Abbeyfield Wey Valley Society Limited

Wey Valley House

Inspection report

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Date of inspection visit:
28 June 2017

Date of publication:
30 August 2017

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 took place on 28 June 2017. The visit was unannounced.

Wey Valley House provides residential care for a maximum of 26 people and domiciliary care to people living in their own homes. Some people receiving the services were living with dementia. On the day of the inspection 25 people were receiving residential care, and five people personal care in their own homes.

There were registered managers in post for the residential home and the domiciliary service. 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 their care records contained up to date risk assessments to guide staff in how to protect people from risks whilst enabling them to remain independent. People were protected against the risks of potential abuse because the provider followed safe recruitment practices and staff knew how to safeguard people. People were supported by sufficient staff to meet their individual needs and medicines were administered safely.

Staff worked in accordance with the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. People's nutrition and hydration needs and preferences were met. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP, district nurse, tissue viability nurse, community mental health team, or other health care professionals.

Staff were caring and knew people well. People were encouraged to be independent. Staff promoted people's privacy and dignity, and people were able to have a say in the running of their home.

Care plans were detailed and contained information on people's lifestyles and preferences. They included details on people's routines and what support people liked to receive. People's needs were assessed and their care was regularly reviewed.

People had access to a range of activities and were able to choose what activities they took part in. People and their relatives knew how to make a complaint and raise concerns. People had their concerns responded to.

There was a registered manager in place who promoted a positive culture and supported their staff. Staff

and people were involved in the running of the home. People and those important to them had opportunities to feedback their views about the home and quality of the service they received

Audits were completed frequently, were thorough, and were used to make improvements to the service people received.

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 sufficient staff to meet their individual needs.

People told us they felt safe.

Care records contained up to date risk assessments so staff had guidance in how to care for people whilst protecting them from risks.

The provider had followed safe recruitment practices.

People were protected against the risks of potential abuse because staff had been trained to recognise and report any concerns.

Medicines were stored and administered safely and on time.

Is the service effective?

Good

The service was effective.

People had their rights protected and were free from restraint because staff understood and worked in accordance with the principles of the Mental Capacity Act 2015.

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles

People were supported by staff who had supervisions (one to one meetings) and an annual appraisal with their line manager.

People's dietary needs and preferences were met.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to the appropriate healthcare professionals.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion in their day-to-day care by kind and compassionate staff.

People had their dignity and privacy maintained because staff knew people very well and treated them with respect.

Staff knew how to communicate with people and people were encouraged to remain independent.

Is the service responsive?

Good

Peoples care had been planned and their views taken into account. These plans guided the staff in providing individualised care focussed on people's lifestyles and preferences.

People had a range of activities they could be involved in which they said they enjoyed.

People's spiritual needs were met.

People knew how to complain and their complaints had been used to make improvements.

Is the service well-led?

Good

The service was well led

Audits were completed frequently and were thorough and used to make improvements.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received.

Staff were involved in the running of the home and they felt supported.

The service had a positive culture which staff understood and used when caring for people.

Wey Valley House

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 26 June 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to this inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law.

Following the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we considered the evidence from this inspection.

As part of our inspection we spoke with eight people (six receiving residential services and two domiciliary services), two relatives, three staff, two health care professionals, the registered managers of the residential home and the domiciliary care agency, the chief executive officer and the chairman. We also reviewed a variety of documents which included the care plans for six people, six staff files, training records, medicines records, quality assurance monitoring records and various other documentation relevant to the management of the home.

The service was last inspected on 17 February 2014. All essential standards of safety and quality were being met.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I feel safe. There is nothing disastrous, risk is well assessed." A second person said, "I definitely feel safe, we have very good locks on the doors," and a third person said, "I feel relatively safe. There are fire drills, staff are very caring and they are not changed all the time. That makes a lot of difference." Staff also told us they felt people were safe. One staff member said, "I think people are safe. It's a nice clean, warm home. We know people, we can tell when they are unwell," and another staff member said, "People are very safe." We found that external doors were locked for safety and there was a signing in book to identify any visitors.

