Corner House Care Limited

Millard House

Inspection report

Church Street
Bocking
Braintree
Essex
CM7 5LL

Tel: 07748903235

Date of inspection visit:
08 July 2016

Date of publication:
19 September 2016

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

Millard House is a residential care home providing personal care and accommodation for up to 43 older people, some of whom were living with a diagnosis of dementia. At the time of our inspection there were 32 people living in the service.

Our inspection was unannounced and took place on 8 July 2016. The service was last inspected on 12 August 2014 and we found the provider was meeting the regulations. The service had recently been taken over by a new provider and this was the first inspection of the home under the new leadership.

The service is spread across two floors. Some bedrooms were located on the ground floor but a majority were situated on the upper floor and accessed via stairs or a passenger lift. The service had two double rooms. On the day of the inspection one was being used as a single occupancy and the other was empty. There were several communal areas including a dining room and a quiet lounge area where people could sit and listen to music. People had access to a pleasant outside courtyard area within the grounds. A day centre was also located within the service and we saw that people living in the home were able to attend activities and eat their meals there if they chose to.

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

People were kept safe and protected from harm by staff who had a good understanding of what action to take if they suspected someone was being abused or mistreated. Accidents and incidents were monitored to identify themes and to help prevent any reoccurrence. There were sufficient numbers of experienced and caring staff to support people. Risks to people had been assessed and measures were taken to prevent avoidable harm and to help ensure their freedom was supported and respected.

Staff received training which enabled them to meet the needs of the people they cared for and provided them with continued personal development. Relatives were complimentary about the effectiveness of the care and many told us they had seen improvements in their family member's well-being since moving into the service.

The service had safe systems in place to ensure that appropriate recruitment checks had been carried out on staff before they were employed. This determined that new employees were suitable to work with the people living at the service. Staff received annual appraisals and supervision, which provided opportunities to discuss and monitor their performance and training needs.

There were robust measures in place to support people to take their prescribed medicines safely and staff competencies were maintained through annual training, spot checks and observations.

The environment was monitored and assessed to help ensure it was safe for people to live in.

The registered manager and staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS are in place to protect the rights of adults by ensuring that if there is a need for restrictions on their freedom and liberty these are assessed and decided by appropriately trained professionals. People's best interests had been considered when decisions that affected them were made and applications for DoLS authorisations had been submitted where restrictions were imposed upon people to keep them safe.

People were offered a varied diet and could have alternatives to the menu if they chose. Where necessary, staff assisted people with eating and drinking. Systems were in place for staff to monitor people's nutrition and hydration with action being taking when concerns were identified. Staff ensured that people's health needs were effectively monitored. They supported people to access a range of health care services to maintain and improve their health and wellbeing.

Staff knew the people they supported and provided care in a consistent way. We saw that staff approached people in a friendly and respectful way and relatives said that staff were kind and patient when providing support. People were given choices in their daily routines and staff supported people to make day to day decisions which enabled them to remain as independent as possible. We saw people being treated with dignity and respect at all times.

People and their loved ones, where able, were involved in the planning and reviewing of how they received their care.

People knew how to complain and felt confident their concerns would be listened to and people's complaints were valued and used to improve the service.

People and their relatives were very complimentary of how the service was managed. The registered manager demonstrated strong leadership and expected high standards. Systems were in place to check the quality of the service and take the views and concerns of people and their relatives into account to make improvements to the service. There were strong links with the community to help people continue to be part of the local area.

Notifications were sent to us as required, so that we could be aware of how any incidents had been responded to.

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.

Staff understood how to safeguard people from abuse and knew how to report possible abuse or concerns about a person's safety.

Risks associated with people's care were managed to help ensure their freedom was supported and respected.

Staff had been recruited safely with appropriate pre-employment safety checks.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had a good understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards and how these impacted upon people.

People were given support to ensure their hydration and nutritional needs were met.

People's health was monitored by the staff and there was access to healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff were kind and patient.

People were given choices in their daily routines and staff supported people to make day to day decisions which enabled them to remain as independent as possible.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and reflected people's preferences, choices and personal histories.

There were organised activities for people if they wanted to take part.

The provider had a complaints procedure in place and people told us they knew how to make a complaint.

Is the service well-led?

Good

The service was well led.

The registered manager carried out quality assurance checks regularly in order to develop and improve the service.

