People were supported to eat and drink sufficient amounts to maintain good health.

The culture of the service was person centred. People were supported by staff to express their views where they were able to, and have choice over their day to day care. People were seen to be treated with respect, kindness and compassion. People's diversity and dignity was respected and promoted at the service.

We saw staff cared about the people they supported, were knowledgeable about people and had formed positive relationships with them. People's care plans were detailed and contained information individual to the person.

Confidential information was stored in line with the Data Protection Act, and information was provided to people in a format that met their needs.

Systems and processes were in place to support people should they need to raise a complaint. People living at the service felt confident the registered manager would address any concerns appropriately.

Staff spoke highly of the registered manager and the culture they promoted. Staff told us they felt happy speaking to the registered manager if they had any concerns and felt they would be listened to.

Quality assurance systems were in place to assess and monitor the quality of service people received and identified any areas that required improvement.

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.

Infection control procedures were in place.

Risk assessments were completed with associated actions to ensure people were always protected from avoidable harm.

People received their medicines safely.

Safeguarding processes were in place and people told us they felt safe living at the home. Staff were safely recruited and sufficient staff were deployed to meet people's needs.

Is the service effective?

Good

The service remained good.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained good.

Is the service well-led?

Good

The service remained good.

Ivanhoe Residential

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.

Inspection site visit activity started on 28 June and ended on 3 July 2018 and was unannounced on the first day. The inspection was undertaken by one inspector on day one and two inspectors on day two. It included visiting the service and speaking with people living at the service, visitors, the registered manager and staff.

Before the inspection, we reviewed the information available to us about the service. For example, the notifications that they had sent us. A notification is information about important events, which the provider is required to send us by law. We also asked the local authority safeguarding and quality assurance teams for their views about the service. We did not ask the provider to send us a 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.

During the inspection we spoke with five people who used the service and one visiting relative. We also observed interactions between people and staff in communal areas of the home. We spoke with seven members of staff, including the registered manager, operations director, deputy manager, and four care staff. We spoke with the provider and two visiting healthcare professionals.

We checked five people's care records which included pre-admission assessments, care plans and risk assessments. We reviewed documents relating to the assessment of mental capacity and Deprivation of Liberty Safeguards (DoLS). We checked the management and administration of people's medicines. We looked at recruitment records for three staff, staff training and supervision records, complaints, accident and incident records, maintenance records and reviewed the provider's quality assurance systems.

Good

Is the service safe?

Our findings

At the last inspection we found there were some areas of the environment and practice that could have been improved in relation to good infection prevention and control. At this inspection the registered manager told us and records confirmed that a weekly infection control audit had been implemented which included checks of hoists, commodes, mattresses, laundry room and toilets. Cleaning records were completed daily and we saw records relating to checks of toilets, bathrooms and storage of people's bed linen. The registered manager completed a 'daily walk around' of the service and we saw part of the morning criteria included checking all communal areas were clean and tidy such as bathrooms and toilets. These fed into a daily/weekly monitoring system which highlighted any shortfalls found and actions taken.

We completed a walk around the service at the start of our inspection on the first day. The environment was clean, tidy and odour free. Two storage baskets in a downstairs bathroom were found to contain two used hair combs. Two bedrooms we looked in had small amounts of staining on the bottom sheets of the beds. We brought these minor concerns to the attention of the registered manager who took action; removing the items from the bathroom and purchasing new bed linen for people's beds.

Suitable systems were in place to safely order, administer and dispose of people's medicines. Medicines were stored safely in locked steel cabinets, and the temperature of the medicine room and fridge were taken regularly. Accurate records were kept when medicines were received, administered and returned to the pharmacy. There were audit systems in place to ensure the medicines were being stored and given to people correctly.

People we spoke with told us that they felt safe living in their home. One person told us, "I feel safe with the atmosphere and the girls [staff] are very good to me and do what I want them to do. I would speak with the staff if I was worried. I look at it like this if I wasn't happy I would open my mouth and tell them." Another told us, "I feel safe, I get on really well with everyone."

