Care Quality Commission

Care UK Community Partnerships Ltd

Langley Oaks

Inspection report

2 Langley Oaks Avenue
South Croydon
Surrey
CR2 8DH
Tel: 03333218260
Website: www.heaverscourtcroydon.co.uk

Date of inspection visit: 7 and 8 September 2015
Date of publication: 11/12/2015

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

Overall summary

We visited Langley Oaks on 7 and 8 September 2015.

The inspection was unannounced. The last inspection took place on 27 November 2013 during which made the service met the regulations we inspected.

The service provides residential care and support for up to 40 older people who may be living with dementia. At the time of the inspection there were 35 people living at the service and one person receiving respite care.

The service had a registered manager. 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 at the service felt safe. Staff had completed safeguarding of adults training and knew how to recognise and report abuse. They knew how to escalate concerns. The service provided a safe and comfortable environment for people, staff and visitors. People's needs were assessed and appropriate risk assessments

Summary of findings

developed. There were sufficient numbers of staff to meet people's needs and safe recruitment procedures were followed. There was an issue around infection control that was not the fault of the service and has been addressed since our inspection. People received their medicines safely and as prescribed.

Staff had the skills, knowledge and experience to deliver safe and effective care and support. The provider ensured staff were well trained. Staff were supported with regular supervision sessions and appraisals. Mental capacity assessments were completed to establish each person's capacity to make decisions. Where it was necessary to deprive people of their liberty to deliver care and support the service had applied for authorisations under the Deprivation of Liberty Safeguards. Staff had completed mental capacity training. People were supported to have a healthy diet and to maintain good health. Individual needs had been met by the adaptation, design and decoration of the service.

People and visitors commented positively about relationships with staff. People and their representatives were supported to express their views and were involved in making decisions about their care and treatment. Staff respected people's privacy and dignity and supported them to maintain as much independence as possible.

People received personalised care and support. Care plans were person centred and addressed a wide range of social and healthcare needs. Care plans and associated risk assessments reflected people's needs, goals and preferences. People were encouraged to take part in activities that reduced the risks of social isolation. A wide range of activities were available to people. The provider had systems to obtain feedback about the quality of the service they provided in order to learn and improve.

Staff spoke positively about the management team who had an open door policy if people, visitors of staff wanted to speak with them. The service had a system of audits and checks to monitor and assess the quality of service they provided. The provider had a clear set of visions and values.

Summary of findings

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 safe. Staff were trained in and understood safeguarding and associated procedures. The service provided a safe environment. People's needs were assessed and appropriate risk assessments developed. There were sufficient numbers of staff to meet people's needs and safe recruitment procedures were followed. People received their medicines safely.

Good

Is the service effective?
The service was effective. Staff had the skills, knowledge and experience to deliver safe and effective care and support. People's capacity to make decisions was assessed. People were supported to have a healthy diet and to maintain good health. Individual needs were met by the adaptation, design and decoration of the service.

Good

Is the service caring?
The service was caring. People and relatives commented positively about staff. Staff were aware of people's needs and preferences. Staff respected people's privacy and dignity.

Good

Is the service responsive?
The service was responsive. People received personalised care and support. People were encouraged to take part in activities that reduced the risks of social isolation. The provider had systems to obtain feedback about the quality of the service they provided in order to learn and improve.

Good

Is the service well-led?
he service was well-led. Staff spoke positively about the management team who had an open door policy if people, visitors of staff wanted to speak with them. The service had a system of audits and checks to monitor and assess the quality of service they provided. The provider had a clear set of visions and values.

Good

Langley Oaks

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 8 September 2015 and was unannounced.

The inspection team comprised two adult social care 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 which provides dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service which included statutory notifications and safeguarding alerts sent to us by the provider. We spoke with eight people using the service, eight visitors and eight members of staff including management. We carried out general observations throughout the inspection. We looked at records about people's care and support which included eight care files. We reviewed records about staff, policies and procedures, general risk assessments, accidents and incidents, minutes of meetings, complaints and service audits. We inspected the interior and exterior of the building and equipment used by the service.

