Salisbury Care Limited

Aaron Court Care Home

Inspection report

328 Pinhoe Road
Exeter
Devon
EX4 8AS

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24 May 2017

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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 was unannounced and took place on 23 May 2017. The previous inspection of the home was carried out on 7 and 11 January 2016 where we found breaches of regulations. These related to safe care and treatment and safeguarding service users from abuse and improper treatment. The service was rated as 'requires improvement' and the provider was required to submit an action plan explaining what they were doing to meet the legal requirement to improve the service. We carried out this inspection on 23 May 2017 to check whether these improvements had been made and rated the service 'good'.

Aaron Court is registered to provide accommodation for 24 people who require personal care. At the time of the inspection there were 20 people living at the home.

There is 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.

The registered manager had kept us informed about progress towards achieving the provider's action plan, and we found some improvements in the areas requiring improvement since the last inspection. However, we also identified some areas for further improvement. At the last inspection in January 2016 we found people's rights were not always protected under the Mental Capacity Act 2005 (MCA). Staff did not have an understanding of the MCA or how the principles applied to their practice. People's capacity to make particular decisions had not always been assessed and documented, or a best interest process followed. In addition, people had not been referred for assessment under the Deprivation of Liberty Safeguards (DoLS). This meant, at that time, they were potentially being deprived of their liberty to receive care and treatment without being assessed to determine if this was in their best interests and legally authorised under the MCA.

At this inspection in May 2017 we found applications had been made for people to be cared for under DoLS where appropriate. Staff understanding of the MCA had improved significantly following training, and records showed that people's capacity had been assessed and decisions made in their best interest where appropriate. However, we found further learning was required regarding the protection of people's legal rights when they did not have capacity to consent to the use of a pressure pad to alert staff of their movements, for example if they were at risk of falls. Although the use of a pressure alert pad is a measure to keep people safe it is seen as a restriction of people's free movement and requires a best interest decision making process. We have made a recommendation that the service seeks support and further training to enable them to consolidate and build on their knowledge of the MCA and ensure people's legal rights are fully protected.

At the last inspection we identified that risk assessments, care plans and reviews were not up to date, which meant staff did not have access to accurate written information about potential risks or the actions they must take to reduce those risks. At this inspection we found improvements had been made and there were

systems in place to ensure risk assessments, care plans and reviews were comprehensive, current, and supported staff to provide safe care. Care plans were reviewed every week by the person and their keyworker, and formally once a month. However, relatives had not always been involved in the formal reviews of their family member's care plan, although the service kept them informed about the welfare of their family member. We discussed this with the registered manager, who, by the second day of the inspection had written to all relatives inviting them "to be more involved in the care planning process" if they wished.

When we inspected in January 2016 we found people did not have individual fire risk assessments or a personal emergency evacuation plan (PEEP) to show what support they would need in the event of a fire or other emergency. At this inspection we found emergency plans were now in place and reviewed monthly which meant they remained accurate if people's needs changed.

There was a committed staff team at the home which was well supported by managers and the providers. An induction and training programme was in place to support them to do their jobs effectively. Ongoing professional development was encouraged for all staff members. One member of staff told us, "There's enough training. I'm always quite happy to do it. It's good to have 'refreshers'". We identified that further steps could be taken by the registered manager and provider to ensure the service keeps up to date with best practice and developments in adult social care. We have made a recommendation that they seek further support and training in this respect from a reputable source.

The service had a quality assurance system to ensure they continued to meet people's needs safely and effectively, although further improvement was required to ensure people's legal rights were protected when restrictive practices were in place. People's views were actively sought and suggestions acted on.

People were supported by a caring staff team who knew them well. Staff spoke with great affection when they told us about the people they supported. One member of staff said, "I love to sit and talk to them, sing the old songs, do the knitting with them…I think we've got a special home".