We looked into the safeguarding systems within the service and found safeguarding concerns were being recorded and analysed with actions and the outcome. Staff were able to tell us the different types of abuse and were able to explain confidently how they would report alleged abuse. One member of staff told us, "If I saw bad practice or any incident I would go to my senior, the management or CQC and report it."

At the last inspection we found there were times when there was insufficient staff on duty, mainly at tea-time at the weekend. At this inspection people and staff told us overall they felt there were enough staff to care for them safely. Comments from people included, "I have a call bell and they [staff] check on me during the night" and "I think they come quickly enough when I press my bell." Another person gave us a contrasting view about the levels of staff, they said, "I have a buzzer [call bell], I have to wait and sometimes they [staff] forget to come." We fed this back to the registered manager to follow up. A member of staff commented, "Staff have increased. Standards are a lot higher now." A relative told us, "Staff levels have improved. Some have left and staff have changed for the better. There are more of them. Maybe four or more of them [on shift]."

We noted that on both days of this inspection visit there were enough care staff on duty. The operations director told us and records confirmed that they had accurately established and reviewed how many care staff needed to be on duty. This involved taking into account the number of people living in the service and the level of care each person required. Since the last inspection an additional staff member had been deployed between one and eight PM seven days a week. Records showed that sufficient care staff had been deployed in the service during the two weeks preceding the first day of this inspection.

Staff were recruited safely and the files we observed contained all of the required checks. This included employment history and references. All DBS requirements were in place. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Risks to people were assessed and their safety monitored. People received support with the management of skin integrity, falls, eating and drinking and moving and handling. All staff were trained in moving and handling people safely and we saw staff used equipment to transfer people. Staff we spoke with understood whether people needed the support of one or two staff members. For example, if they needed moving equipment such a hoist, that would require two staff. One told us, "People have to be assessed [for equipment]. There has to be two of us and we make checks and position people safely, for example, making sure their legs are safe and that the sling is not on their neck." A healthcare professional said, "I visit one person who had a pressure sore on their back. We advised a memory foam pad for the back of their chair. We popped in today to see how this was working and found they have the pad on the chair. Staff have been very good."

Accidents and incidents were recorded and actions taken to reduce future risks of injury. All accidents/incidents were logged and reviewed each month. For example, one person had sustained a skin tear to their leg. Actions were taken, medical advice and district nurse support was sought and this had been reported to the local authority for investigation. This meant that patterns or trends were identified and actions taken where needed.

We checked the systems in place to protect people in the event of an emergency. We found that personal emergency evacuation plans (PEEPs) were in place for all people who used the service and were kept in a 'red emergency pack' along with the business contingency plan located near the front door the service. This meant the information available for staff and the emergency services was up to date and available in the event of the building needing to be evacuated. There were three monthly fire drills, weekly internal checks of bedrails, the fire alarm system, water temperatures and legionella, and daily checks of the nurse call system. We saw equipment had been serviced according to the manufacturer's instructions. We reviewed servicing certificates which were in date for gas, electrical installation, hoists, the passenger lift, portable electrical equipment and fire alarm systems. A fire risk assessment was in place.

Good

Is the service effective?

Our findings

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 we spoke with understood the MCA legislation and how people required support, and the importance of obtaining people's consent. They could confidently explain to us what it meant to obtain a person's consent. One told us, "We carry a card with the five principles [of the MCA] on. Sometimes I will refer to them. For example, one person doesn't talk but uses facial expression. I will know if they are happy [for me to help] as they will smile." Another said, "We always assume capacity until proven otherwise. I ask people if they would like me to help, what they want to eat, drink and wear." We observed staff explaining what they were doing before they undertook care tasks such as assisting people to use the bathrooms and supporting to eat and drink.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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 and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had policies and procedures in place and staff had received training on the MCA and DoLS. The registered manager had made applications to the supervisory body where they had identified this was required. They used a tracking sheet to monitor when applications had been made and when the authorisations expired. People's mental capacity had been assessed and DoLS had been applied for when required.