Good

Is the service safe?

Our findings

We spoke with people using the service who told us that they felt safe living at Langley Oaks. One person told us, "Yes, I feel very safe here – everything is really good." We also spoke with visitors and members of staff. One visitor said, "When I leave I always feel contented that [my relative] is in a good place." Another visitor told us, "It's a nice home. If I ever did hear or see anything that I didn't think was right I would speak directly to [the manager]." One member of staff said, "Everybody is safe."

We were told by staff they had completed training to safeguard adults from abuse which was confirmed in their training records. We also asked staff various questions about safeguarding. Their responses showed an understanding of how to recognise different types of abuse and how to report safeguarding concerns. They also knew how to escalate concerns if they were ignored or not dealt with to their satisfaction.

One member of staff told us how they had reported an incident between two people using the service. Another member of staff told us about an incident where staff had reported a colleague behaving inappropriately when providing care and support and who was subsequently dismissed. They were confident that the provider would deal with any safeguarding issues appropriately. The provider had a safeguarding and whistle blowing policy and information on these topics were included in the employee handbook.

We saw handovers took place three times a day to brief incoming staff. Information was passed on about how individual people were feeling and behaving, any concerns about people, and details of any accidents or incidents that may have occurred in the preceding shift. This ensured staff had the most up to date information about people when they started their shift.

The service provided a safe and comfortable environment for people, staff and visitors. The building was purpose built to provide residential care and was well maintained. There were records of safety certificates and safety checks were carried out at appropriate intervals. They included gas, electrics, fire safety (alarms and equipment), legionella and food hygiene. The service had general risk assessments in place for the building, fittings, equipment and outside spaces. Fire drills took place once a week. The service had passed its fire safety inspection. Staff received training in first aid and fire safety.

People's needs were assessed before they moved into the service by the manager, deputy manager or one of the team leaders. We saw a pre admission assessment. It identified people's needs with a view to more detailed assessments taking place over time when the person moved in. We looked at risk assessments in care plans that were stored on a computerised care system. We saw a range of risk assessments that were relevant to each individual's care plans and included areas such as mental health, falls, nutrition, pressure ulcers and mobility. The risk assessments were clear and detailed and provided staff with necessary information to provide safe and appropriate care.

When we spoke with staff it was evident they had a good knowledge about people's needs and associated risks. In addition to their day to day dealings with people, daily notes and handovers ensured they were up to date and able to meet people's needs. Risk assessments were reviewed every month or in response to any accident or incidents. We found two cases where information had been recorded in care plans and daily notes but the risk assessment had not been updated. We were told by the management team that the risk assessments would be reviewed and staff reminded to update the risk assessments when relevant information came to light.

There were sufficient numbers of suitable staff to meet people's needs. Staff told us there were times when it got very busy and recently a floating member of staff had been removed from the staff roster (the floating member of staff was not assigned to a unit and could move between units providing extra help when needed). At the time of the inspection there were two team leaders covering four units over three floors and one team leader at night time. Each of the four units were staffed by two care assistants on the early and late shifts and one care assistant at night time. The manager and / or deputy manager were available most days of the week. Staff were also supported by catering and domestic staff seven days a week. The manager told us they did not use agency staff but had a pool of bank staff to fill gaps in the staff rota. We found there was a robust

Good

Is the service safe?

recruitment policy in place that included checks with the Disclosure and Barring Service, a full work history and references which ensured only suitable people were employed.

We saw medicines were managed safely. Members of staff wore a red tabard when administering medicines so that they would not be disturbed or distracted. We checked three medicine's rooms. Medicines, including controlled drugs, were stored safely and securely in an appropriate environment and administered by appropriately trained staff. Support was provided to staff through medicines training, guidance, procedures and policy. There were clear procedures for ordering and returning medicines.

We looked at records for the administration of medicines to people using the service. We found there was a list identifying staff initials. There was a profile sheet that preceded each person's medicine's administration record. It showed the name of the person with a recent photograph and identified any special precautions (in red) and how people preferred to take their medicines. Pro re nata medicines, commonly known as 'when required' medicines, were listed as were homely remedies that had been agreed with the GP.

