Mr Richard Marchant

St Anne's Residential Care Home

Inspection report

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Date of inspection visit: 2 & 3 January 2015
Date of publication: 19/03/2015

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

This inspection took place on 2 and 3 January 2015 and was unannounced. St Anne's Residential Care Home provides personal care and support for up to 23 people. On the first day of our inspection there were 18 people living at the home, one person was in hospital. St Anne's provides care for older people with mild mental health needs including people living with dementia. Some people at the home required nursing intervention and this was provided by the local district nursing team.

St Anne's had a registered manager in place. 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.

Throughout the inspection there was a calm, friendly and homely atmosphere. People were relaxed and happy.

Summary of findings

People, their relatives and all health care professionals spoke highly about the care and support St Anne's provided. People felt supported by knowledgeable, skilled staff who effectively met their needs. One person stated; "Most of them are wonderful and knowledgeable"; "I feel like they do the best they can"; "Sometimes the staff are busy. Most staff are very, very good." Relatives commented, "There's never anyone out of view of staff. They are always around, watching…nobody is left to their own devices."

Information we requested was supplied promptly. Care records were comprehensive and personalised. People's communication methods and preferences were taken into account and respected. People's risks were considered, well-managed and regularly reviewed to keep people safe. One relative told us "Mum is safe, I don't even have to think about that." Where possible, people had choice and control over their lives and were supported to engage in activities within the home and outside where possible.

Staff put people at the heart of their work. Staff were kind, compassionate and gentle in their interactions with people. Strong relationships had been developed and practice was personalised and not task led. The service had an open door policy, relatives and friends were welcome and people were supported to maintain relationships with people who mattered to them. Staff were supported with an induction and on-going training programme to develop their skills and competency was assessed.

Staff understood their role with regard to the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Applications were made and advice sought to help safeguard people and respect their human rights. Staff had undertaken safeguarding training and they displayed a good knowledge on how to report concerns and were able to describe the action they would take to protect people against harm. Staff were confident any incidents or allegations would be fully investigated. People told us they felt safe. One person said "I feel safe and am well looked after."

People knew how to raise concerns and make complaints. People told us they had not needed to make a complaint but the management team were visible and approachable and would deal with any concerns promptly. We saw complaints which had been made had been recorded and investigated in accordance with the home's policy. Learning from incidents was used to drive improvements.

People, relatives and staff described the management as very supportive and approachable. Staff talked positively about their jobs and took pride in their work. One staff member said, about management, "Always around, good atmosphere". The registered manager explained their role to us "Supporting staff, keeping up with legislation – filtering the information down; an overview of the whole system; risk assessing and minimising the risk to people – ensuring service users are confident they can come to us".

The service had an open and transparent culture. The registered manager had set values which were respected and adhered to by staff. Staff felt listened to and were encouraged to share any concerns they had so issues were promptly dealt with. The staff worked closely with external agencies such as the local authority to raise issues and seek advice promptly when required.

People's opinions were sought formally and informally. Audits were conducted to ensure the quality of care and environmental issues were identified promptly. Incidents, accidents and safeguarding concerns were investigated and, where there were areas for improvement, these were shared for learning.

Staff recruitment files showed appropriate checks had been undertaken before staff began work. . The registered manager assessed the competency of staff in areas of their care work such as administering medicines, using the stair lifts and monitoring infection control practices. Any concerning issues were promptly followed up and action taken where necessary.

Staff had undertaken infection control training and there were policies and procedures within the home for staff to refer to when required.

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.

There were sufficient numbers of skilled and experienced staff to meet people's needs. Recruitment checks were thorough.

Medicines were managed safely.

Staff were confident with safeguarding procedures. Risk assessments were comprehensive to minimise risks to people.

The home was clean and hygienic.

Good

Is the service effective?
The service was effective. People received care and support that met their needs.

Staff had received appropriate training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. Staff displayed a good understanding of the requirements of the act, which had been followed in practice.

People were supported to have their choices and preferences met by skilled staff.

People were supported to maintain a healthy diet.

Good

Is the service caring?
The service was caring. People were supported by staff that promoted independence, respected their dignity and maintained their privacy.

Positive caring relationships had been formed between people and supportive staff.

People were informed and actively involved in decisions about their care and support.

Good

Is the service responsive?
The service was responsive. Care records were personalised. Staff knew how people wanted to be supported and met people's individual needs.

Activities were meaningful and were planned in line with people's interests.

People's experiences were taken into account to drive improvements to the service.

