Ashmere Care Group

The Firs Care Home with Nursing

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

This inspection visit took place on 2 and 3 March 2016. The inspection was unannounced.

The Firs Care Home with Nursing provides accommodation, nursing and personal care for up to 42 people, including people who lived with dementia. There is an extra care unit within the location providing specialist dementia care for up to 12 people. At the time of our inspection, 33 people lived at the home.

The service had a new manager. They had not yet applied to be a registered manager with the Care Quality Commission. The provider assured us that the manager intended to register. 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 felt safe, and were supported by staff who understood how to keep them safe from the risk of abuse or preventable harm. Care and activities were risk assessed and people were supported to take part in activities whilst remaining safe.

People received care and support from a trained and motivated group of staff. There were enough staff to meet people's needs, and staff supported people when they needed it. The provider ensured they recruited staff who were suitable to work in a caring environment, and provided new and existing staff with training to ensure they had the right skills and knowledge to meet people's needs.

People received their medicines as prescribed. Staff were trained to manage medicines in a safe way and in accordance with professional guidance.

Staff obtained consent from people before providing support. Where they were not able to do this, staff understood the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported to maintain a balanced diet by staff who understood people's individual needs and preferences.

People were supported by staff who demonstrated kindness and a positive caring attitude. We saw staff consistently support people in a patient and respectful way, and people's dignity was promoted at all times.

People were supported to maintain relationships that were important to them, and relatives were welcomed to visit and participate in life at the home. People were supported to remain active and to take part in activities and hobbies they enjoyed both in the home and their local community.

People were involved in making decisions about their care as much as possible, and staff understood

people's specialist needs, particularly in the area of dementia care.

The provider had a clear complaints policy, and people and relatives felt able to make a complaint or raise concerns. The provider investigated complaints according to their policy, and created opportunities for people to provide regular feedback about the service, which was acted on.

There were systems to monitor and review all aspects of the service, and these were undertaken regularly. This meant the provider was able to identify areas of good practice and areas for improvement, and to make changes to improve the quality of the service.

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 felt safe and were protected from the risk of avoidable harm. Staff knew how to keep people safe, and felt confident to raise concerns about people's care. Medicines were managed safely. There were sufficient staff to meet people's needs and keep them safe.

Is the service effective?

Good

The service was effective.

The provider and staff understood and followed the principles and requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were supported to have a healthy balanced diet, and staff ensured people had access to health and social care professionals when needed. Staff received training in a range of skills the provider identified, including dementia care.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and compassionate. Staff knew people well, and cared for them with dignity and respect. We saw positive interaction between people and staff, and people's right to family and private life was promoted.

Is the service responsive?

Good

The service was responsive.

People were provided with the care they needed, by staff who knew them well. People were involved in making choices about their care, and had regular opportunities to take part in activities that met their personal preferences. The provider regularly sought people and relatives' views and made improvements to the service.

Is the service well-led?

Good

People, relatives and staff felt able to make suggestions and raise concerns. The provider regularly audited the quality of care and the home environment to ensure that people received a consistent quality service.

The Firs Care Home with Nursing

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 1 and 2 March 2016 and was unannounced. The inspection visit was conducted by two inspectors and a specialist nurse advisor.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about important events which the service is required to send us by law. For example, notifications of serious injuries or allegations of abuse. We spoke with the local authority and health commissioning teams and Healthwatch Derbyshire, who are an independent organisation that represents people using health and social care services. No concerns were raised by them about the care and support people received. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group.

We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

During the inspection we spoke with eight people who used the service and four relatives. We spoke with six care staff, one nurse, the cook, the activities coordinator, one housekeeping staff, the deputy manager, the manager and the area manager for the provider. We also received the views of one healthcare professional. We looked at a range of records related to how the service was managed. These included eight people's care and medicine administration records, three staff recruitment and training files, and the provider's quality auditing system.

Not all of the people living at the service were able to fully express their views about their care. 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.

Good

Is the service safe?

Our findings

People consistently told us they felt safe. One person said, "I'm safe; the staff are looking after my safety." Relatives told us they felt people were cared for safely and protected from the risk of avoidable harm. For example, one relative said, "Safe? Of course [my relative] is." Another relative said, "Obviously I worried when [relative] moved in, but I can go away and I know staff will look after [my relative] safely."