People told us they felt safe and there were sufficient numbers of staff deployed to meet their needs. One person commented, "I feel safe – funnily almost too safe. From time to time I have to leave to go to medical appointments but I'm always so pleased to get back here". There was additional monitoring in place for people who found it difficult to use the call bell system, for example because they were living with dementia. People were protected from the risk of abuse through the provision of policies, procedures and staff training, and an effective recruitment process. Systems were in place to ensure people received their medicines safely.

People were supported to maintain good health and had access to healthcare services. People were referred appropriately and guidance followed. One health professional commented, "If the nurses highlight a concern or a problem, they tend to 'get on with it'. They listen to our concerns and take on board what we say".

People had sufficient to eat and drink and received a balanced diet, and care plans guided staff to provide the support they needed. They spoke positively about the food. Comments included, "We have two choices of meals. If we don't like either, they'll find us something else", "I have a choice about where I can eat my meals" and, "Lunch was lovely today".

Staff promoted people's independence and treated them with dignity and respect. People were supported to make choices about their day to day lives, for example how they wanted their care to be provided and

how they wanted to spend their time.

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's needs were assessed to ensure risks were identified and the risks were safely managed.

There were emergency plans in place so that people would be supported in the event of a fire or other emergency.

There were appropriate staffing levels to safely meet the needs of people who used the service.

There were effective systems in place to ensure people's medicines were managed safely.

Is the service effective?

Good

The service was not fully effective.

People's rights were protected because the service acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

People received effective care and support from staff with the experience, skills and knowledge to meet their needs.

People were effectively supported with nutrition and hydration.

People were supported to maintain their health and access healthcare services. Staff sought medical advice appropriately and followed it.

Is the service caring?

Good

The service was caring.

People were treated with kindness and dignity.

Staff were committed to promoting people's independence and supporting them to make choices.

The service provided effective care and support to people at the

end of their lives.

Is the service responsive?

Good

The service was responsive.

Care plans had been regularly reviewed with people to ensure they reflected their current needs.

People were able to take part in a range of social activities.

There was an effective complaints process which people were supported to use if necessary.

Is the service well-led?

Good

The service was well-led.

The provider and registered manager were committed to developing and improving the service for the benefit of people and staff working there.

The staffing structure gave clear lines of accountability and responsibility and staff received good support.

There was a quality assurance programme in place which monitored the quality and safety of the service provided to people, although further improvement was required to ensure people's legal rights were protected when restrictive practices were in place.

Aaron Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 23 May 2017 and was unannounced. It was carried out by one adult social care inspector and an expert-by-experience with expertise in the care of people with physical and mental health needs. 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 the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about), other enquiries from and about the provider, and other key information we hold about the service. We looked at the information in the Provider Information Return (PIR) completed by the registered manager prior to the inspection. 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 looked at a range of records related to the running of the service. These included staff rotas, supervision and training records, medicine records and quality monitoring audits.

We looked at the care provided to people, observing how they were supported, looking at four care records and speaking with 10 people to help us understand their experiences. We spoke with four relatives and eight staff including the registered manager, the deputy manager, activities organiser and chef. During the inspection we also spoke with a health and social care professional who supported people at Aaron Court, to ask for their views about the service.

Good

Is the service safe?

Our findings

At the last inspection in January 2016 there was a risk that people may not receive safe care, because risk assessments, care plans and reviews were not up to date. At this inspection we found improvements had been made because care plans and risk assessments now supported staff to provide safe care. Risk assessments related to a range of areas including falls, ability to use the call bell, nutrition, choking and pressure area care. They identified the level of risk and the actions needed to minimise them. For example, a risk assessment for a person at risk of skin breakdown aimed, "To maintain level of mobility to prevent pressure damage". The measures to achieve this included, "Walking frame available at all times. Foam mattress on bed, check pressure areas regularly". A relative told us the measures to minimise the risk of skin breakdown for their family member were effective. A health professional confirmed risks were managed well because "the record keeping and monitoring is good". Risk assessments were reviewed at least monthly by senior staff, who had been given dedicated time for this task. The registered manager told us, "The senior carers need time when they're off the floor, they don't do it on top of other duties". This meant the risk assessments were comprehensive, detailed and current.

