Carebase (Redhill) Limited

Acorn Court Care Home

Inspection report

The Kilns
Redhill
Surrey
RH1 2NX

Tel: 02088796550
Website: www.carebase.org.uk

Date of inspection visit:
11 February 2016

Date of publication:
27 April 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection that took place on 11 February 2016.

Acorn Court Care Home is a nursing home for up to 86 people, with a range of support needs.

The home was split into four units; each unit had a head of unit managing the team of care staff. The units consisted of the ground floor with people who had an acquired brain injury and nursing needs, with a separate unit for people who had personal care needs only. The first and second floors were for people had nursing and end of life care needs and for people with a diagnosis of dementia.

On the day of our inspection there were 84 people living at the home.

The home was run by a registered manager. The registered manager was on annual leave on the day on inspection. '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 and associated regulations about how the service is run. The deputy manager oversaw the management of the service in the registered manager's absence.

Some people's human rights were affected as the requirements of the Mental Capacity Act 2005 was not always followed. Where people lacked capacity to make some decisions, people did not always have a mental capacity assessment or best interest meeting. Staff were heard to ask people for their permission before they provided care.

Where people's liberty was needed to be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards (DoLS) and sent of the appropriate referrals to the local authority to ensure the person's rights were protected.

There were not always enough opportunities for activities for people. Relatives and care staff told us that they felt there should be more activities on offer to people. The activity timetable indicated that one activity occurred daily whilst there was impromptu 'our organisation makes people happy' (oomph) session on the afternoon of our visit.

People's, staff and relative's views and opinions were sought on a regular basis. There was an annual staff and relatives survey.

People were safe guarded from the risk of abuse because staff had received training in safeguarding adults and were able to evidence to us that they knew the procedures to follow should they have any concerns. They knew of types of abuse and where to find contact numbers for the local safeguarding team if they needed to raise concerns.

Risks to people were managed and staff had knowledge of the risks and knew how to keep people safe. Staff knew how to respond to an accident or incident. The management team had no oversight of incidents and accidents that occurred in the home. Recording certain events such as incidents and accidents means that the manager can identify possible trends, learn from events and appropriately manage high risk situations.

Care was provided to people by a sufficient number of staff who were appropriately trained. Staff were seen to support people to keep them safe.

People were protected by the systems in place to manage medicines. Medicines were administered, disposed of and stored safely. Processes were in place in relation to the correct storage of medicine. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

People had enough to eat and drink and was a choice of food and drink. People had access to fluids throughout the day.

People were supported to maintain their health and wellbeing as they were assisted to see health and social care professionals, such as a GP or dietician when required.

Staff treated people with kindness and maintained their dignity and respect. People and their relatives told us that they felt involved in planning their care. Staff knew peoples likes, dislikes and their preferences.

People received personalised care. People's needs were regularly reviewed and updated when things changed. Peoples care plans were not always reflect the care that they were given.

People and their relatives told us they felt comfortable to raise a complaint and that it would be dealt with effectively. There were monthly people and relatives meetings to discuss activities, what was going on in the home and improvements planned.

People, relatives and staff told us that they felt the registered manager was approachable and supportive. There was an open and honest culture in the home.

There was a quality assurance programme in place to continually improve the quality of care provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of the safeguarding adult's procedures.

Medicines were managed safely, and people were supported to take their medicines themselves. There were appropriate systems in place to manage medicines safely.

The provider ensured there were enough staff on duty to meet the needs of people individually.

Staff were recruited safely and the appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

Written plans were in place to manage risks to people. Staff knew how to respond to accidents and incidents.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act were not always followed.

Staff had the skills and knowledge to meet people's needs.

Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were offered a choice of food that met their likes and preferences.

Is the service caring?

Good

The service was caring.

People told us they were well cared for. We observed caring staff

that treated people kindly. Staff were friendly and patient when providing support to people.

Staff took time to speak with people and to engage positively with them.

People were treated with respect and their independence, privacy and dignity were promoted. People and their relatives were included in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Relatives and care staff told us more activities could be provided.