Staff demonstrated a good understanding of how to keep people safe from abuse and the risk of avoidable harm. Staff felt confident to raise concerns about people's care, and knew who to share their concerns with. Staff also knew and felt confident to report concerns to the local authority or the Care Quality Commission (CQC) if they felt this was necessary. One staff member said, "I feel the training gives me the confidence to spot it [potential abuse]." They said they were supported to speak up and felt their concerns would be treated seriously. Contact details were displayed around the home for people to use if they had concerns about people's safety or the risk of abuse.

People were supported to transfer and move around the home in a way that encouraged their independence but also kept them safe. For example, one person told us, "I'm not allowed to walk alone; the staff are looking after my safety." The staff asked the person if they felt able to try to walk with their walking frame, and reassured them another member of staff would be close by with their wheelchair, should they become tired. The person was happy to, "Give it a go," and supported the person to walk. Staff were supportive and mindful of promoting the person's independence along with assisting them in a safe manner.

Staff had a good knowledge of the risks related to each person's care, and understood how to provide care and support in the safest way. One person told us, "I'm not allowed to walk alone; the staff are looking after my safety." Risk assessments were completed and reviewed regularly, and staff had access to the provider's policies and guidance on managing risk for people's care. This meant people were protected from the risk of avoidable harm.

There were enough staff to keep people safe and meet their needs. People told us there were enough staff available to support them. One relative told us there were, "Plenty of staff." Another relative told us that they always visited at different times, and described the staffing levels as, "Good and consistent, whenever I visit." Staff told us there were enough staff to meet people's needs. Throughout our visit staff were visible in the communal areas and always responded to people promptly. The manager and deputy manager told us a dependency tool was used to help calculate staffing levels needed based on people's level of dependency and the amount of support they required. The staffing rotas reflected the staffing numbers determined by the dependency tool.

The provider undertook pre-employment checks to ensure prospective staff were suitable to care for people. This included checking references and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is suitable to work with vulnerable people. All staff had a probationary period to give the provider an opportunity to check the new member had the skills and values needed for

the role.

People were supported to remain safe in the event of an emergency. Staff understood what their role and responsibilities were if there was an emergency or unforeseen event. The provider had up to date personal emergency evacuation plans for everyone who lived at the location. These contained important information about how people needed to be supported in the event of an emergency, for example, fire evacuation. The provider had a contingency plan in place to ensure people continued to receive support in the event of the building becoming unusable, for example, if there was a fire or disruption to utilities.

People told us they received medicines when they should. One person told us, "I'm happy for nurses to give me my tablets; I have a lot and I'd rather they do them." Another person told us, "The staff sort my medication for me and it is better that way." A relative told us, "Staff sort out medicines for [person]; it is safer and it is easier for [person]."

Staff received training in safe management of medicines, and had their skills reviewed by the registered manager. Staff told us they had sufficient training to manage people's medicines safely. The provider had up to date guidance for staff which was accessible for staff who dealt with medicines. We saw all medicines were stored, documented, administered and disposed of in accordance with current guidance and legislation. Staff took time to explain to people what their medicines were for, and checked that people were happy to take their medicines. One person who had previously refused medicines was now being given them in disguise (covertly).Records showed staff did this in accordance with best practice guidance. For example, the provider had involved the person's GP and a pharmacist in deciding whether it was in the person's best interest to have their medicines in disguise.

People were protected from the risk of infection. Staff told us they recently had training in infection prevention and control (IPC), and were confident this was sufficient to enable them to reduce risk of infection in the service. Staff we spoke with understood what their responsibilities were to ensure that the environment was kept clean, and we saw staff were using appropriate personal protective equipment when this was necessary. Staff felt there were enough domestic and laundry support staff on to ensure that the service was cleaned properly, with two domestic staff available seven days a week, and one laundry staff member during weekdays. The staffing rotas we saw supported this.

