The Orders Of St. John Care Trust

Apple Trees Care & Reablement Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 10 March 2016 and was unannounced. This was the homes first inspection since it was registered.

The home is new and purpose built incorporating design to support people with dementia to remain independent. It is registered to provide accommodation with personal care for 64 people. The home is split into four households with 16 bedrooms in each household. There are two households downstairs and two upstairs. One of the upstairs households provides reablement care to support people to return to their own homes and to be independent. The door to this household is mainly closed to support these people to have quiet time and space to complete their rehabilitation. The other three households are for people living with a dementia, their doors are open and people are supported to move between these three households whenever they choose. There were 63 people living at the home on the day of our inspection.

The home has 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 home is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. The registered manager had made appropriate requests for people to assessed under the DoLS and all the care provided minimised the restriction on people. However, at times care plans were not always clear on how individual assessments of people's decision making ability had been completed and how decisions had been made in people's best interest.

The registered manager monitored staffing levels to ensure there were enough staff to meet people's needs and completed appropriate check to ensure staff were safe to work with the people living at the home. Staff were polite, respectful and caring worked to the provider's values to promote independence and support people to live a fulfilled life. In addition the staff worked together as a team to provide a high quality service to people living at the home.

People's needs were assessed and people were involved in developing their care plan so that it met their individual needs. In addition staff monitored people's abilities and changed care plans to reflect changes in needs. Staff were kind and compassionate when providing care and ensured that people were fully involved in their care and supported to be as independent as possible. the provider and registered manager had used the options in the design of the care home to offer people's the ability to store their medicines in their own room. This facilitated medicines being offered to people in line with how people would manage their own medicines at home. Risks to people were identified and care was planned to reduce risks and to keep people safe from harm.

People were supported to access a choice of food and were able to access hot and cold drinks on demand. In addition the provider had incorporated good practice around supporting people with dementia to access and enjoy their food. People's ability to maintain a healthy weight and to eat safely was assessed and support from healthcare professionals had been accessed when needed.
The provider had worked collaboratively and built good relationships with the healthcare professionals needed to support people in the reablement unit and throughout the home.

The provider had effective systems in place to monitor the quality of the care provided and to ensure that staff stayed up to date with any changes in legislation and guidance on how care should be provided. In addition the provider listened to the views of people living at the home, their relatives and staff to make changes to how care was provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by staff who had received training to keep people safe and knew how to raise concerns. Risks to people while receiving care had been identified and action had been taken to keep people safe.

Staffing levels were monitored to ensure that there was enough staff to meet people's needs and appropriate checks were completed to ensure staff were safe to work with the people living at the home.

People received their medicines in a timely person centred manner and were supported to be independent with their medicines when they had the ability to do so.

Is the service effective?

Good

The service was effective.

People had been appropriately referred for assessment when there was a risk they may have their liberty restricted. However, processes for making decisions in people's best interest were not clearly recorded.

People received their care in a purpose build home which supported them to be independent and to access outside space.

People received support from a variety of healthcare professionals who visited the home and communication between visiting professional and staff supported people to receive a high quality of care.

People were supported to access food and drink whenever they wanted and staff monitored people's ability to maintain a healthy weight.

Is the service caring?

Good

The service was caring.

Staff were attentive to people's needs and provided emotional and physical support for people.

People were involved in planning their care and care plans supported staff to build relationships with people.

Staff protected people's privacy and helped them to maintain their dignity.

Is the service responsive?

Good

The service was responsive.

Staff monitored people's needs and made changes to their care plans when needed. In addition care provided was compassionate and tailored to the individual's needs.

People were encouraged to be active and access a range of hobbies and interests to keep them entertained. They were supported to access the community and to live meaningful lives.

Is the service well-led?

Good

The service was well led.

The provider's values were understood by staff and supported them to provide care which promoted independence and valued people as individuals.

The registered manager was available and approachable. People living at the home, relatives and staff were all confident in the registered manager's ability to resolve problems.

People living at the home, relatives and staff were asked for their views on the care provided and action was taken to resolve any issues. In addition the provider used effective audits to monitor the quality of the care provided.

Apple Trees Care & Reablement Centre

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 10 March 2016 and was unannounced. The inspection team was made up of two inspectors, a specialist advisor and an expert by experience. The specialist advisor had knowledge around reablement and supporting people to become independent and return to their own homes. The expert by experience had personal experience of using or caring for someone who receives this type of care.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home. 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 home, what the home does well and improvements they plan to make.