The risks associated with people's health or care had been identified and assessed. People were cared for by staff who had access to these assessments detailing the actions they should take to minimise any risks to people. Every person had a thorough assessment before receiving a service. Where risks were identified, a more detailed risk assessment took place. Risk assessments were in place for falls, skin integrity, nutrition and hydration, moving and handling, social isolation, diabetes, sunburn and going out. Risks to people were managed in both the residential home and the domiciliary care agency. Staff followed guidance in relation to risk by offering care to people that met their needs and reduced the risk of harm. For example, one person living with dementia in their own home had a risk assessment that identified they were at risk of forgetting to take their medicines. This risk was managed by staff prompting them to take their medicines. They were supported to have medicines put into blister packs because this made them easier to track. Staff signed the medication administration record when medicines were taken to ensure it was clear when the person had taken their medicines so the risk of them missing a dose was reduced. Where fire issues were identified in peoples own homes, such as a lack of a smoke alarm, the fire service was contacted. The registered manager of the domiciliary care agency had built links with the fire service and they had recently visited one person to install a fire alarm.

The provider had followed safe recruitment practices to ensure new staff were suitable to work with the people. Staff files included application forms and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Records seen confirmed that staff members were entitled to work in the UK. People living in the home were involved in the recruitment of staff. One staff member said, "I was interviewed by the people living in the residential home. I was so overwhelmed with that so I took the job."

People were protected against the risks of potential abuse. Staff understood the indicators of abuse and what to do if they suspected any type of abuse. One staff member said, "The signs of abuse vary. They include withdrawal, depression, anger, bruising, not eating and not sleeping. If I suspected abuse I would preserve any indicators, not ask leading questions and speak to my manager. If needed I would involve the police. If the manager was involved I would go to the chief executive officer." A second staff member said, "I would report abuse straight away. I wouldn't interfere. I would know if someone was off their food or a bit agitated. I wouldn't tell staff I would report it." A third staff member said, "I would suspect someone was being abused by unexplained bruises, changes in mood, them not wanting to mix. You see a change. They

might flinch. I would report it to the manager straight away." A safeguarding policy and whistleblowing policy were available to staff. Staff also carried flash cards with safeguarding information on. Staff had received safeguarding training. People had been provided with a guide that explained how to tell someone if they were being abused and what would happen when they did.

People were supported by sufficient numbers of staff to meet their individual needs. The residential home used a dependency tool to calculate the staffing required. Rotas demonstrated that this was being used to determine what staff needed to be rostered. Staff members in the residential home told us that some afternoons they were short due to staff sickness and on these occasions the team leader would help. A staff member said, "There are enough staff most of the time. It can be a problem when someone phones in sick last minute. We are able to meet people's needs though." A second staff member said, "Someone rang in sick this afternoon. The team leader will help." A third staff member said afternoons can be a bit tight. It's mainly through holidays and sickness. It doesn't make a difference to residents though. They get what they need. It doesn't interfere with their care." People told us that staff were always quick to answer the call bell if they used it. One person said, "They (the staff) are very fast." A second person said, "They (the staff) are very quick." We observed the call bell being responded to within two minutes on the day of the inspection. Following the inspection the registered manager of the residential home told us they had taken on board the staffs feedback and said, "We will try to ensure cover is in place if staff are off sick or if the well-being of our residents is affected."

In the domiciliary care agency they used a system to schedule visits and deploy staff. It showed that people were matched with consistent staff and that staff had enough travel time between visits. People told us that staff always arrived on time.