People's care was personalised to reflect their wishes and what was important to them. Support plans and risk assessments were reviewed and updated when needs changed.

Staff were knowledgeable about people's needs, their interests and preferences in order to provide a personalised service.

People and their relatives told us that they felt comfortable making complaints and they were acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no management oversight or recording of incidents and accidents.

There were systems in place to obtain feedback from people and their relatives.

There was an open and positive culture which focussed on people.

There was a system in place to monitor the quality of the service provided and as a result continual improvements had been made.

Staff were supported by the registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns.

Acorn Court Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 11 February 2016 and was unannounced.

The inspection team consisted of four inspectors and two experts by experience (Ex by Ex). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we gathered information about the home by contacting safeguarding, quality assurance and care management teams within the local authority. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit, we spoke with 24 people, ten relatives, the deputy manager, three heads of units, the maintenance person, the chef, the administrator, the business manager and eight members of staff. We also spoke with two health professionals who were visiting on the day.

We also spent time observing care and support provided throughout the day of inspection, at lunch time and in the communal areas and looked around the home, which included people's bedrooms, the different floors within the building and the main lounge and dining area.

We looked at eight peoples care records, medicine administration records, staff rotas, ten recruitment files,

supervision and training records, maintenance records, menus and quality assurance records We looked at records that related to the management of the service. These included minutes of staff meetings, complaints and audits of the service. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did.

The last inspection was on 22 April 2013 where we had no concerns.

Good

Is the service safe?

Our findings

People told us that they felt safe and secure in the home. Staff told us what types of abuse there were, one staff member told said "I know that abuse can be bad care even if it isn't deliberate." Staff knew what to do if they suspected abuse. One staff member said "I would let my manager know if I suspected abuse. I know they would tackle it but if not, I would come to you (the Care Quality Commission)." The service had a safe guarding policy in place which detailed contact numbers of the relevant agencies who lead on safe guarding concerns. The registered manager sends in relevant notifications to CQC to alert CQC of any potential safe guarding.

Relatives told us that they felt that people were safe in the home. One relative said "I feel she is safe, I know the staff and they would tell me straight away if there was problem." Another told us "I feel she is safe, they seem to care, I go home feeling she is ok."

People's freedom was protected and risks to people were identified and managed safely. One staff member said, "Most of the people on this floor have dementia and would be at risk if they left it. We have keypad entry systems to prevent that but other than that people can move freely". Staff were knowledgeable about risks to people; for example one staff member told us "I know that this person is at risk of falling, so we make sure we always walk with her."

People had individual risk assessments in place, they identified the risks to the person and a plan on how to minimise the risks. People had risk assessments in place for tasks and activities like personal care and accessing the garden. There were also risk assessments in place for managing people's specific health conditions such as diabetes, malnutrition and those who are at risk of pressure sores. They were reviewed on a regular basis.

The home had a plan which told staff what to do if there was an emergency and how to continue the service to people. The deputy manager told us the home had an emergency plan in place should events stop the running of the service. People had personal emergency evacuation plans in place (PEEP) which guided staff on how to safely support a person if there was an emergency. Staff confirmed to us what they would do in an emergency. Staff knew what to do in the event of accidents and injuries occurring to people.

There was enough staff to ensure that people's needs were met. Call bells were answered efficiently. People were not waiting for staff to meet their needs. People told us there were enough staff to meet their needs. Most people said that when the call bell was pressed, staff responded quickly, one person said "I am never left waiting."

Relatives told us that there were not always enough staff, one said "I would like to see more staff, often there isn't a carer in the lounge and it would be nice to have a designated carer for the lounge – staff are always on the go."

The deputy manager told us that they used a formal tool to assess the changing care needs of people which

calculated staffing levels. Copies of these assessments were kept in each person's care plan. Staff told us that there were enough of them to keep people safe. We were told that individual needs and staffing levels were reviewed regularly. The dependency tool was reviewed regularly and the registered manager responded to the increase in need for an extra member of staff required on one floor at night. Some people in the home received 1:1 staff support to manage their health and communication needs.

