Nara Healthcare Limited

Tudor House

Inspection report

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Date of inspection visit:
12 January 2016

Date of publication:
19 February 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 12 January 2016 and was unannounced. Tudor House is a family run business and is registered to provide nursing care and accommodation for up to 24 people living with dementia and other health needs. At the time of our inspection 19 people were living at the home. The provider was in the process of refurbishing the home and was not planning to admit any new people until all the maintenance and redecoration work had been completed. Tudor House is a large detached property in a built-up area of Bognor Regis. It is close to the town centre and seafront. There is a communal sitting room with an adjacent conservatory area and a separate dining room, with access to the garden. Some bedrooms have en-suite facilities.

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 were protected from avoidable harm and abuse. Staff were trained to recognise the signs of potential abuse and knew what action to take if they had any concerns. Risks to people were identified, assessed and managed appropriately. Accidents and incidents were reported and people's risk assessments and care plans were reviewed following any incident. Premises and equipment were managed safely and the provider was updating and redecorating the home. Staffing levels were sufficient and duty rotas confirmed the number of staff on duty was consistent. Safe recruitment practices were in place. People's medicines were managed safely.

Staff were trained in a range of areas and provided effective care to people. They received regular supervision and had annual appraisals. New staff shadowed experienced staff and followed the Care Certificate, a universally recognised qualification. Staff meetings were held four times a year and records confirmed this. Staff were trained to understand their responsibilities under the Mental Capacity Act 2005 and associated legislation and put this into practice. People were supported to have sufficient food and drink and to maintain a healthy lifestyle. They had access to a range of healthcare professionals and services.

People were looked after by kind, caring and friendly staff who knew them well. People and their relatives spoke highly of the care they received and of the staff. People were involved in planning their care as much as they were able and were supported to make decisions. Care plans contained detailed personal histories, which enabled staff to form positive relationships with people. People were treated with dignity and respect.

Care plans contained comprehensive information about people and guidance to staff on how they wished to be cared for. Care plans and risk assessments were reviewed monthly. The provider was in the process of upgrading the care plans and were moving to an online, computerised system. Activities were structured

and planned in line with people's choices; there were outings into the community every week. Complaints were responded to and managed appropriately in line with the provider's policy.

People were asked for their feedback about the service and had the opportunity to attend residents' meetings to discuss matters of importance to them. Relatives were also asked for their views about the home and positive comments had been recorded. Staff felt that the home was well led and that the management team was approachable. A range of robust audit systems enabled the provider to monitor the quality of the service overall.

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 risks were managed appropriately and staff were trained to recognise any signs of potential abuse.

People's medicines were managed safely.

Staffing levels were sufficient and new staff were checked to ensure they were suitable to work in the care profession.

Is the service effective?

Good

The service was effective.

People had sufficient food and drink and were supported to maintain a healthy diet. They had access to a range of healthcare professionals and services.

Staff had been trained in a range of areas and received regular supervision and annual appraisals.

Staff understood the requirements of the Mental Capacity Act 2005 and associated legislation and put this into practice.

Is the service caring?

Good

People were looked after by kind and caring staff; they were treated with dignity and respect.

Care plans contained information about people's backgrounds and personal histories.

People were encouraged to be involved in planning and making decisions about their care.

Is the service responsive?

Good

The service was responsive.

Care plans provided detailed information about people which enabled staff to provide personalised care.

There was a range of activities on offer to people and outings into the community were arranged weekly.

Complaints were responded to and managed appropriately.

Is the service well-led?

Good

The service was well led.

People and their relatives were involved in developing the service and there were opportunities to attend meetings.

Feedback from people, their relatives and staff was obtained through surveys.

Good management and leadership were in place. There was a range of systems in place to measure the quality of the service overall.

Tudor House

Detailed findings

Background to this inspection

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

The inspection took place on 12 January 2016 and was unannounced. Two inspectors undertook this inspection.