We examined the medicines administration records which had been completed correctly. We examined medicines and other relevant records. Room and refrigerator temperatures were monitored and recorded each day. The controlled drugs register and the returns books were up to date. Medicines available tallied with records of medicines administered.

The building itself is owned by the London Borough of Croydon and was purpose built as a care home. Maintenance of the building and gardens, including cleaning, is provided by Eldon Housing Association. Care and support for people using the service is provided by Care UK. The London Borough of Croydon and Eldon Housing Association are not registered with CQC in relation to Langley Oaks.

During our inspection we smelt strong odours on the second floor. Staff explained that this was urine and part of an identified ongoing problem that the domestic staff were attempting to clean with the products they had available. The carpet was not appropriate for this area of the building and could have an impact on the control of infection in that area. We discussed our concerns with the management team who explained they had been working with Eldon and Croydon council to fit more appropriate flooring in this area. Since our inspection the carpet has been replace with a more suitable floor covering.

As a result of the smell we looked more closely at the prevention and control of infection on all floors. We did not identify any other areas of concern. Communal areas and rooms were clean, tidy and odour free. The domestic staff worked in line with cleaning schedules. Staff used disposable, personal protective equipment at appropriate times when delivering care and support. Clinical waste bins were clearly identifiable. Laundry baskets were colour coded to prevent cross infection. We saw staff washing their hands at appropriate times. We saw staff had completed training in infection prevention and completed a refresher course every 12 months. Some staff were due refresher training and were awaiting allocation of training dates.

Good

Is the service effective?

Our findings

Staff had the skills, knowledge and experience to deliver effective care. New members of staff completed an induction programme that included familiarisation, training, mentoring and competency assessment. The induction met the requirements of the Care Certificate which sets out explicitly the learning outcomes, competences and standards of care that are expected of a care worker.

Staff completed training on a regular basis that was relevant to the service including areas such as mental capacity, health and safety, fire safety, dementia and medicines administration. Staff told us they regularly had to attend training sessions. We examined the training matrix for staff which confirmed what they had told us. Staff were also supported with additional training requests. We found that six members of staff were in the process of completing a Health and Social Care course (Qualifications and Credit Framework Level 3). Almost 60% of staff had a Level 2 qualification. Some members of staff had completed further training so they could provide training to other members of staff in specific topic areas including two care assessors.

We found staff received regular supervision sessions and appraisals. Team leaders carried out supervisions with care assistants and the deputy carried out supervisions with team leaders.

We spoke with staff and found the supervisions were structured and took place every six to eight weeks. Areas covered included goals, performance and development.

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. Staff had completed MCA refresher training including DoLS. We spoke with staff about both subjects and they understood what was required. We saw the service had systems in place to assess and record people's mental capacity to make decisions. Records showed people's involvement in and consent to care and treatment. We saw evidence of best interests meetings and decision making in relation to DoLS and a number of applications had been made to supervisory body for authorisations.

People had sufficient food to eat and liquids to drink. We saw meals were served in dining areas in each of the four units. Food came from the kitchen on a hot trolley and was served by a member of catering staff. Hot meals were tested with a catering thermometer to ensure temperatures were correct. The menus and meals we saw indicated that food was balanced and nutritious. People were provided with meal choices which were displayed on menu cards. There were additional options for people who could not have or did not want the options on the menu. We saw there were detailed sections within care plans and risk assessments that addressed people's nutrition and hydration needs.

We observed meals at different times and in different places. We were impressed with the support provided by staff who took meals to where people were sitting and where necessary prompted or helped people to eat. When they were not serving, clearing away or helping people they sat down at tables and joined in with conversations. Nobody was rushed to eat or complete their meals. We saw three examples where people finished their meals much later than everybody else. People always had a drink within reach. Outside of normal mealtimes, there was a kitchenette in each unit with a microwave, refrigerator and facilities to make hot and cold drinks and snacks. One visitor told us, "It's the most wonderful home. The food is marvellous, he has breakfast, tea, lunch, more tea, they look after him very well."