People's mental capacity had been assessed for some decisions. Where people were found to be unable to make decisions for themselves a best interest process had been followed. This was in line with the MCA code of practice. We found information to record who had attended the best interest meeting and their input was not always consistently recorded for all decisions. For example, when specific decisions had been made for the use of bedrails, documentation was not always in place which showed how the decisions had been reached and who was involved. The provider told us they would review this practice to ensure records of individuals involvement in best interest meetings was robustly recorded. After this inspection we were provided with evidence to show the correct procedures following the MCA had been recorded for five people who had bed rails in place.

Staff we spoke with told us they worked well together, communication was good, and that they were kept up to date with training. Comments included, "Before [Name of manager] started I was on the verge of leaving. Since [manager] has been here you can talk to them. They have created a daily routine plan which gives us our responsibilities", "Staff morale is better. Teams are better and the staff are happier" and "My

training since the new manager started is good. You can ask for it [training] and [Name of manager] will get it for you."

We saw that staff were receiving regular training which included safeguarding, medicines (where required), moving and handling, food hygiene, infection control, deprivation of liberty, mental capacity and fire safety. We saw some gaps in the providers training plan for equality and diversity, dementia and end of life care. The operations director told us this training would be updated with staff completing on-line training as required.

New staff completed an induction which included receiving a staff and operational handbook. Staff also signed to confirm they had reviewed the service policies including equality and diversity, confidentiality, supervisions, training and whistle-blowing. Staff told us and records confirmed they received supervision to discuss their training and development.

Overall people we spoke with were happy about the quality of the food at the home. One person said, "The food is fantastic. They [staff] come round with a list every day for food [choices]. They will make you something else if you don't like it – they have done this for me before." Another told us, "I can eat okay. There are always choices. Like today at dinner time it was chicken but I didn't feel like eating it so I am having it for my tea." A third person said, "I can choose my food but I don't like it, it's always the same choices." We fed this back to the registered manager to follow up.

We observed the lunchtime meal on the first day of inspection. The majority of people ate in the dining room and some people chose to eat in their rooms. There was a menu in the entrance hall and people's nutritional and personal preferences were known by the cook preparing meals and staff serving meals at the home. The tables were laid with small vases and flowers and people had access to condiments. We saw staff asking people if they had enough or would they like more and did they need any assistance. The food served looked and smelt appetising. Food was covered, placed on trays and taken to people who chose to eat in their rooms. There were soft drinks available in the lounge and communal areas.

People's care plans gave information on their likes and dislikes, if they ate independently and specific diets. This was under the advice of a dietician or other healthcare professional. Staff we spoke with were aware what type of diet each person had such as pureed or soft. We also saw that people's weights were regularly monitored. This meant that people were given choices for their food preference and that any concerns around drinking, eating or weight loss were acted upon.

People's care needs were assessed to identify the support they required prior to them moving into the home. We saw these assessments covered people's physical abilities, communication, mental health and social care preferences and identified the support they may require from staff.

People told us and records confirmed that healthcare professionals were quickly involved if they needed them. Information we reviewed in people's care plans recorded the involvement of healthcare professionals and we saw that staff worked with other agencies to make sure people accessed other services when their needs had changed, or in emergency cases. One person said, "The other week I was poorly and they rang the doctor straight away." A relative told us, "[Name] hadn't been very well. They [staff] noticed a [illness] and got the doctor straight away."

We saw dementia signage to highlight areas of the home such as toilets and bathrooms. Toilet doors were yellow and seats were red. Dementia signage is specifically designed to aid comprehension for people with dementia using words, colour contrast and pictorial images to aid understanding. We saw the large lounge

contained a tactile activity board, jigsaws and a large clock which displayed the time and day of the week. There was a smaller lounge with comfortable seating, a well-stocked bookcase and a television. In the entrance hall photographs of the staff team were displayed. People's bedrooms were personalised to the persons taste. We saw people's bedrooms contained their own belongings such as televisions and tea making facilities.