During the inspection we spoke with eight people who lived at the home, three relatives and a visitor to the home and spent time observing care. We spoke with the registered manager, the area manager, two senior care staff, four care staff, the activities coordinator and the training lead. We also spoke with eight visiting health care professionals. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at seven care plans and other records which recorded the care people received. We also looked at management records including how the quality of the care provided was monitored.

Good

Is the service safe?

Our findings

A person living at the home told us, "I love being here. Why wouldn't I, it's like a hotel. There is a lot of coming and going because it's a big place, but I have never felt worried about safety." A member of staff said they felt people were safe at the home. They said, "Yes, they are well looked after, their needs are met and they are protected." A visitor told us they felt their relative was safe at the home. They said, "Staff are caring, they take care about who they recruit and they have the facilities to make it easier for staff to provide good care."

Staff had received training in keeping people safe from harm and were clear on the steps to take to report harm both within their organisation and externally. Contact details for the local authority safeguarding team were available for staff in the offices in each household.

Risk assessments had been completed to identify each person's risk of falls, developing pressure ulcers, nutritional risk, and risks associated with moving and handling. These had been reviewed monthly. Risk assessments were then linked with care plans which provided information for staff on how care should be provided to reduce the risks. When people had a history of falling, interventions were put into place to reduce the risk of injury if the person fell again. For example, their bed was lowered and a mat placed on the floor to provide cushioning. We also saw that there was good recording of information for staff to help them understand people's individual care needs and how this impacted on the level of risk. For example, we saw that one person would often become anxious and this would impact on their risk of falling and mobility as they would become dizzy and forget to use their stick.

Records showed that the care needed to keep people safe had been completed. For example, when people needed assistance to change their position to prevent pressure ulcers, records showed this was completed in line with the requirements identified in their care plans. Where people had had an accident such as a fall they were kept under observation to ensure that they were safe and well and did not require care from a healthcare professional.

Staff told us how they supported people who expressed their emotions in a way which distressed themselves and others. A member of staff said they tried to identify triggers of the behaviour so that these could be avoided as much as possible or steps taken to remove the triggers. They talked about how one person became agitated if the environment was noisy. They said it was possible to calm people as they knew them well.

Fire risk assessments had been completed so that in the case of an emergency the level of support people needed would be available to emergency personnel. In addition the registered manager was working with the local emergency services so that they understood the needs of people living with a dementia and the impact this may have in an emergency situation.

People living at the home told us that the staff were attentive and were normally responsive to the call bell. One person told us, "I have had to call for assistance a couple of times and as long as it is not a busy time,

they always come." Call bell times were recorded on the computer and were audited by the registered manger to monitor if staffing levels ensured people received their care in a timely manner.

Staffing levels were normally set at one member of staff to every four or five residents. The registered manager explained that this was company policy and reflected the latest best practice in relation to staffing ratios for dementia homes. The registered manager then monitored the staffing levels by observing care and monitoring how long it took staff to answer call bells particularly at busy times of the day.

Two of the three members of staff we talked with told us they felt there were sufficient staff rostered on duty to provide the care people required. However, one staff said they felt they needed an extra person on the ground floor to enable some of the people with complex needs to be given more one to one time. They gave the example of a person who we had observed walking throughout the day and at times becoming anxious about the whereabouts of a relative. When we raised this with the registered manager they had already identified this an issue and were looking to provide the person with some one to one support.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. In addition they include the home's values in the interview process to ensure staff had the right ethos to care for people. For example, how they would empower people to contribute to the community both within and outside of the home.

The required checks had been completed to ensure that staff were safe to work with people who live at the home. A person who had started work at the home within the last six months said they had references checked and a disclosure and barring service check prior to commencing work at the home.

There were systems in place to ensure that medicine was ordered promptly and was always available for people. People's medicines were stored in a locked cabinet in their bedrooms. Trained care staff administered medicines when they were providing personal care for people. This meant people received their medicines in a person centred way. For example, if people were prescribed to take their medicine at bed time it was given to them when they went to bed. People's medicine administration records (MAR) were stored in their bedrooms so that they could be completed when the medicine was administered and contained information to support the safe administration of medicines.

People who had been admitted for reablement and who had plans to return to their own homes were supported to keep and self-administer their medicines. This helped them to retain their abilities and an understanding of what medicines they would take when they returned home.

