Atlas Care Homes Limited

Aspen Court

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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection carried out on 3 May 2017.

This was the first inspection of Aspen Court since it was registered with the Care Quality Commission in November 2015. The premises had previously been owned by another provider.

Aspen Court is registered to provide personal and nursing care to a maximum of 63 older people, including people who live with dementia or a dementia related condition.

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

People said they were safe and staff were kind and approachable. There were sufficient staff to provide safe and individual care to people. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff knew the needs of the people they supported to provide individual care. Care was provided with kindness and people's privacy and dignity were respected. Records were in place that reflected the care that staff provided.

Appropriate training was provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were able to make choices where they were able about most aspects of their daily lives. People received a varied and balanced diet to meet their nutritional needs. However people who lived with dementia were not always encouraged to make choices with regard to their food.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. Systems were in place for people to receive their medicines in a safe way. However, we have made a recommendation about the management of medicines.

Changes had been made to the environment by the new provider. It was brighter and most areas had been refurbished. There were plans that it would be designed to promote the orientation and independence of people who lived with dementia. We have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

Activities and entertainment were available to keep people engaged and stimulated.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. The provider undertook a range of audits to check on the quality of care provided.

People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service. People had access to an advocate if required.

Staff and relatives said the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm.

Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way. However we have made a recommendation about medicines management.

Regular checks were carried out to ensure the building was clean, safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff received supervision and training to support them to carry out their role effectively.

People's rights were protected. Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet. Support was provided for people with specialist nutritional needs.

A programme of refurbishment was taking place around the home. Further improvements were planned to ensure it was designed to promote the orientation of people who lived with dementia. We have made a recommendation the environment should be designed according to best practice guidelines for people who live with dementia.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were kind and patient.

Staff were aware of people's backgrounds and personalities. This helped staff provide individualised care to the person. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People were encouraged and supported to be involved in daily decision making. However, systems for people to choose their food required refining.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. There was a good standard of record keeping to help ensure people's needs were met.

There was a programme of activities and entertainment to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was readily available to give advice and support. They were very complimentary about the changes that had been made in the home.

Improvements had been made by the registered manager and provider and were being maintained by the registered manager and management team to promote the delivery of more person centred care for people.

The home had a robust quality assurance programme to check on the quality of care provided.

Aspen Court

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 3 May 2017 and was unannounced. The inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for older people including people who live with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care.

During this inspection we carried out observations using 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 communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with nine people who lived at Aspen Court, 10 relatives, the registered manager, the registered provider, one registered nurse, eight support workers including one senior support worker, the activities coordinator and two members of catering staff. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for six people, recruitment, training and induction records for six staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and

quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

People who used the service and relatives expressed the view that they and their relatives were safe at the home. One person told us, "I'm quite safe here, although I'd rather be at home." Another commented "It's good enough for me." A third person told us "It's alright staff are good but they don't have time to come to chat very much." Relatives' comments, included "Ask and staff come straight away", "I think there are enough staff they respond straight away", "[Name] doesn't wait long to go to the lavatory" and "Staff keep checking on [Name]. They go in and out of the bedroom to make sure they're okay."

There were thirty three people living at the home at the time of inspection. Staffing rosters and observations showed on the top floor ten people, with general nursing needs were supported by two support workers and a registered general nurse. On the middle floor nine people were supported by two support workers including one senior support worker. On the ground floor 13 people who lived with more severe dementia were supported by three support workers including one senior support worker. Overnight staffing levels included one registered nurse and five support workers throughout the building.

A staffing tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in a number of daily activities of living. The dependency formula was then used to work out the required staffing numbers. The registered manager told us this would be kept under review as people's dependency changed and staffing levels would also be increased as more people moved into the home as it was not yet fully occupied since the change in ownership.

Staff were clear about the procedures they would follow should they suspect abuse. They were able to explain the steps they would take to report such concerns if they arose. They expressed confidence that allegations and concerns would be handled appropriately by the registered manager. They informed us they had received relevant training. One staff member told us, "I've done safeguarding training with the local authority."

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduce risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care and nutrition.

Medicines were given as prescribed. We observed part of a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MARs) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their tablets and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

The medicines policy provided guidance for the use of 'when required' medicines which may be required when people were in pain, agitated or distressed. However guidance was not available in people's care

plans, which detailed the differing level of support needed by each person. The information available did not provide staff with a consistent approach to the administration of this type of medicine and when it should be given.

Records showed that where people lacked mental capacity to be involved in their own decision making, the correct process had not always been used. For example, with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had not taken place with the relevant people. NICE guidelines state, "A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests."