Good

Is the service well-led?
The service was well-led. There was an open culture. The management team were approachable and defined by a clear structure.

Staff were motivated to develop and provide quality care.

Quality assurance systems drove improvements and raised standards of care.

Good

St Anne's Residential Care Home

Detailed findings

Background to this inspection

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

The inspection was undertaken by one inspector for adult social care on 2 and 3 January 2015 and was unannounced.

Before the inspection we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 12 people who used the service, two relatives, the provider, the registered manager, four members of staff and a visiting district nurse. We observed the care and interactions between people and staff during mealtimes and in the lounge.

We looked around the premises and observed how staff interacted with people throughout the day. We looked at five records related to people's individual care needs, five staff recruitment files and records associated with the management of the service including quality audits.

Good

Is the service safe?

Our findings

People who lived at St Anne's told us they felt safe. Comments included "I feel safe and am well looked after"; "I feel very, very safe here, staff are good and kind." One relative told us "Mum is safe, I don't even have to think about that."

Records showed staff were up to date with their safeguarding training. Staff were confident they knew how to recognise signs of possible abuse. Staff reported signs of suspected abuse and were confident these would be taken seriously and investigated thoroughly. For example, the registered manager told us they had recently identified a safeguarding concern. They had raised the issue with the local authority and immediate action was taken to resolve the matter promptly and help ensure people were safe. Staff knew who to contact externally should they feel their concerns had not been dealt with appropriately.

There were enough skilled and competent staff to help ensure the safety of people. Staff were visible in the communal areas and sensitive to people's needs. People told us they felt there were sufficient numbers of staff to meet their needs and keep them safe. People told us "They are sometimes busy and you have to wait but I don't have a problem with that." Staff said there were enough staff on duty to support people. A staff member commented; "I never feel rushed. There are enough staff to be able to give people the time they need, when they need it." Staff carried out their work in a calm, unhurried manner. The registered manager told us staffing levels were "dependent on the needs of service users" in the home and regularly reviewed to ensure they could meet the needs of people. During times when staffing was low, the team worked together to cover additional hours to ensure people received care from staff they knew. Whilst a new cook was being recruited, staff and the registered manager were flexible in providing cover in the kitchen.

Staff recruitment files showed appropriate checks had been undertaken before staff began work. The registered manager assessed the competency of staff in areas of their care work such as administering medicines, using the stair lifts and monitoring infection control practices. Any concerning issues were promptly followed up and action taken where necessary.

People were supported to take everyday risks and moved freely around the home. Where people were able, they made their own choices about how and where they spent their time. For example we spoke with one person who liked to spend all of their time in their room and this was respected. Risk assessments were in place to maintain people's independence. For example, we heard about one couple who enjoyed gardening and washing up but they were at risk of falls. Staff sat with them and completed risk assessments to reduce the possibility of falls. This respected their right to take risks, promoted their freedom and helped keep them safe. Where people were less independent and there were risks relating to their health, for example falls, dietary needs or pressure ulcers, risk assessments were in place to minimise risks and clearly linked to people's care plans. For example one person had recently been diagnosed with a health condition which made them more at risk when walking. The risk assessment identified this recent change and measures were clearly recorded to reduce the risk of falls.

Each person had an individual evacuation plan in the event of a fire and equipment had been checked. Routine maintenance within the home and environment was undertaken to ensure the environment remained safe. For example fire door testing, electrical testing and other health and safety checks on the stair lifts, water, and equipment had been completed.

Medicines were managed, stored, given to people as prescribed and disposed of safely. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. Staff undertaking the medicines round in the morning ensured people had time to take their medicine. Medicine Administration Records (MARs) were all in place and had been correctly completed. Medicines were locked away as appropriate and, where refrigeration was required, temperatures had been logged and fell within the guidelines that ensured the quality of the medicines was maintained. Body charts were used to indicate the precise area creams should be placed and contained information to inform staff of the frequency at which they should be applied. Staff were knowledgeable with regards to people's individual needs related to medicines. A relative told us "…on the ball with medicines, like clockwork."

People's complex needs with regards to administration of medicines had been met in line with the MCA. The MCA

Good

Is the service safe?

states that if a person lacks the capacity to make a particular decision, then whoever is making that decision must do so in their best interests. For example one person required their medicine to be given covertly. This had been assessed by their doctor to be in their best interests and was recorded in their care records. This showed the correct legal process had been followed.