Where there were concerns that people were declining or not taking them medicines in a consistent manner they were referred to their GP for advice. For example, we saw that one person who was very sleepy in the mornings had the time of their medicines changed to support them to be taken more consistently and improve the benefits they got from the medicine.

Good

Is the service effective?

Our findings

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 home 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 identified a number of people who were at risk of having their human rights restricted. For example, they were unable to make a decision to live at the home and were under constant supervision. The registered manager had appropriately referred them to the local authority DoLS team to have their situation assessed. In addition the provider had literature available for family members which explained the process and how they may be involved to support a decision to be made in the person's best interest. Care plans clearly recorded where people living at the home had legally delegated decision making responsibilities to other people.

Staff were respectful of people's ability to make decisions for themselves and we saw people were offered and supported to make choices about all aspects of the care they received. However, care plans did not always record when people had been assessed for their ability to make individual decisions and it was not always clear how a decision in the person's best interest had been made. For example, one person had one mental capacity assessment for all decisions related to personal care and covert medicine administration. Covert medicine is where medicine is given to a person in their food without their knowledge. There was a note on each of the care plans that care was required in the person's best interests, but no record of who had been involved in making the decision.

The provider had systems in pace to identify provide and monitor the training each member of staff needed. In addition there was a comprehensive induction programme for new staff to ensure they were fully supported to learn how to care for people safely and respectfully. This consisted of time spent completing classroom training and then shadowing an experienced member of staff. In addition in the first 12 weeks they were required to complete the care certificate, which is a nationally recognised training programme to support care staff. New staff were also observed when providing care to ensure they had understood the correct methods of providing care to keep people safe. A new member of staff told us that they had felt supported by colleagues. They said, "They are all great, they look after me."

Existing staff received regular update training to ensure their skills remained safe and reflected the latest

best practice for providing care. Training records showed that the registered manager and provider were monitoring the training and identified when staff needed to access update training. If staff did not complete training when prompted this was discussed with them in their supervision and the importance of completing training was emphasised. In addition staff told us that the registered manager and provider were supportive if they identified training needs in different areas if it would improve the care provided for people. Supervisions were a mixture of performance development sessions where career aspirations and training needs were identified, group supervisions and individual supervisions. Records showed supervisions had been completed in line with the provider's policy.

People told us they were happy with the quality of food provided to them and we saw that they were offered a choice of food at the time they were eating and that picture menus were available to support them to make choices. One person told us, "It took me a while to get the hang of the food here. We get our main meal at night. Well in the afternoon really. I really like the fish and chips. There is always plenty of food though and plates of little cakes appear sometimes." In addition, people were support to access hot and cold drinks throughout the day in the kitchen area of each household and the central café. One person said, "You can help yourself to a drink at any time here and they always offer us drinks after we have eaten."

We saw that people's ability to maintain a healthy weight was monitored. When people were unable to maintain a healthy weight their food and fluid consumption were monitored and if needed they were referred to a dietician or GP for advice and support. Where people were struggling to eat safely they were referred to the speech and language team for advice. Where people needed a special diet they were supported to access this. In addition they were offered similar option to everyone else. For example, one person who needed gluten free bread but was then offered a choice of filling the same as everyone else. Where people needed to eat a soft diet this was attractively presented and moulds were used to make the pureed food resemble the unpureed meals.

There was food available throughout the home to support people who may not want to sit down and at mealtimes. For example, we saw that there were pastries, crisps and fruit in the communal areas and at various places along the corridors for people to help themselves. Snacks were also offered to people at regular intervals. On occasion people were supported to access food from outside the home.

People in the reablement unit were supported by a team of NHS staff as well as the staff at the home. For example, they had input from occupational therapists and physiotherapists as well as community nurses and care assistants. A multidisciplinary team meeting was held once a week to support communication, care and discharge planning for people. In addition people were also supported by visiting specialist nurses such as the Parkinson's nurse and the dementia specialist nurse. This meant that the registered manager and staff were supported to provide high quality care and to access specialist advice when needed.

A visiting healthcare professional told us that staff were always friendly and helpful when they visited people living at the home. They said that concerns were appropriately raised and that they were confident that any care that they requested to be put in place was completed effectively.

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed. One relative told us, "My father has a chiropodist come every six weeks. He loves that." This had been arranged by the home.

Time and effort had been put into the design of the home to ensure it met the needs of people living there.

For example, we saw that for people living with dementia their drawers had lower fronts so that they could see what was stored in each home without opening it. Their wardrobes had glass in their so they could see their cloths. The lights in the ensuites came on automatically so that people who could not remember how to turn a light on were supported. Handrails had three bumps at each end to support people with a loss of vision.