Good

Is the service caring?

Our findings

Overall people spoke highly of the staff and a relative told us the staff were caring and their family member were treated with dignity and respect. They commented, "[Name's] personal care is better than I could give as [Name] wouldn't let me. [Name] is always clean, well-cared for and is not underweight. They even let [Name] stay for an extra week for free whilst we were waiting for the social worker to return off holiday. [Name] has had so much care and compassion. I see [staff] with their arms around [Name]." People living at the home told us, "I love it here. The staff couldn't be better" and "Staff are kind and caring. I have a good relationship with them." One person commented that they didn't feel staff always concentrated on them when supporting them with their care. We discussed this with the registered manager to follow up.

We saw one comment left by a person's relative that said, "The lovely dedication and care you showed to my wife. That care made visiting so pleasant and contented and we had lots of laughs together. I will always treasure that." A visiting healthcare professional said, "Every time I have been [to the home] and sometimes I have just popped in, staff are welcoming and people always look well cared for and clean."

Staff knew people well and people's preferences, likes and dislikes were recorded in their care plans. For example, we saw one member of staff enter a person's bedroom and began talking with ease to them about football. The person was smiling and laughing with the member of staff and clearly enjoyed this interaction about a subject they enjoyed. A relative told us their family member was very particular about how they liked their cup of tea. They said staff make their drink exactly how they liked it. This demonstrated that staff knew people's preferences well.

People were supported to maintain relationships with friends and family. A relative told us they could visit when they wanted and were always made to feel welcome at the home. People were supported by relatives and staff to participate in planning their care. Care plans had been signed to say that they had been agreed by the person or their relative. A relative told us, "I went through [Name's] care plan with [Name of manager]." One person said, "I have a care plan. There is lots of information in it. My son sorts it out for me."

Care plans reflected people's diversity and protected characteristics under the Equality Act. For example, care plans contained information on people's protected characteristics, significant relationships, religion, gender and communication. The staff we spoke with understood people's diverse needs and were able to give us examples of how they supported people who chose not to eat certain foods and required specific wash cloths for washing and drying during personal care. There were policies in place to help ensure staff were considering people's individualised needs in the delivery of care.

Staff encouraged people to be as independent as possible. People were supported to walk with their walking aids, and when eating and drinking. Staff did not hurry people giving them time to eat their meals or mobilise. We saw examples of staff interacting with people in a kind and patient manner. We observed one member of staff supporting a person who had become upset. The member of staff went and got the person their cardigan and a blanket. The member of staff helped the person on with their cardigan and wrapped them in the blanket. We saw the person became relaxed and fell to sleep.

People said staff maintained their privacy and dignity. One person told us, "They [staff] always knock on my door before they come in my room." People were supported to maintain their dignity in different ways. For example, whilst we were chatting with one person in their room a staff member knocked on the door and waited for the person to invite them in. During lunch we saw staff discreetly asking people if they would like to wear a clothes protector. We also heard staff ask people if they were ready to be assisted.

Staff spoke positively with us of the care they provided. They said, "People are looked after", "People are cared for and all seem content" and "I love this home. I come in early to help people to eat and drink. My loyalty is to the people who live here." A relative told us, "[I came one day] and someone had done [Name's] make-up and they looked lovely."

The registered manager had details of advocacy services that people could contact if they needed independent support to express their views or wishes about their lives, these were also available on the notice board in the service hall. Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities

We saw that any personal information relating to people or staff was stored securely in locked cabinets. Some documents were stored on computers which was password protected. The provider was aware of the new General Data Protection Regulation (GDPR). GDPR is new legislation which comes in effect in May 2018 and will give people more control over how their personal data is used. This meant the service was planning for change and ensuring they were working in line with the requirements for the change in legislation.