Staff recruitment records contained information to show us the provider took the necessary steps to ensure they employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS) check. The DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

There were procedures in place for the safe administration, storage and disposal of prescribed medicines. We observed staff administer people their medicines. Staff did not sign the MAR (medicine administration record) until the medicine had been taken by the person. We looked at people's MAR charts and confirmed this had happened and there were no gaps in people's records. Staff had knowledge of the medicines that they were administering.

Medicines were stored safely. Where medicine needed to be kept cool, they were stored in fridges, which were not used for any other purpose. The temperature of the fridges and the rooms in which they were housed was monitored daily to ensure the safety of the medicines.

For people that were prescribed as required medicine (prn), such as some pain relief, there were guidelines in place which detailed the signs people would display that may indicate when the person needed the medicine administered and the correct dosage.

Three people at the home were given medicines covertly, that is staff administering their medicine without their knowledge or permission. Staff had guidance in place and health professionals were involved in these decisions. One person administered their medicine without staff support.

Requires Improvement

Is the service effective?

Our findings

People's human rights could have been affected because the requirements of the Mental Capacity Act were not always followed. 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.

For some people who lacked capacity to make decisions regarding their care, mental capacity assessments and best interest decisions had not always been completed. For example, for those people who lacked capacity regarding their consent to care and use of moving and handling equipment. People's next of kin often consented to the care on the persons behalf. Next of kin does not give people the legal right to make choices about people's care. There was not always evidence of people's capacity been assessed and best interest discussions occurring when next of kin consented to people's care.

Where people lack capacity to make decisions regarding their care, the registered manager to ensure that the appropriate records are maintained in line with the Mental Capacity Act.

Some people had mental capacity assessments completed and best interest decisions for decisions such as administering medicines covertly to some people.

Staff had a good understanding of the mental capacity act, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Staff were seen to ask for peoples consent before giving care throughout the inspection.

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 are called the Deprivation of Liberty Safeguards (DoLS). Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible.

Staff had the skills and knowledge they needed to care and support people effectively. All staff had completed mandatory training in areas such as safe guarding people, Dementia awareness, first aid and infection control. Other areas of training that staff had was supporting people to eat safely, caring for people in end of life care and epilepsy. We saw evidence of staff having completed training by the certificates in their staff files, the training management tool and by asking staff. Some staff told us that they would like to have extra training around supporting people with Dementia, how to engage people more in activities and how to manage some behaviours. Staff were observed undertaking care practices to ensure that the dignity and respect of people was upheld. This meant staff developed essential skills to provide the appropriate support to people in a positive way.

Nurses met monthly to develop their skills and knowledge. We saw minutes of meetings where external staff had come in to give training in catheter care. Updates in practice and discussions around improving clinical care were also included in the minutes.

Staff told us they received supervision, sometimes known as 1:1 support. We saw records that staff received supervision once every two months.

New staff that started at the home completed an induction programme and the Care Certificate. This is a certificate that sets out standards and competencies for care workers. Induction also consisted of attending mandatory training and new staff shadowing other staff members for up to two weeks, to observe the care and support given to people prior to them caring for people own their own.

People's dietary needs were met. People told us that they had enough to eat and drink and there was a good choice. There was fresh fruit and drink available in communal areas. People had access to cold drinks in their bedrooms. The chef told us that there was a 4 week rolling seasonal rota. The chef told us that some people were on special diets such as pureed food and he was aware of people's allergies and likes and dislikes. For people that needed a high calorie diet, the chef made special smoothies. When people's needs dietary needs changed, nursing staff put this in writing to the chef.

We observed a lunch time. You could see from the chatter and the laughter that the meal time was calm and relaxed. People were served their food off a hot plate. People had a choice of what they wanted, even if it was different from what they had ordered in the morning. For people who needed support to choose, staff showed people two plates of food so people could make an informed choice. However, people on a pureed diet were not given a choice of two meals.

Some people used adapted plates and cutlery to enable them to eat their meal independently.

Some people needed staff to feed them their meal. We saw staff support the person to eat and drink at their own pace and with patience.