Medicines were administered safely and on time. People were aware of the medicines they were taking and what they were for and were able to self-administer their medicines if they wished. We observed the lunch time medicines round. We heard the staff member administering the medicines asking people if they were in pain and saw that they administered people's medicines at the times they wished. For example, one person liked to have their medicines after they had eaten lunch. Staff authorised to administer medicines confirmed they had completed training in the safe management of medicines, and had undertaken a competency assessment where their knowledge was checked. There were appropriate arrangements for the ordering and disposal of medicines from the pharmacist. Medicines were stored securely and in an appropriate environment. Regular medicines audits were completed to ensure safe systems were being followed. The most recent one was completed in June 2017. The local pharmacy had also completed an audit in December 2016 with no issues identified. A very detailed medicines policy was in place in both the residential home and the domiciliary care agency which staff had read and signed.

The risk of fire had been assessed in November 2016 and plans were in place to minimise these risks. The fire detection system was tested regularly. On the day of the inspection we saw the fire detection system being tested. Fire drills were being completed and all staff had received fire training. Personal Emergency Evacuation Plans (PEEPs) were in place for every person. These provided staff with the knowledge they needed to safely support each person in the event of a fire and how they should be helped to evacuate the home. There was also an emergency evacuation box in place.

Accidents and incident records were maintained and appropriate action had been taken following accidents and incidents. These were discussed with staff during the daily handover meetings. However, care plans were not always updated following accidents and incidents. We spoke to the registered manager about this who put procedures in place to make sure this happens. There were procedures in place for staff and the managers to follow should an accident or incident occur.

The provider had developed plans to help ensure that people's care would not be interrupted in the event of an emergency, such as loss of accommodation, loss of electricity supply, boiler failure or severe weather. The service had a business continuity plan, which had been reviewed in November 2016.

Good

Is the service effective?

Our findings

Staff worked in accordance with the Mental Capacity Act 2005 (MCA) in the residential home. The 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 had their mental capacity assessed. However, best interest decisions were not always clearly recorded. We spoke to the registered manager about this and they agreed to improve the recording by introducing specific paperwork for this to be done. No-one receiving the domiciliary service lacked the capacity to make decisions about their care.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had made a number of DoLS applications for people who were unable to go out on their own safely.

Staff were able to describe the principles of the MCA. In the PIR the registered manager told us that staff were aware of the 5 principles of MCA and carried an 'aid-memoir' to assist them. One staff member said, "You never assume a person doesn't know what they want. It's their choice. Their decisions are never unwise." A second staff member said, "If people have the capacity they can choose. If they can't we have to use best interests. For example, we might have to go out for a walk with someone rather than them go on their own to keep them safe." A third staff member said, "Everybody is entitled to make decisions. If they are confused, you can help them to make a decision best for them. It has to be the right decision for them." Staff showed us the aid-memoir they used. Records showed that staff had received MCA training.

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. One person said, "They (the staff) are well trained." One staff member said, "I have had mandatory training. This includes safeguarding adults, food hygiene and moving and handling. Training is face to face with a house trainer who assesses our competency. Next year I'm doing an in-depth three day first aid course." A second staff member said, "We have to do training every year to keep updated. This includes safeguarding, first aid, dementia, diabetes and moving and handling. A third staff member said, "I had induction. For the first two weeks I shadowed staff. I learnt how to do personal care. I did a lot of training, I did the care certificate. The trainer supported me with this." The care certificate is a nationally agreed framework which sets a basic standard for skills staff need to have to support people safely. Training records confirmed staff were receiving training to meet the needs of people and that staff had achieved or were working towards obtaining an NVQ level 3 or above in Health and Social Care.

In the domiciliary care agency the registered manager only recruited staff who had completed an NVQ level 3 or above. Staff training in personal care was broken down into tasks such as mouth care, shaving and washing. Staff were observed doing these tasks and had to be signed off as competent before doing them

independently.

People were supported by staff who had supervisions (one to one meetings) and an annual appraisal with their line manager. Staff told us they received regular one to one meetings (called supervision). One staff member said, "I have supervision every couple of months. We can ask for training we would like to do. I have just had my first appraisal with the deputy." A second staff member said, "Supervision is themed. I have just had my appraisal. I have one action." A third staff member said, "I have just recently had an appraisal. They (their manager) want me to do my NVQ." Records confirmed that staff received regular supervisions and appraisals.

