Autumn House Care Limited

Autumn House Residential Home

Inspection report

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23 August 2022

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Autumn House is a residential care home providing accommodation and personal care for up to 44 older people many of whom had dementia. At the time of this inspection there were 40 people living at the home.

People's experience of using this service and what we found
Most people and their family members gave us positive feedback about the home and told us staff were kind and caring. We observed positive communication between staff and people.

There were usually enough staff to support people's needs and the provider was recruiting further staff to increase staffing levels especially at night. Appropriate recruitment procedures had generally been followed to help ensure only suitable staff were employed. Staff had received training and support to enable them to carry out their role safely.

Systems were in place so that medicines were administered safely and as prescribed which staff usually followed. The manager had taken action to improve the meals being provided. Infection prevention and control measures were in place and followed government guidance.

Individual and most environmental risks were assessed and managed appropriately. People had access to any necessary equipment where needed, which helped ensure people were safe from harm.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

There were appropriate policies and systems in place to protect people from the risk of abuse and the management team and staff understood the actions they should take to keep people safe.

Care plans contained detailed relevant information about people's health and social care support needs. People and, where appropriate family members, were involved in the development of care plans. People were able to access health and social care professionals if needed.

The management team carried out regular checks on the quality and safety of the service and understood their regulatory responsibilities. People, their family members and external professionals said the manager was approachable and supportive. Staff were also positive about the manager.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 30 March 2021). The provider

completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

At our last inspection we recommended that the provider review local safeguarding adults board procedures to ensure robust processes are in place to safeguard people from abuse. At this inspection we found appropriate action had been taken.

Why we inspected
This inspection was prompted by a review of the information we held about this service. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to good based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Autumn House Residential Home on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service well-led? The service was well-led. Details are in our well-led findings below.	**Good**

Autumn House Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Autumn House Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Autumn House Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post however, the manager had applied

to CQC to become the registered manager.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 23 August 2022 and ended on 7 September 2022. We visited the location's service on 23 August 2022.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. This included inspection reports, action plans submitted by the provider and notifications. Notifications are information about specific important events the service is legally required to send to us. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and ten family members about their experience of the care provided. We received feedback from two external professionals. We spoke with 11 members of staff including the manager, deputy manager, provider's quality lead, care workers, activity staff, administration staff, catering staff and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed care being provided within communal areas of the home and viewed the home and garden.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including records of checks completed on the fire detection systems. We looked at training data, policies and procedures, records of accidents or incidents, complaints and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement.

This meant some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Preventing and controlling infection
At the last inspection completed in January 2021 inspectors identified that the provider had failed to safely manage infection control risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had made the necessary improvements and was no longer in breach of regulations.

- Appropriate arrangements were in place to control the risk of infection.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection and that safe systems were in place when people were admitted to the home.
- We were assured that the provider was using personal protective equipment [PPE] effectively and safely. Staff had been trained in infection control techniques and had access to PPE, including disposable masks, gloves and aprons, which we saw they used whenever needed.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was responding effectively to risks and signs of infection. The provider was accessing testing for people using the service and staff which followed best practice guidelines in place at the time of the inspection. Staff told us they were undertaking COVID 19 home tests several times a week and systems were in place to ensure evidence of these were available for the provider.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. The home appeared clean and overall well maintained. Housekeeping staff completed regular cleaning in accordance with set schedules. A family member told us, "The place is always clean and tidy."
- We were assured the provider was making sure infection outbreaks can be effectively prevented or managed. The provider's infection prevention and control policy was up to date and reflected current best practice guidelines. Infection control audits had been completed. A community health professional told us, "In terms of infection prevention and control. The care home staff have been appropriately masked and have been keen to support video consulting where appropriate to reduce infection risk during times of COVID -19."

Visiting in care homes
Safe systems were in place to enable people to receive family visitors. Family members confirmed they were able to visit and take people on outings away from the home. One family member said, "I still have to make

an appointment to visit – 24 hours in advance, take evidence of a negative lateral-flow COVID test, then have a temperature scan before being allowed in. We're limited to an hour per visit – they also insist on wearing masks." However, another family member told us, "They're more flexible about visiting now – it's a seven-hour drive for us to get to the Isle of Wight, but originally we didn't get any allowance on the one-hour slot."