We saw records for one person which referred to the use of covert medicine. When we asked we were told they were not always taken covertly as the person would "sometimes accept them." However, a record was not available that reflected this guidance or to show how the decision had been made as there was no evidence to show that a best interest meeting had taken place. There was no documentation to show why covert medicine was required or to show if all other ways had been exhausted before the decision was reached. The registered manager told us that this would be addressed.

We recommended the registered manager considered the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. These were referred to if the building needed to be evacuated in an emergency.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

A refurbishment of the home was almost completed and the garden areas were also being attended to. Lounges, dining rooms, bathrooms and shower rooms had been refurbished. All bedrooms now had ensuite facilities and the rooms had been decorated and carpets and furniture replaced. We were told the kitchen was to be part of the refurbishment. The building was bright, airy and spacious. Corridor walls were recently decorated but bare. We discussed this with the registered manager who told us the environment was going to be designed to ensure it was stimulating and therapeutic for the benefit of people who lived there. There was to be visual and sensory stimulation to help maintain the involvement and orientation of people with dementia. The registered manager discussed their plans for displays and themed areas around the home to help people recollect and remind people as they sat or walked around. Appropriate signage was planned for around the building to help maintain people's orientation. For example, lavatories and bathrooms were to have pictures and signs for people to identify the room to help maintain their independence.

We recommended the registered manager continued to research best practice regarding the design of accommodation for people who live with dementia.

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the registered manager. One staff member told us "I receive supervision from the deputy manager. Other staff comments included "We get supervision every six weeks" and "I feel well-supported in my role particularly by the manager." The registered manager told us appraisals had started with staff to evaluate their work performance and to jointly identify any personal development and training needs. They were then planned to take place annually.

Staff members were able to describe their role and responsibilities. A number of staff members had worked at the home for several years. Newer staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. A staff training matrix for staff showed that a range of courses took place to ensure they had the knowledge to meet peoples' care and treatment needs. Staff training courses included, dementia care, dignity in care, food nutrition, positive behaviour, equality and diversity, palliative care, mental capacity and deprivation of liberty safeguards.

Staff told us and training records showed they were kept up-to-date with safe working practices. Staff members comments included, "I'm training to be a dementia champion in the home", "We do face to face and practical training", "We have opportunities for development" and "All my training is up to date."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as, General Practitioners (GPs), a speech and language team (SALT) and psychiatrists. Records were kept of visits. Care plans reflected the advice and guidance provided by external professionals.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the community mental health team. Staff told us they followed the instructions and guidance of the community mental health team for example to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

A weekly clinic took place at the home. The clinic was run by the General Practitioner from a local surgery, a specialist nurse and supported by a nurse from the home. The clinic was held to review people's health needs and their medicines and make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital. We were told relatives also had the opportunity to attend the clinic to support their family member. A relative told us "If [Name] isn't well, they (staff) will tell me straight away."

We checked to see how people's nutritional needs were met. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. They told us they received information from nursing staff when people required a specialised diet.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them to eat.

Food was well presented and looked appetising. People and relatives were positive about the food saying there was enough to eat and they received nice food. One relative told us "The food is good. There's a choice of two options." Another relative commented, "The food always looks lovely."

Staff told us communication was effective to keep them up to date with people's changing needs. Their comments included, "We have a handover morning and night", "Communication is good" and "We get a detailed handover that tells us what's been happening when we've been on our days off." A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. This was to ensure staff were made aware of the current state of health and wellbeing of each person.

We noted a handover with staff that took place straight after lunch on the lower floor did not include information about if people had received their lunch. We were aware two people had not had lunch and the heated trolley that contained their meal was removed by the new staff coming on duty. I was told the member of staff who had been on duty in the morning would make the two new staff members on duty aware, this did not happen until we intervened. We discussed this with the registered manager the need to ensure this important information was communicated more effectively to ensure people's nutritional needs were all met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 procedure 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. 33 DoLS applications had been authorised by the relevant local authority. There was evidence of mental capacity assessments and best interest decisions in people's care plans.

Good

Is the service caring?

Our findings

Staff appeared to have a good relationship with people and knew their relatives as well. People and relatives we spoke with said staff were kind, caring and patient. People's comments included, "I'm well looked after here" and "Staff are very kind." Relatives were positive about the care that staff provided. Their comments included, "Staff are attentive to people and really supportive", "Staff treat all residents like family. [Name]'s happy, if they're poorly they bounce back with the care they're getting", "It's absolutely fine", "We've found it great", "The care [Name] gets is great." Other relatives' comments included, "Staff are absolutely brilliant", "They (staff) are so friendly and kind to everyone. If someone is upset they take special care of them", "It's lovely. The girls are brilliant" and "[Name] is getting the best attention here."