People's nutrition, hydration needs and preferences were met. In the residential home people were able to choose what they ate and drank. One person said, "At night they (staff) come down to take what you want, and they ask what I want for pudding, the same for every food." A second person said, "If I don't like what is on the menu I can have an alternative. They are very good about that." People told us they enjoyed the food. One person said, "The food is good. Breakfast is always brought to me on a tray." A second person said, "It's (the food) very, very good." At lunch time we observed people were given a choice of drinks and one person was serving their friends a sherry. People had a choice of main meal and fresh vegetables. Staff supported people to serve their vegetables and explained what was being served. The food looked nutritious and appetising.

In the PIR the registered manager told us that feedback was sought from people following meals. When people had finished their meal we heard staff asking if people had enjoyed their meal. During the inspection we observed drinks being offered throughout the day in people's rooms and the lounge. If someone's weight changed their nutrition plan was reviewed. People who were at risk of becoming malnourished and dehydrated were given support with eating and drinking. People were being weighed and if there was a weight loss they were referred to their GP and had their food and fluid intake monitored for four days. We spoke to the registered manager about this as this may not be sufficient for some people. They agreed to introduce ongoing monitoring and to introduce fluid intake targets with peoples GP's if needed. People who had difficulty swallowing had been referred to the Speech and Language Therapy Team (SALT) and staff were following their guidance.

People receiving domiciliary care had care plans that contained information on people's preferences as well as their dietary requirements. For example, one person liked cheese toasties for lunch, a cup of tea and toast at breakfast. This was in their care plan. People were supported to cook for themselves. One person said, "They (the staff) help me to cook for myself."

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP, district nurse, tissue viability nurse, community mental health team and other health care professionals as and when required. One person said, "If I need anybody they (the staff) ask them to come." A second person said, "When I need the doctor they will come in the afternoon." A third person said, "I have chiropody once every two months. A young lady comes, very good that young lady." A health care professional told us, "The staff here are a breath of fresh air. The staff are on board." Records demonstrated people's health needs were being met. For example, one person was having their arm dressed by a district nurse and their pressure areas checked by a district nurse and staff recorded the progress and visits.

People's rooms in the residential home were personalised. One visiting health professional said, "I'm impressed with the environment. The rooms are like little homes. There are always familiar things around and people are not isolated in their rooms." The living room and dining rooms were all colour coordinated and the living room had a number of small seating areas so people could choose who to sit with and what to

do.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person said, "They (the staff) are caring, wonderful, very lovely bunch of people." A second person said, "They (the staff) very, very caring. If you ask anything they will do anything for you. They never ever ill-treat no one," and a third person said, "We have a joke with all of them (the staff). All wonderful people." Throughout the inspection we observed positive caring interactions. We saw staff chatting with people about their day and about their interests.

Staff knew people well. They were knowledgeable about people's needs and backgrounds. A visiting health professional in the residential home said, "There are regular staff and they know the residents." Care plans had detailed life histories which included information on people's childhood, career, family, holidays, and hobbies. Staff used these when talking with people and when organising activities. For example, a number of people were Christians so church services and bible study took place. One person whose hobby was gardening was being supported to grow fruit and vegetables for the home.

One person receiving care from the domiciliary care agency was being supported by staff to make a life story. This was something the registered manager planned to introduce for all people over time.

People were treated with respect. People told us staff called them by the names they preferred. One person said, "I'm called by my Christian name or darling, I don't really mind." A second person said, "They call me (name of person) and I am happy about that."

People were encouraged to be independent. For example, one person's care plan recorded that they were able to do lots of tasks for themselves and just needed prompts. It was important to them that they always answered the door. This was clear in their care plan. A number of people went out for walks independently and carried a card on them in case of an emergency. One person said, "When supporting me with personal care they (the staff) always ask me about what I want to do." Peoples care plans clearly stated what people were able to do.