We saw that incidents, concerns and safeguarding issues were recorded, action taken promptly and reviewed regularly by the registered manager. Any themes were noted and learning from incidents was shared with the staff team or individuals as appropriate. This helped to minimise the possibility of repeated incidents. For example each person now had personalised care plans which included monitoring tools, their medical history and current medicines. These changes had been made as a result of learning through safeguarding meetings and the service's action plan to address these areas and prevent any further incidents.

Staff had undertaken infection control training and there were policies and procedures within the home for staff to refer to when required. The service had a recent infection control issue. Staff had sought advice promptly and taken the necessary infection control precautions to minimise any risks to people and themselves until professional advice was available. Staff understood their roles and responsibilities to minimise risk and the environment was clean and hygienic. There was ample hand gel, hand washing facilities and protective equipment for staff to wear. Staff wore aprons and gloves to carry out people's personal care needs.

Some areas of the home had a strong odour. The registered manager told us people had continence needs and behaviours which made maintaining a clean environment more challenging. Plans were in place to consider the furnishings of these rooms to make them easier to clean and keep hygienic. Where the management team had questions regarding waste disposal, advice had been sought from the local authority.

Good

Is the service effective?

Our findings

People felt supported by knowledgeable, skilled staff who effectively met their needs. One person stated; "Most of them are wonderful and knowledgeable"; "I feel like they do the best they can"; "Sometimes the staff are busy. Most staff are very, very good."

St Anne's staff undertook a 14 week induction programme. The registered manager made sure staff had completed all the appropriate training and had the right skills and knowledge to effectively meet people's needs before they were permitted to support people. New staff shadowed experienced members of the team until both parties felt confident they could carry out their role competently. Ongoing training was planned to support staff's continued learning and was updated when required. A member of staff told us; "I shadowed staff at different times of day to understand people's needs". Staff told us most of the essential training was via e-learning. Some staff felt practical training and discussion alongside the e-learning training would be better and would enhance their theoretical learning.

The registered manager informed us the tissue viability nurse had visited the home and delivered two training sessions so staff had the skills to prevent pressure ulcers. End of life training was planned for 2015.

Research was used to promote best practice. Staff used the Malnutrition Universal Screening Tool (MUST) to identify if a person was malnourished or at risk of malnutrition and the 'waterlow' pressure sore assessment, to assess the risk of an individual developing a pressure sore. For example, weight loss had been recorded as a concern for one person. The person's GP had been contacted to discuss a plan to address this.

We also saw other assessment tools used such as the Distress Baseline Assessment. This measures baseline distress cues in people who have memory difficulties. The Abbey Pain Scale was another tool used to measure pain in people with dementia who could not easily verbalise. The Morse Fall Scale was also used with some people to help identify the risk of falling. Staff told us these tools helped them provide ongoing support effectively and provided them with the knowledge they needed to plan and deliver appropriate care that met people's needs.

People when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who lack the capacity to make decisions for themselves and provides protection to make sure their safety is protected. The MCA is a law about making decisions and what to do when people cannot make decisions for themselves.

Where DoLS applications had been made and evidenced the correct processes had been followed. Health and social care professionals and family had appropriately been involved in the decision. The decision was clearly recorded to inform staff. This enabled staff to adhere to the person's legal status and helped protect their rights.

Staff showed a good understanding of the main principles of the MCA. Staff were aware of when people who lacked capacity could be supported to make everyday decisions. Staff knew when to involve others who had the legal responsibility to make decisions on people's behalf. A staff member told us they gave people time and encouraged people to make simple day to day decisions. For example, what a person liked to drink. However, when it came to more complex decisions such as a do not resuscitate order, a health care professional or, if applicable, a person's lasting power of attorney in health and welfare was consulted. This helped to ensure actions were carried out in line with legislation and in the person's best interests. The MCA states, if a person lacks the mental capacity to make a particular decision, then whoever is making that decision or taking any action on that person's behalf, must do this in the person's best interests.

People were involved in decisions about what they would like to eat and drink. Care records identified what food people disliked or enjoyed and listed what the staff could do to help each person maintain a healthy, balanced diet. People were encouraged to say what foods they wished to have made available to them. People told us "They know what I like and don't like"; "Food is very nice. If I don't like something I can choose something else." Some people told us they would like a more substantive snack later in the evening as tea was at 5pm and they were often hungry by 9pm. Another person said more fresh fruit would be good. We fed this back to the management team and were told this would be addressed.

