Doulton Court Limited

Aspen Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Aspen Lodge Care Home on 17 May 2016. This was an unannounced inspection. The service provides care and support for up to 52 people, including those requiring nursing care. When we undertook our inspection there were 34 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks.

There was 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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there was no one subject to such an authorisation.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe.

People were treated with kindness and respect. The staff in the home took time to speak with the people they were supporting. There were many positive interactions with staff and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

Staff had taken care in finding out what people wanted from their lives and had supported them in their choices. They had used family and friends as guides to obtain information. However, there was a lack of social activities for people to take part in, which the registered manager was addressing.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that

required it. Some changes were being made to the environment to ensure it was safe and addressed the specific needs of everyone with in the home.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home and quality checks had been completed to ensure services met people's requirements.

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.

Checks were made to ensure the home was a safe place to live.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were stored safely. Record keeping and stock control of medicines was good.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires Improvement

The service was not consistenly responsive.

People's care was planned and reviewed on a regular basis with them.

Detailed care planning had taken place to ensure people's wishes were adhered to, no matter how long this took. Staff accessed a variety of resources in the community.

Activities were not always planned into each day, but people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

Is the service well-led?

Good

The service was well-led.

People were relaxed in the company of staff and told us staff were approachable.

Audits were undertaken to measure the delivery of care, treatment and support given to people against current guidance.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

Aspen Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 May 2016 and was unannounced.

The inspection was undertaken by an inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, the provider completed 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.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service.

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

During our inspection, we spoke with seven people who lived at the service, seven relatives, seven members of the care staff, a trained nurse, an administrator, the registered manager and the area manager. We also observed how care and support was provided to people.

We looked at 16 people's care plan records and other records related to the running of and the quality of the

service. Records included maintenance records, staff files, audit reports and audit reports the registered manager had completed about the services provided.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. A relative told us, "I feel [named relative] is very safe here."

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the registered manager would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis. This ensured any changes to practice by staff or changes which had to be made to people's care plans was passed on to staff. Staff told us they were informed through shift handover periods when actions needed to be revised.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. For example, where people had a history of falls. A falls assessment had been completed over a number of days. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct equipment was in place for each person and their falls recorded accurately and walking ability observed. This was recorded in each person's care plan. We observed staff assisting people to use a variety of walking aids throughout the day. Staff gave reassurance and advice to each person on how to walk safely around the building. One person told us, "I'm a bit wobbly, but I'm trying to walk by myself. I like my independence."

Staff and people's records confirmed that assessments had taken place on the capability of people to visit the community either with an escort or on their own. Staff told us that some people would not remember how to get back to the home; so a member of staff escorted them on trips out or for health appointments. This was recorded in people's care plans.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help with walking due to poor mobility. A plan identified to staff what they should do if utilities and other equipment failed. Staff told us they had received training the previous week on using evacuation sledges to ensure people could be moved safely out of the building. The provider was now waiting for delivery of the evacuation sledges. Staff knew how to access this document in the event of an emergency. We saw two bedroom doors which had been propped open, which contravened the provider's fire policy. The wedges were immediately removed and the registered manager began to source other methods of allowing those people to have their bedroom doors open, which they told us they preferred.

Some refurbishment of the environment had occurred since our last visit and areas looked clean. We were invited into five people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. They told us they were happy how their rooms were kept clean. Some areas

of the home were being used as storage areas, including a sitting room. The registered manager told us that the sitting room was not used by people who lived there as there was ample sitting room accommodation in other parts of the building. We saw people using other sitting rooms and a dining room. The conservatory ceiling was in need of repair, but the work on this commenced during our visit. Some equipment required to be repaired, but this was on a list for the maintenance person to complete.

We saw that a gate, leading from the main car park to the back of the building had not been locked. People could gain access to the back of the building and into the home through patio doors, which were also unlocked. As soon as this was pointed out to the registered manager the gate and patio doors were locked. Staff told us the patio doors were usually locked unless people were sitting there for some fresh air, which we observed later in the day. Two doors upstairs which lead to some stairs were unlocked and staff told us some people walked those areas who had memory loss. They would not therefore remember whether the area was safe. Immediately after the inspection the registered manager sent us an environmental risk assessment which had been completed, which showed how the provider was going to address the issue of safety for people when doors led to stairways and the access for people from outside the building. Each section had a timescale.