Staff promoted people's privacy and dignity. One person said, "I am very independent, they (the staff) do respect privacy and dignity." A second person said, "They (the staff) always knock before getting in." We observed during the day that staff knocked on doors and doors where closed when personal care was being provided.

Staff knew how to communicate with people. Care plans identified how people like to be communicated with. For example, one person preferred having a one to one chat, did not like to be questioned and needed re-assurance when they became anxious. Another person liked to have a one to one chat in their room. Staff communicated with people as written in their care plans throughout the inspection.

People's spiritual needs were met. One person said, "I go to church with a couple of residents every Sunday. They do have a service here as well." A second person said, "We have a church service once a month plus

communion service once a month." A bible study group was held on a monthly basis and grace was said before lunch.

Relatives and friends were able to visit the home at any time. Visitors were made welcome. One staff member said, "Relatives visit regularly, they can have lunch. " We saw relatives being greeted and offered drinks. All of the relatives who responded to a quality assurance survey in May 2017 said they were made to feel welcome in the home and were invited to join in activities.

Good

Is the service responsive?

Our findings

Care plans were detailed and contained information on people's lifestyles and preferences. They included details on people's routines, what support people liked to receive when washing, when they liked to bathe, what clothing they liked to wear, what they liked to eat, how they liked to sleep, and what they liked to do. For example, one person's care plan said that they had their bedding changed on a Monday. It also said they liked a shower twice a week. Personal care tasks were listed in detail to say how they liked them done. It also detailed how they liked their nightwear warmed before putting it on. Peoples care plans detailed the support people needed in areas such as daily life, mobility, communication, nutrition, personal care, oral health, skin integrity, sleeping, sexuality, health needs and mental health needs. Records demonstrated support was being provided by staff according to people's needs and preferences.

Staff were very knowledgeable about people's care and what was in their care plans. For example, they were aware of people's life histories, their likes and dislikes, daily routines and how people preferred their personal care needs to be attended to. They were aware of people's communication needs, eating and drinking and the support they required.

Pre-assessments were completed prior to people moving in or receiving the service so it could be ensured the service was able to meet their needs. People's needs were then regularly assessed and the care they received was regularly reviewed.

People were involved in developing their care plans. This was confirmed in the providers May 2017 quality survey that people said they were involved in developing their care plan. Records demonstrated this was the case.

People had access to a range of activities and were able to choose what activities they took part in. An activities coordinator prepared a monthly timetable of activities which was given to everyone. The activities included roulette, day trips to places such as Windsor, bowling, chair based exercises and manicures. One person said, "They have quite a lot of activities, cards, scrabble, and dominoes." A second person said, "I like afternoon singing and games together. I like throwing rings. That's my favourite." A third person said, "My favourites are bingo on a Saturday and card games. I love all the activities." We were introduced to one of the people living in the residential home as, 'The head gardener.' They showed us their garden. They were growing vegetables, fruit and flowers for the home and were growing a pumpkin for a local competition. A volunteer was working in the home two days a week handing out drinks and chatting to people. Both the volunteer and people were enjoying these chats.

People and their relatives knew how to make a complaint. One person said, "I will go to (name of manager). I will complain if I need to. I can go to the CEO (The Chief Executive Officer). We are encouraged to complain and they always listen. I will not be afraid to raise an issue." A second person said, "I have had no need to complain. I have felt happy to raise any issues with staff." A third person said, "If you have a complaint tell the reception they will pass it through quickly." In the May 2017 quality assurance survey relatives who responded said they would know who to contact if they wished to make a complaint. The domiciliary care

agency had received no complaints since it had set up in January 2017 and the residential care home had received none in the last year. The registered manager told us they did record minor issues they had addressed. There were seven of these recorded since September 2016. These included concerns around food and the menu which were addressed by the catering contractors, loss of a piece of clothing which was found, and the attitude of a staff member. This was addressed with them. The complaints procedure was available to people and visitors in the form of a complaints leaflet with details of who to complain to and what would happen to their complaint. There was a 'comments compliments and complaints' book for anyone to write in if they wished at the reception.