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 any improvements they plan to make. We examined the previous inspection reports and notifications we had received. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including seven care records, five staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we spoke with two people living at the service and two relatives. We met with the majority of people living at the home, but due to the nature of people's complex needs, we did not always ask direct questions. For some people, being asked questions by an inspector would have proved too distressing. We did, however, chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, a deputy manager from one of the provider's other homes, a team leader and three care staff. We also spoke with a district nurse who was visiting the home on the day of our inspection.

This is the first inspection at Tudor House since a change in legal entity.

Good

Is the service safe?

Our findings

People were protected from avoidable harm and abuse. One person confirmed they felt safe living at the home and told us, "Yes I do, I feel safe here". Relatives also felt their family members were safe living at the home. One relative said, "[Named family member] is much safer and happier here than at home. They had begun to fall quite a lot and were quite vulnerable really". Another relative told us, "It's a real home from home and I know they feel protected and safe". A key coded pad by the front door prevented people from leaving the home independently. One person told us, "It wouldn't be wise for me to go out on my own". We asked staff about their understanding of risk management and keeping people safe, whilst not restricting their freedom. One staff member said, "We do risk assessments and if someone can do something for themselves, we let them". Another staff member told us, "Keeping people safe is a priority, but not too much". Care plans contained risk assessments and consent forms which had been completed for events such as trips out into the wider community.

Staff had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would report any concerns to the manager, not that I have had any". Another staff member said, "I would go outside the home to make sure someone was protected if I had to, but I know the manager would do something anyway".

The provider's incident and accident records showed that there had been 13 accidents or incidents involving people in the previous three months. We looked at all of these and action had been taken as a result to minimise the chance of a reoccurrence. All accident and incident records contained a clear description of the event and indicated whether it should be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (1995). Written guidance was provided to staff on when and how to report any incidents or accidents under these regulations.

Risks to people were managed safely. Care plans included risk assessments for people in a range of areas such as behaviour, physical capability and mobility, continence, communication and medicines. Risk assessments contained detailed information and guidance to staff and were reviewed monthly. For example, one risk assessment for a person in moving and handling included the nature of the risk, the identifiable risk and action required by staff to mitigate the risk. The assessment included potential risks for a person rising from a chair, transfers to and from the toilet or their bed, bathing, walking and stairs. Risk assessments were also in place to assess skin integrity and people's risk of developing pressure ulcers, which can be caused by prolonged immobity. A district nurse who was visiting the home on the day of our inspection told us, "I've had no problems with the care here, the staff are quite co-operative" and added, "Communication is very open between us". In the Provider Information Return (PIR), the registered manager stated, 'Audits and reviews are conducted on various aspects of the service, such as infection control, health and safety and medication to check for patterns. If risks or concerns are identified, action is taken to minimise risks to the resident. This may include the purchasing of equipment, such as hospital beds, pressure relieving equipment or manual handling aids'.

Premises and equipment were managed to keep people safe. Risks had been assessed relating to the premises and the maintenance/refurbishment programme that was in progress. Some areas of the home had been cordoned off as maintenance work was completed. A number of rooms had already been redecorated and carpeted and there were plans in place to carpet all rooms. Covers were fitted to radiators to prevent the risk of people burning themselves against hot surfaces. The provider stated that they were purposely operating under capacity with several vacant rooms. This was planned to enable all areas of the home to be redecorated with minimal disturbance to people already living at the home. Personal emergency evacuation plans were in place for people and provided information and guidance to staff on how to support people in the event of an emergency such as fire, power failure or flood.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. On the morning of our inspection, the following staff were on duty: a team leader, an assistant team leader, four care staff and the registered manager. Care staff also had additional responsibilities that included cleaning. We asked staff about staffing levels at the home. One staff member said, "There's no problem really. I always have time to do what needs doing". Another staff member told us, "We have enough time and there's always time to talk with the residents".

We looked at the staff duty rota for the period between 14 December 2015 and 10 January 2016. The rota showed that staffing levels were consistent across the time examined, with six care staff in the mornings, four in the afternoon and evenings plus the registered manager, and two care staff at night. The provider did not use agency staff. The cook, who worked part-time in this role, was due to leave. Several staff members were qualified to step into this role in the interim and the registered manager explained that care staff would take turns to prepare meals until a full-time replacement cook was recruited. Staff were aware of this and were satisfied with the arrangement. In the PIR, the registered manager stated, 'Staff have been signed up to the new course in January 2016 provided by [named council] Level 2 Award in Healthier Food and Special Diets'.

