Ourris Properties Limited

Autumn Gardens

Inspection report

73 Trent Gardens
London
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Date of inspection visit:
06 August 2018
07 August 2018
08 August 2018

Date of publication:
27 November 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 6, 7 and 8 August 2018. Autumn Gardens is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Autumn Gardens is registered to provide accommodation and personal care to up to 85 older people, some of whom may have dementia. The home provides a service for people, primarily from the Greek community although they also work with people that speak English and other languages. The home is a purpose-built unit with two floors. There are three communal lounges on the ground floor and a large well-kept garden.

There was a registered manager in post. 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.

The service has been subject to a period of increased monitoring and support by commissioners. The service has been the subject of multiple safeguarding investigations by the local authority and partner agencies. As a result of concerns raised, the provider is currently subject to a police investigation. We have reported further about this under the 'well-led' section of the report.

Risk assessments were not consistent. Some risk assessments provided staff with guidance on how to mitigate known risks whilst others did not. However, staff that we spoke with were aware of people's risks and how to manage them.

People received their medicines safely and on time. Systems were in place to monitor medicines and staff had received training in medicines administration.

The home managed behaviour that challenges well and healthcare professionals were positive about how this was managed. Staff understood how to work effectively with people to manage their behaviour.

People had access to call bells if they required help and call bells were answered promptly.

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.

Staff had received training in infection control and were aware of how to control and prevent infection.

People received diets appropriate to their needs. Special diets were documented and staff were aware of people's individual needs. Drinks were available throughout the day and night.

Staff received thorough induction when they started work at the home as well as regular, effective supervision and appraisal.

People were supported to access routine healthcare and referrals were made to specialist healthcare professionals when necessary.

Care plans were not always person centred. However, the home had recognised this and were in the process of updating all care plans.

There were systems in place to identify maintenance issues. Staff were aware of how to report and follow up maintenance.

We observed kind and caring interactions between staff and people. People were treated with dignity and respect.

Relatives were welcomed and able to visit whenever they wished.

The home understood the importance of activities and engaging people in things that were meaningful and important to them. There were regular scheduled activities in communal areas and for people who spent the majority of time in their rooms.

People were supported and encouraged to access the community and stay in contact with relatives and friends.

Staff were positive about the management and the support that they received.

There were regular surveys and bi-annual meetings with friends and family members to seek their opinion and share information.

Audits were carried out across the service on a regular basis that looked at things like, medicines management, health and safety and the quality of care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Risk assessments were inconsistent and did not always provide guidance for staff on how to minimise the known risk.

Staff understood safeguarding and how to report any concerns.

People's care needs were assessed monthly and staffing levels reflected people's care needs.

People were supported to have their medicines safely.

People were protected from the risk of infection and appropriate equipment was used.

Is the service effective?

Good

The service was effective. Staff had on-going training to effectively carry out their role

Staff were aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and how this impacted on the people that they worked with.

Staff received regular supervision and appraisal.

Peoples healthcare needs were monitored and referrals to specialists made when necessary.

People were supported to have enough to eat and drink so that their dietary needs were met. Where people had specialist dietary needs, these were understood and catered for.

Is the service caring?

Good

The service was caring. People were supported and staff understood individual's needs.

We observed that people were treated with respect and staff maintained privacy and dignity.

Staff treated people kindly and were patient and kind in their

interactions.

People were supported in their preferred language.

Relatives were welcomed and able to visit at any time.

Is the service responsive?

Good

The service was responsive. Care plans were being updated to be more person centred.

Staff were knowledgeable about people's individual support needs, their interests and preferences.

The home provided a lot of activities and people were encouraged to take part. Activities were provided in English and Greek.

There was an appropriate complaints procedure in place. The home responded appropriately to any complaints.

End of life care was documented and regularly reviewed.

Is the service well-led?

Good

The service was well-led. Staff were positive about how the home was run and understood lines of accountability.

The home had addressed recent safeguarding concerns in a transparent way.

There were regular audits that identified any actions required to improve the quality of care.

People's and relatives feedback was actively sought through surveys and meetings.