People told us their needs were being met and there was sufficient staff available each day, except one person. They said, "They are always short of staff, sickness and holidays." One person said, "Whatever I need and whatever I want to do, staff are there for me." A relative told us, "My [named relative] is checked on through the night and that is recorded." The relative showed us the records the staff kept to show how often their relative was checked through the night."

Staff told us that the staffing levels were stretched and that at certain times of the day it would be beneficial if more staff were available. One member of staff said, "It's full on, but we give the care." Another staff member said, "It's harder in the afternoons." The registered manager acknowledged that at times it was a struggle, for particularly the trained nurses, to attend training as there were fewer of them to maintain the numbers required on the rota system. Staff told us that if there were short term staff shortages that the registered manager would assist with the care and treatment of people who needed it.

The registered manager told us how they had calculated the numbers of staff required, which depended on people's needs and daily requirements. These had been discussed with the commissioners of services and reflected what had been agreed for each person, which was documented in care plans. The calculations were presented in a grid format and deemed the home was adequately staffed. Contingence plans were in place for short term staff absences such as sickness and holidays. Gaps were filled by part-time staff working more hours or bank staff. Bank staff are employed and paid on a shift basis. The staffing levels in use showed that the registered manager had taken into consideration the dependency needs of people, but could adapt them if those needs increased and more staff were required.

We looked at three personnel files of staff. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. There were no current staff vacancies. Trained nursing staff told us the provider had recently provided them with a revalidation folder. This is a recent requirement of the Nursing and Midwifery Council (NMC) for all nurses on the professional nurse register. Staff told us they were being given time to complete their documentation to ensure they could still practice as nurses. The registered manager showed us documentation that the registration of all trained nurses employed at the home was checked. Each person had a valid registration.

People told us they received their medicines at the same time each day and understood why they had been prescribed them. This had been explained by GPs and staff within the home. This was recorded in people's

care plans. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in two locked areas. One was very small, but the registered manager told us a new space was being arranged so staff had more room to move around. There was good stock control. Records about people's medicines were accurately completed. Medicines audits we saw were completed regularly. Any actions had been signed as completed.

We observed medicines being administered at lunchtime and during the afternoon and noted appropriate checks were carried out and the administration records were completed. Staff stayed with each person until they had taken their medicines or the process of giving the medicine through a special machine had been completed. Staff who administered medicines had received training. Reference material was available in the storage area and staff told us they also used the internet for more detailed information about particular medicines and how it affected people's conditions.

Good

Is the service effective?

Our findings

A member of staff who had been recently recruited told us the process which had taken place for their employment to commence. This followed the provider's policy for induction of new staff. This included assessments to test their skills in such tasks as manual handling. This provided the skills they needed to meet people's needs safely. Details of the induction process were in the staff training files. The registered manager told us that the provider was embracing the principles of the care certificate for all staff. This would give everyone a new base line of information and training and ensure all staff had received a common induction process.

Staff said they had completed training in topics such as manual handling and infection control. They told us training was always on offer and it helped them understand people's needs better. The training records supported their comments. Staff had also completed training in particular topics such as dementia. This ensured the staff had the relevant training to meet people's specific needs at this time. We saw that competencies of staff and the value their training had, was discussed at supervision sessions.

Staff told us the provider was encouraging them to expand their knowledge by setting up courses on topics such as palliative care and syringe driver training for trained nurses. Although staff told us they would like more end of life training. The provider had developed a programme for care staff to develop their clinical skills. This was called a Care Home Assistant Practitioner (CHAPS) role. This involved staff being trained to monitor blood glucose levels, undertake simple dressings and obtain venous blood. Two staff told us they were considering the role. The home was also part of a project group with the local Hospice to develop training and information for those caring for people whose life was coming to an end.

Staff told us a system was in place to test their competences and also that they received formal supervision six times a year. They told us that they could approach the registered manager at any time for advice and would receive help and supervision until they were competent in a task. The records showed when supervision sessions had taken place, which was in line with the provider's policy. There was a planner on display showing when the next formal sessions were due.