The provider had a detailed daily, weekly and monthly cleaning schedule, and we saw daily cleaning tasks being carried out. The housekeeping staff were responsible for ensuring this was done and we saw this was being carried out as planned. The provider had clear accessible policies and procedures for cleaning and minimising the risk of infection. Staff understood what their duties and responsibilities were. For example, one person had an infection which required all staff to provide care in a way that minimised the risk of infection spreading to others. Staff told us they understood the risks and preventative measures, and records supported this. They also demonstrated how to provide care and keep the environment clean in accordance with best practice. This showed us the provider was taking action to ensure that the service was free from the risk of infection.

Good

Is the service effective?

Our findings

People were supported by staff who understood their needs and were trained and supported to provide care. The manager gave staff time to become familiar with people's documented care needs. For example, one member of staff spent their shift reviewing people's care plans and talking with people about their needs. They explained they had been off work for a period of time, and would not deliver care until they were up to date with people's needs.

Another member of staff described how to support a person when they became restless or agitated. Throughout the day, staff demonstrated they understood how to support this person, and followed the guidance in the person's care plan. One healthcare professional we spoke with said that they had delivered additional training about dementia which staff had requested, and that staff had a positive attitude towards learning about people's care. We saw staff use equipment to assist people to move and transfer. This was done safely and people were communicated with throughout in a reassuring and calm manner. We saw and heard staff ensure people understood what was expected of them and what was going to happen when being assisted.

All staff had a probationary period before being employed permanently and undertook an induction period of training the provider felt essential to meet people's health and social care needs. New staff undertook the Care Certificate as part of their induction. The Care Certificate is a set of standards linked to values and behaviours that social care and health workers apply in their daily working life.

During the induction period, staff worked alongside (shadowed) experienced colleagues so they could learn people's individual needs and preferences. One staff member said, "I had induction training for a week and then three weeks shadowing staff to learn how people like their care." Records showed that staff received ongoing and regular training in skills the provider felt necessary to maintain a good standard of care. The provider also had specialised training for staff working in the extra care unit. All staff in the extra care unit had completed the training, which covered topics the provider felt relevant to good dementia care.

There were regular staff meetings which enabled staff to discuss information relating to care. Staff also had individual meetings with their supervisor throughout the year to discuss their performance and training. They told us this was an opportunity to get feedback on their performance and raise any concerns or issues.

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. People were assessed in relation to their capacity to make decisions about their care. Where they were able to make their own decisions, their care plans clearly recorded this. Where people lacked capacity to make certain decisions, the provider followed the principles of the MCA and ensured that best interest decisions were made lawfully. Staff had good understanding of the practical application of the principles of the MCA, including how to support people to make their own decisions. For example, one staff member described how they would try to explain clearly and simply what choices were available, and if necessary, come back and speak with people at a time that was better for them.

Capacity assessments and best interest decisions were reviewed regularly. For example, where people had bed rails in place, we saw that people's capacity to consent to this restriction had been checked, and where appropriate, a best interest decision was recorded. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. The provider had assessed people as being at risk of being deprived of their liberty and had made applications to the relevant Supervisory Bodies appropriately. People with a DoLS authorisation were supported by a relevant person's representative. This meant people's rights were being upheld, and restrictions in people's care were lawful.

People were supported to maintain a balanced diet, and told us they were satisfied with the quality and choice of meals. One person told us the food was, "Very good and beautiful." Another person told us, "There's always plenty and there's always a choice." Two relatives told us they were always offered a meal and drinks when they visited people, and we saw that this happened. Another relative told us, "The food's excellent – I can't fault it. The staff ask for menu suggestions."

People were provided with a choice of meals, and if they did not like what was on the menu, they were offered an alternative meal. Staff supported people to make their choice of food and drink. The cook catered for people with specialist diets and was knowledgeable about their individual requirements. They told us, they attended the daily shift handover meetings to ensure they were up to date with people's needs. For example, they prepared meals for people who required a soft food diet or a fortified diet. Fortifying is when small quantities of everyday foods, such as cream or butter are added to a food or meal to increase the nutritional content without increasing the portion size. People were provided with specialist cutlery and equipment to enable them to eat independently. People who needed assistance to eat were provided with support in a discreet way.

People were supported to maintain good health and to access healthcare services in a timely way. One person told us, "The doctor visits when I need one; I get plenty of help from the staff." A relative told us, "If [person] needs a doctor, the staff will contact and arrange for a visit." The person confirmed this and told me, "If I'm unwell the staff call for the doctor and will let my wife know for me." Another relative told us their family member's needs were complex, and said staff sought advice and support from health professionals in a timely way which improved the person's health.