The atmosphere in the home was calm, friendly and welcoming. Staff promoted positive and caring relationships. People were spoken with considerately and staff were polite. We observed people were relaxed with staff. One relative told us "[Name] feels more at ease here."

Staff interacted in a caring and respectful manner with people. Staff acted with professionalism, good humour and compassion. A relative told us "[Name] is really happy here and that has helped us. I can go home and relax." Another relative commented "[Name] wasn't very well when they (the provider) took over but they've lifted [Name]'s spirits." A third relative commented "I can go home with no worries and sleep at night. Someone has given us that opportunity to rest."

People's privacy and dignity were respected. People told us staff were respectful. We observed that people looked clean, tidy and well presented. A relative commented "[Name] is always nice and clean." Staff knocked on people's doors before entering their rooms, including those who had open doors. A relative told us "Staff always makes sure there's no one else in the room when they're providing personal care. They close blinds and curtains." Staff received training to remind them about aspects of dignity in care and a dignity champion was also appointed from the staff team to promote dignity within the home.

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, when to get up and go to bed and what they might like to do. People's comments included, "I like a long lie in bed in the morning." We heard staff ask people for permission before supporting them, for example with personal care or assisting them to mobilise.

Care plans provided information about how people communicated. Examples in care plans recorded, 'Staff to talk to [Name] at a normal rate and tone. Give them time to consider their reply' and '[Name] is able to inform staff if they are feeling unwell or in pain.' This information was available for staff to provide guidance about how a person should be supported.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. A relative told us, "They (staff) asked anything [Name] likes or dislikes." This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions

and looked for signs of discomfort when people were unable to say for example, if they were in pain.

People were encouraged to make some choices about their food. However we considered some improvements were needed. We were told people ordered their meal choices the day before. We discussed with the registered manager that people may not always want the meal choice they had made the previous day. People who lived with dementia or people with memory issues may also not recall their order. The registered manager told us that this would be addressed so people could order on the same day or sufficient food of each choice be available so that people could choose at the meal time.

We observed the lunch time meals in the dining rooms. We saw the meal time was relaxed and unhurried. A pictorial menu was available on the lower floor to help inform people about the food but menus were not available elsewhere in the home. People sat at tables that were set with tablecloths, napkins and condiments. Some people remained in their bedrooms to eat or in the lounges. To the lower floor we considered improvements were required to the organisation of people's dining experience. We observed the tables were not set before people sat down to lunch. People sat at tables and were served their meal but had to wait until staff obtained cutlery for them to eat their meal. Cutlery and glasses for drinks were not available for everyone and these were collected from the kitchen whilst people waited. Staff did not remain in the lower floor dining area to provide help and encouragement to people. People in this dining room who were left to eat their meal independently were later supported by staff, by which time their meal was not hot. Staff when they did provide assistance or prompts to people to encourage them to eat, did this in a quiet, gentle way. Staff talked to people as they helped them. For example, "Is that enough" and "Do you want a drink now?" The meal time organisation on the lower floor was discussed with the registered manager who told us it would be addressed immediately.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. We were told the service used advocates, such as an Independent Mental Health (IMHA) advocate as required in the process where people did not have a relative. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Good

Is the service responsive?

Our findings

People and relatives confirmed there was a choice of activities available. Relatives' comments included "It's really good here, there's a lot going on", "Entertainment is put on", "[Name] the activities person gets them involved in drawing and painting", There's singing and dancing and hairdressing," "[Name] does the exercises on Monday." Other relatives' comments included "They bring animals in for therapy", "There's arts and crafts" and "Staff support [Name]."

An activities organiser was employed and a programme of activities advertised activities that were available and this included, pamper sessions, 'pat a dog', reminiscence, singing, newspapers, music therapy, movie afternoons, armchair exercises, baking and crafts. As part of the refurbishment people were to be involved in helping select the pictures and themed areas for the home.

There was a garden that was being landscaped, a new fence had been erected and plans were being made so people would have the opportunity to sit out when the weather was fine. Entertainment and concerts also took place. A pie and pea supper had recently taken place. The hairdresser visited weekly and a local member of the clergy visited regularly. People had the opportunity to go out and be part of the community. They went on trips and these included activities such as shopping, visiting the Metro Centre, pub outings, garden centre and for fish and chips.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs.

Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Reviews of peoples' care and support needs took place with relevant people. A relative commented, "We used to have an annual care plan review but this was changed due to [Name]'s condition.' Another relative told us "Not sure if we've had a review but staff are approachable and you can discuss anything with them."

Care plans provided information for staff about how people liked to be supported. For example, some care plans for personal hygiene stated, 'Prompt [Name] to brush their teeth and assist to put toothpaste on the toothbrush' and 'Assist [Name] to their ensuite and allow them time and privacy to us the lavatory.' Care plans were broken down to provide details for staff about how the person's care needs were to be met. They gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted.