People were supported with their healthcare needs. Most people using the service were registered with a local GP. A range of healthcare professionals visited the service to provide advice and care for people. People were supported with healthcare appointments. People were weighed

Good

Is the service effective?

monthly to identify any significant weight gain or loss or any patters showing a steady increase or loss of weight. Care plans and risk assessments addressed any areas of healthcare that were a risk or had been diagnosed.

Langley Oaks had been purpose built to provide residential care. We found the service met the individual needs of elderly people and people with dementia through the design, adaptation and decoration of the building. Lighting throughout the building was appropriate for people using the service. The eyesight of older people deteriorates with age and people living with dementia have further difficulties. Appropriate lighting enables people to see their environment, move around more safely, recognise people and places and take part in activities. We saw that doors were clearly sign posted. Signs were made up of contrasting colours to make them clear. People's bedrooms were identified by name and a photograph. Walls, floors and other surfaces, such as toilet seats, were defined and distinguished through contrasting colours.

There were quiet areas for people, especially those living with dementia, who were sensitive to noise and might be confused by a mixture of background noises (such as music and conversation). In each unit we saw a large whiteboard showing the date, names of staff, the weather and that day's activities. We also saw a reminiscence board with black and white photographs of wartime Britain along with a ration book and an ID card. In general, music being played was appropriate for people using the service. Staff had received specific training in relation to dementia awareness and fulfilling lives. The provider also issued a useful guide for friends, relatives and staff about communicating with people living with dementia.

Good

Is the service caring?

Our findings

We spoke with people and visitors about their experiences of the care and support at Langley Oaks. One person told us, "They are really nice people here; they look after me very well. The food is nice and the staff are all cheerful." A visitor told us, "How nice it was how the home is split into smaller units – it's very homely. I come and see [my relative] every day and it's always nice." Another visitor said, "Oh yes, they are good and [my relative] is very happy." Another visitor said, "Staff are always very welcoming. I only wish we could have found a space here earlier." One visitor told us, "I've never seen a carer here who is not good or very good. The staff are very caring and cheerful. [My relative] is very happy here."

Care was delivered by staff in a patient and friendly manner. Throughout the inspection we observed and heard many positive and inclusive interactions between people and staff. There were occasions when the staff were unaware we were observing them. Staff interaction with people was consistently engaging. Staff approached people in a sensitive manner. For example, staff ensured they were at the same level with people when talking to them. If they were sitting, staff sat next to them or bent down to talk without invading people's personal space. People were referred to by their preferred form of address which in most cases was their first name. Staff allowed people to do things at their own pace. There was a calm and warm atmosphere yet staff were attentive to people. We could see from people's positive reactions they had a good relationship with staff.

People using the service were assigned a key worker; a member of staff who took particular interest in their care and support. They provided an initial point of contact for any concerns or requests. For people new to the home and their friends and relatives the key worker provided an instantly recognisable point of contact and reassurance. The following were some of the responsibilities of key workers in relation to the people they were assigned to: bedroom checks; identifying faults; obtaining toiletries; accompanying people to appointments and on outings; providing extra support; supporting people to maintain relationships with family and friends; spending time with people and taking an interest in their background and interests. Staff were able to tell us who they were assigned to as a key worker and were able to talk about more general details of people's lives such as their work history or extended family. When people came into the

service for respite care they retained the same keyworker so there was some continuity in their care and support.

People and their relatives were supported and actively encouraged by the service to express their views and to be involved in planning their care and support. It was evident in the care plans we saw that people and/or their relatives were involved in the care planning process. The importance of contributing and being involved in care and support was emphasised to relatives particularly for people with dementia. Relatives, where appropriate, were encouraged to attend review of care plans and risk assessments. Where they were unable to attend in person their contributions were welcomed over the telephone.

It was evident in the records we saw and in conversations with relatives and staff that consideration was given to people's choices and preferences. For example, care records showed how people liked to wake up and have breakfast such as having an early morning cup of tea; their bathing preferences; where people preferred to eat; likes and dislikes and so forth.