Good

Is the service responsive?

Our findings

People told us their choices and preferences were respected. One person said, "They [staff] always come and ask me what I want. If I want to stay in my room I can, or if not I can go downstairs." Another told us, "If you ask them they will do it for you." A relative commented, "They [staff] knew my [relative] loves Tom Jones and they downloaded this for her to watch."

We reviewed three peoples care records and found that each person had received an admission assessment prior to moving into the home. Care records contained care plans which were individualised to people's needs. The care plans described what help people needed with mobility, eating and drinking, emotional wellbeing, continence, personal care. Relevant healthcare professionals were involved where required. Some plans also included information in a 'memory book' on the person's background, family, hobbies and significant relationships. One person's memory book was blank. The registered manager told us they were currently working on transferring all care plans over to a new format. The deputy manager told us they were currently supporting the registered manager with updating peoples care plans. They said, "We have one person newly admitted and I am waiting for their family to meet with me to discuss the plan." We reviewed one person's care plan that had been transferred to the new format and saw this contained up to date, relevant information.

The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment, or sensory loss. All providers of NHS and publicly funded adult social care must follow the Accessible Information Standard. CQC have committed to look at the Accessible Information Standard at inspections of all services from 01 November 2017. The service was proactive in identifying and meeting the information and communication needs of people with disabilities and sensory loss. For example, people's individual communication needs were recorded as part of the service's care planning process which indicated people's ability and chosen way to communicate and any support they needed.

Staff gave us examples of how they enabled people to access information such as reading it to them and watching their facial expressions. One person had a visual impairment and we saw they had difficulty understanding the need to use their walking aid. The service had referred them to the falls team who had made some recommendations, one of which was for the person to have a hearing test. The person was awaiting a visit from a local sensory team to look at any further support that could be offered.

People's preferences and spiritual choices were recorded and highlighted in their care plans. The care records we reviewed included a 'client transfer form' which was designed so this could be taken with the person if they went to another care setting such as hospital so the hospital would also be aware of their preferred method of communicating, language used, religion and preferred name.

We saw people's care plans were updated regularly to reflect their changing needs. It was evident from the information held in them that people and their relatives had contributed to the plans. One person said, "I have a care plan in the office. They [staff] talk to me about the information. They would change this if I

wanted them to." A relative told us, "I went through [Name's] care plan with the manager." Staff we spoke with knew people very well and how they liked to be supported, staff described how they supported people and this was observed during the inspection. One member of staff commented, "Care plans are different to any have seen before. There is lots of detail."

People's end of life wishes had been recorded. Some people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form in place. A DNACPR is used when a medical professional and the person agree that resuscitation would be unsuccessful. The registered manager implemented a 'red dot system' on the second day of inspection. This consisted of a red dot placed on the side of each person's care plan which provided staff with a visual aid to identify quickly which people had current DNACPR's in place.

We received varying opinions from people when we asked if they had the opportunity to participate in activities. One person told us, "There are no activities. We see some entertainment maybe twice in a year." The person went on to say, "I have been out to the park across the road. [Name of staff] takes me in their own time. They are very good." Others said, "I like to do colouring", "I am able to go out" and "I am not sure when I last went out. I have been told we are having a garden party. We have a singer that comes in regular. I get a paper delivered every day and I enjoy watching property programmes."

The registered manager told us, and we saw that the member of staff who worked between one and eight PM each day supported people between the hours of two and four PM, to participate in activity if they chose to do so. A member of staff told us, "Activity has improved a lot. There is now someone on the rota in the afternoon for activity. The sweet cabinet we have is now full of sweets if people want them. Something happens every day. People have one to one time, go to the park, shops, have their nails done, do dancing and exercises."