People, their relatives and staff were positive about the management of the home.

Millard House

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 8 July 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On this occasion their area of expertise was in dementia care.

Before the inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us and previous inspection reports. A notification is information about important events, which the service is required to send us by law.

During the inspection we focused on speaking with people who used the service and the staff who cared for them. We observed care and support in communal areas, and saw how people were supported during lunch. We spoke with people in private and looked at five care plans and associated care documentation. We looked at how medicine was managed, stored, administered and disposed of. We also looked at documentation relating to the management of the service including policies and procedures, staffing rotas covering the last six weeks, staff training records, a range of audits and the results of quality assurance surveys.

We spoke with six people who lived at the home, five visiting relatives, and eight care workers, two members of the catering team, the maintenance person and the deputy manager. We also spent time with the registered manager and toured the building looking at the safety and cleanliness of the environment. We also looked at two staff files to see whether staff had been recruited safely and looked at complaints and compliments received by the service.

Some people living at the Millard House could not easily give us their views and opinions about their care. To help us gain a better understanding of people's experiences of living in the service we used the Short

Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe. One person told us, "This is a nice place, staff are kind and I feel safe here." Some people were not able to fully communicate with us because they were living with dementia, but we spent time with some of those people, chatting with them. People appeared relaxed and content with staff and did not give any impression they were worried or fearful for their safety. A relative we spoke with told us they had confidence in the staff to keep their relative safe.

People were kept safe because staff had a good understanding of the different types of abuse and knew how to respond should they suspect someone was being abused, mistreated or neglected. One staff member told us about the training they received on how to safeguard people from harm. Another member of staff told us that they were aware of the whistleblowing and safeguarding procedures. They were confident that they could report any suspicions or concerns to the management of the service and these would be taken seriously and resolved. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. The manager also understood their role in safeguarding the people in their care and their responsibility with regard to reporting incidents in the service to the local authority and the CQC.

People were supported to manage risks to their safety whilst not restricting their freedom. Risks to individuals were assessed when they were admitted to the home and were regularly reviewed. The deputy manager informed us that they had recently assessed a person, but due to their particular needs and challenging behaviour they did not feel that the service would be appropriate for them. They explained to us that as well as the person's needs they had to consider the well-being and safety of the existing people using the service.

We found that people had detailed risk assessments in place to provide guidance and direction for staff about how to support people correctly and keep them as safe as possible. These included, risks related to mobility and falls, weight, nutrition, health and hygiene and the prevention of pressure areas. Where the risk assessments had identified people were at risk of pressure ulcer formation appropriate pressure relieving equipment had been provided and was in use.

The service had systems in place to monitor the incidence of falls, pressures ulcers and urinary tract infections (UTI) throughout the home. This enabled the manager to identify and take action if particular trends or occurrences were identified.

We saw the manager and other members of staff supporting and caring for people during the inspection who were confused as to time and place. People's care plans contained information for staff about how to settle people if they became distressed, this included providing reassurance, walking and talking with the person and offering them a drink. We saw staff putting this into action throughout the day.

On the day of the inspection there were sufficient staff on duty to keep people safe and protect them from harm. The manager told us that due to staff vacancies and maternity leave the service currently had a large

number of vacant hours. The shortfall in staffing was being covered with the use of well-known bank staff, plus occasional agency staff. The manager told us that they tried to use agency staff who were familiar with the service. We looked at the staffing rota for the past six weeks and saw that, despite the vacancies, the staffing was consistent across the day and night duty. The manager explained and we saw from the rota that the senior team had allocated them time to work directly with the staff supporting people with their needs. We saw that the manger had a recruitment plan in place. They told us that in the past they had found it difficult to recruit staff but that they were confident that with the support of the new owners they would be able to fill the current vacancies.

Within each care plan was a dependency assessment document used as a guide to calculate staffing levels. The manager told us that staffing levels were reviewed on a regular basis to ensure there was sufficient staff available to meet people's identified needs. Staff told us that although at times they were very busy they considered there were enough staff on duty to meet people's needs.

We found that staff were visible around the home. We saw that call bells were placed near to people's beds or chairs and that staff responded to people in a timely manner. The service had assessed that a person would not understand how to use their call bell to summon assistance. This identified risk had been recorded and the action was for staff to visit the person each hour when in their room to check upon how they were, we saw this put into action by staff during the inspection.