We asked how staffing levels were established by the provider. The provider did not use a formal tool to assess the changing care needs of individuals and calculate staffing levels accordingly. Instead the registered manager re-assessed staffing levels according to occupancy rates and changes noted in people's care needs.

Safe recruitment practices were in place. Appropriate checks were undertaken before staff commenced employment. Staff files showed that criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work in the care profession. There were also copies of other relevant documentation in staff files including character references, job descriptions and copies of identification documents, such as passports.

Medicines were managed safely and were ordered, stored, administered and disposed of appropriately. We observed a senior member of care staff administering medicines to people at lunchtime. The member of staff wore a protective apron and checked the temperature of the medicines stored in the medicines trolley. The staff member then looked at the Medication Administration Record (MAR) and checked which medicines were needed by people. A Monitored Dosage System enabled tablets to be transferred safely from the blister pack into a separate dosset pot. Each person's medicines were prepared individually and the staff member then administered the appropriate medicine to people, making sure that the medicines trolley was locked when unattended. We observed the staff member approach one person and said, "Hello [named person]. It's your medication time. Okay my chicken, can you open your mouth for me?" The person responded positively to the staff member's words and were encouraged to take their medicine. The

staff member then offered tablets off a spoon, which they carefully placed into the person's mouth, then offered a drink. They said, "That's your Paracetamol to help with your pain".

MAR charts were all completed appropriately. In one instance, a staff member had signed that a medicine for one person had been administered, when the tablet had not been given. An explanation that the MAR had been signed in error had been recorded appropriately on the reverse of the sheet. The registered manager observed staff administering medicines on a monthly basis, to check their competency. Stocks of medicines were kept securely in a separate area dedicated for this purpose. We checked stock levels and audits of some medicines and found that these were correct. A leading pharmacy was due to undertake an audit of medicines on the day of our inspection.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. We spoke with staff about their experiences of induction when they commenced employment. One staff member told us, "I hadn't done this kind of work before and so I did a lot of shadowing. On my first day I spent four hours just getting to know the residents. I wasn't expected to do anything else". Care Certificate training was now undertaken by all new care staff. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

We spoke with staff about the training opportunities on offer. One staff member said, "It's never ending and there's lots of it!" Another staff member told us, "I learn more every day and it's good because the training is about things that affect the people we look after". The training matrix and staff files showed that all staff were able to access training in subjects relevant to the care needs of the people they were supporting. The provider had made training and updates mandatory for all staff in the following areas: infection control, health and safety, moving and handling, fire awareness, safeguarding vulnerable adults, whistleblowing, first aid, food hygiene, Mental Capacity Act (2005), Deprivation of Liberty Safeguards and dementia awareness. Other additional training included: medicines management, eating well, equality and diversity and effective communication. Staff were also undertaking or had completed training in National Vocational Qualifications (NVQ) in health and social care at various levels; these are work based awards.

We asked staff how they were formally supervised and appraised by the provider. All staff we spoke with had received a recent, formal supervision or a yearly appraisal. One staff member said, "I can talk about me and my progress". Another staff member told us, "I get listened to and that's what matters". The supervision and appraisal records we checked showed that staff had received regular supervision and yearly appraisals had been undertaken or were planned, in line with the provider's policy.

Staff meetings were held at least four times a year and we looked at the minutes of the latest meetings. Staff were able to discuss matters of importance to them and the people they were looking after. However, the minutes did not contain a review of the minutes of the previous meeting or an action plan for the current one. This meant it was not possible to ascertain whether issues raised previously had been resolved. We discussed this with the registered manager who stated that they would record any matters arising at staff meetings in the future and check that any action points had been completed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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. The registered manager had undertaken capacity assessments for everyone living at the home and had applied for authorisations under DoLS. No authorisations had yet been completed by the local authority and the registered manager kept in regular touch with the DoLS team to monitor the progress of the authorisations needed for people at Tudor House. The registered manager told us about a best interest meeting that had been held for one person concerning the administration of a particular medicine that had been recommended by a medical professional. In another person's care plan it stated that a relative had Lasting Power of Attorney (LPA) to make health, welfare and financial decisions on the person's behalf. However, there was no record on file to prove the relative did have LPA. We discussed this issue with the registered manager who stated they would obtain a copy of the LPA to be placed in the person's care plan as required.