When we inspected in January 2016 we found people did not have individual fire risk assessments or a personal emergency evacuation plan (PEEP) to show what support they would need. This meant staff and the emergency services would not easily be able to find information about the safest way to move people quickly and evacuate them safely. At this inspection we found emergency plans were now in place so that people would be supported in the event of a fire or other emergency. The plans were reviewed every month which meant they remained accurate if people's needs changed. Staff had received training in fire safety, and fire checks and drills were carried out in accordance with fire regulations.

At the time of the last inspection in January 2016 the service was recovering from a period of staff sickness and movement. To promote continuity of care during this time, existing staff had provided cover on overtime. At this inspection the registered manager told us there were sufficient numbers of staff deployed to meet peoples' needs and to keep them safe, saying, "Everything's good at the moment. The staffing structure has settled down". A relative commented, "The girls really care for [family member] There are never different ones. It's a stable staff team". Managers or senior staff were on-call in case of emergency 24/7.

People told us they felt safe. Comments included; "I feel safe – funnily almost too safe. From time to time I have to leave to go to medical appointments but I'm always so pleased to get back here" and, "The night care I need is really important to me, and what they provide makes me feel safe". This view was shared by relatives who told us, "It's brilliant here. I know my [family member] can be very difficult, but I know they are safe here and I'm happy about that when I leave" and, "I think [family member] is safe here. Safe as anywhere".

People living at Aaron Court had access to call bells in communal areas and in their bedrooms, should they need to call for assistance. They told us the response times varied. Comments included, "I can get to the alarm if I need to and at night they come straight away. In the daytime you have to wait longer – sometimes

for ten to fifteen minutes", "You can often wait for a considerable period of time before carers arrive in response to calling for them" and, "I can use the buzzer system but the response times can vary. They come quickly at night time though". Some people, for example those living with dementia, found it more difficult to use the call bell system. A relative said, "My [family member] can't access the buzzer and has no idea how to use the pendant alarm. I don't know what they do to call for help because I don't think they ever can". We discussed this with the registered manager who provided reassurance that staff made regular checks to monitor people's well-being. Fire doors were sound activated which meant they could be kept open, enabling staff to monitor people in their rooms when they were passing. One person, who was particularly vulnerable, had moved to a room in the busiest part of the home. The registered manager told us, "They are now situated so that they can be seen every few minutes". Pressure mats were used where appropriate to alert staff if a person had got out of bed. Pendant alarms were given to people with poor mobility who might find it difficult to reach a call bell. During the inspection we observed staff responding to requests for support in a timely way.

Risks of abuse to people were minimised because the registered manager ensured all new staff were thoroughly checked to make sure they were suitable to work at the home. Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. The DBS checks people's criminal history and their suitability to work with vulnerable people.

The service protected people from the risk of abuse through the provision of policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. They were aware of the service's whistleblowing policy and told us they would feel confident to use it. The registered manager confirmed it had been used by staff and action taken as a consequence. One member of staff told us," If I had an issue about anybody I would go the managers, I really would".

Systems were in place to ensure people received their medicines safely. All staff completed medicine administration training and were 'signed off' as competent before they were allowed to administer people's medicines. The community nurses had trained staff in the administration of insulin for people with diabetes. Medicines were dispensed in boxes and bottles, rather than blister packs, as recommended by the pharmacist, and were kept securely in a locked trolley. Medicines which required additional security were kept in a locked safe attached to the wall. We looked at the medicines administration records (MAR) and saw they had been correctly completed with two staff signatures on the MAR sheet for controlled drugs. Medicines were audited regularly and action taken to follow up any discrepancies or gaps in documentation.

Staff had a good understanding of the policy and procedures related to accident and incident reporting. Records were clear and showed appropriate actions had been taken. These records were audited by the registered manager in order to identify any causes, wider risks and trends. The provider and registered manager could then take any preventative actions that might be necessary to keep people safe. The registered manager gave an example of a person who experienced several falls. An analysis of the falls audit showed the falls were caused by the person's medication, so the medication was changed.