Healthcare professionals and relatives were positive about communication within the home.

There were regular staff meetings.

Autumn Gardens

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 6, 7 and 8 August 2018. The inspection was carried out by three adult social care inspectors, a CQC nurse specialist advisor and five experts 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. Three experts by experience attended the inspection and spoke with people to gain their views and opinions of the home. Two other experts by experience supported this inspection by carrying out telephone calls to people's relatives following the inspection.

Before the inspection we looked at information that we had received about the service and formal notifications that the service had sent to the CQC. We also looked at safeguarding notifications that the provider had sent to us. Providers are required by law to inform CQC of any safeguarding issues within their service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 20 staff including the registered manager, the operations director, the operations manager, the registered manager, two assistant managers, the activities coordinator, two nurses, one chef, one domestic and nine care staff. We also spoke with 38 people that were living at the home as well as two healthcare professionals and six relatives that were visiting the home at the time of the inspection. We looked at 15 care records and risk assessments, 67 people's medicines records, 11 staff files, and other paperwork related to the management of the service including staff training, quality assurance and rota systems. Following the inspection, we spoke with 14 people's relatives.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at Autumn Gardens. People commented, "I love this place and I feel safe enough", "Yes, I do feel safe. It is alright here nothing has happened that has caused me concern." Another person told us that they felt safe and told us that if they asked for anything it was always there. Relatives that we spoke with were positive about their loved one's safety in the home.

All care records viewed had risk assessments which clearly identified any risk factors. The risk assessments viewed included Waterlow score assessment, which is a tool for assessing the risk of developing pressure ulcers, Malnutrition Universal Screening Tool (MUST), which is a tool used to assess the risk of malnutrition, bedrails, moving and handling, falls, medicines, breathing, continence, chocking and specialist feeding regimes. Some risk assessments provided good guidance for staff on how to minimise known risks.

However, despite risks being identified, other risks assessments were not consistent and did not always provide enough information to enable staff to minimise known risks. For example, one person had diabetes. However, the risk assessment failed to state how staff could recognise a person's high or low blood sugar. Another person that was at risk of urinary tract infections (UTI) did not have a risk assessment to provide staff with guidance on how to recognise if the person was experiencing a UTI. Where people had pressure ulcers, the home had not been completing wound management care plans and risk assessments. However, nursing staff that we spoke with were aware of each person that required wound care management and were addressing this appropriately. Staff that we spoke with were able to explain people's individual risks and steps they would take if they thought the risk was happening. We raised this with the operations manager who told us that they were aware that the risk assessments required updating and all risk assessments were currently being reviewed.

Where people were bed bound and required help repositioning themselves we saw that turning charts were in place and completed each time the person was repositioned by staff.

All staff members that we spoke with were able to explain how they would keep people safe and understood how to report any concerns where they felt people were at risk of harm. Staff were able to explain different types of abuse and how to recognise it. Staff training records showed that staff had completed training in safeguarding which was refreshed yearly. We have reported further on safeguarding in the 'well-led' section of this report.

The service followed safe recruitment practices. Staff files showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK. This minimised the risk of people being cared for by staff who were inappropriate for the role. Criminal records check were completed every three years in line with best practice.

Falls were documented and analysed monthly to see if there were any patterns to people's falls. People who had experience re-current falls were referred to the Enfield Care Homes Assessment Team falls clinic to be

monitored and equipment such as sensors put in place if necessary. There were risk assessments in place including the use of bed rails as part of risk management to reduce the risk of falls. We saw that there were also meetings with family members, where appropriate, to make decisions around falls prevention.

People's medicines were well managed and there were clear systems in place to support this. People's medicines were recorded on medicines administration record (MAR) sheets and used the bio-dose system provided by the local pharmacy. Bio-dose provides people's medication, including any liquid medicine, in a pre-packed plastic pod for each time the medicine is required. We saw that people's medicines were given on time and there were no omissions in recording of administration in the month prior to the inspection. There were appropriate arrangements in place for recording and disposing medication when required.