Some people's dietary needs were met via a percutaneous endoscopic gastrostomy (PEG); these are used when people have significant swallowing problems to receive their food directly into their stomachs. Staff managed to administer the food safely and in a dignified way to people.

Peoples weights were regularly reviewed when it was required. Staff kept food and fluid charts for people who were at risk of weight loss and dehydration. A visiting health professional told us that staff managed well in meeting peoples nutritional needs and kept thorough food and fluid charts.

People were supported to maintain their health and wellbeing. Care plans contained up to date guidance from visiting professionals and evidence that people had access to other health care professionals such as GP's, psychiatrist, speech and language therapist (SALT), dieticians, older peoples mental health teams and chiropodists.

Individual exercise programmes had been developed for the people with an acquired brain injury as a physiotherapist visited the home twice a day. The home had two moving and handling specialists in the team who would support the physiotherapist in moving and handling assessments to keep people safe.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring, one person said "."Staff are very nice." Another said "You can't fault the staff." One relative told us "Staff go the extra mile." Another said "Staff are warm and friendly."

Staff were caring and had developed positive relationships with people. We observed staff interact positively with people in communal areas. Companionable, relaxed relationships were evident during the day. A relative told us "Staff are brilliant, they make people laugh, they talk to people. "One staff member told us "I speak to people how I like to be spoken to." Staff were attentive, caring and supportive towards people. Staff engaged with people using humour and touch. Another staff member said "We try to treat people as we would want to be treated."

Staff were positive and passionate about supporting people and knew people as individuals. One staff member said "We are very passionate about what we do here. We are dedicated and love what we do." They were able to describe people's likes and dislikes in detail, as well as what they had done in life before they came to live here. Examples staff gave us were confirmed with people, and matched with the information in the care records.

People's privacy and confidentiality was respected by staff. Care files were kept in an area to be accessible to staff, but not to other people, such as visitors. Care staff did not discuss people in front of others, so people would not overhear confidential information.

Staff were able to communicate effectively with people. They spoke clearly and in a manner that people could understand. Where people were not able to speak, staff were also able to understand hand gestures, body language and facial expressions. One staff member said "I speak to people how I like to be spoken to."

Staff spoke to relatives professionally and with respect. We saw a staff member speak with a relative, they asked how they were and told them what the person had been doing that day, what they had eaten and how they were, this was done sensitively. A staff member told "We have a duty of care to the person and to the family, it's a complete package."

People and their relatives were involved in planning their care. A keyworker system was operated which enabled staff to build up relationships with people and their relatives. Where possible peoples care plans and assessments had been completed with input from people and their relatives.

There was an obvious affection between staff and people living at the home and people responded to staff in a positive way. A person told us "I am just so comfortable here, I have no complaints." Another told us "Staff are marvellous, they are never unkind." People were encouraged to spend time how and where they chose. People were actively encouraged to make choices in their daily lives.

People appeared relaxed and content. The overall atmosphere was relaxed and homely. Staff popped into people's rooms regularly to ensure they had everything they needed and chatted to people sat in communal

areas. Staff stopped and chatted to people when they passed in the corridors or walked past people's rooms.

People's privacy and dignity was respected. Staff knocked on people's bedroom doors and waited for an answer before they entered. A person told us "They (staff) treat with dignity, the care isn't too quick." Staff explained how they protected people's privacy and dignity such as ensuring people were covered when they were provided personal care and closing curtains and doors so other people could not look in. A staff member told us "I will leave her (a person on the toilet) and close the door and get her to ring the bell when she has finished. I will close people's curtains (when giving personal care)."

Requires Improvement

Is the service responsive?

Our findings

Relatives and care staff told us more opportunities for activities could be provided to people. One person said "We do get asked about the things we like to do, but I'm not so active".

There was a monthly activity time table in place on display in all communal areas. The activity for the day was a trip to the local garden centre and an impromptu Oomph (our organisation makes people happy) session in the afternoon on one floor, on another unit was a karaoke session. A visiting health professional told us "Staff really do care, there is a happy atmosphere… (there's), musical entertainment, one to one chatting, colouring, music."