During breakfast people were relaxed and told us they had sufficient choice. We observed people having a leisurely breakfast with support from staff when required and

Good

Is the service effective?

nobody appeared rushed. We noticed staff helping two people to drink their tea. Staff gave both people time, made eye contact, and spoke encouraging words to keep them engaged.

Care records highlighted where risks with eating and drinking had been identified. For example, one person's assessment had identified a potential choking risk. Staff sought advice and liaised with a speech and language therapist (SALT). A soft diet with thickened fluids had been advised to minimise the risk and staff made sure this was given to the person. The assessment had been regularly reviewed to ensure it met the person's ongoing needs. Staff told us "we make sure the food is mashed or soft and at the right temperature (to prevent burning)" and "we worry when they don't eat as this is a sign they are not well." Staff knew who was diabetic and the support needed but those who were able managed this aspect of their care and diet themselves.

We saw reviews were undertaken in partnership with external health and social care professionals involved in people's care for example the local community health team. District nurses frequently visited the home to care for people who were unwell. Staff told us they sought their advice on the best way to care for people when they visited. We spoke to one visiting district nurse who told us the staff always followed their advice and contacted them when they were concerned about people.

Good

Is the service caring?

Our findings

People were consistently positive about the care they received. Comments included; "All kind and caring"; "All my choices are respected, I can bathe or shower when I want to, choose my own clothes"; "They're excellent, very kind – they listen, they are caring, if you ask for something you get it"; " Staff will do anything"; "They know what I like and I don't like"; " Most staff are very, very good." Relatives reinforced people's comments "They're amazing – it's been phenomenal the way they care for mum"; "They provide the personal touch, go above and beyond."

We observed staff interacting with people in a caring manner. For example when waking one person to move them as they were sliding down their chair, staff gently stroked their cheek to rouse them. Staff knelt down to talk to people at their level and so they could hear them and a quiet tone was used so as not to startle them. We observed another staff member helping someone to drink. They were calm, gentle and chatted to them to keep them alert and engaged so they drank a little more. When staff asked people if they needed to use the bathroom, they whispered in their ear so their privacy and dignity were maintained and other people did not hear the exchange.

People's needs in terms of their disability, race, religion or beliefs were understood and met by staff in a caring and compassionate way. For example, one person we met had communication needs which meant staff needed to adapt how they communicated with them so they understood. Staff used their hands and facial expressions to explain to the person what was happening.

Staff respected people's sexual and relationship needs. For example a couple had developed a relationship within the home. Both people had mental capacity and their families were aware of the relationship.

Staff told us "I like everyone to have the little things which may seem unimportant but make them feel looked after"; "If I can't help someone straight away I always tell them that I will be back and ensure I do come back or ask someone else to help"; "I try to be patient and tolerant with people." Staff explained if people did not want to engage with personal care they would return later in the morning and try again. They explained they took time to talk to people, listen to them and explained what they were doing and this helped them work alongside people.

Care plans instructed staff how to care for people's different needs. For example one person sometimes dressed inappropriately for the weather. Care plans detailed the risk this might pose to the person if they were going out and how to encourage the person to dress so they were warm and safe outside. People's personal likes were recorded and actioned. For example, one person liked to wear perfume and have their lipstick on and we saw that staff had done this for them.

People told us their dignity and privacy was respected at all times. Staff always knocked on people's doors and covered them whilst providing personal care.

Staff used assessment tools and their training to support the delivery of compassionate care. A pain measurement tool was used for one person at the end of their life to ensure the care being provided was not causing them distress. As a result of these being used a plan had been developed alongside healthcare professionals to nurse the person in bed and adjust their pain medicine.

People's human rights and choices were respected. For example one person with capacity had been called for routine health screening. The screening was explained to the person, the benefits and risks and they had refused. Their refusal was discussed, noted with the health and social care professionals involved and respected. Another person had recently passed away at the home. They had refused to go to hospital at the end of their life. Following discussion with their doctor, the staff supported their wishes, ensured their last days were peaceful, and they died at the home with dignity.

People's independence was encouraged where possible. Those who were able to go out into the local town were encouraged to maintain their interests and go to the shops or out for coffee. Staff supported others to go into the local community safely if they wished. Care plans detailed what people were able to do for themselves, for example whether they were able to shave. Some people had lost skills to live independently and we saw that meetings had been held and plans were in place to help some people regain those skills through being more involved in the running of the home with staff encouragement and support. For example one person was assisting with the laundry and laying the table.