We spoke with the health professional involved in a person's care, who confirmed that staff knew when to ask for support. They said staff were knowledgeable about people's needs, and always followed professional advice. For example, if additional monitoring of people's sleeping patterns or bowel movements were needed, staff always kept detailed records as requested. The health professional confirmed that this type of information would then be used to help develop better care or treatment for people.

Records showed people's health was monitored in accordance with their care plans and professional guidance was sought in a timely manner. For example, one person's health had changed recently and staff

had requested a GP appointment, which took place during our inspection visit. Staff communication was supported by regular meetings to pass on essential information, and we saw this was done verbally and confirmed in writing in a communications book.

Good

Is the service caring?

Our findings

People were supported by staff who demonstrated kindness and a positive caring attitude. People consistently said that staff were caring, and praised the quality of care. One person said, "The staff are wonderful; they are very caring." Another said, "Care is second to none." Relatives also felt that staff provided care in a kind, caring and inclusive manner. For example, one relative said, "The staff are good; I can't fault them," and another commented, "Staff are very caring, they always make sure we're both ok."

Throughout the two days of our inspection visit, staff interacted with people in a caring, friendly and respectful way. They ensured people were comfortable and took time to explain what was happening around them in a patient and reassuring manner. Staff spent time with people who appeared anxious or agitated. Staff explained to us they needed to take time to try to establish what people wanted to do and actively listen to what they were saying, or what their body language was communicating. For example, we saw staff speak calmly and with patience to a person who was anxious. The person was not able to explain to staff what they wanted, but took staff to show them what they wanted. This had a positive effect on the person and their anxiety reduced.

The home was taking part in the local authority's Dignity Award campaign. Derbyshire County Council states, "A key test is if you're treating people with the same dignity and respect as you would want for yourself or your family." One relative described how staff encouraged their family member to take part in conversations, stating, "Staff always go down to [person's] eye level to talk – it's very respectful and dignified." We saw staff interacted with people in the manner described by the relative.

People were treated with dignity and respect by staff who understood their individual preferences. One person told us they needed help to move and transfer and they were frightened, but the staff reassured them to ease their fear. Staff understood how to support people with dignity and maintain their privacy. For example, staff asked people about personal care in a discreet manner, and when people were supported to the toilet, staff did this in a way that maintained people's privacy and dignity.

We saw information around the home relating to people's rights and dignity, including a dignity tree poster with certificates of commitment from staff, and a poster reminding everyone, 'Our residents do not live in our workplace. We work in their home.' This demonstrated that dignity and respect for people living at the home were central to the staff's values.

Throughout the visit, we saw staff take an interest in people's activities and lives, as well as attending to their care needs. People were complimented on their choice of clothing and their appearance. We heard a staff member compliment one person on their choice of top, saying, "I like your t-shirt, it really suits you." We observed several activities throughout the two day visit, and saw staff support people to be involved in chair based exercises and an afternoon of musical entertainment. People laughed and sang along, and there was a lot of positive interaction between people and staff. Staff encouraged people to participate as much as they wanted to. For example, two staff supported a person using a walking frame to dance to the music.

Throughout our inspection visit, staff promoted people's choices and gave them clear information about care offered. One relative said, "It's the little extras they do, like making sure [person] has an extra strong cup or tea, and they know [person] likes stopping up for a drink and biscuit before bed." They felt this ensured the person's choices were respected. The provider had displayed information about local advocacy services, and staff understood how to support people to access these. Advocacy seeks to ensure that people are able to have their voice heard on issues that are important to them and to have their views and wishes considered when decisions are being made about their lives.

People were supported to spend private time with their family members if they wished. Relatives told us they were able to visit whenever people wished, and there were no restrictions on visiting hours. Relatives could request a key card which allowed them access to the building without needing to wait for staff to let them in. One person had been able to bring their cat with them when they moved to the home. Staff told us this was very important for the person, and the cat was now looked after by both staff and family members. This showed people's right to private and family lives were upheld and their human rights respected.

Good

Is the service responsive?