We looked at the policies and procedures of the previous provider for safeguarding and whistle-blowing. The policies and procedures to be used by the service from the new provider were being examined by the management team. Training was being arranged so that the staff would be aware of the new policies and procedures.

We looked at the recruitment files of two staff members. Safe recruitment and selection processes were followed. Files contained the relevant documentation required to enable the provider to make safe recruitment choices. Each file contained job descriptions and offer letters clearly stating the terms and conditions of employment, references, proof of identity and the relevant health checks for each member of staff. Prior to starting employment, new employees were also required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people.

Records we saw showed that new members of staff completed an induction program and were given support throughout their probationary period to discuss any issues or difficulties. The probationary period needed to be successfully completed before the staff member was confirmed as suitable for the post and their employment confirmed

The service had a policy and procedure for the administration of medicines and that the service completed monthly medication audits. We found that medicines were given appropriately and the recording of their administration was clear and concise. We looked at the medicine room based on the ground floor of the service. The room was kept locked at all times when not in use and the controlled drugs cabinet located within it, was also locked. We checked the medicines in the controlled drug cabinet and saw that the stock balances agreed with what had been recorded in the controlled drug book and also the medicine administration records (MAR). The temperatures of the room and fridge were checked daily so that they were within acceptable limits.

Each person had a medication profile with allergies listed. There were protocol in place for offering and administrating medicines given to the person as required (PRN). Staff told us that they had received training

on the administration of medicines and the controlled medicines were administered by two members of staff who had completed their training and had been assessed as competent to administer them. We looked at the MAR for seventeen people and found that these had been completed correctly, with no unexplained gaps. We saw that there were protocols in place for ordering medicines and for the return and disposal of any unused or unwanted medicines. On the day of the inspection the person designated to order medicines was working with the pharmacy to arrange medicines to be delivered to the service and return any medicines that were not required. The member of staff explained the system that was used to us. This included ensuring that the pharmacy signed to acknowledge for any medicines that were returned.

The environment was monitored and assessed to ensure it was safe for people to live in. There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency.

The manager undertook regular environmental audits and we saw action plans in place relating to issues that had been raised and resolved. A maintenance person was employed who maintained records that showed the regular monitoring and servicing of equipment and the environment including the fire alarm, emergency lighting and moving and handling equipment. All taps in the communal areas were fitted with Thermostatic Valve Controls and the water temperature was checked on a monthly basis and recorded as being within a safe range. Where appropriate the company used external contractors to audit and ensure they met the legal requirements to keep people safe. We saw a recent fire safety audit had been undertaken and that personal electrical appliance (PAT) testing had been carried out to ensure that electronic equipment was in safe working order.

Good

Is the service effective?

Our findings

People who lived at the home told us they received care appropriate to their needs. One person told us, "The staff look after all of us very well." A relative told us that they were very happy and that they were confident in the staff's ability to care for their family member. They told us, "We've been extremely pleased with everything." A member of staff informed us that they enjoyed working as part of a good team with clear care goals for each person. We listened to the handover of information from the early to the late shift. Explanations were given of what happened during the morning and what colleagues coming on duty needed to achieve for the on-going care of people at the service.

Staff had the skills and knowledge they needed to provide effective support to the people that they cared for. Staff told us that they had an induction before they worked on their own with people, which had included all elements of core training, such as safeguarding, moving and handling, fire safety and infection control. Training records confirmed that on-going training such as dementia care, diet and nutrition and falls awareness was planned to further develop and maintain their knowledge and skills.

An induction programme was in place for new members of staff. One member of staff told us about the training which included infection control and care of people with dementia. They also explained to us that part of the probationary period was working with and observing an experienced colleague before working on their own. We saw evidence that annual appraisals of staff performance had been completed or planned for all staff. Members of staff confirmed that they were supported by regular supervision and an annual appraisal. Some staff had completed additional training so that they became internal champions in that area. They used this responsibility to support staff colleagues with particular aspects of care delivery to people living at the service.

Some people who lived in the home were not able to make important decisions about their care and how they lived their daily lives. The manager understood her responsibilities under the Mental Capacity Act 2005, (MCA) and around protecting people's rights. The 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).