During the first day of inspection we saw an external company visited to provide a taster exercise session to people at the home. Eight people took part in this and we saw they all were smiling and taking part with the exercises. Records of activity logs we reviewed from March 2018 onwards confirmed that people had taken part in activities which included watching movies, visiting the local park and shops, watching football games during the World Cup, pamper afternoons, armchair exercises and visiting music entertainers. People that chose to stay in their rooms were offered one to one activity such as balloon passing, chatting and having their nails painted.

People told us they knew how to make a complaint or raise a concern. One person said, "I would speak to [Name of registered manager]. They pop in and see me and ask what I think [of the service]." A relative told us, "The office door is always open. I would contact the manager if I had any issues." People and relatives we spoke with felt that their concerns would be dealt with appropriately. We saw there was information available to people, visitors and relatives which showed how to make a complaint. Staff told us they were always available to people and would discuss any concerns they had. There was a complaints policy in place and where a complaint had been received an investigation had been undertaken and an appropriate response given.

Good

Is the service well-led?

Our findings

The provider had in place a comprehensive quality assurance and auditing system. There was an annual system in place which continuously monitored and assessed the quality of the service delivered. This consisted of daily, weekly and monthly checks of areas of the service which included infection control systems, medicines, nutrition and hydration, safety and maintenance of the environment, activity, effective recording, kitchen, appearance of people's rooms, safeguarding, accidents/incidents, staff files and training. At the end of each year a business plan was drawn up with five objectives which mirrored the CQC domains of safe, effective, caring, responsive and well led. Each objective set out who was responsible, the timescale for achieving the objective and what criteria was required to be successful.

The documentation we reviewed showed that management and staff took steps to action any issues highlighted in the monitoring systems and put measures in place to address these in a timely manner. Examples included where faults had been found with the nurse call system and people's equipment such as wheelchairs, these had been actioned swiftly to keep people as safe as they could be.

There was a registered manager in post who promoted a positive, supportive and inclusive culture within the service. The registered manager had many years of experience working in the social care sector. In discussions with us they were very confident of the provider's vision of the type of care they wanted to deliver and the culture they wanted in the service. They told us, "The companies vision is to provide high quality care. We have a very in-depth structure of quality assurance. I see the culture of [Name of service] as support, support, support. There is openness, guidance and a hands-on approach." During both days of this inspection the registered manager was regularly seen around the service, stopping to say hello and offering assistance if people required this.

All of the people, staff and visitors we spoke with were positive about the registered manager at the service. Feedback we received included, "They [manager] always come and ask if I am okay", "[Managers'] door is always open, they are lovely", "What I have seen of [manager] I think they are very responsible and quick to act. First and foremost, the residents are put first" and "[Name of manager] manages the service really well. They know how to speak to people and are really good."

People were asked for their feedback about the service in questionnaires, meetings and by the staff in general conversation. There was a suggestions box in the entrance for people, relatives and staff to leave anonymous feedback. Staff told us they felt supported and part of a team with the people using the service as their main focus. Comments included, "This [the service] is a really nice place now. We have meetings [where we talk about] expectations and we are asked for our views. They [managers] let us speak", "[Name of registered manager] has put some stability in the home. We are asked to attend team meetings and they are regular. I have seen a marked improvements since [Name of registered manager] started. There is lots of nice new furniture and they are very on the ball with cleanliness" and "It's nice to be praised which happens."

The registered manager understood their legal responsibilities and appropriate notifications had been

made to the Care Quality Commission (CQC). The rating from the last inspection was displayed both in the service and on the providers website in line with our requirements.

There was a network of support for the registered manager which included a deputy manager, care team managers, team leaders, care staff, housekeepers and catering staff. The registered manager spoke positively about the support they received from their managers. We spoke with the provider and operations director who had a shared vision of the culture within the service and told us they had regular contact with the registered manager.

The registered manager and staff team worked in positive partnership with other agencies to support care provision so that people living at the service received effective care. For example, occupational therapists were visiting a person during the first day of inspection. There was also clear correspondence and outcomes in people's care records from a variety of healthcare professionals.