For people who were unable to or did not want to go to the garden centre there were no other activities on offer. Care staff told use that there were some days when there were no activities on offer on their unit. Care staff told us that they felt more activities could be offered to people. In the morning both lounges (same floor) had a different film on but no one was watching it or was asked what they would like to watch. In the afternoon musicals were put on and one person did remark on the scenery but no one was asked what they wanted to watch.

On one unit in the afternoon people were sat in the communal lounge with staffing popping in and out without interacting with people for a 20 minute period. The television was on, but no one was watching it.

There is small gym available for people on the ground floor with adapted equipment available for people with an acquired brain injury. We saw this being used by people on the day.

Relatives and staff told us more could be done around activities for people. One relative said "It would be nice to have more singers." Another said "I would like her to join in activities, they don't take her to any, we don't get information about what's on."

Some people's care plans said generic things like 'engage (person's name) in an activity' but no information of what they liked to do was included. Other people's care plans detailed what people's hobbies and interests were.

The activities timetabled were once daily and ranged from therapy dogs visits, trips out to garden centres, seasonal activities such as pancake day and external singers/entertainers coming in. Other activities include an Oomph trained member of staff, who runs activity sessions such as music, exercise and singing.

We recommend that opportunities for activities are reviewed for people in line with current guidance.

Since the inspection the registered manager has told us that three staff members will be trained in the 'hearts' process, which is a combination of therapeutic approaches to enhance well being, such as massage and use of touch for people with high support needs and who are at end of life. The registered manager told us this would be implemented by the end of May 2016.

Since the inspection, the registered manager told us that more Oomph sessions have been rolled out to people that have high support needs.

People told us they were involved in their care. One person said "I can stay in bed if I want to in the morning, but I need to give staff a reason why." Two people told us that they did not want male carers washing and dressing them and that this was not always happening. Since the inspection the registered manager told us they would look into this and ensure that staff respected people's preferences.

The majority of the homes' care plans were hand written, some care plans were difficult to read due to illegible hand writing. There was an inconsistency in how person centred people's care plans were however some care plans were personalised and very detailed.

The unit on the ground floor had trialled a computer care planning programme which enabled care plans to be printed off, which allowed changes in people's needs to be better monitored. The business manager told us that this was to be rolled out across the home by the end of September 2016 and for the hand written care plans to be archived, once people had received their new care plan.

The programme also enabled a record of what activities people have engaged in. We saw evidence that people had engaged in activities in and out of the home. Daily records were kept for people.

People received personalised care. The plans also contained a personal history, which gave staff a picture of what people had achieved in their life, who they are and where people have come from, people's likes and dislikes. Staff were able to tell us in detail about people's lives, their past medical histories and what they did prior to coming here. One staff member said "I know (person's name) so well, if they are quiet or not sleeping then something is not right." One staff member told us "We use the same staff, they know peoples individual preferences, they know how to engage with them."

Staff had a good understanding of what person centred care meant. One staff member told us, "It's about making sure the care revolves around them (people), not us". Another said "Different people need different care. We try to provide that". One person became distressed as they wanted to know about their tax return. A member of staff spoke with the person about how the tax system worked and was re-assuring them that the letter would be with them soon. This personalised interaction calmed the person down.

There was evidence in people's care plans that people and family members were involved in planning peoples care. Relatives told us that they were involved in planning people's care. One relative told us "I am involved in all reviews of their relatives care, and staff inform me immediately of any changes to keep me involved at all times." Another said "I get told when things happen, the nurse is fantastic."

Care plans contained an initial assessment of people's needs that had been completed by the home prior to people moving in. This identified what care and support people need. Care plans contained relevant information, such as how to support a person with their personal care and how to support a person with their communication. There were care plans outlining how to support a person with a specific health condition, such as epilepsy. Care plans were reviewed on a monthly basis. A visiting health professional told us "Nursing staff know a lot about the person."

Outside all of the rooms for people on the first and second floors, were memory boxes. Memory boxes contain objects from the past which are used to help people reflect on the past and to stimulate memories. People and relatives were encouraged to personalise these. There were also objects such as knitting, books, clothes pegs, soft objects dotted around communal areas to enable people to engage with them when they

wanted to. We saw this happen throughout the day.