Four people using the service took their medicines covertly. This means that the person's medicines are either crushed or disguised to enable the person to take them. This had been done in the person's best interest and a mental capacity assessment completed to ensure that the person lacked capacity to make that decision. Best interest decisions were clearly documented involving the GP, the pharmacist, the home and where appropriate, the person's relative. Where people's medicines were given covertly there were clear guidelines on how staff should administer the covert medicines.

Controlled drugs were stored and managed appropriately. Controlled drugs are medicines that the law requires are stored, administered and disposed of in a specific way under the Misuse of Drugs Act 1971 due to their potential for abuse. A weekly audit count was carried out by the deputy manager and evidence of this was seen in the controlled drug book.

Staff had received medicines training and we saw that all staff that administered medicines underwent annual competency assessments or more frequently if there were any concerns around competency. This ensured that staff understood how to safely administer the medicines and were regularly monitored. One person said, "I get my tablets on time, the nurses are good."

All bedrooms and bathrooms had a call bell system in case people required help. We saw that one person was physically unable to use their call bell and the person's care plan clearly explained this. There were hourly checks in place and records showed this was being done. We saw that call bells were answered promptly and people in bed during the day had easy access to their call bell.

Accidents and incidents were documented. The incident itself and the immediate action had been recorded. Incident reports also included the details of any follow-up action and people's care plans were updated if necessary.

A dependency score for each person was completed monthly. The dependency tool looks at each person's care needs and identifies any changes in people's care requirements which helps inform staffing levels. The registered manager told us, "We go according to the dependency tools and then manager discretion. We can increase staff and plan for routine appointments." We saw that staff were well deployed and there were enough staff on duty throughout the inspection.

The home worked with people that could show behaviour that challenged. A healthcare professional told us, "When it comes to challenging behaviour they [staff] are very good and quick to report. They use de-escalation techniques and are quick to learn." For example, one person received regular visits from a relative and the relative was going away for an extended period. The registered manager told us that they had identified that this may increase behaviour that challenges and had put in place an increased programme of activities for the person.

The home ensured that staff understood infection control and how to protect people from infection. Staff had been trained in infection control and the service ensured adequate supplies of personal protective equipment (PPE) such as gloves and aprons. Staff told us that they always had access to PPE. We observed staff using PPE throughout the inspection.

The home was clean and smelled fresh throughout the inspection and we saw domestic staff conducting thorough cleaning of people's bedrooms and communal areas. The home had up to date maintenance checks for gas, electrical installation and fire equipment. Staff understood how to report any maintenance issues regarding the building.

Good

Is the service effective?

Our findings

Staff received an induction when they began working in the home. One Greek speaking staff member told us that their induction had been given in English and translated into Greek on a computer screen to help them understand. During their induction period staff received training including, safeguarding, health and safety, mental capacity, moving and handling and fire safety. Staff also shadowed more senior staff before being able to work alone.

Staff received a wide range of person centred training to enhance their performance such as moving and handling, dementia awareness, diabetes awareness, equality and diversity, infection control, safeguarding, wound management and medication training. Staff told us and records showed that they received refresher training each year in areas such as manual handling, safeguarding, MCA and DoLS and medicines. During the inspection we observed a training session that was taking place. We saw that one staff member that was attending the training was translating the course material into Greek for another staff member. We raised this with the operations director as we were concerned that the staff member translating may not be able to fully participate in the training. The operations director told us that this would be looked at and they were reviewing the way in which training was being provided following a recent safeguarding concern that had been raised.

Staff told us and supervision records showed that staff received monthly supervisions. Staff were positive about their supervision and felt that it helped them to assess their performance and raise any concerns. One staff member told us, "It's two-way communication." Staff told us that they were able to request training if they felt it necessary. Staff that had been employed over one year had received an annual appraisal and staff told us that they had input into their appraisals.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. Where people required a DoLS we saw that this was in place with information on when these needed to be reviewed. Staff that we spoke with had a good understanding of mental capacity and records showed that all staff had received training in MCA and DoLS including yearly refresher training. One staff member told us, "I should presume that the person [has] got capacity" and if decisions are made on the person's behalf they, "Should be the least restrictive as possible."