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).

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. We found that the provider had followed the requirements in the DoLS. One application had been submitted to the local authority in 2014,

after a best interest meeting had taken place with all interested parties. The final decisions had been made by the supervisory body in 2015, where the application had been denied. Records showed the provider was still monitoring the person's capacity to make decisions. The provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times best interest meetings had been held and assessments completed to test their mental capacity and ability.

People told us that the food was good and that it had recently improved since a new outside catering firm was supplying the meals. One person said, "I like the meals." Another person said, "A better choice of tea time, not just sandwiches." People had also made comments in a book. One stated, "An improvement in meals and a good choice and tasty." We observed one person say to the head cook, "That sausage was so tender, how did you cook it?" The head cook told them it was in a casserole and clearly knew, with the conversation we heard, that they were aware the person had been a cook. This was confirmed in the care plans.

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet. The head cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes, foods to avoid because of the medication people were taking and the type of diet required. This ensured people received what they liked and what they needed to remain healthy. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs.

Menus were available and on display within the kitchen area, on notice boards and in the dining room. Staff told us they were consulting people about the new menus and visited people each day to obtain those views. New menus were in the process of being produced in word and picture format. This ensured people felt included in the menu planning and their specific needs were taken into consideration. We observed staff helping people with drinks throughout the day and asking for help to set the tables for the lunch time meal. We observed the lunchtime meal. The experience was rather chaotic as people wanted to leave the dining room in the middle of the meal. This left the area short of staff to ensure people who required assistance could enjoy their meal at their own pace. Some people were becoming agitated at sitting together and staff had to rearrange some of the seating arrangements. Staff had to ask people to wait for items such as a clean apron or a cup of tea. The lunch time meal we observed was not a relaxed experience on that day for people, but afterwards people told us they had received sufficient to eat and drink.

We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. For example, one person was being encouraged to walk during the day to help their mobility. We heard staff speaking with relatives about hospital appointments and home visits, after obtaining people's permission. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made.

People told us staff treated them with dignity and respect at all times. One person said, "When I have a bath, staff make sure they cover me up." Another person said, "I like to be private and staff respect my wishes."

We observed staff knocking on doors prior to being given permission to enter a person's room. They asked each person's permission prior to commencing any treatment and respected if they wanted pain relief

medication prior to commencement of treatment. One person asked not to have a bath at a certain time, so staff arranged a mutual time to help them. We observed staff ensuring people had suitable clothing on when going out of the building and sitting in communal areas. A staff member said, "[Named service user] sometimes forgets to pull her skirt down when she has been walking about and we know some people could be embarrassed if they see another person's legs."

People told us staff obtained the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people's behaviours had changed and when they required health checks such as eye care checks for those with diabetes. We also saw in the records when people had visited the opticians and dentist. Several of the people had hospital appointments which they had attended. Staff had recorded outcomes of those visits. Staff told us they had a good rapport with other health professionals and felt supported by them when they required assistance.

Good

Is the service caring?

Our findings

People told us they liked the staff and they were confident staff would look after them and they liked living there. They told us they were well cared for by staff. One person said, "The girls are lovely and kind." Another person said, "They are all so caring." Relatives also commented on the care their family members were receiving. One said, "Care is better than very good, some of them go the extra mile, 60 to 70% better than good." When referring to staff a relative said, "I have nothing bad to say about them."

The people we spoke with told us they were supported to make choices and their preferences were listened to. One person said, "Staff are patient and caring, they are always open to listening." A relative told us, "[Named relative] always been treated very well and although [named relative] is [named treatment being received], the staff are getting the SALT team in to assess [named relative], as [named relative] would love to have a drink." We confirmed the person was receiving food and drink through another feeding method. The SALT team are a specialist hospital based team who assess people's ability to eat and drink and take into consideration a person's medical needs.

People were given choices throughout the day if they wanted to do some of their own dusting in their bedrooms or where they would like to sit. Some people joined in happily and readily. Others declined, but staff respected their choices on what they wanted to do.