Staff had completed training in respect of the MCA and DoLS and further refresher training was planned for staff this year. The staff we spoke with understood their responsibilities to ensure people were given choices about how they wished to live their lives. Where people did not have the capacity to consent themselves we saw that the service had operated in line with the requirements of the MCA. We saw that some people had appropriate DoLS in place and we did not see any restrictive practices for those who did not.

Where people lacked capacity, the care plans showed that relevant people, such as their relatives or an

appropriate health or social care professional had been involved in making decisions about their care. Any decision made on behalf of a person was done in their best interest and the least restrictive option was chosen. The manager had completed a number of DoLS referrals to the local authority in accordance with new guidance to ensure that restrictions on people's ability to leave the home were appropriate.

If people had appointed someone as their Lasting Power of Attorney (LPA), who this was and in what capacity was clearly documented in their care plans. An LPA is a legal document that allows someone to appoint one or more people to help them make decisions or to make decisions on their behalf.

We saw that staff consistently asked people for their consent before providing care and treatment.

People were supported to have a balanced diet and could have alternatives to the menu if they wished. For example one person did not like the options for that day and we saw that they had chosen something that was not on the menu.

At lunch time we observed staff supporting and encouraging people in a patient and appropriate manner. People could choose where they ate their meals, a majority of people sat at dining tables in the main dining area but other people chose to eat in their rooms or in the lounge areas. People were provided with assistive products such as plate guards to enable them to remain as independent as possible at meal times and condiments and drinks were available on the tables. We saw that staff gave people the time to eat at their own pace and that people with specific dietary requirements, such as pureed meals, had their needs met appropriately.

Nutritional assessments had been completed and where people were found to be at risk of not taking enough food or drink, appropriate measures were put in place to support them. Where necessary staff supported people with their food or prompted them to eat. One person ate only a little of the food on their plate before they stopped eating, we saw a member of staff gently encouraging them to eat and they began to eat again. This happened on several occasions throughout the meal and each time they stopped eating the member of staff gently encouraged them to eat a little more. At the end of the meal they had eaten a majority of the food on their plate.

Systems were in place to monitor people's weight and fluid intake and where there was cause for concern appropriate measures were taken to manage this including referring people to the dietician and Speech and Language Therapist (SLT).

People's healthcare needs were monitored effectively and people said they were supported to obtain treatment if they needed it. Relatives we spoke with told us that staff worked well with health professionals to ensure their relations got the best and most appropriate care. A relative told us,. "I am kept informed of all appointments and the outcomes." We saw that in each care plan a diary of visits from healthcare professional was completed after their visit. Further information regarding the work of the professional was recorded in the plan. People's care records showed that their day to day health needs were being met and that people, where appropriate, had access to the healthcare professionals including the optician, dentist, chiropodist and GP. We saw evidence that when necessary people were referred to specialist healthcare professionals such as physiotherapists, respiratory nurses and the hospice. There was evidence that district nurses visited the service where people had developed nursing needs, such as wound care and diabetes. Records showed that people were supported to attend hospital and other healthcare professional's appointments away from the service.

Good

Is the service caring?

Our findings

The people that we spoke with were happy with all aspects of their care. They said staff were kind, friendly and helpful. We saw that when staff spoke with people they were polite and courteous. Relatives were complimentary about how staff treated their family members. One relative told us that they always found staff to be, "Bright, cheerful and positive." Another relative said, "The staff know [my relative] and provide good care."

Relatives told us that staff recognised the importance of encouraging people to maintain their independence and supported people in a way that promoted this. We saw staff encourage people to do things for themselves where possible to promote their independence. For example, staff encouraged people to mobilise as independently as possible and supported them to do this.

We saw interactions between people and members of staff that were caring and supportive which demonstrated that staff listened to people. Staff interacted with people in a relaxed and caring manner. We found staff spoke to people in a kind tone of voice and used effective communication skills such as establishing eye contact with people before speaking with them. We saw members of staff taking the time to sit with people and chat to them.

Care plans were personalised and contained detailed information which enabled staff to provide care for people in the way in which they chose. Within each plan there was detailed history of the person. The plan identified people's needs and their preferences of how they wished their care to be provided, including how they liked to dress, hobbies and interests and what they liked to eat and drink. One relative told us that their loved one no longer had the capacity to make decisions for themselves. They went on to tell us how when staff assisted them with personal care they supported them to choose what to wear and how important it had been to family members that they still looked like "themselves".