Advocates were involved where needed. For example one person had a DoLS authorisation in place and an advocate

Good

Is the service caring?

was involved in ensuring this was in their best interests. The registered manager encouraged friends and family to be involved where possible and kept families up to date with any changes to people's health. Family we spoke with confirmed they were kept up to date by telephone and email if they were unable to visit their family members.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission and a more in depth care plan developed as people settled into the home. Health and social care professionals, family and friends were involved in this process to ensure the staff could meet people's needs. The district nurse we met told us the home had a good feeling and staff were responsive to the needs of people who lived there.

Care records contained detailed information about people's health and social care needs. They were written from the person's perspective and reflected how individuals wished to receive their care and support. Records were well organised, gave guidance to staff on how best to support people's particular needs and were regularly reviewed to respond to people's changing needs. For example care records detailed people's needs in relation to their diet, personal care, sensory adjustments, activities and their end of life wishes. Individual preferences were documented, for example people's preferred names, their faith, allergies and any health and social care professionals involved in their care.

Staff gave many examples of responding to people's changing needs. One person had periods where their dietary intake changed due to their mental health problems. Their weight was monitored closely each week and when the staff had noticed the person was losing weight, prompt advice was sought from the GP and dietary advice considered. Another person's mobility had been affected by a new health condition. We saw their care plan and risk assessments detailed the support and equipment required to ensure they were mobilised safely to reduce the possibility of falls.

People were supported where possible to undertake the activities they enjoyed. We were told activities were "service user led." For those who were more independent they enjoyed helping with the household tasks such as laying the table and laundry. This helped them feel like they were at home. We saw some people relaxing with a newspaper and other people sitting with their friends and partners socialising. Those who were able to go out enjoyed walks and visits to the local community. Care plans detailed the activities people liked such as reading, cooking and drawing. Staff told us they encouraged people to continue with these within the home and one person told us she helped with the cooking in the home and loved this.

The registered manager told us some people who were living with dementia became more agitated during the late afternoon. The staff had found a singing session late afternoon helped to calm people. One staff member told us how someone nearing the end of their life liked her to dance and sing to her in their room and this made the person smile. The staff explained activities and stimulating people had helped to reduce incidents between people and reduce people's anxiety. Staff were aware of the research indicating cognitive stimulation reduces the progression of dementia.

People were supported to have as much choice and control as possible. Care records detailed the skills people had and these were encouraged to be maintained so people did not lose their independence. People were able to have a say in how they wished to live their lives. Some people chose to live in their rooms and remain separate from others in the house. Staff respected their wishes and provided all their care in their room.

Care was personalised to people's needs. For example one person we met had sensory impairment. They were becoming anxious waiting for a health appointment. Staff used a range of communication including spoken word, facial movements and hand gestures to have a conversation with them and explain the district nurse was running late but would be there soon. Staff immediately understood why the person was agitated and soothed them quickly.

People's friendships were encouraged and respected. One person had friends visit but liked staff to inform them when they had arrived and for them to remain outside initially to ensure they were prepared to see them. This was clearly detailed in their care record and the importance of these friendships in maintaining this person's contact with the outside world. Relatives informed us they felt welcomed at the home and informed of their relative's well-being at all times.

Some people due to their health needs did not leave the home often. The registered manager was aware of the need to ensure people did not become isolated or restricted due to their disabilities. One person used to attend the memory café for people living with dementia in the local community. However they had found visiting there increasingly disorientating and distressing. Staff told us they gave these people more one to one time and

Good

Is the service responsive?

developed activities on a personal level. Staff confirmed they did have time to spend one to one time with people. This mental stimulation and activity is important to help prevent cognitive decline.

The provider had a policy and procedure in place for dealing with any concerns or complaints. This was made available to people, their friends and their families. The policy was clearly displayed in the home. People knew who to contact if they needed to raise a concern or make a complaint. People who had raised concerns, had their issues dealt with straightaway. A relative told us; “Any problems at all, I just speak to the staff and it’s dealt with immediately, there is never a need to complain.”

The registered manager told us people were encouraged to raise concerns verbally or through resident forums and questionnaires. These were used for people to share their views and experiences of the care they received. Any concerns raised were thoroughly investigated and then fed back to staff so learning could be achieved and improvements made to the delivery of support. The registered manager told us “We record complaints and go through them with staff. They are used as a learning tool.” Staff confirmed any concerns made directly to them were communicated to the registered manager and were dealt with and actioned without delay. Verbal complaints which had been made to staff with the registered manager had been promptly investigated and dealt with to the satisfaction of all parties.