Staff were responsive in meeting people's needs. The deputy manager told us that one person's health had recently deteriorated and required 1:1 staff support to keep the person and others safe. The home implemented this level of care for the person prior to funding being agreed. The deputy manager had contacted the relevant health professionals to update them and to ensure that the person's health was reviewed so the appropriate treatment could be prescribed.

People told us they knew how to make a complaint, people said that they would complaint to staff or to the registered manager. One relative told us "If I'm not happy then I will complain and it's dealt with very efficiently." Another relative said "I made a complaint and it was investigated and dealt with in a timely way." Where people and their relatives had made complaints, the service's complaints procedure had been followed and the complaint had been dealt with effectively.

There was a monthly residents meeting where all residents and their relatives are invited to attend. Minutes of the meeting indicated that planning of activities and ideas to improve the service were discussed.

There was a relative's forum held monthly, to discuss ideas for the service. This group was run by a relative of a person who used to live at the home. The registered manager also arranged a monthly lunch outside of the home for relatives past and present meet with the registered manager. Relatives told us that they found the group supportive.

Requires Improvement

Is the service well-led?

Our findings

The management team did not have an overview or keep a central record of incidents and accidents. We asked the business manager to provide copies of incident and accident reports. Only two were located from one floor, pertaining to one incident between two people. We were told that incidents and accidents were recorded in people's daily record notes.

An external quality assurance audit of the service from 2 and 3 February 2016 stated that "The manager stated that she did not collate accidents and near misses as the service users at the home did not ever have an accident or near miss."

From reviewing CQC notifications received from the provider and the relative's survey, we noted there was one incident that occurred where the person required hospitalisation. Another one where one person had spilled a bowl of soup in their lap causing a burn. However accident or incident reports could not be located for these. Recording certain events as incidents means that the manager can identify possible trends, learn from events and appropriately manage high risk situations.

We recommend that the registered manager reviews the accident and incident reporting procedures in line with the regulations.

There were routine systems in place to obtain feedback from people, staff and relatives. An annual staff survey was recently sent out and the provider is waiting the results and will feedback to the staff team.

A relative's staff survey for 2015 was recently completed and evidence compiled. There were 38 surveys completed and returned. Relatives said that the management and staff are the home were effective, but some people said not always available when needed. There were generally positive comments from relatives. All of the relatives felt that the management team were helpful in answering their questions or concerns.

There are systems and processes in place to improve the quality of care. The registered manager completed a monthly audit, which reviewed items such as health and safety of the home and peoples care plans. The business manager completed monthly audits and an external auditor visited quarterly.

Actions were followed up by the registered manager, for example it was identified that guidelines were not in place for prn medicines, we checked that these and they were now in place.

There were regular staff meetings in place for each unit. Minutes of meetings showed that issues such as staff responsibilities were discussed, internal quality audits, the safe guarding and confidentiality policy was discussed.

Staff said they felt supported by the registered manager and that the home is well led. One staff member said, "I think so yes. The head of unit is really good and very caring". Another staff member told us, "I

wouldn't stay if the manager wasn't good".

There was an open and transparent culture at the home. Staff told us that they felt proud to work and the home and felt valued by the organisation and by the registered manager. The provider runs an annual staff ward programme. People, relatives and other staff had nominated staff members for a Heart of Gold.

Staff meetings occurred on a regular basis, they were undertaken per floor/unit. Minutes of these confirmed that care practices were discussed, a policy was discussed and read out and ideas for improving care.

The registered manager was nominated and won the 'beyond the call of duty' award at Surrey Care Association awards in 2015. The award was aimed at an individual who consistently goes above and beyond their role in which they are employed for. The nominations came from two relatives who had people living at the home. One relatives said that the registered manager "Goes out of her way to help everyone (residents, ex relatives and staff alike)." Another said "She is a very rare person, full of kindness and compassion. Dedication should be her middle name as should vision and inspiration."

The provider had ensured that appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely in the home.