We observed that staff respected people's privacy and dignity. Staff were mindful to ensure doors were closed when supporting people in toilets, bathrooms and their bedroom. Staff knocked at bedroom doors before entering. People were asked, prompted and encouraged to do things. We heard one member of staff say to two people, "Would you like to sit at your table, lunch will be here soon." We observed people were clean. Their nails were clean and tidy and were a reasonable length. People were appropriately dressed in clean clothing.

People were supported and encouraged to maintain as much independence as their capability allowed. For example, people were encouraged to carry out daily living tasks that they were able to complete such as tidying rooms, completing personal care or elements of it. We saw one person finish their breakfast and take their plate and cup to the kitchenette area where they washed both items. The care assistant watched and when the person had finished washing up went across and helped them back to their seat.

Good

Is the service caring?

We saw people's preferences for end of life care had been considered with them and family and recorded in line with their wishes. People who preferred to do so could be supported to spend their final days at the service. The service worked closely with St Christopher's Hospice and the GP to ensure people's wishes were prepared for and met. Staff were supported with appropriate training and guidance. We received positive feedback from a healthcare professional about end of life care at Langley Oaks.

Good

Is the service responsive?

Our findings

People received personalised care and support. We looked at a selection of care records that included care plans and risk assessments. Records were kept on a computerised system called Caresys. We found the system was easy to navigate and individual care plans were quickly accessible. The care records we saw were person centred. Care plans identified people's care and treatment needs and recorded people's choices and preferences. They were the framework for the provision of person centred care and provided staff with guidance to deliver safe and effective care and support.

People's diversity, values and human rights were respected and care records included information about their needs. The service took these needs into account when planning and providing care and support to individuals. This included support with their spiritual, cultural and religious needs. Staff knew how to respond to people's individual needs and gave examples of meeting these such as providing preferred cultural meals and respecting people's faith or beliefs.

There were a range of activities for people that took place and were aimed at both individuals and groups of people depending on their capabilities. Activities were important for people because they enhanced their lives and reduced the likelihood of any social isolation or distancing. Many activities took place quite naturally and informally on a daily basis such as watching TV, having conversations and eating meals with other people.

We noted that the televisions in unit were switched off in the daytime. Staff told us daytime TV was not considered appropriate and the only time the TV was switched on in the daytime was if somebody wanted to watch a particular programme or there was a special event taking place. Instead, we found music playing that was appropriate for the age range of people within the service. In one unit we did find 1980s music playing at lunchtime. People were obviously enjoying the background music and whenever a popular song came on people became more active, tapping their feet and clapping hands. Some members of staff encouraged this by singing or dancing with the music when they had time. Each unit had what was effectively an activities table where items were available for people and staff to engage in activities such as board games, jigsaw puzzles, playing cards, books, magazines and newspapers. We saw people talking to staff on a one-to-one basis, people reading, one resident doing a jigsaw and staff playing a game with people.

We noted that the provider promoted activity based care within the service. The service had an activities coordinator who was away at the time of the inspection. In our conversations with people and relatives it was quite evident the activities coordinator was popular. One relative told us, "[The activities coordinator] is wonderful, really good with everybody here." Another visitor said, "[The activities coordinator] is fantastic. Nothing is too much trouble. Always arranging trips out." A staff member told us the activities coordinator, "…is very good. Activities are more structured and she is putting the effort in." The activities coordinator was responsible for a rolling four week programme of planned activities. Activities included gentle exercises, arts and crafts, quizzes, sing along, reminiscence, bingo, simple maths and English. In addition there were day trips out and visiting speakers. Where people were unable to join in group activities one to one sessions were arranged. There were also quiet rooms and areas where people could get away if they wanted peace and quiet.

The provider had systems to obtain feedback about the quality of the service they provided in order to learn and improve. Any accidents and incidents were recorded and included the actions taken in response both at the time and subsequently. If necessary, accidents and incidents were further investigated by the manager and any learning was passed on to staff. The service viewed safeguarding incidents as a learning opportunity and responded by addressing any areas requiring improvement.