We discussed visiting with the manager who said a booking system helped ensure there was sufficient space for safe visiting however, any ad hoc requests would be met wherever possible and end of life visiting was unrestricted.

Assessing risk, safety monitoring and management
At the last inspection completed in January 2021 inspectors identified that the provider had failed to safely manage risks to people using the service and to take action to mitigate risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider had made the necessary improvements and was no longer in breach of regulations.

● Systems were in place to identify and manage most foreseeable risks within the service, meaning people were generally protected from the risk of harm.
● Fire safety risks and risks from water systems, had been assessed by a specialist. However, the manager was unaware of the improvements which the fire risk assessment completed by an external professional in December 2021 had identified. This had been prior to their commencing employment. Once aware they immediately initiated actions to ensure these were completed. Risks posed by asbestos had not been recently reviewed and the provider agreed to ensure this was regularly undertaken.
● We noted that most bedroom doors did not have automatic devices which would ensure doors closed in the event of fire alarms sounding. This meant bedroom doors had to be kept closed at all times and placed people at risk of social isolation. Although people could open these from the inside some people living with dementia may feel isolated if spending long periods of time in their bedrooms with doors closed. Risk assessments for social isolation had not been completed and we were not assured all reasonable action to mitigate this risk had been taken. We discussed this with the manager who said, they would look to provide automatic door opening devices where indicated and also look into alert systems so that staff would know if other people were entering vulnerable people's bedrooms.
● Other risks relating to individual people had been assessed and recorded, along with action staff needed to take to mitigate the risk. For example, risk assessments were in place for people at risk of falling, medicines management, skin integrity, nutrition, dehydration and mobility. Daily records of care showed staff were following risk mitigation measures. For example, a person was at risk of choking and required their food and drinks in a particular texture. Daily records showed staff recording food and drinks in the appropriate format had been provided. Risks were managed in a way to ensure people were able to be as independent as possible. For example, several people liked to smoke cigarettes. They were supported to do this safely in an outside area.
● Records showed equipment was monitored and maintained according to a schedule. In addition, gas, electricity and electrical appliances were checked and serviced regularly.
● Fire detection systems were checked weekly. Personal emergency evacuation plans had been completed for each person, detailing action needed to support people to evacuate the building in an emergency. Training records showed that staff [other than a few newly recruited] had received fire awareness training.

Staffing and recruitment
● The provider had appropriate recruitment procedures however, these had not always been fully followed

meaning there was a risk unsuitable staff could be employed. We found that two references were not always received prior to new staff commencing employment. Investigating any gaps in employment and applicants completing a health declaration had also not been consistently completed before new staff commenced working in the home.

● We brought this to the attention of the manager who said that they intended to undertake a full review of all staff files to identify any missing information. We noted this was included on the manager's service improvement plan but had not yet been undertaken.

● Staffing levels were determined by the number of people using the service and the level of care they required. The manager said they would like to provide an additional member of staff on night shifts but was finding it hard to recruit to these roles. At the time of the inspection duty rosters showed there were usually two-night staff provided for 40 people from 8pm until 8am. Although records of care showed people were receiving care throughout the night it was unclear how this would be maintained if a person required prolonged additional care requiring both staff. The manager said on call staff were available who lived nearby who staff could contact in an emergency.

● One staff member told us, "We have time to do everything we need to do." They also confirmed two staff were always available when required to support people who needed a higher level of support such as with moving and repositioning. Whilst another staff member said, "I feel like most of the care homes across the island/country we can be 'short' staffed, which results in people not getting the full care and needs being met to a high standard. We are trying a new 'delegation' which has helped to a point, although with a lot of high dependency clients it is hard to provide the care other clients may need." Appropriate numbers of ancillary staff, housekeepers and catering staff were employed.

● People were supported by staff who they described as kind and caring. For example, one person said, "I have those staff I feel I can talk to more than others but generally they're all OK." Another person told us, "The staff here are pretty good and they treat me well they seemed to know what they're doing." With one exception all family members were positive about the home's care staff. Positive comments included, "The staff are very dedicated, they call my mother by her name and know her well." And, "The staff talk to her and seem to know what she needs. They come and talk to her or just sit and hold her hand."