We asked staff about issues of consent and their understanding of the MCA. All staff we spoke with had undertaken recent training in this area and most had a good understanding of the legislation. This included the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Some staff members could tell us the implications of DoLS for people they were supporting. One staff member referred to the MCA and explained, "I think it's about making safe choices for people when they can't make them for themselves". Another staff member told us, "It's about making sure people are safe if they can't make their own decisions".

People were supported to have sufficient to eat, drink and maintain a balanced diet. A senior member of the care team was preparing lunch on the day of our inspection. The lunch menu choice was chicken Kiev, potatoes, cabbage and carrots with gravy or beef curry. Banana and custard was on offer for dessert, but people could also choose from other options. A range of drinks and snacks were available to people throughout the day. One staff member referred to food choices and said, "We try and maintain what people are used to". People were involved in planning the menu and their views were sought at residents' meetings. People had chosen to have a roast lunch on a Sunday and to have fish as one option on a Friday. At supper time, people could choose to have a hot option or sandwiches. People selected what they wanted to eat for lunch when morning drinks were served on the same day. To aid people's understanding of the menu, pictures of food and photo references were used to enable people to make their preferred choice.

We asked people what they thought about the meals at Tudor House. One person said, "Very good. I like most things. I don't like anything that's fatty, but I eat all vegetables. We do pretty well and there's plenty of food here". They added, "Staff come and ask me if I'm all right. They make sure I have plenty to drink". Another person referred to the food and said, "It's okay. I don't make a fuss about food". We observed staff supporting people to eat their lunchtime meal. We saw that one lady sat with their untouched meal in front of them and that they were wearing a clothes protector, but no staff were sitting with them and the meal was getting cold. After several minutes, a member of staff noticed the person sitting unattended and immediately offered assistance, offering to reheat their lunch for them. People were encouraged to eat as much as they comfortably could and staff supported them in a sensitive and caring way. We observed that puddings were also served to some people at the same time as their first course. In one instance, we saw that the banana had turned brown having been left and did not look particularly appetising. We discussed this with the registered manager who stated they would ensure that puddings were served fresh as needed.

People were assessed to identify whether they were at risk of malnourishment. The provider employed a tool specifically for this purpose, the Malnutrition Universal Screening Tool (MUST) which used a combination of people's height, weight and body mass index to identify whether they were at risk of malnourishment or were overweight. People's MUST assessments were reviewed monthly so that their

nutritional needs could be monitored. We observed that one person received a pureed diet and this was attractively presented with the various food groups separated into individual bowls. The member of staff was asking the person which particular food they fancied eating and this encouraged the person to have control over what they chose to eat. Where needed, professional advice had been sought for people who had difficulties in swallowing, for example, risk of choking or aspirating on food. Special diets were catered for and low sugar/carbohydrate diets were in place for people with type 2 diabetes.

People were supported to maintain good health and had access to healthcare services and professionals. One person confirmed that staff supported them to attend their hospital appointments. Care plans recorded when people had received input from healthcare professionals such as their GP, community psychiatric nurse, chiropodist or from an optician or dentist. When people were weighed every month, their blood pressure was also recorded and any changes were monitored and appropriate advice sought from a health professional. Advice and guidance given by professionals was followed and documented in people's care plans. On the day of our inspection, visitors included a member from the DoLS team, a social worker and a pharmacist. In the PIR, the registered manager stated, 'In the event of hospital admission, 'Knowing Me' booklets are sent with the resident to assist hospital staff with caring appropriately for the resident'. ('Knowing Me' is a document which holds information about the person, including their personal history, medical history and healthcare needs.)