The provider actively sought feedback from people using the service and relatives. The manager showed a regular presence around the units. We observed that she knew everybody's name and people reacted positively towards her. People using the service completed an annual survey about the care they received which was carried out by an independent company (Ipsos Mori). The results were collated and reported on independently resulting in a document called 'Your Care Rating.' The document, which is available to the public, provided a detailed assessment of different areas of the service provided.

We found that relative's meetings were held every quarter. We saw minutes of the last four meetings. The most recent

Good

Is the service responsive?

had taken place in May 2015 and had been attended by 15 relatives. Discussion topics included finances and activities. There was also an annual satisfaction survey. In the most recent version one of the strengths identified was the accessibility to the manager. Relatives were also encouraged to attend the Thursday coffee afternoon which provided an opportunity for individual or informal feedback. The manager had an open door policy and we found that people using the service and relatives felt they could approach staff and the manager with any concerns. One relative told us, “The manager is really nice and very approachable.” Another regular visitor said, “The manager is fantastic, staff seem to look up to her, absolutely superb.”

The service had a procedure to deal with complaints. Most people were satisfied that they could approach staff or the manager with concerns either in person or through meetings and surveys. There were some issues that were brought to our attention but these had already been raised and had either been dealt with or were being addressed. Where formal complaints had been made we noted they had been recorded and addressed in a timely manner.

The information collated from accidents and incidents, formal and informal feedback, surveys and meetings were considered at both manager and provider level and where learning or possible improvement was identified action was taken at a local or provider level.

Good

Is the service well-led?

Our findings

The manager was appropriately qualified and registered with CQC. When we spoke with staff we found they viewed the manager positively. Staff told us they felt well trained and supported and the management team at the service were very approachable. Staff acknowledged the manager was regularly seen out and about in the units. One member of staff who had worked at the service for a long time told us, "The manager is very supportive, we see her around the home a lot and she knows all the relatives." This mirrored the comments we heard from people using the service and from relatives and visitors. We saw staff meetings were held regularly with specific staff meetings for team leaders and night staff. Staff meetings were a two way process where information was fed from management to staff and staff were given an opportunity to give their views. We found staff spoke openly about the service and were proud of the work they did. One member of staff said, "There have been a lot of improvements, things are much better."

The service had a number of systems to assess and monitor the quality of the service they were providing. A number of audits were carried out to ensure care and support was being delivered safely and effectively. The manager had a schedule of audits that identified areas to be audited each month covering areas such as health and safety; medicines management; nutrition; tissue viability; infection prevention and control; documentation; and, activities. The manager also conducted night visits. Provider visits took place every month and the manager was required to submit monthly reports to the provider. The provider carried out periodic Regulatory Governance Audits that identified areas that were good and where improvements could be made. We saw Service Improvement Plans which were the responses to the governance audits. There were audits carried out by external bodies such as the local authority that commissioned services and the pharmacy that provides medicines.

The provider had a wide range of policies, procedures and guidance to support staff to carry out their roles. We examined a variety of records relating to the provision of care by the service. These documents, in paper or electronic form, were accurate, legible and up-to-date. Where appropriate, documents were stored securely and access was limited to those people who had been approved and needed to use them. Staff were aware of confidentiality issues. We reviewed CQC records and were satisfied that statutory notifications were submitted when required and in a timely manner.

We found the provider had a clear and succinct set of visions and values that expressed their ethos of service provision. The visions and values were supported by 'icare' which outlined the minimum standards expected in the provider's services. There was also the 'icare' customer promise that told customers what they could expect: a warm welcome; quality of life, personalised care; choice; a safe and clean home; tasty nutritious food; and, community involvement. There was also a promise to act on feedback. This is an abbreviated interpretation but in essence reflects the provider's aims and was taken from the induction booklet for care staff. Members of staff were expected to buy into the vision and values and carry out their duties accordingly. To support the vision and values the provider ensured staff were well trained and encouraged staff to take further qualifications and provided the finance and facilities to do so.