Our findings

People told us staff involved them in making decisions about their care, and encouraged them to make their own decisions. People felt that the care they received was consistently good, and where possible, they were involved in planning and reviewing their care. People's care needs were clearly documented and reviewed regularly. The provider and staff understood the needs of people who lived with dementia. For example, in the extra care unit, people were served their meals on coloured plates. Staff explained this was good dementia care practice as it enabled people who lived with dementia to recognise food better, and demonstrated that staff and the provider had implemented professional best practice to support people to eat well. People in the extra care unit were offered doll therapy by staff that have additional training in supporting people with dementia. Doll therapy is a therapy that can have a positive impact on agitation or distress in people with dementia. The provider employed a dementia specialist who was involved in developing additional training for all staff working in the extra care unit, and all staff were undertaking the Dementia Friends training developed by the Alzheimer's' Society.

People's care plans contained detailed information about their likes and dislikes, hobbies and friendships, and key information about life events. Where it was not possible to obtain this information from people directly, staff asked family members to provide information they felt was important about people's lifestyle choices. One relative told us they were asked lots of questions about the person's routines and preferences, and they saw staff tried to ensure they provided care in a way the person would like. Another relative described how their family member was supported to celebrate their birthday with their family. Staff offered them private space to celebrate. The relative said, "Staff baked [person] a birthday cake and decorated the conservatory for us to spend time in. It's this personal touch that's so good." Staff told us that they asked people how they would like to celebrate their birthdays, and this always included cake or an appropriate alternative for people who could not eat cake. We saw photographs of people celebrating their birthdays.

Records contained information about people's communication styles, and we saw staff understood and used this guidance. For example, one person's care plan stated, "It depends on my concentration on how well I answer you." Staff described how they would ensure that the person was supported to take part in conversations, by making sure the environment was free from distraction, or that the person was awake and alert. We saw staff support the person in this way in relation to an activity.

The provider employed a full time activity coordinator to ensure that people were supported to maintain their hobbies and interests. People told us they enjoyed the range of activities offered and we were shown photographs of different activities throughout the year. A relative told us staff levels meant people were given the opportunity to participate and be supported in activities. Examples they gave were, trips to the coast in the summer and a boat trip. Another relative described the activity coordinator as, "Absolutely wonderful," and said that activities were tailored to people's likes and preferences.

Records showed that there was a wide range of daily activities within the home, and that people were supported to participate in trips and events in their local community. Examples we saw were photographs around the home of people participating in activities, external entertainers visiting, and a memory book of

activities and occasions at the home. The activity coordinator demonstrated comprehensive knowledge of people's personal preferences, and activities and hobbies were organised to reflect these. The staff and the deputy manager told us they continued to develop links with the community and that staff were involved in supporting people to use local facilities. For example, the provider had arranged a Valentine's Day celebration for people, families and friends in a local community centre. We saw evidence of the success of the event, and staff told us that the local mayor visited to celebrate with people.

The activity coordinator had won the East Midlands Care Home Activity Organiser Award 2015. This award is part of the Great British Care Awards, which celebrate excellence and promote best practice in care. During our inspection there was a planned activity which most people joined in. Staff took a "sweet shop" trolley to people. People joined in talking about their favourite childhood sweets with staff and each other, and chose a selection of sweets to have with a drink. Staff showed us the choice of sweets, some of which were chosen to be suitable for people on a soft food diet, or for people with diabetes. This demonstrated staff were motivated to provide people with an environment which provided stimulation and enjoyment through a variety of activities tailored to people's preferences.

People were supported to maintain family contact if they wished this. One relative said, "Staff are aware we are a couple and they respect that." Another relative said staff, "Make every effort and go above and beyond," to support people to see family. We saw family members welcomed to the home, and offered drinks and meals. We also saw, and staff confirmed, that people were supported to spend private time with their partners if they wished this. Relatives were kept informed about activities and events at the home, and records showed they were encouraged to visit the home and join in. This showed that staff supported and encouraged people to maintain relationships that were important to them.

We observed a staff handover between shifts where each person's care was discussed with respect and dignity. The handover was detailed and staff showed good knowledge of people and their needs.