All the staff approached people in a kindly manner. They were patient with people when they were attending to their needs. For example, one person was worried about using a wheelchair. Staff gently talked through how they would be transferred into the chair and reassured them throughout the process. The person smiled broadly when the process was complete. Another person required assistance to walk. The person had to walk slowly due to a medical problem. Staff walked slowly with them and gave encouragement when necessary. Some people were observed patting staff's hands, which appeared to reassure those people.

Staff supported people's wishes and needs when their lives were drawing to a close. Staff were supporting a person and their family who were extremely anxious about the end of life process. Staff had accommodated the person in a single room, provided open visiting access and liaised with the kitchen for the person's dietary needs. A recliner chair was on offer if family wished to stay overnight. Staff were working closely with the palliative care team. This had helped a family whose relative was suffering from dementia but also whose life was drawing to a close. The person wanted to go home but had been assessed as not being able to cope. With help from the palliative care team and staff the family were reassured about the care of their relative. All the person's needs were now being fulfilled at the home.

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made.

People told us they could have visitors whenever they wished. We saw several signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us some families visited on a regular basis and they were offered refreshment and opportunity to speak with staff. This was recorded in the care plans. This ensured people could still have contact with their own families and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display. There were no local advocates being used by people at the moment.

Requires Improvement

Is the service responsive?

Our findings

The people we spoke with gave us mixed views about the response times of staff to their needs. Some told us staff responded to their needs quickly, whilst others told us at times the response was slower. One relative said, "Call bells do ring sometime I would be lying if I said they didn't." Another person told us, "It's fine, you expect to wait sometimes, there are a lot of people here, it's not quite like being home alone."

People told us staff had talked with them about their specific needs. This was in reviews about their care. They told us they were aware staff kept notes about them. People told us they were involved in the care plan process, but if they could not read their notes staff would do this for them. A relative told us, "[Named relative] is safe and cared for, I was involved with the care plan and [named relative] has been assessed by the physio". This was confirmed in the care notes we reviewed. However, there were no other methods for staff to use except the written English word for notes and assessment tools. No nationally recognised assessment tools were used for people who had a learning disability, impaired cognitive ability or other communication difficulties; such as those associated with dementia. This meant people may not understand their care plans if they did not understand written English, unless they were read to them. Staff also used some terminology in the care plans which was no longer used' such as Primary Care Trusts, which have been replaced with Clinical Commissioning Groups.

Staff received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten.

People told us staff had the skills and understanding to look after them and knew about their social and cultural diversity, values and beliefs. People told us that staff knew them well and how their beliefs could influence their decisions to receive care, treatment and support. Staff knew how to meet people's preferences with suggestions for additional ideas and support. This means people had a sense of wellbeing and quality of life. Staff had used local resources in health and social care, plus the internet to ensure messages were received by people about health matters.

People told us that staff took time each day to discuss their care and treatment. As well as the opportunity to speak with other health professionals. This was recorded in each care plan. For example being able to see a dentist when they wanted one for both routine and urgent treatments. We observed a relative asking a staff member when the chiropodist would be visiting. The staff member was very responsive, found the appointment times in the diary and asked whether a time could be arranged. This was done straight away.

Four of the care plans we reviewed were for people whose life was coming to an end. Staff had documented all visits and advice sought by other health care professionals. The Do Not Attempt Cardiac Resuscitation forms had been correctly completed by other medical practitioners. A system on the care plans termed by staff as 'clinical hotspot stickers' identified to staff where people had high risk and complex needs. Staff were aware of the importance of involving other health care professionals to establish resuscitation status.

Professionals' visits to the service say it was focused on providing person-centred care. On-going improvement is seen as essential and lessons learnt are past to all staff. Social care professionals we had contact with before the inspection told us staff informed them quickly of any issues. They were confident staff had the knowledge to follow instructions and did so.

We were informed that two activities co-ordinators were usually employed, but there was currently a vacancy for one person. People and relatives told us there was a lack of any meaningful stimulation. One relative said, "Terrible". One relative told us they had complained and referring to the activities timetable they said, "Has not been up there for months". A person told us a saxophone player had recently come to play, but staff hadn't informed them so they didn't attend the full session. The registered manager was aware that activities had recently been given a low priority by staff and was now addressing this issue by ensuring staff had more training in this area, especially for people with memory loss.