Staff also understood the need for gaining consent before carrying out any care. One staff member said, "I

would ask. If the person refused I would try a couple of times, leave the person for a while then try again. Get a different person to approach them and use other methods to encourage them." Where a person was not able to consent due to their dementia, we saw that relatives that had legal authority to act on their behalf had been involved and signed the care plans. The home completed MCA assessments in areas such as finance, personal care and bed rails.

Prior to moving into the home people had a pre-assessment that looked at the person's care needs as well as their well-being and preferences. People and relatives were able to visit the home prior to the person moving in. Pre-assessments helped form the basis of people's care plans.

People received a balanced diet. Where people required a specialist diet such as pureed food, we saw that this was being provided. Staff were aware of people that had thickened fluids due to swallowing difficulties and understood the importance of ensuring that guidance from Speech and Language Therapists was followed. The chef told us that whenever a person's dietary needs changed or there was special instruction, this was explained to them by one of the managers.

On the first day of the inspection we observed a person being supported to eat pureed food in their room. We saw that the food was mixed together like a soup. We raised this with the operations director and discussed the importance of ensuring that food looked appetising and people's experience of meal times was positive and enjoyable. On the second day of the inspection we saw that this had been addressed and people on pureed diets were served their food with each element of the meal separate on their plate.

We observed two meal times and saw that where people required help to eat, staff supported them appropriately. People were encouraged to eat independently if they were able. Where people needed required support to eat, we saw that this was done at an appropriate speed and staff spoke with the person as they were supporting them. People had access to drinks with meals and throughout the day. Where people were in their rooms we saw that there were jugs of juice and water available to maintain people's hydration.

One of the chefs told us that people could have an alternative meal if they wished and said that people asked for soups, salads and sandwiches. We observed a person that requested and received an alternative meal. People told us, "I've had my breakfast. It was nice", "It's ok. I get enough food here" and one person rubbed their stomach when we asked if their lunch had been nice.

People's personal files had details of healthcare visits, appointments and reviews such as dentists, doctors and opticians. Guidance given by professionals was included in people's care plans and updated where necessary. The home worked effectively with other healthcare professionals and we saw that there were referrals to specialist services that supported people's health and wellbeing.

Good

Is the service caring?

Our findings

The majority of people living at Autumn Gardens had been diagnosed with dementia and because of this it was sometimes difficult to gain people's opinions of living at the home. We observed staff interactions with people to gain an understanding of how people experienced their care. People we were able to speak with said, "The care is excellent. The staff are very caring and very professional" and "They're all so nice to me." Relatives told us that they felt that staff were kind and caring. Comments included, "Staff are lovely, all the girls know our values, and show respect to my mum", They [staff] are very good and patient the best thing they speak to my mum in Greek" and "This nursing home is good, wonderful staff and very helpful."

We observed kind and caring interactions between people and staff throughout the inspection. For example, we saw a staff member helping a person who was spending time walking in the corridors. The staff member was chatting and dancing with the person without rushing them and the person responded by laughing and smiling. In one of the communal lounges we saw a staff member enter the room and a person called them over and hugged them. The staff member returned the hug and sat to have a conversation with the person whilst gently holding their hand.

People were treated with dignity and respect. Staff were aware of how to conduct personal care ensuring privacy by closing doors and curtains. During the inspection we observed a person that had become incontinent. Two staff gently reassured the person who was quickly taken to their room and supported to change with minimal fuss.

As well as Greek speaking staff, the home also had English speaking staff that helped to support people who communicated in English. This promoted a friendly communication environment and ensured that people were able to express themselves. We saw that for people that spoke different languages, the home had provided ways for people to engage. For example, one person had a specific television channel where they were able to watch films in their first language. We observed that other people had access to radio stations in their first language.

Throughout the inspection we observed staff knocking on bedroom doors and waiting for a response before entering. People had the option of having their door left open or closed whilst in their rooms. For example, we saw that one person liked to keep their bedroom door locked when they were not in their room. There was a notice on their door that said, 'I like to have my bedroom door locked when I am not in.'