There were effective arrangements in place to manage the premises and equipment, and all relevant checks were up to date.

Good

Is the service effective?

Our findings

When we last inspected in January 2016 people's rights were not being protected under the Mental Capacity Act 2005 (MCA). 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. However, we found there was no documentation in place to support a best interest decision making process, where people lacked the capacity to make an informed decision.

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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the last inspection in January 2016 several people were eligible for assessment under DoLS but had not been referred.

We checked whether the service was now working within the principles of the MCA, and whether applications had been made for people to be cared for under DoLS where appropriate. We found that although people's human and legal rights were better protected, further improvement was needed.

Following the inspection in January 2016 the registered manager had sought advice and guidance from the local authority in relation to DoLS, and people had been referred appropriately for assessment. Staff had completed training on the MCA and DoLS, and were able to describe how they supported people to make decisions when their capacity to do so was impaired. For example, a member of staff told us how one person lost capacity to make decisions about their care when they were unwell and was currently refusing support with their personal care. They said, "We have to make best interest decisions at the moment. For [the person's] own benefit, we will step away, come out and go to another member of staff. A different face sometimes helps. We know [the person] well and what works". Care records showed that people's capacity to make particular decisions had been considered and decisions made in their best interests where appropriate. One person's care plan stated, "[Person's name] does hold capacity to be able to think and decide for themselves. This is impaired dramatically when their levels of anxiety are high. Aim to encourage and support [person's name] to remain as involved as possible in making day to day decisions. Allow time for [person's name]'s decision to be made". The registered manager described how they had instigated and contributed to a capacity assessment and best interest process where a person had been assessed as being at risk of choking, but was choosing to eat foods that would put them at risk. However, during discussion with the registered manager and staff it became evident that further learning was required regarding the protection of people's legal rights when they did not have capacity to consent to the use of a pressure pad to monitor their movements. Although a pressure alert mat is used to keep people safe, this can be seen as restrictive practice. This was relevant to one person living at Aaron Court whose file contained no evidence that a best interest process had taken place. We discussed this with the registered manager who provided assurance that the service had been acting in the persons best interests, in consultation with the person's family, and that the equipment had been effective in reducing their falls and risk of injury. They acted immediately to gain written consent from the person's legal representative. Following the inspection we

received additional information confirming that the legal representative had given their consent for the pressure mat to be used in the person's best interests.
People continued to receive effective care and support from staff with the experience, skills and knowledge to meet their needs. Staff knew people well and there was a consistent staff team. The registered manager told us, "I've always had a backbone of staff who have been here a long time". Relatives commented, "I've been visiting [family member] for two years now, on a regular basis. I think they are very well cared for and I've never had reason to raise any concerns about their care" and, "I can't fault the care here, but I think the carers' job is getting harder as more people here need a lot more care than residents used to a few years ago".

New staff had a comprehensive induction, which gave them the basic skills they needed to care for people safely. This covered a range of essential topics like moving and handling, first aid, and fire safety. During this period they worked alongside more experienced staff to get to know people and about their care and support needs. The registered manager told us staffing levels were increased during this period so that the senior member of staff had dedicated time for this task. In addition staff were encouraged to complete the national skills for care certificate, which is a more detailed, nationally recognised training programme and qualification for newly recruited staff.

There was an ongoing training programme for all staff which allowed them to keep their knowledge and skills up to date. This included both face to face and on line training and included the MCA, safeguarding, medicines administration, moving and handling, first aid, dignity, and infection control. In addition staff were encouraged to learn from visiting health care professionals. The registered manager told us, "We work well with the community nurses. We go in with them and get consent to do so. We ask, "Do you mind if I observe? Can I help?" It's a good way for them to learn." One member of staff told us, "There's enough training. I'm always quite happy to do it. It's good to have 'refreshers'".

Staff told us they were well supported by their managers and by the organisation. They received an annual appraisal and regular formal supervision, which was an opportunity for them to receive feedback about their performance and discuss any problems and areas where they need to improve. One member of staff told us, "I can ask for support along the way if I need to".