Good

Is the service caring?

Our findings

We observed that positive, caring relationships had been developed between people and staff. People were treated with kindness and compassion and staff were patient and attentive to people's needs. The atmosphere at Tudor House was warm and friendly and staff clearly enjoyed their work; there was a real energy and 'buzz' about the home. One person confirmed that they were happy at the home and said, "I've made it my business to know everyone here and we have a laugh". Another person said, "Sometimes I feel lonely, but I'm well looked after here". Staff spoke with people in a gentle and reassuring way and knelt or sat down to maintain eye contact with people, rather than standing over them. We asked relatives about the caring approach of staff. One relative said, "The staff are really kind and caring. I visit often at all times of the day and the welcome is always the same". Another relative referred to staff and said, "They always keep me up to date if there are trips planned of if [named family member] has had a bad night". Throughout our observations at inspection, care given was of a consistently high standard.

We observed care in communal areas throughout the day. The care was safe and appropriate with adequate numbers of staff present. Excellent interaction took place between people and staff, who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff. Consequently, where possible, people felt empowered to express their needs and received appropriate care. People were encouraged and supported to be involved in making decisions about their care and to express their views. One person confirmed they were involved in planning their care and said, "They'd better involve me or they'd be told off!" Care plan agreements were in place and had been signed by the person and/or their relative to show they had read the contents and agreed with their plan of care. Care plan review meetings were held every month and people and their relatives were encouraged to attend these meetings. There were opportunities to alter the care plans if the person or their relative did not feel they reflected their care needs accurately. People or their representative's consent was also sought on a variety of issues, including the sharing of information with external agencies, photography for identification purposes, administration of the 'flu vaccine and administration of medicines.

Care plans contained life histories and social assessments for people. These had been compiled in conjunction with people and their families where possible and contained information staff could use to build relationships, for example, people's previous occupations and hobbies. One person had helped to complete their personal history and had written about their experiences of making cordite and shell cases for bombs during World War II.

People were treated with dignity and respect. We asked relatives how people's dignity was maintained. One relative told us, "That just seems to come naturally to staff". Another relative said, "It's not just with my relative. I've watched staff with other people and they are always kind and considerate. They don't talk over people or rush them". Our observations at inspection confirmed this. For example, staff brought screens to place around one person, to maintain their privacy, when a district nurse visited to look at the person's legs. Staff were also offered training in equality and diversity and in dignity and respect.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans contained detailed information about people's care needs, for example, in the management of the risks associated with accessing the wider community and environmental hazards. The care plans also contained detailed information about people's personal histories, their likes and dislikes, as well as their choices and preferences. The daily records were detailed and showed that these were taken into account when people received care, for example, in their choice of where to take their meals. Care planning and individual risk assessments were reviewed monthly and audited regularly to ensure they contained detailed and relevant information. For example, in relation to one person who could exhibit challenging behaviour from time to time, their care plan contained a detailed behaviour plan which outlined steps staff should take to distract the person or de-escalate the situation, whilst keeping other people and staff members safe. The same person had also suffered unexpected weight loss in the previous six months. The provider had taken appropriate steps to discover why this was happening and had taken action to remedy the situation. This was done by a referral to a community dietician who advised changes to the person's diet.

In the PIR, the registered manager stated, 'We are in the process of upgrading our care plan system to the computerised [named software program]. This will assist with making care planning more effective and responsive. With clearly designed sections, assessments and useful visual charts to record, for example, weight – this system will assist the home to be more responsive to residents' needs'. We asked one person whether staff were responsive to their needs. They said, "When I want them there, but I don't need to be entertained".

A range of activities was available to people and these were discussed at residents' meetings. A notice in the hall area showed that on Mondays external entertainers came to the home, on Tuesdays chair exercises were organised and people could also do some baking supported by a member of staff. A minibus outing was organised every Wednesday and pets visited the home on a Thursday. In the PIR, the registered manager stated, 'We will be purchasing an i-Pad for the home to assist the staff to provide person-centred activities for residents. Training on effective use of i-Pads with residents will be given by [named person] on 20 January 2016'. This would enable staff to spent 1:1 time with people to engage in activities individually. Some people living with dementia found it difficult to engage in group activities and preferred to look at magazines or watch DVDs. Monthly church or Communion services to meet people's religious needs were also organised by visiting clergy if people wished to participate.