People did not have any complaints about the home. People told us if they had any concerns then they would speak directly with staff. One person told us, "I don't have any complaints, but if I did I would tell the staff." They went on to say they had every confidence, "The staff would put things right." Another person told us, "It's fabulous; I've no complaints other than it's ready for decorating." Relatives told us that they knew how to raise concerns or make a complaint. One relative said when they raised issues or concerns with staff, "I am responded to in the way I want." They gave an example of a concern they raised: the issue was investigated promptly and they received a full explanation in writing. The provider had a clear policy on complaints management and information about this was displayed in the home.

The provider held regular meetings for people and their families to enable them to share their views about the home. Surveys asking people, relatives and visiting professionals for their views about the service were regularly sent out. The provider analysed the feedback and told people and their relatives what action was taken to improve the service. For example, a relative told us the home needed redecorating, but said this was happening. Records showed other people and relatives had said they felt the home needed redecoration. The manager and staff were aware of the need to redecorate, and showed us an action plan for the refurbishment of the home.

Good

Is the service well-led?

Our findings

The new manager had only been in post for one week at the time of our inspection visit. They and the area manager told us that they had started the process to apply to be a registered manager with CQC. Our records supported this. The manager understood their responsibilities, for example, in relation to making notifications to CQC about significant events. Records showed that prior to the new manager starting, the home had been without a registered manager since July 2015. We saw that the provider had recruited and appointed a manager in September 2015, but they did not become the registered manager, and subsequently left employment with the provider. Throughout this time the provider had supported the deputy manager to ensure care continued to be provided.

We found that notifications had not consistently been made to CQC, specifically; we had not received any notifications relating to DOLS authorisations. We spoke with the deputy manager and area manager about this and they confirmed this was the case, as they had not been aware of this requirement. They assured us they would review their DOLS authorisations and make the appropriate notifications. We received appropriate notifications for other events.

People and their relatives told us they were happy with the care provided at the home. One person told us, "It's alright here; they [staff] look after me." A relative said, "They always listen to me about [person's care. They [staff] take the time to stop and listen." People consistently told us that all staff, including the new manager, were approachable and helpful, and they felt confident they received good care.

People, relatives and staff felt able to make suggestions to improve the service, and raise concerns if necessary. The provider also regularly sought people and relatives' views about the service, responded to comments and complaints, and investigated where care had been below the standards expected. This assured us people, relatives and staff were able to make suggestions and raise concerns about care, and the provider listened and acted on them.

The service had a clear set of values which were central to developments and improvements. These values included respecting people's human rights, privacy, dignity, independence and choice. Relatives we spoke with praised the service for employing staff who demonstrated these qualities on a daily basis.

Staff told us they felt fully supported by the provider, the area and deputy managers, and by their colleagues. They understood their roles and responsibilities, and felt able to raise concerns or make suggestions to improving the quality of the care people received. One staff member described the team as, "We're like a big family." Another staff member described the provider as, "Responsive," and said that care staff's communications skills were very good with people and each other. A third staff member said, "You couldn't wish for a better deputy – I can always go to her." All the staff we saw demonstrated enthusiasm for their work, and many of the staff had worked for the provider for a number of years. When asked what motivated them to provide care for people, one staff member said, "I absolutely love it. I love seeing people smiling."

The provider had an "employee of the month" award, where people, relatives and staff could nominate a staff member who they felt demonstrated excellent care skills. Two staff had recently received this award for organising an activity based on people's memories of visiting an old fashioned sweet shop. This showed that the provider had a way of identifying good care and encouraging all staff to develop their skills to improve the service.

The provider had systems to monitor and review all aspects of managing the home. This included essential monitoring, maintenance and upgrading of the facilities, and regular monitoring of the quality of care. We saw action had been taken to improve the service. For example, a health and safety audit in November 2015 identified issues with the fire safety of some internal doors. Records showed that action had been taken to ensure that the doors met the standards identified in the fire risk assessment.

We saw organisational policies and procedures which set out what was expected of staff when supporting people. Staff had access to these, and they were knowledgeable about key policies. We looked at a sample of policies and saw that most of these were up to date and reflected professional guidance and standards. The provider's whistleblowing policy supported staff to question practice and assured protection for individual members of staff should they need to raise concerns regarding the practice of others. Staff confirmed if they had any concerns they would report them and felt confident the manager would take appropriate action. This demonstrated the open and inclusive culture within the service.