Care plans guided staff to provide the support people needed to ensure they had sufficient to eat and drink and received a balanced diet in line with their preferences. For example, "[Person's name] enjoys their meal on a small plate with an average portion. They like their roast potatoes to be cut up for them. Likes to have meals in the dining area with other service users". People were weighed every month and their nutritional status monitored regularly. The service catered for people with special dietary needs, for example a diabetic or pureed diet, or allergies, following guidance from health professionals. The cook told us they prepared foods that were as 'normal as possible' for people with special dietary needs, so that they would not feel different to everybody else. For example they had been taught by the speech and language therapist (SALT) how to make a sponge using 'thick and easy', which is a food thickener for people who have difficulty swallowing. The consistency was soft and not crumbly, so it would not be a risk to people at risk of choking. Fluids were readily available and we observed staff offering people drinks throughout the day to ensure they remained hydrated.

The daily menu was displayed in the main lounge and people's food choices were discussed with them each day. People commented, "We have two choices of meals. If we don't like either, they'll find us something else", "I have a choice about where I can eat my meals" and, "Lunch was lovely today". We observed practice during part of the lunch time period. Lunchtime was a sociable experience. Staff provided calm reassurance and support to people who needed it. People were not rushed, but encouraged to take as long as they

needed to finish their meal. Equipment was provided to help people to eat independently, like plate guards.

People were supported to maintain good health and had access to healthcare services. The service worked closely with other agencies to ensure people's needs were met and their involvement was documented in people's records. Community Nurses were visiting people at the home during the inspection. One visiting health professional told us, "If the nurses highlight a concern or a problem, they tend to 'get on with it'. They listen to our concerns and take on board what we say. They work collaboratively, for example if someone has a pressure sore they will work with us". They added, "I would have been happy for my Mum to come here".

We recommend that the service seek support and further training from an appropriate source to enable them to consolidate and build on their knowledge of the Mental Capacity Act 2005 (MCA) to ensure people's legal rights are fully protected.

Good

Is the service caring?

Our findings

The atmosphere in the home was happy, relaxed and welcoming. All staff we met with and observed were kind and caring in their interactions with people. There was lots of laughter and friendly banter and people responded very positively to staff. Staff spoke with affection when they told us about the people they supported. One member of staff said "I started as a cleaner and worked my way up…I love to sit and talk to them, sing the old songs, do the knitting with them…I think we've got a special home".

The majority of people told us they were supported by kind and caring staff, although two people commented, "Most of the carers here are lovely, but one or two make me feel like I'm an inconvenience" and, "I know I moan a bit, but I think the carers see me as a problem. They always tell me someone else is worse off than me". Other comments included, "I love it here. I wouldn't go anywhere else. They're all lovely people", "I can't fault the staff. They really are good. We pull their leg and have a laugh", "Staff regularly talk with me – they make me really happy" and "On Mothers' Day we were treated to breakfast in bed and flowers". A health professional who visited frequently said, "The residents seem very happy. I have observed staff when they are not aware, interacting appropriately. There is fun and laughter".

Staff were committed to promoting people's independence and supporting them to make choices, One member of staff told us they would "get the clothes out and let them see. Let them feel. If people can't see they can touch and feel and make a choice that way". Care plans guided staff to promote people's independence. For example one care plan said, "Take time to listen to give [person's name] a sense of empowerment. Maximise staff support to assist [person's name] in finding a solution to problems that ordinarily they could perform independently". People confirmed their choices and preferences were respected. One person said, "I can choose to eat either in my room or in the dining room. I can choose when I want to get up and nothing's too much trouble for the staff here"

Staff respected people's dignity and privacy and all personal care was provided in private. The registered manager told us, "This is their home and we work in it". Staff knocked on bedroom and bathroom doors before entering, and told us they ensured doors and curtains were closed while supporting people. We observed that they asked for people's consent before providing support. One member of staff explained how one person was sometimes reluctant to take their medication, telling us, "It's nice to have a little chat first as sometimes they don't want to take their tablets. It's good to offer some encouragement". Care plans contained signed consent forms for sharing information within the care sector and consent to have their photograph taken, for example for use with the medicines administration records and activities around the home.