Good

Is the service well-led?

Our findings

People and those important to them had opportunities to feedback their views about the residential home and quality of the service they received. One person said, "We get one (a survey) yearly. We had one recently. I have mentioned things I hope they will take into account, but it was nothing major, all minor." A second person said, "We have it (a survey) from time to time. They send a big sheet of paper and you can put your opinion in it." Surveys were sent out in May 2017. Thirteen people and 14 relatives had responded. An analysis had been done and actions identified to deal with areas of concern. These included communicating activities to people with limited sight, activities being more organised and telling relatives about hospital referrals. People and relatives were positive about the staff, outings, and people's quality of life.

Audits in the residential home were completed frequently and were thorough. These were carried out by the registered manager. They included falls, infections, water temperatures, health and safety, infection control and medicines. The half yearly health and safety audit carried out in January 2017 had a 98% compliance rate and identified two items related to the office. These had been dealt with. An infection control audit in May 2017 identified that toilets and the sluice room were not clean and that staff were not washing their hands when they should. During the inspection we saw that the registered manager had dealt with these. Falls were analysed so that staff could see where falls were occurring and what injuries were occurring and look for ways to prevent them re-occuring.

The domiciliary care service had their first full audit in progress at the time of inspection. A quality assurance policy was in place. Care records had been audited and files were up to date. Feedback forms had just been finalised for the domiciliary care service and were about to be sent out to people, relatives and staff.

Spot checks were carried out every three months on staff in the domiciliary care service whilst they provided care to people. They were unannounced and records seen were thorough and followed a standard format.

People were involved in the running of their home. Monthly residents meetings were held. One person said, "All the residents have a meeting once a month. All residents can voice their opinion." A second person said, "We have a residents meeting once a month which is a good opportunity to talk about anything and everything," and a third person said, "At residents meetings we discuss the menu." Minutes were recorded for each meeting. Topics discussed included the quality of food, lost property, ideas for activities and outings and gardening. People's requests were taken on board. For example Ryvita was provided for the cheeseboard as requested, a gardening project had started and positive feedback was given on improvements to the supper being offered
People knew who the managers were and found them supportive and accessible. One person said, "The managers are [names of managers]. The office door is always open and we are welcome." A second person said, "They (the managers) are very, very caring they really are." A third person said, "I get my voice heard and my opinion."

Staff were involved in the running of the home. Monthly staff meetings took place where staff received important messages and shared good practice. Records showed staff and managers discussed ideas for

making the dining room more appealing, equipment needed to be included in next year's budget, training, health and safety, the laundry, fundraising, staffing, and the use of social media. Staff were thanked for their hard work.

Staff told us they felt supported by the management. One staff member said, "Managers are very supportive. If I want to chat I can. If I want to rant and rave I can. I was off sick and they sent a nice bunch of flowers. It meant the world to me." A second staff member said, "The managers are brilliant. They helped me build my confidence." The service had been awarded the Investors in People gold award. The Investors in People award is, 'The sign of a great employer, an outperforming place to work and a clear commitment to sustainability.'

The service had a positive culture based on the values of the society. In the PIR the registered manager told us that the society has a clear vision which is displayed and is included in the staff handbooks and that core values are also published and promoted. A staff member showed us the cards titled 'Visions and Expectations.' A second staff member said, "The code of practice is to be professional, wear the correct dress, greet people and speak to people how you like to be spoken to." A third staff member said, "Abbeyfield want to be the best. In my eyes they are one of the best. I am proud to tell people I work for them. I love my job."

The registered managers were aware of their responsibilities to report significant events, such as notifications to the Care Quality Commission. This meant we could check that appropriate action had been taken.