Other information was available in people's care records to help staff provide care and support. For example, '[Name] is able to stand and transfer supported by one staff member' and '[Name] prefers to be asked by staff if they can help.' Staff completed a daily diary for each person and recorded their daily routine

and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People's care records and personal profiles were up to date and personal to the individual. They contained information about people's history, likes, dislikes and preferred routines. Examples included, 'Likes music and dance', 'I enjoy listening to music and having a head massage', 'Likes rum and coke', 'Enjoys going to the pub and reading any paper' and 'Likes a cooked breakfast and loves bread and butter.'

Regular meetings were held with people who used the service and their relatives. The registered manager told us relative meetings were not very well attended. One relative told us "They do have meetings but I've not attended." Another relative commented "I don't go to the meetings. If there's anything I want I go to see [Name] the manager." A separate monthly meeting also took place with people who used the service and we saw menus, activities and outings were discussed.

People knew how to complain. People we spoke with said they had no complaints. A relative told us, "I know who to speak to if I had any complaints." Another told us "I feel I could just go and knock on the office door if I did have a complaint." A third relative commented "If there's any query there's always someone in the office." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and a complaints procedure was in place to ensure they were appropriately investigated. We saw compliments had been received from relatives of people who used the service thanking staff for the care provided.

Good

Is the service well-led?

Our findings

The home had a registered manager who had become registered as the manager for Aspen Court in November 2015. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

The registered manager had been appointed when the home was registered with the current provider in November 2015. They were enthusiastic and had introduced many ideas to promote the well-being of people who used the service. One relative told us, "I think it (the home) has improved a lot with the change in ownership. It's great, it's all been decorated and now they have things going on with activities." Staff were positive about the management of the home and had respect for them. Staff commented, "The manager is really approachable", The manager has created a staff team with the blend of new and longstanding staff", "Staff morale is good" and "The new manager is very approachable."

The atmosphere in the home was lively and friendly. Relatives said they were always made welcome. Staff, people and relatives said they felt well-supported. Their comments included "We met [Name] the manager straight away and felt they were honest. I decided they would tell the truth. This was our first option", "[Name] the manager is always around and we can go to them for anything", "The registered manager has been 100% available", [Name], the manager is nice, very friendly." People and relatives told us they were listened to by the registered manager. One relative gave an example of when they'd asked for a change of room for their family member and it was accommodated straight away. Another relative told us they had queried a chair their family member was using "I spoke to the registered manager and the next day the chair was changed."

People and relatives were all positive about the home and the changes that had taken place or were planned. They all said they would recommend the home to other people. Comments included "Great, can't fault it", "Care [Name] gets is great", "This is a good care home", "Staff are amazing here", I'd recommend the home to anyone," "Only thing I query is the garden" and "Much better management."

The registered manager assisted us with the inspection, together with another home manager. Records we requested were produced promptly and we were able to access the care records we required. The registered manager was able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way. One of the providers attended the feedback from inspection.

The registered manager said they were well supported in their role by the provider and area managers. They told us they subscribed to a range of care industry and related publications and kept up to date with best practice and initiatives.

Staff told us monthly staff meetings took place and minutes of meetings were available for staff who were unable to attend. Staff meeting minutes showed topics discussed included training, care planning, staff performance, mental capacity, complaints and incident reporting. Staff meetings kept staff updated with any changes in the service and were an opportunity to discuss any issues.

Auditing and governance processes were robust within the service to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. All audits showed the action that had been taken as a result of previous audits. A monthly risk monitoring report that included areas of care such as safeguarding, complaints, infection control, pressure area care and serious changes in a person's health status was completed by the registered manager for analysis.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. The registered manager completed some daily audits such as a daily walk around the building to check the environment and check morale of staff and people who used the service. Some records were also monitored daily by the registered manager for example the daily handover sheets that recorded the handover that took place between staff were also passed to the registered manager for their information.

Monthly audits included checks on medicines management, safeguarding, care documentation, training, kitchen audits, accidents and incidents and nutrition. Three monthly audits were carried out for infection control, falls and health and safety. We were told monthly visits were carried out by one of the providers who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the registered manager to ensure they had acted upon the results of their audits. All the registered manager's audits were available and we saw the information was filtered to ensure any identified deficits were actioned. However, records from the monthly visits carried out by the provider were not available. We discussed this with the provider and registered manager who told us it would be addressed to provide documentary evidence of the external monitoring that was taking place.

The registered manager told us the provider planned to monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were to be sent out annually to people who used the service and staff. Surveys were to be sent out and people's and visitors views would also be captured after the home's open day on 19 May 2017 when the newly refurbished home was to be open to visitors to see the changes that had taken place.