People were supported to maintain ongoing relationships with their families and told us they were able to have visitors at any time. Each person had a single room where they were able to see personal or professional visitors in private. Relatives told us the service kept them informed about the welfare of their family member, saying, "They would phone if there was a problem." Staff commented, "I think we work well with the families that come in and out. It works well if we are all on the same wavelength."

The PIR stated, "We are very good at supporting individuals when entering their end of life stages, using our care planning to adhere to their specific wishes at this sad time". Staff completed training in end of life care. People's end of life wishes were recorded in their care records which meant staff and professionals would know what the person's wishes were and could ensure they were respected. The registered manager told us, "We are not only supporting the person but also the family". They told us they 'took the lead' from the family, who could visit and spend time with the person whenever they wanted and stay as long as they liked with meals and drinks provided.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. From the initial assessments care plans were devised to ensure staff had information about how people wanted their care needs to be met.

Care plans contained clear information about people's mental, physical and emotional health, as well as their support needs, communication needs and daily routines. The PIR stated, "Care planning is based on individuality and we encourage both residents and families to have an input into this process, especially the 'Life History' section as this can give us a personal insight to the resident and can help shape and understand how they choose to be cared for". Care plans asked people, "What's important to you? What gives you a sense of comfort?" They provided the information staff needed to provide care in a personalised way. For example, one person's care plan said, "[Person's name] usually gets up at 8am and likes to wash and dress with one carer before having breakfast served in their room".

Records showed that people participated in the planning and reviewing of their care as much as they were able to. People had signed their care plans to confirm they agreed and consented to their care being provided as described. Where they hadn't signed, their involvement had been documented, for example, "[Person's name] has chosen not to sign this care plan. They become anxious and worry about what they are signing. They understand the importance of this care plan but choose not to sign it".

Care plans were formally reviewed once a month with residents and informally with the person's keyworker every week to make sure they were up to date. A keyworker was a named care worker allocated to oversee an individual's care. It was their responsibility to ensure people's needs and preferences were correctly documented and liaise with families. They told us, "Every weekend we go round with the care plan. We will sit with the residents and ask them, are they happy? Do they have any concerns?" However, one relative told us they had not always been involved in reviewing their family members care, even though the person did not have capacity to make decisions about how their support needs were met. We discussed this with the registered manager, who, by the second day of the inspection had written to all relatives inviting them "to be more involved in the care planning process" if they wished, stating, "We would have to gain consent from the residents who hold capacity on this particular subject, as this care plan is the property of the individual".

People had opportunities to take part in a range of activities and social events, including art therapy, drama therapy and one to one counselling. An activity co-ordinator was employed for 20 hours a week. Staff told us, "There are weekly outings and there's always an activity in the afternoon. We will spend time one to one if people are in their rooms. We always pop in and make sure they're alright. Last week we spent time painting nails. People don't like the TV on in the communal area, they prefer to sit and chat, and we encourage people to socialise." On the day of the inspection people were having their hair done in the home's 'salon' by a visiting hairdresser. We heard the activities organiser asking people, "Are you going to do card making with me this afternoon? We will get all sticky and messy! Sticky shapes and pretty flowers. They will look nice". We later saw people enjoying this activity, and looking forward to afternoon tea on the sea

front the following day. People could choose whether or not to join in. One relative told us, "My [family member] spends a lot of time in their room. They don't enjoy it in the lounge where there's lots of chatter".

There was an effective and responsive complaints process in place. However, the registered manager told us they encouraged people and their families to talk to them in the first instance to in order to resolve any concerns. There had been no formal complaints since the last inspection. One person told us they felt unsafe with the way a particular member of staff supported them with personal care. They told us they had expressed their concerns and this had been followed up by the registered manager. The registered manager confirmed they were working with the person, their family and the member of staff to understand and resolve the issues. Another person told us, "I raised an issue about my medication that I wasn't happy about, but that was quickly dealt with and it hasn't happened since". A relative confirmed, "Generally their care is very good. They listen to you when concerns are raised. As soon as there is anything they're on it straight away".