There were central kitchen, dining and lounge areas in each household for people to spend time together. However, each household had two corridors and at the end of each household was a small sitting room and access to secure enclosed outside space, both upstairs and down. People could also access the enclosed garden through the downstairs café.

In the dementia households toilet doors were painted red so that they were easily identifiable for people. On the reablement unit bathroom doors were painted the same as all the other doors as people living on this unit did not require that level of support. This showed the provider had considered the needs of people using each unit and had adapted the environment accordingly.

Despite all the good design features each dementia household was decorated in the same style and colour. This meant that there were no easily identifiable makers to orientate people living with a dementia to which household they were in. We saw that one person was unable to distinguish which household their bedroom was in. The registered manager had put a blue sheet of paper on one bedroom door to help them find their way to their bedroom.

Good

Is the service caring?

Our findings

People living at the home and their visitors told us that the staff were kind and caring. One relative told us, "If mum gets tearful which she does sometimes, the staff are so sweet to her. I couldn't ask for more." Another relative told us, "I have never seen anything other than people being very kind and caring. Some residents walk around with their coats on, but they never pressure them to take them off. It's like a real home." While comments from people living at the home included, "Nothing is too much trouble for these people[staff]. I am really glad I came here." "The staff seem to know everyone well, I don't know how they do it." A person in the reablement household said, "They had better be careful, I won't want to go home."

One relative told us how they were encouraged to bring a chair from home so their relative could be more comfortable. They told us, "When it became obvious that mum could not seem to get comfortable in any of the chairs, the manager asked whether she had a favourite at home. When I said that it was very old and would look out of place, the manager replied that is probably what she needs. So we brought it in and it worked."

Staff were very attentive to people's needs and they used their names at all times and stooped to be at the same level as them when talking gently. We saw a member of staff assisting a person with their breakfast. They were chatting with the person about the person's family and the song playing in the background. When another person came towards the table, the staff said, "Are you going to have your cup of tea with me?" "Come and sit with us." "Are you doing anything today or are you going to see what the day brings?"

We saw that staff monitored people's emotional needs. For example, we saw that one person was walking around looking distracted and staff went to them and supported them to sit with some of their friends. Staff were patient with people and where people were unable to make decisions staff prompted them with choices without overwhelming them with options.

We saw that people were supported to celebrate their abilities. For example, one person who was living with dementia was an artist and had some of their watercolours on display in the hallway near their bedroom. This helped the person recognise their room as they were near something familiar.

One person had been able to take their dog into the home when they moved in. We saw they spent time with the dog and it was well liked by all the people living in that household. People were able to take turns in taking the dog for a walk. One person living at the home told us, "My friend was allowed to bring her dog here too as she missed him so much she was fretting. He gets a lot of attention."

Care plans supported staff to build relationships with people by recorded people's communication needs and when they needed extra support or time to communicate their wishes. For example, we saw one person's care plan recorded that they would often struggle to find the right word or phrase.

People were supported to make choices about their everyday lives. For example, we saw three people in one household chose to have their meal in their room. We asked staff if this was usual and they explained that

each day was different. They said, "Some people always stay in their room, but we always ask if they want to come to the dining area. Others like to come here and chat." A person living at the home said, "Sometimes I go to my room in the afternoon and fall asleep. They don't mind. If there is a good programme on telly and I am in the lounge I stay there until it finishes. When I asked if he was told when to go to bed he said "I'm a bit past that. People usually drift off to their room bit by bit and then I go myself. I like my room so I don't mind."

People were involved in planning their care, One person told us, ""If I have any questions about my care, I ask the carer." While a relative said, "I was involved in dad's care plan right from the start. They are good at telling me what is happening." Another relative told us the home kept them up to date when there were changes in care. They said, ""The home always talk to me about what has been happening with mum. I don't need to worry." A member of staff told us, "We work hard to find out what the residents want and then try to organise it for them." However, people's involvement in care planning was not always recorded in their care plan.

During the day we saw staff protecting people's privacy and maintaining their dignity, speaking quietly and sensitively to them about personal issues and knocking on people's bedroom doors before entering. In addition staff were able to explain how they protected people's dignity during personal care by covering them as much as possible, drawing curtains and closing doors. People were offered the key to their room so that they could lock their door if they wanted to when they chose to spend time in the communal areas or go on outings.