Any activities which had occurred in the last year were recorded in the care plans. This was mainly group events such as art sessions, music to movement and entertainment. Staff told us no one had any current hobbies that they were involved in. A large proportion of the people resident at the home were receiving end of life care and many preferred to stay in their bedrooms. Each room had been personalised to their wishes and needs. We observed staff talking to people about family photographs on display and about television or radio programmes.

We did not observe any notices around the home to guide people who might have memory loss; either on their bedroom doors or to guide the way to other areas such as the dining room. We did observe staff directing people to those areas. The registered manager told us this was a work in progress and was part of environmental changes. We later saw the changes to be completed in the environmental risk plan which was sent to us. The smoking area was going to be reviewed. Currently people can only smoke in a designated area of the garden. Only one person required assistance to use that area and staff supervised them when they wished to smoke.

Whilst being shown around the building we observed a relative visiting with a dog. This was a daily occurrence for that person. Staff told us as this had been a success and they were arranging for a 'pat dog' to visit the home. This is a scheme where a specially trained dog and it's owner come to the home to discuss animals and allow people to pat and see the dog, if they wished.

We observed some people using recently purchased equipment that provided cognitive and therapeutic stimulation. People appeared to enjoy what they were doing.

People are actively encouraged to give their views and raise concerns or complaints. People's feedback is valued and concerns discussed in an open and transparent way. People told us they were happy to make a complaint if necessary and felt their views would be respected. Each person knew how to make a complaint. No-one we spoke with had made a formal complaint since their admission. People told us they felt any complaint would be thoroughly investigated and the records confirmed this. We saw the complaints procedure on display.

The complaints log detailed the formal complaints the manager had dealt with since our last visit. It recorded the details of the investigations and the outcomes for the complainant. Lessons learnt from the cases had been passed to staff at their meetings in 2015 and 2016.

Good

Is the service well-led?

Our findings

There was a registered manager in post. People told us they were well looked after, could express their views to the registered manager and felt their opinions were valued in the running of the home. One person said, "The manager has been lovely any concerns I can go to her." Another person said, "The manager is very good. [Named manager] is always there."

People who lived at the home and relatives completed questionnaires about the quality of service being received. People told us they had completed questionnaires. The last questionnaire had been in 2015 for people who used the service and was very positive.

Staff told us they worked well as a team and felt support by the registered manager. One staff member said, "I really do enjoy it here. Everyone is so helpful. It's fantastic." Another staff member said, "I enjoy coming to work."

Staff told us staff meetings were held. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of the staff meeting for March 2016. The meeting had a variety of topics which staff had discussed, such as; staffing. This ensured staff were kept up to date with events. Staff told us they felt included in the running of the home. This was reflected in records seen.

The registered manager and area manager were seen walking around the home during our inspection. They talked with people who used the service and visitors. They could immediately recall items of information about each person. They gave support to staff when asked and checked on people's needs. Where necessary they also assisted with some personal care tasks; such as assisting someone to have a drink and being the witness when some strong pain relief medicine was given.

There was sufficient evidence to show the registered manager had completed audits to test the quality of the service. These included medicines, care plans and infection control. Where actions were required these had been clearly identified and signed when completed. Any changes of practice required by staff were highlighted in staff meetings and shift handovers so staff were aware if lessons had to be learnt.

A system called 'Our quality of life programme' allows anyone to use a touch screen pad which was situated by the main door. It provided regular feedback questionnaires to the provider about any concerns plus compliments people wished to make. Relatives particularly liked this method of communication. Although one person told us they had not received feedback about the lack of activities comments they had made. If people were unfamiliar in using a touch screen a comments book was also available, which people had used. The last company newsletter from December 2015 the provider had put together was on display. This gave people a flavour of other homes within the group and what they were doing, plus information for relatives about caring for people.

People's care records and staff personal records were stored securely which meant people could be assured

that their personal information remained confidential. The registered manager understood their responsibilities and knew of other resources they could use for advice, such as the internet and local multi-agencies. This home is part of a larger company so the registered manager had the opportunity of meeting with other home's managers, area staff and head office staff on a regular basis. This was welcomed by the registered manager as extra resources for advice and support.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.