Good

Is the service well-led?

Our findings

The provider and the registered manager took an active role within the running of the home and had good knowledge of the staff and the people who used the service. There were clear lines of responsibility and accountability within the management structure. The service had notified us of significant events which had occurred in line with their legal obligations. People told us "Yes, it is well run – you only have to say excuse me and they will be there – all very pleasant;" "Always around, good atmosphere."

The registered manager explained their role to us as "Supporting staff, keeping up with legislation – filtering the information down; an overview of the whole system; risk assessing and minimising the risk to people – ensuring service users are confident they can come to us" and "A finger in every pie!"; "I lead by example". They felt it was important to know and understand all the roles staff undertook and the registered manager frequently worked care shifts to maintain a "hands on knowledge of people."

The management team worked closely with their human resource support to ensure personnel problems were quickly addressed and did not impact unnecessarily on the staff. We were told there was "an open door policy – we always try to get things sorted out." Staff confirmed this. The management team worked closely with the local authority safeguarding team, notifying them quickly of any issues and working alongside them to address and improve areas identified. Staff encouraged families to share any concerns. This ensured any of their worries were promptly addressed and relatives had confidence in the home. Praising staff for their hard work was seen as important.

People and their relatives told us the provider encouraged people to voice their opinion and they felt listened to when they did. The registered manager told us resident meetings had not been that successful so the management team sought one to one opinions, were visible and frequently worked in the home to ensure people were happy with the care provided. This also gave them the opportunity to seek people's views of the service. One person told us "They ask my opinion – what would you do? Is that right? I like it that they ask for my advice."

Staff meetings were held to provide an opportunity for open communication, develop the team and drive improvement. Staff told us they were encouraged and supported to question practice. In addition staff one to one meetings were held to discuss issues on a more personal basis. These meetings supported the on-going improvement of staff and the service.

Staff knew and understood what was expected from them. They felt communication was a positive two-way experience enabling the discussion of decisions, actions and performance. Staff questionnaires were being planned for 2015. On the first day of our inspection we raised concerns staff one to one meetings (supervision) were not being held on a consistent basis throughout the year for all staff. The registered manager took note of this and by the second day of our inspection a supervision plan for the following year was in place. Feedback provided was used to drive improvement.

Staff told us they were happy in their work, were motivated by the management team and understood what was expected of them. Comments included; "I'm really made to feel valued, it's lovely working here.", "I love my job and I'm always being praised." Staff felt supported when they joined the team at St Anne's, had an induction, time to read the policies and procedures, people's care plans and told us "It was a supportive experience with time to ask questions."

Information was used to aid learning and drive quality across the service. Daily handovers, communication books, and staff meetings were seen as an opportunity to reflect on current practice and challenge existing procedures. For example a record was kept of all complaints, these were discussed with staff and used as a learning tool to improve practice and reduce the likelihood of a reoccurrence.

The provider promoted an open culture. The service had an up to date whistle-blowers policy which supported staff to question practice and defined how staff that raised concerns would be protected. All staff we spoke with felt able to talk to the registered manager or provider and felt they would be listened too. Staff told us "The registered manager is approachable, visible – concerns would be actioned."

Partnership working supported the development of a positive culture which was personalised. Health and social care professionals who had involvement in the home, confirmed to us communication was good. They told us the staff worked alongside them, were open and honest about

Good

Is the service well-led?

what they could and could not do, followed advice and provided good support. The local authority support worker had been working alongside the home to improve care plans. Recommendations that had been suggested to improve practice had been actioned.

Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so that quality of care was not compromised. Additional audits included environmental checks such as electrical testing, health and safety risk assessments and equipment checks. Safeguarding alerts and recommendations were recorded and patterns examined. Complaints and compliments were recorded and analysed for themes. HR / personnel issues were audited, medicine audits occurred monthly and cleaning checks were undertaken. Where issues had been identified we saw these had been actioned or plans were afoot to address areas.

There was an effective quality assurance system in place to drive continuous improvement within the service. St Anne's belonged to the Devon Dementia Quality Kite Mark (QKM). This is a peer review system that has been set up to support delivery of best practice within care homes in Devon. Managers and core group members who have completed QKM training conduct peer reviews of current practice in care homes that belong to the core group. Suggestions of where improvements can be made to raise the standards of delivery in care are noted. A full objective report is then sent to the service and improvements are made accordingly. The registered manager told us they were waiting for their annual review to maintain this status.