We saw that the care plans were reviewed regularly by members of staff so that they were up to date and accurate. Although the service did not always formally meet with people and their relatives to review care plans, people and their relatives told us that they felt that staff kept them well informed and included them in any discussions about changes to the provision of their care. One relative remembered helping to write the initial care plan for their loved one and they felt that they were kept regularly informed of any developments but they could not recall a face to face meeting with their relative and staff to review the care.

During our visit the manager and deputy manager were visible around the home and people who lived at the home and their relatives clearly knew who they were.

People told us they were involved in managing their daily care and that staff respected their privacy and dignity. Throughout our inspection we saw staff knocked on the doors to people's rooms and communal bathrooms and always waited for permission from people before they entered. On one occasion we observed a, a member of staff attending to a person in their room who had pressed their buzzer, they knocked on the door, and when the person invited them in they entered the room. When they had attended

to the person they left the room and stood along the corridor, the member of staff said, "[They] normally buzz a couple of times so we wait here for a few minutes to make sure that everything is ok."

Staff were well supported by the local hospice to care for people who chose Millard House as their preferred place of care. We saw that peoples care plans contained clear information for staff about people's wishes and how and where they wanted to be cared for at the end of their life.

Good

Is the service responsive?

Our findings

People who lived at the home received personalised care from staff who understood their needs. A relative told us, "They are superb and they support the family as well."

The people who lived in the home had a wide range of different needs; the care plans in place were person-centred and provided clear information for staff about how to provide care and support in accordance with the persons expressed wishes. The care plans we viewed gave good accounts of the daily issues people faced. The different aspects of care for each person was recorded, clearly covering areas such as how to support someone with their personal care or communicating well with them.

People's needs had been assessed before they moved in to ensure that the staff could provide the care and treatment they needed. Pre-admission assessments recorded people's needs in areas including health, mobility, communication and nutrition and hydration. Assessments included a section entitled "Getting to know you," this explored and recorded aspects of people's lives that were important to them, such as relationships, interests and hobbies. One person described themselves as a quiet person who enjoyed reading and we saw them sitting in the quiet lounge reading a book in "their favourite chair."

Where needs had been identified through the assessment process, a care plan had been developed to address them. Care plans were in place for areas including communication, nutrition, personal hygiene, skin integrity, continence and mobility. We looked at the records of people who had difficulty in maintaining their skin integrity and people who had a chronic illness such as diabetes. We found the documentation was effective as they had enough detail to inform staff of ways to respond to any complications. Some people had pre-existing medical conditions that placed them at a higher risk of developing chest and urine infections. Their care plans contained information for staff detailing symptoms that the person may display if they were developing an infection and clear instructions outlining what action to take and how to care for the person. One relative described staff as being, "Really on top of things," when managing their family members skin integrity. They went onto tell us that their relative was at a high risk of developing pressure sores but that since they had moved into the service they had not experienced any problems with managing pressure areas.

There were several communal lounge areas throughout the service. The main lounge area had a television in it but this was not a strong focus in the home. There was also a "men's lounge" where people gathered to watch sporting events and a "music lounge" for people who wanted a quieter area, it had music playing but there was no television. There was also a quiet lounge located on the first floor which relatives told us was used by families as a quiet area when they visited. We saw that throughout the day people moved freely between the rooms. We saw that some people chose to remain in their rooms or not to participate in organised activities. Throughout the home there were books, newspapers and puzzles available for people to use if they chose.

The service employed two activity co-ordinators. On the day of the inspection one of the co-ordinators was on annual leave and the other was based in the day centre which was located within the service. People

living in the service had the choice to attend the organised activities taking place at the day centre if they wished and we saw that two people chose to do this. We observed a word game that was taking place, the member of staff leading the game introduced it by saying, "OK, this is our brain game!" They ensured that everyone in the room was engaged in the game and called out words to prompt people with answers if necessary. It was clear that people enjoyed the game and the social interaction that it produced, at one time, the room spontaneously started singing and humming a tune to one of the answers called out.

The activities coordinator told us that there was no allocated budget to fund activities. External events such as singers and entertainers were funded from the profit raised from an annual fete that the staff organised. We looked at the activities bookings diary and saw that music events had been arranged on a regular basis.

People had access to a well maintained courtyard area, where there was a seated area and shade provided by parasols. On the day of the inspection we did not observe anyone using this area but staff, people and relatives told us that it was usually well used by people. The manager told us that the raised beds and plants had been planted by people living in the service.