Good

Is the service well-led?

Our findings

The home was managed by a person who had been registered by the Care Quality Commission. They had managed the service for 11 years. Staff spoke positively about them and told us the service was well led. Comments included, "[Manager's name] is a good manager. They are easy to talk to"; "I love how we are all one big unique family. I love the way the home is run. I think we do a really good job", and "It is a well led service, I wouldn't have learnt what I've learnt otherwise". Relatives confirmed the registered manager was supportive and approachable, telling us, "We feel supported by the manager and the owners".

The registered manager was available throughout our inspection. They were very visible in the home and they knew the people who lived there very well. They said, "We've just as much to offer as the big, grand homes. The care is excellent. I just want everyone to be happy. I want things to be meaningful and for care staff to walk away and feel 'I've done my best today'". They emphasised the importance of valuing staff saying, "I always make sure I praise my staff… I want them to be recognised…We have team building sessions, we go to the pub, have a summer BBQ. I tell them, if something's gone on in your personal life that affects your work, let's talk about it. I get more out of my staff if I have an open and transparent culture".

The provider promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. Since the last inspection in January 2016 the registered manager and provider had acknowledged the areas in which the service needed to develop and improve, and been proactive in making this happen. For example, a revised staffing structure had improved monitoring and accountability and meant staff now received regular recorded supervision and support. The registered manager told us all care staff took responsibility for one person and their room as the person's keyworker. They said, "I would expect to see equipment clean and belongings taken care of. Care plans should be up to date and there should be contact with families". Senior carers were responsible for auditing the care plans and providing supervision and feedback to the care staff. This oversight enabled them to identify any gaps or areas for improvement, and ensure care staff had the support and training they needed to be effective in their role. The senior carers were supported and supervised by the registered manager and deputy manager. Regular staff meetings provided an opportunity for all staff to be updated about any changes or developments at the service and to put forward their ideas about how things might be improved or done differently.

There were quality assurance systems in place to monitor care and plan on going improvements. This included audits and checks to monitor the safety and quality of care, looking at areas such as medication, falls, accidents and incidents, and care plans. However, further improvement was required to auditing systems to ensure people's legal rights were protected when restrictive practices were in place. People living at Aaron Court and their relatives were invited to express their views of the service through annual satisfaction surveys and residents and relatives meetings. Minutes of residents meetings showed there had been discussions about a range of issues including suggestions for menus and activities, as well as updates on staff changes. In the PIR the registered manager stated, "We recently held a quality assurance meeting, inviting all of our families to attend and the evening was incredibly successful. Again listening to how the

families felt they needed support and also their suggestions on what they expected from Aaron Court". They told us this had been a 'wine and cheese' evening, which "gave families a chance to come in, meet each other, have a chat and offload any concerns." The evening had provided an opportunity to "create the community we want and also explain we are striving to make it the best we can". A relative confirmed," [Managers name] holds family meetings. I attend and they always listen. I can't fault them here".

Provider visits were undertaken every two weeks by the directors. They toured the home and spoke with staff, people living there and their families. The managers and staff told us they were supportive and wanted the best for the home. The directors met regularly with the registered manager so any issues could be discussed and addressed. The registered manager told us, "If I need help I ask. I'm quite confident in asking. I feel supported".

The registered manager used a range of methods to keep up to date with developments and best practice, which included learning from other care professionals, and accessing relevant information on-line and from care magazines. They were also considering joining the local authority 'Provider Engagement Network' (PEN), where they could meet and share ideas and information with other providers of adult social care. In addition they planned to undertake a diploma in management in order to increase their skills and knowledge and continue to develop professionally, which would also benefit the people using the service and staff.

We recommend that the registered manager and provider take further steps to ensure they keep up to date with best practice and developments in adult social care, seeking support and further training from an appropriate source.