People's communication needs were documented in their care plans. For example, 'I am able to communicate my needs in Greek but at times I am confused. My speech is soft but I like talking to people' and 'My speech is muddled. I want staff to talk slowly and clearly for me to respond to simple instructions.' We observed that staff knew how to interact with individuals and in ways that was most effective for that person.

Relatives told us that they were involved in planning the care of their relatives and were kept well informed by the home of any changes in their relatives' care needs. The operations manager told us that relatives

were contacted on a regular basis to discuss people's care plans. Care plans were currently being reviewed and updated and relatives were being contacted through this process. A person told us, "My nephew visits me and he knows about my care plan."

People's faith was documented in their care plans. There was a Greek Orthodox priest who visited the home on a regular basis. People could see the priest in groups in one of the communal areas and other people were able to see the priest in the privacy of their own room.

Staff that we spoke with were aware that homophobia was a form of discrimination. Staff told us, "Each and every one will be welcome to come [to the home] regardless of their ethnicity and background." Another staff member told us, "I would make LGBT (Lesbian, Gay, Bisexual and Transgender) people very welcome and respect their partners involvement."

We saw that relatives and friends were able to visit at any time and we observed people receiving visitors throughout the inspection. We saw that visitors spent time with people in their rooms and in the communal areas ensuring that people had the option of privacy.

Good

Is the service responsive?

Our findings

Each care plan had a front page called, 'Individual Dependency Plan'. This was a one-page summary of the person's needs that gave staff guidance on the person and what to do to maintain their day-to-day health and wellbeing.

Care plans and individual dependency plans were written in English and Greek speaking staff told us that they could read them and were able to ask an English-speaking colleague if they needed any clarification. When Greek speaking staff started working at the home senior staff sat with them and went through the dependency plans in detail to ensure that they understood people's needs.

However, care plans were not always person centred. For example, one person's care plan noted that staff were to, 'support and encourage [person] to engage in activities. However, there was no information on what activities the person enjoyed. We raised this with the operations manager who told us that the home had identified that care plans were not as person centred as they should be and they were in the process of updating the care plans and said, "We have tried to make them person centred as much as possible." At the time of the inspection seven care plans had been updated. We reviewed two of these and found that they were more person centred with good background histories and included people's preferences. For example, one person's care plan said, 'My hair is very important to me. I like to have it dyed regularly and to be kept nice.' We found that the person regularly saw the hairdresser.

There were three communal lounges on the ground floor that all had a view of the garden. Two of these were used mainly by Greek speaking people and the third was used by non-Greek speakers. However, the registered manager told us that people had a choice of which lounge they wished to use. We observed people moving between the lounges during the inspection.

At the time of the inspection the weather was warm. The home had a large well-kept garden and we saw people were encouraged to spend time outside with staff. People were engaged and chatting and we observed that staff provided people with sun cream, cold drinks and snacks. The home had also created a safe outdoor area. Around the home was a secure landscaped walk way. The operations director told us that this was done to ensure that people who liked to walk had a safe environment and were able to get fresh air. There were benches placed along the walkway to ensure that people could relax if they wished. One person said, "I can come in the garden when I like."

The home employed two full time activity coordinators. Activities provided included exercise classes, sensory sessions, flower arranging, baking, board games and arts and crafts. One person had been a machinist during their working life. The home had purchased a sewing machine to help engage and support the person. Where people stayed in their bedrooms, the activities coordinator told us that they spent time with people in their rooms each day looking at the person's photographs, watching a film or reading to them. People were given a choice of what they wanted to do. We saw that there were trips out to the park or to local coffee shops for small groups of five or six people. Religious festivals, birthdays and special events were regularly celebrated.

A healthcare professional said that the activity coordinator was, "Inspiring, very appropriate and ensures people understand the approach and her attitude towards residents is brilliant." People commented, "I like reading", "I like colouring in" and "I love to watch Bengali movies and sometimes I watch Hindi and English movies, I can decide if I want to go the lounge." A relative said, "My mum is settled down here, she sits in the lounge and participates in all activities."