There was a garden centre with a café in it located next to the service. Staff, people and relatives told us that this was regularly used by people and we saw people visiting it with their relatives on the day of the inspection. The manager had developed links with the local community. They told us that the local primary school choir visited to sing to people and that the service had recently received a donation from a recently held village fete.

In the main corridor there was a notice board entitled, "You said-we did." It displayed suggestions that people had made to improve the service during relatives meetings and what action the service had taken to implement their ideas. We also saw that photographs of people enjoying activities, activities timetables and weekly menus were on display long the corridors.

The people we spoke with told us that they knew how to raise any concerns or complaints, but none of them had needed to. Relatives we spoke with told us any issues they raised with the staff were always dealt with quickly and to their satisfaction. The service had a complaints procedure in place. We looked at the complaints log and found that, whilst there were very few complaints received, they had been investigated and responded to appropriately.

Good

Is the service well-led?

Our findings

Relatives told us the service was well run and that they had confidence in the registered manager. Throughout our visit the manager was visible around the service. We observed the manager interacting with people on a regular basis and it was evident that they had a good rapport with people. The manager told us, "I have a great relationship with the relatives and always have had. I have an open door policy. If they want me they know where to find me. And if I'm not in here they'll come and find me out on the floor."

Everyone that we spoke with described the manager as supportive and approachable. One relative told us, "She's fantastic!" They went on to tell us how the manager had supported them during a difficult discussion with their loved one, about their DNAR status. They told us that the manager had been able to reassure the person and explain it in a way which was not upsetting for the person or the family.

The manager's office was located at the main entrance of the home, this meant that she could see people coming and going and was visible and accessible to talk to people who lived in the home and their relatives. The manager told us that by maintaining regular communication with people and their relatives they felt that they were able to avoid complaints by encouraging people to raise concerns before their dissatisfaction escalated.

On the day of the inspection we saw people, relatives and staff regularly popping in and out of her office. One relative told us, "She really sorts out the ship. If people are fretful she will sit with people, take them out for a walk, do whatever to settle them."

Throughout our inspection we observed staff working well together and they promoted an inclusive environment. Staff supported each other and it was evident that an effective team spirit had been developed. The minutes of staff meetings showed that they took place on a monthly basis and gave staff an opportunity to meet and discuss issues around the service.

People and their relatives were able to voice their opinions at residents and relatives meetings, which were held regularly. We checked the minutes of these meetings and found any issues raised were revisited at future meetings to ensure action had been taken to resolve them. Relatives also approached the manager individually on a regular informal basis. The manager was confident that any issues of concern were raised and dealt with to the satisfaction of both people who lived in the home and their relatives

The home had recently been brought by new owners. We saw that the manager had arranged regular meetings with people living in the service, relatives and staff to keep them informed about the process. We saw minutes from a resident and families meeting which had taken place on the evening before the inspection during which the new owners had been present and had answered questions from people living in the service and their relatives. Everyone that we spoke with was very complementary about how the changes had been managed and the support that the manager had provided during this time. The manager was extremely positive about the future of the service and the opportunities that the change in ownership had brought with it and it was clear that they had conveyed this to the staff and people living in the service.

One of the new owners was present at the service on the day of the inspection and shared with us some of the future plans that they had for the service, including recruiting permanent staff to reduce the reliance upon agency staff and to improve the décor of the home. The manager told us that the owners visited the service two to three times a week and that she felt well supported by them, she told us, "I really feel like we are all on the same page."

The registered manager had implemented effective systems to monitor and improve the quality of the service. Regular audits were carried out which checked key areas of service delivery, such as accidents and incidents, medicines management and infection control. A report of each audit was produced and the actions taken where areas had been identified for improvement. For example, during an infection control audit hoist slings had been found in bathroom, in response to this the slings had been removed and laundered. On another occasion the audit had found that some of the dining room chairs had rips and tears in them, we saw evidence that new dining room chairs had been ordered.

The management team were aware of their responsibility for reporting significant events to the Care Quality Commission (CQC). We used this information to monitor the service and ensure they respond appropriately to keep people safe. Records relating to people's care were accurate, up to date and stored appropriately. Staff maintained daily records for each person, which provided information about the care they received their health and the medicines they took.