Systems and processes to safeguard people from the risk of abuse

● Appropriate systems were in place and followed, which protected people from the risk of abuse.

● People said they felt safe using the service. A person said, "I feel safe they seem to know me well and I can do my own thing. "Family members also felt people were safe. For example, one family member told us, "Safe? Absolutely. He spends much of his time in his room – his choice - but he takes his meals in the dining room with other residents." Whilst another said, "Yes, my mother is definitely safe at Autumn House which I'm relieved about since she has advanced dementia and is very vulnerable."

● Staff had received safeguarding training and knew how to prevent, identify and report allegations of abuse. One staff member described the actions they would take if they witnessed or suspected abuse may have occurred. They told us, "I'd go to the manager or [provider]. If they didn't take any action I'd go directly to safeguarding (local authority safeguarding team) or to you [CQC]."

● When safeguarding concerns had been identified staff had acted promptly to ensure the person's safety. However, whilst reviewing records of care we identified a safeguarding incident between two people living at the home. Although staff had taken appropriate action at the time the manager was unaware of the incident. It had not been reported to safeguarding and other actions the manager could have considered to reduce the risk of repeat occurrences had not occurred as they had been unaware of the incident. The manager subsequently investigated the report in the daily records and reinforced to staff the need to report incidents to the management team.

● The manager understood the actions they should take should they have a safeguarding concern.

Using medicines safely

● Suitable arrangements were in place for obtaining, storing, administering, recording, disposing safely of unused medicines and auditing of medicines systems although care staff had not always followed these correctly.

● Two staff had failed to sign medicines administration forms when medicines had been received without a pre-printed administration sheet. This meant errors may not be detected. A process was in place to record the exact time regular dose medicines such as paracetamol were administered however, care staff had not always used this meaning there was a risk people may receive these medicines too close together. The manager and deputy manager undertook to remind staff of these procedures and ensure they were fully followed in the future.

● Staff monitored fridge and room temperatures where medicines were kept, checking medicines were stored within safe temperature ranges. Systems were in place to ensure that when additional medicines such as antibiotics were prescribed, these were obtained promptly meaning there were no delays in commencement of administration.

● Guidance was in place to help staff understand when to administer as required medicines and in what dose.

● Staff had been trained to administer medicines and had been assessed as competent to do so safely. The provider's procedure ensured this was reassessed at least yearly using a formal approach.

Learning lessons when things go wrong

● Where an incident or accident had occurred, the provider had a process for staff to follow. Records reviewed showed that care staff completed electronic accident and incident forms when required. Staff then assigned these for review by a member of the management team. Where required action was taken to reduce the risk of future similar incidents.

● The provider's quality monitoring systems including logging incidents such as falls onto a computer system. This enabled patterns or trends such as time of day or location of falls to be analysed. This would help in determining if further action was required to reduce future falls.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

When we last assessed effective we rated this key question requires improvement. At this inspection the rating has changed to Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience

- People received care from staff who had the necessary knowledge, skills and experience to perform their roles. A family member told us, "The staff show understanding and, to an extent, anticipate her needs."
- Staff completed a range of training to meet people's needs, which was refreshed and updated. Staff were also supported to gain vocational qualifications relevant to their roles. This was confirmed by care staff we spoke with.
- Whilst reviewing training information we noted that some newer staff had not yet completed all induction training. We discussed this with the manager who told us new staff completed a programme of induction before being allowed to work on their own. This included a period of shadowing more experienced members of staff. Staff who were new to care were supported to complete training that followed the Care Certificate and were expected to complete this within 8 weeks of commencing employment. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.
- Our observations of staff indicated that they followed training provided when caring for people. For example, we observed staff communicating with and supporting people with mobilising. The procedures observed were appropriate and people were supported to feel safe throughout.