People were smartly dressed and looked nice. However, people were supported to make their own decisions relating to cloths and those were respected. For example, we saw one person had chosen to have their coat on. They walked around the home thinking that they were getting ready to go out. Staff supported them in their reality and the person was happy and contented.

People were supported to continue to maintain contact with their local community. For example, a number of people chose not to use the hairdressing salon in the home but instead continued to visit the salon they used prior to admission.

Good

Is the service responsive?

Our findings

Relatives all told us how well the care supported their family member to live a fulfilled life and that they were confident care was meeting people's needs. One relative told us, "When I leave here, I know that mum is well taken care of. My sister organises everything and they speak more to her about her care, but I am happy she is in good hands and certainly safer than at home these days." Another relative said, ""My mother visibly relaxed the day she moved in here. She has dementia now quite badly and doesn't know who I am sometimes, but certainly she has been calmer since being here. I think she likes it and the staff are lovely."

Care records for people living in the dementia households contained a full assessment of people's care and support needs that had been completed prior to or on admission to the home including risk assessments. Care plans were in place giving details of the care and support people required on a daily basis. These contained a good level of detail people's personal preferences in relation to their care were documented. People living with a dementia had been supported by staff and relatives to complete an 'All about me' document. This recorded key events and memories in their lives, people who were important to them and information on their hobbies. This enabled staff to get to know the person better and suggest activities and entertainment.

People on the reablement unit were supported by a number of visiting healthcare professionals, for example, occupational therapists, physiotherapists and community nurses. This enabled them to regain the skills needed to live independently. In addition, planning the equipment and support needed when they returned home was also included in the care. However, some of the care plans did not contain all the information needed to provide safe care. While it was the responsibility of NHS community staff to complete this paperwork, the lack of information could impact on the care the person received. For example, we saw one person who was at high risk of falls and had monitoring systems in place did not have this recorded in their care plan. We discussed this with staff who immediately reviewed the person's needs and updated their care plan and discussed the concerns with the NHS staff responsible.

We saw that staff continuously monitored people's abilities and made changes to care to support them to be independent. For example, we saw staff served one person their lunchtime soup in a cup instead of a bowl. When we asked why staff explained that the person had spilt their soup the day before and therefore putting it in a cup was safer for them, while retaining their independence. Any changes in people's care needs were discussed in the handover meeting when shifts changed.

We spent time observing care and saw staff provided safe personalised and compassionate care . For example, we saw a person being hoisted, the two members of staff supporting the person were gentle, encouraging and talked to them throughout. They ensured that the person's dignity was preserved. We asked the person how they had felt being hoisted, they said, "It is quite a pleasant experience." We also observed a person walking with two members of staff. They were unable to move very fast at all but staff were encouraging and allowed them to rest every few steps. Staff offered a wheelchair but the person declined. Staff stayed with the person until they were settled into an armchair.

Care records contained information in relation to people's hobbies and identified the ways in which they enjoyed spending their time. There was a dedicated activities person who had received training to provide activities which supported people living with a dementia. A relative said, "[The activities coordinator] goes round and spends time with people individually." "As she goes past [my relative's] room she will stop and give them a kiss."

We saw people engaged in activities in groups and on a one to one basis throughout the day. Staff sat down with people who could not participate actively and chatted to them, used photographs to reminisce or pampered them with some beauty treatment. People were asked if they wanted to participate in activities in a way which made the activity sound attractive and fun. For example, we heard one member of staff say to someone, "We've got a music group upstairs if you would like to join us. There's a nice young man come to do exercises with everyone. Why don't you come upstairs and you can meet him."

We saw a table tennis game taking place and several additional people were enjoying watching the game. We saw a member of staff playing badminton in the hall with one person and a soft football was also used to play football with some people. A 'pets as therapy' dog visited and we saw the faces of some people light up when they spent some time with the dog. The activities coordinator explained that the number of men living at the home had increased and they were targeting some of the activities towards the men such as a furniture restoration project, trips out to see trains and a pub night.

People were supported to be involved in the local community. A member of staff said they tried to take people out when they expressed an interest in going out. They said they had taken people into town to do their Christmas shopping. They said, "There is always something going on. We have a good variety of different things." In addition the provider and registered manager had welcomed the community into the home and the Princes Trusts visited the home and held a French class for anyone interested in learning the language. They also support people to spend time gardening in the summer. Furthermore the registered manager had worked with a local equine charity and had arranged for everyone to spend time at the centre visiting the horses and taking part in arts and crafts. While some people only stayed for a few hours, others had stayed overnight, depending upon their needs.