Complaints were managed appropriately. The provider's complaints policy and procedures was displayed in a communal area. The policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies such as the Local Government Ombudsman. However, the address shown for the Care Quality Commission was incorrect and the registered manager stated they would rectify this. One formal complaint had been made in the past year. The complaint had been resolved in a timely and satisfactory manner. The registered manager had written to the relevant parties with action points, to prevent reoccurrence.

Good

Is the service well-led?

Our findings

People were actively involved in developing the service. Minutes of the latest residents' and relatives' meetings showed that people and their representatives were able to discuss matters of importance to them. For example, people were included in discussions on the refurbishment of the home and were able to make decisions relating to the colour schemes. One person confirmed that they liked living at Tudor House and said, "It doesn't interfere with my life. I get on with my life as I want to". In the PIR, the registered manager stated, 'We hold quarterly residents' meetings where they have an opportunity to discuss matters of interest to them, such as ideas for menu choices or activities. Most recently, discussion has been had about the interior decorating and their ideas on colour schemes. We hold relatives' meetings twice a year, where relatives have an opportunity to put forward their queries or suggestions. We also use this time as an opportunity for learning. For example, at our last relatives' meeting in November 2015, [named company] attended and gave a talk about how they test the residents' eyes'.

A questionnaire had been sent to people, visitors and relatives at the end of 2015. Questions were asked on a variety of topics such as whether staff were welcoming, satisfaction of the care provided, staff appearance and dress, the environment, whether they were treated with respect, that the home was clean and odour free, that relatives were free to visit and that people had confidence in the management team. One relative had responded saying, 'Very pleased with the management and staff care. I feel that my father is safe and content in their care'. Another relative stated, 'Very pleased with the way the staff care for [named family member] and her complex needs. I am confident she is safe and well'.

Staff were also asked for their views about the home and, out of 19 surveys sent out, 15 staff responded, with positive feedback. We asked staff about the vision and values of the home. We asked the question, "What is the purpose of the home and what does it offer to people?" One staff member said, "It's to provide a caring environment I would say. And it can be fun too". Another staff member told us, "It's just like a family home. I think we are all just one big family". Staff confirmed to us that the registered manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence.

The service demonstrated good management and leadership. We asked staff if they thought the home was well led. One staff member told us, "There have been a lot of changes since the new people took over and they're all good". Another staff member said, "The manager is really approachable and I know they have plans for this place like new carpets and the like. That's a good sign I think". The registered manager said, "We expect staff to be committed. Some staff have come in and done training even on their day off".

We talked with the registered manager about the home; they explained that it was a family run business and that members of the family worked collaboratively at this and the other home they owned locally. The registered manager explained, "It's a family run business and it shows. We're all involved. I have a good support network from people I trust". They went on to talk about the experience of their family in running care homes and said, "We can use those skills to create a home that runs to a good standard. When we see things, we can deal with it. We can buy things and get things done quickly".

The service delivered high quality care. One relative said, "I've seen a great change with mother since she's been here". A robust quality assurance system was in place to measure the quality of the care that was delivered. The provider had completed a quality assurance report for 2015. This included audits in a range of areas such as moving and handling, medicines, risk assessments (relating to people and the environment), staff training and supervision, accident and hospital admissions review. The registered manager told us that they were planning to undertake an overall audit of accidents and incidents in order to establish any possible patterns and trends. They told us, "Taking over any business is always a challenge. The residents were living here already and staff were in place," and added that major improvements to the premises were needed to achieve an acceptable standard. The registered manager added, "We have quite high standards. We have a lot of drive, enthusiasm and ambition. It can be frustrating, we need to get everyone on board". They went on to talk about the importance of reassuring families about the continuity of care since the home had changed ownership and whilst refurbishment was in progress.