Supporting people to eat and drink enough to maintain a balanced diet

- We received mixed views from people and family members about the food provided at Autumn House. For example, one person said, "The food is a bit hit and miss we don't get much meat but some meals are nice and some are pretty poor." And another person told us, "I don't have a big appetite but the foods OK some meals are not so great but most are alright." Whilst a family member said, "My relative is active. Lunch recently was one potato, two very small pieces of chicken and a small spoon full of veg. The quality of the food is good but needs to be matched to residents' size and appetite." Other comments were more positive including, "Yes, it's nice, very nice", and "Yes, the food is ok here."
- We observed lunch whilst we were in the home. The dining room was full and most people appeared to have the same meal - fishfingers, chips and peas. Meals were on the small side and looked basic, however, people were eating and seemed to enjoy it.
- We discussed family members and people's comments about meals with the manager who said, they had also recently identified that meals were not as appetizing or provided in sufficient quantity for everyone. They had now taken action to change the staff within the catering team and said they would be continuing to monitor meals provided to ensure these met people's needs.
- Individual dietary requirements and people's likes and dislikes were recorded in people's care plans and

catering staff had relevant information to support people's needs and preferences. A family member told us, "My relative lives with Coeliac disease hence their diet has to be controlled carefully – the staff are very supportive." Daily records of care indicated that people received appropriate meals to meet any health needs and were frequently offered hot and cold drinks.

Adapting service, design, decoration to meet people's needs

● All bedrooms were for single occupancy although some could accommodate two people if specifically requested for example, if a couple were admitted and wished to share a bedroom. Some family members commented on the small size of some bedrooms with one stating that their relatives' room was too small for a chair.

● The provider's quality lead explained how they were working with people and family members to improve personalisation of people's bedrooms. They explained they had asked family members to bring in photographs and items of importance to people and had made sure these were up on the walls of people's bedrooms. For example, we saw one bedroom had a photograph of the occupant's family and a photograph of the person as a young woman with a baby. The quality lead discussed the importance of this to support staff to recognise people's previous life experiences prior to their current care needs.

● There was a range of communal areas available to people, including a dining room and lounges which allowed people choices about where to spend their time. Consideration had been given to supporting people living with dementia or poor vision. Toilets and bathrooms were well signposted to make them easier for people to find.

● All parts of the home could be accessed by a passenger lift.

● The enclosed garden was accessible with even pathways and handrails. New furniture had been purchased and further garden furniture was being bought as one table and chairs was clearly very worn. There was a sheltered area where people could sit out and another shed was being turned into a beach shack style place to sit. In addition, there was an interactive speaker outside gently playing music for people to enjoy while sat in the garden.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Autumn House used an electronic care planning system which was formalised and ensured each aspect of the person's care was assessed. Where necessary a plan was put in place to address identified needs and the choices people had made about the care and support they wished to receive.

● Family members confirmed they and others involved in the person's care had usually been included in assessments of people's needs. One family member told us, "My relative is now always cared for in bed and the new manager has carried out a risk assessment and suggested that this was the best option. They've fixed lights on the ceiling for her to look at and moved her bed to the window where she can see what's happening outside."

● Staff followed best practice guidance, which led to good outcomes for people. For example, they used recognised tools to assess the risk of malnutrition and the risk of skin breakdown. Each person had an oral hygiene care plan in place and staff supported people in accordance with the latest best practice guidance on oral care.

● People's protected characteristics under the Equalities Act 2010 were identified as part of their need's assessments.

● The service made appropriate use of technology to support people. An electronic system allowed people to call for assistance when needed and movement-activated alarms were used to alert staff when people moved to unsafe positions. Care planning and the documenting of care provided was recorded on a computer system, care staff were provided with portable devices which enabled them to have constant access to all information they may require. This system also allowed the management team to monitor care being provided in real time and provided alerts if staff failed to complete any specific tasks.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care

● People and family members told us they were supported to access local healthcare services such as doctors or community nurses. This was confirmed in care records viewed.

● People's health needs were recorded in their care plans and contained information from health care professionals. A health professional told us they were consulted appropriately if staff had new concerns about people. They said, "Staff members that I have spoken to recently do seem to be raising medical concerns appropriately, have respect for the residents needs and hold the resident's well-being in high regard."

● Staff worked together to ensure people received consistent, coordinated, person-centred care and support. At the start of each shift staff received a handover and could access care plans should they wish to confirm any information. Staff explained how they had access to information about people via the handheld electronic care planning system. They said this meant they could check any details at any time.