We also saw that one person living at the home had expressed a desire to work. The registered manager had identified a role they could undertake in the home and they were given an interview and offered the post which they enjoyed.

We saw there was a notice telling people how to complain in the main entrance. People told us they were happy to raise complaints with the registered manager or other staff. Relatives said they knew who to go to if they had any worries or complaints. They felt the registered manager had a good strong presence and was often seen about the home and they could go to them with any issues. One relative who had raised an issue with the registered manager told us they were confident that the management were positively trying to deal with the matter.

Good

Is the service well-led?

Our findings

All the people were positive about the care they or their relatives received at the home. One relative told us, "It is excellent." They commented on the calm atmosphere at the home. Another relative told us they saw the registered manager frequently and said, "She has some very good staff." They added, "This is unquestionable the best care home I have been at."

The provider had a set of values which defined the care and support they wanted to give to people living at their care homes. Staff were aware of the values and how they embedded them in to the everyday care they provided for people. For example, one member of staff talked about being caring and effective. They said they tried to assist people to gain their independence and take more interest in themselves and their appearance. Another member of staff explained that the values supported them to look after people really well and give them the respect and care they deserve.

It was clear that staff were proud to work at Apple Trees Care and Reablement Centre. One member of staff told us, "It is a nice place to work. It's a new build and kept clean and tidy. The manager is good and the training is better here than in other homes. It is more in depth." We all get on as a team." Staff explained how this teamwork supported them to give a better quality of care to people. One member of staff explained "When we need extra pairs of hands for the holiday or for outings, we always get staff that are willing to use their own time to help out. I am the dementia lead and I do it as a volunteer.

All the people were complimentary about the registered manager and felt confident in their ability to run the home. A relative told us, "The manager's door is always open and she often calls out hello as I walk in. She is really nice." A member of staff said, "She is always here. You can go straight to her with problems" They told us the registered manager addressed issues reported to her. Another member of staff said, "She is a really good manager. Her door is always open."

People living at the home, their relatives and visiting health care professionals had been asked for their views on the care. We saw that the results were displayed on the notice board for people living at the home, relatives and visitors to see. The registered manger told us they were working on an action plan.

We saw the minutes of the staff and residents meeting and saw that following each meeting an action plan had been developed and identified action were completed. One person told us, "We asked for soup at the meeting and it looks like everyone is enjoying it." A relative told us they were aware of relatives meetings but had not been able to attend. However, they said they did not feel the need to attend as staff acted on any concerns or suggestions.

Some staff in the home had been allocated lead roles, for example, there was a falls lead and an infection control lead. They were required to keep up to date with changes in their lead area and to support other staff if they had any queries or questions. A senior carer told us they were the falls lead and they would review falls at the staff meetings and discuss what they could do differently.

The provider supported staff with lead roles to attend training and meetings to keep their skills up to date. In addition the provider had policy leads at head office which staff could approach for guidance and support and who ensured the provider's policies took account of changes in guidance and legislation.

Audits were routinely completed to monitor the quality of the environment and care people received. For example, the infection control audit was completed on a six monthly basis. The provider completed an annual quality audit at the home and the last time it had been completed the home received a score of 98.6%. Action had been identified to ensure that areas for improvements were tackled. In addition all the audits were discussed with the senior carers at their meeting so that they were aware of where change was needed. Staff said they received feedback from complaints and audits at staff meetings. They said they held reflective meetings to discuss how they could change things for the better.

The provider was taking part in a local pilot which enabled staff to access to access healthcare support via a computer. The registered manager told us how this had helped them to prevent people having to go to hospital and supported families to be confident that their loved one was getting all the support they required.

The provider had worked with the local university to take part in a research project looking at how dementia affects people's levels of cognition. This was completed in one household in the home. This had helped the care staff to understand how they could alter the way they communicated with people to support people to be able to make decisions about their care. As a consequence the care provided to the people in the project was more person centred and better met their individual needs. The provider was now working with the university to spread the project to other areas of the home and the provider's organisation in a way that would be sustainable across all dementia homes.

The provider was also working with the local community to help people understand the needs of people with dementia. For example, the activities co-ordinator was part of the government's dementia friends scheme and was providing dementia training in the schools and inviting people into the home to access the training. In addition the registered manager was part of the Dementia Action Alliance which helps to raise awareness of dementia and work towards developing dementia friendly communities.