There were advanced care plans in place for people experiencing end of life care. Care plans were regularly reviewed by the nursing team. Where people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR), these were up to date and written in consultation with the family member and appropriate health professionals who had also signed it. A healthcare professional told us, "They contact us regarding end of life care. We did some training which is on-going; person-centred care for people at end of life."

There had been nine complaints received by the home so far in 2018. Complaints were well documented and included a description of the complaint, acknowledgement letter to the complainant, investigation, the outcome and any actions taken. There was a complaints procedure and relatives that we spoke with were aware of how to make a complaint.

Good

Is the service well-led?

Our findings

Staff that we spoke with understood the management structure and there were clear lines of accountability. A staff member commented on the operations director, "She is approachable and friendly but also an effective manager who gets things done." Throughout the inspection we observed that the registered manager and deputy managers were visible around the home and were always available to staff for support. One of the deputy managers told us and we saw that they completed daily 'walk rounds' in the mornings, at meal times and medicine times. Any concerns were fed back to the registered manager and addressed immediately.

Staff were positive about the support they received from the management; the registered manager was described as being very helpful. Relatives that were also positive about the registered manager. Comments included, "I know the manager and can talk to her any time on any issue", "Manager is really good she is easy to talk to. I can raise anything" and "The manager is very good, very open and approachable."

A healthcare professional was complimentary around the communication of the management and staff team and said, "I trust them, they will call if there are any issues. They will give me their thoughts and clinical opinion. They are very knowledgeable in terms of clinical reasoning and evidence base." Another healthcare professional told us, "Staff communication with clients and with health professionals is great. We have regular multi-disciplinary meetings."

On the first day of the inspection we observed a morning handover. This was done in one of the communal lounges with people present. We raised this with operations director at the time of the inspection as we were concerned about people's confidentiality and dignity. The operations director told us that this would be looked at immediately.

In mid-July 2018 a safeguarding alert was raised by the home regarding allegations of abuse; this is being investigated by appropriate agencies. When incidents happen, we look at how well the home has dealt with the issue and ensure that people are kept safe. The home had taken action and the staff members involved had been subject to the home's disciplinary process. The operations director told us that all staff were being re-trained in safeguarding and ensuring that they understood their responsibilities to report any suspected abuse. We saw that staff supervision included discussions around safeguarding. The home had met with families involved and also held a friends and families meeting to explain how they would ensure that people were kept safe.

Audits were completed monthly and included any safeguarding alerts, complaints, new admissions, nursing needs DNACPR's, medicines and people's care files. All senior staff had an area that they audited each month. Audits contained action plans and documented when action were completed. There were six monthly infection control and hand hygiene audits, weekly and monthly medicines audits and care audits that looked at people's care plans and overall care files. The home's pharmacy provider had completed a medicines audit to ensure that medicines were managed safely at all times. The audit was positive with no recommendations.

Quality assurance surveys were completed annually with people, where possible, relatives and healthcare professionals. We looked at the results from the 2017 survey and found that feedback was positive about the quality of care provided by the home.

There were regular staff meetings. Staff told us that they felt well supported and were able to raise any concerns in the meetings. One staff member said, "Senior staff act on staff concerns quickly." The home held monthly 'Carer Forum' meetings. This looked at any training available for staff, and, if there were any changes made at Autumn Gardens, for example new equipment, or a new person moving in. Staff meetings were run at different times to ensure that all staff would be able to attend. For example, night staff, domestics and activities staff had separate meetings. Each Monday the home held a manager's meeting involving all management staff. This looked at any issues within the home, people's care needs and any referrals to healthcare professionals that were necessary.

The home encouraged Greek speaking staff to better their English and had employed an English tutor who held regular English classes. The English tutor told us that 19 staff were attending classes and were, "Keen to learn." Classes focused on English used in care settings.

The home held family and friends' meetings twice a year. These meetings involved information sharing about Autumn Gardens, any changes within the home and activities. Relatives were able to use this forum to raise any concerns or queries.