● If a person was admitted to hospital, staff ensured key information about the person was sent with them. This helped ensure the person's needs continued to be understood and met.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Where people did not have capacity to make decisions, MCA assessments had been completed such as for personal care and receiving medicines. These had included consultation with those close to the person and decisions had been made in the best interests of the person. These had been fully documented.

● Where people had capacity to make decisions, we saw they had consented with the proposed care and support. Where people had capacity and wanted to make unwise decisions this was documented and staff guided to advise the person but respect their decisions.

● Staff were clear about the need to seek verbal consent from people before providing care or support. People's right to decline care was understood. Care staff said that, should people decline care or medicines, they would return a short while later to again offer assistance. Should people continue to decline they would encourage but respect the person's decisions and inform the management team.

● Where necessary, applications had been made to the relevant authority and nobody was being unlawfully deprived of their liberty. There were systems in place to ensure that renewal applications were submitted in a timely way prior to existing DoLS becoming out of date.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care

At the last inspection completed in January 2021 inspectors identified that the provider had failed to operate effective systems to assess, monitor and ensure the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found the provider had failed to notify CQC of significant events without delay. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found the provider had made the necessary improvements and was no longer in breach of these regulations.

● The registered manager left in February 2022. The provider's area manager was now carrying out the day to day management of Autumn House. They had applied to CQC to become the registered manager. This will mean they and the provider's nominated person will be legally responsible for the service.
● The manager had completed an assessment of the service and an improvement plan showed how they were intending to address the various issues they had identified. For example, to address the challenges they were facing with staff recruitment they had contracted with an agency who supplied permanent overseas staff. Some had already commenced employment at the service with additional staff due to arrive soon after the inspection.
● When we identified further areas for improvement the manager was receptive to our suggestions. They acknowledged where they had missed things such as the actions required following the external fire risk assessment and immediately acted to address the priority areas.
● The provider had a quality improvement lead who described the audits and actions they had taken to improve the environment, systems and care people were receiving. A range of audits and monitoring processes were in place completed by the quality lead, manager and deputy managers.
● The provider's representative [Nominated individual] told us they were regularly at the home meaning they could continuously monitor the service provided.
● Staff were organised and carried out their duties in a calm, professional manner.
● Staff were positive about working at Autumn House. Comments from staff included: "I love working here, we all get on well", and "I can always get support if I need it."
● Registered persons are required to notify CQC of a range of events which occur within services. The manager understood their responsibilities and had notified CQC about all incidents, safeguarding concerns and significant events as required.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and their family members were generally satisfied with the service provided at Autumn House and felt it was well managed. One person told us, "The atmosphere here is much better than it used to be." A family member said, "The new manager has identified some issues and it will be interesting to see how things change in the next few months." An external professional told us, "I must say I was impressed on my visit how things have changed."

● People, family members and staff were confident that if they raised any issues or concerns with the management team, they would be listened to and these would be acted on. A person told us, "If I thought something was wrong I would say." A staff member said, "I would definitely say something to the manager or [provider]." Another staff member told us, "Under the new management I am confident to raise my concerns and to voice my opinions on ways we can promote a positive way to help our clients and us as staff in ways that need improvement within the home."

● People, most family members and staff said they would recommend the home as a place to live. Several family members commented on how staff aimed to promote independence for people. One told us, "Unlike her previous home, the staff really know my mother. Where she can do things for herself, for instance washing herself at her hand basin, or other personal care tasks, they encourage her." However, another family member was less positive and said, "He seems to have lost social skills, and staff seem reluctant to recognise his ability to (largely) self-care."

● Pleasant interactions were seen between people and staff throughout the inspection. People appeared to be comfortable with staff and the new manager appeared to have already built good relationships with people. It was clear from talking with staff they had got to know people well.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager was aware of their responsibilities under the duty of candour which requires the service to apologise, including in writing when adverse incidents have occurred.

Working in partnership with others

● The service worked in partnership with key organisations, including the local authority and other health and social care professionals to provide joined-up care. This was evidenced within people's care records and discussions with external health and social care professionals.

● Family members were also viewed as partners in people's care. Most of those we spoke with felt included in assessments and care planning and stated that they were usually kept up to date with their relative's care.

● The manager told us they had identified areas for improvement and were working on these. They said they, "Aimed to further improve relationships with health and social care professionals and would like to increase contact with the local community."