Anchor Trust

Thameside

Inspection report

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Date of inspection visit:
03 February 2016

Date of publication:
20 April 2016

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

Thameside provides care and accommodation for up to 61 people. On the day of our inspection, 57 people were living in the home. The home is divided into five with 12 people receiving care and support in each living area. Many people were living with dementia.

The inspection took place on the 3 February 2016 and was unannounced.

A registered manager was 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.

People and their relatives gave positive feedback about the service they or their family member received. People were very happy. One person said "They look after me well."

People told us care staff treated them properly and they felt safe. One person said; "The staff are kind, I feel safe." We saw staff had written information about risks to people and how to manage these in order to keep people safe. One person had been assessed as being at risk of skin breakdown, we saw a skin risk action plan detailing actions for staff to undertake to minimise the risk to the person which detailed the appropriate pressure mattress settings, repositioning schedules, and reference to nutrition care plans to promote skin healing.

People were kept safe. Staff had received training in safeguarding adults and were able to tell us about the different types of abuse and signs a person may show if they were being harmed. Staff knew the procedures to follow to raise an alert should they have any concerns or suspect abuse may have occurred. One staff member said "I would go to the team leader if I had any concerns and that there was an on-line system to call if support was needed." Another member of staff told us they would discuss anything with the manager and there was a whistleblowing Anchor line that could be used.

Incidents and accident were fully investigated by the registered manager, and actions put in place to reduce the risk to people of accidents happening again such as people falling.

People received their medicines as they were prescribed and when they needed them. Processes were in place in relation to the correct storage, disposal and auditing of people's medicines. One person told us "That the staff adjusts the timing of medicines to fit in with outings away from the home." They felt this supported them having a social life.

Care was provided to people by a sufficient number of staff who were appropriately trained and deployed. People did not have to wait to be assisted. One person said; "I am happy with everything, staff are good'." Another person said "there are always plenty of staff around."

Staff recruitment processes were robust and helped ensure the provider only employed suitable staff to care for people.

People and their families had been included in planning and agreeing to the care provided. We saw that people had an individual plan, detailing the support they needed and how they wanted this to be provided. Staff ensured people had access to healthcare professionals when needed.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw related assessments and decisions had been properly taken.

Staff had the specialist training they needed in order to keep up to date with care for people. Staff demonstrated best practice in their approach to the care, treatment and support people received. Some staff had NVQ in health and social care and other staff were working towards them. Staff received appropriate induction. The registered manager had put in place the care certificate for staff to undertake as well as the providers set induction process.

People were provided with a choice of freshly cooked meals each day and facilities were available for staff to make or offer people snacks at any time during the day or night. Specialist diets to meet medical or religious or cultural needs were provided where necessary. One person said "'The food is good."

People were treated with kindness, compassion and respect. Staff took time to speak with the people who they supported. We observed some positive interactions and it was evident people enjoyed talking to staff. People were able to see their friends and families as they wanted and there were no restrictions on when relatives and friends could visit. One person said "It's an enlivening place if you put your trust in it." The activities on offer to people were varied. People could attend quiz nights, arts and craft, church services, exercise classes, board games, etc. A Valentine's Day dinner was being arranged and external activities come in to the home such as singers or musicians.

People's views were obtained by holding residents' meetings and sending out an annual satisfaction survey. People knew how to make a complaint. Complaint procedures were up to date and people and relatives told us they would know how to make a complaint if they needed to. The policy was in an easy to read format to help people and relatives know how to make a complaint if they wished. Staff knew how to respond to a complaint should one be received.

The provider had quality assurance systems in place, including regular audits on health and safety, infection control and medication. The registered manager met CQC registration requirements by sending in notifications when appropriate. We found both care and staff records were stored securely and confidentially.

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.

Staff knew how to keep people safe and protect them from abuse.

Medicines were stored, managed and administered safely.

The provider ensured there were enough staff on duty to meet the needs of people. Staff were recruited safely, the appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

Assessments were in place to manage risks to people. There were processes for recording and monitoring accidents and incidents to reduce the risk of them happening again.

Is the service effective?

Good

The service was effective.

Staff said they felt supported by the manager, and had access to training to enable them to support the people that lived there.

People's rights under the Mental Capacity Act were met. Assessments of people's capacity to understand important decisions had been recorded in line with the Act.

Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were met.

People had enough to eat and drink and had specialist diets where a need had been identified.

People had good access to health care professionals for routine check-ups, or if they felt unwell. People's health improved as a result of the care and support they received.

Is the service caring?

Good

The service was caring.

People told us they were well cared for. We observed caring staff who treated people kindly and with compassion. Staff were friendly, patient and discreet when providing support to people.

Staff knew the people they cared for as individuals. Staff took time to speak with people and to engage positively with them.

People and their families (where necessary) were included in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred and gave detail about the support needs of people. People were involved in their care plans, and their reviews.

People had access to wide range activities that matched their interests. People chose activities and events within the home.

There was a clear complaints procedure in place. No complaints had been made since our last inspection. Staff understood their responsibilities should a complaint be received.

Is the service well-led?

Good

The service was well led.

The service had a registered manager in place.

The registered manager regularly checked the quality of the service provided and made sure people were happy with the service they received.

Staff felt supported and able to discuss any issues with the manager. Senior managers regularly visited to speak to people and staff to make sure they were happy.

The registered manager understood their responsibilities with regards to the regulations, such as when to send in notifications.

Thameside

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.

Before the inspection we asked the provider to complete 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.

The inspection was carried out by three 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.

During the inspection we spoke with 11 people who lived at Thameside, 14 staff members, three relatives, three visitors, the registered manager, and one health care professional. We observed care and support in 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 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.

We looked at a variety of documents which included seven people's care plans, five staff files, training programmes, medicine records, four weeks of duty rotas, maintenance records, menus and quality assurance records. 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 undertaken on the 3 December 2013 where no areas of concern were identified.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. Comments included; "I am really safe here" and "I've never felt safer."

The registered manager and staff had taken steps to help protect people from avoidable harm and discrimination. The registered manager and staff were able to describe what they would do if they suspected someone was being abused or at risk of abuse. Staff told us they had received safeguarding training and were able to describe the procedures to be followed if they suspected any abuse. People told us they would approach the registered manager if they had any concerns.
The risks to individuals and the service; for example health and safety, were managed so that people were protected and their freedom was supported and respected. One person said; "I am free to go where I want." We saw several examples of staff support or guiding people to walk and pointing out hazards for them. For example, one staff member said, "Mind the chair."

Incidents and accidents were reported appropriately and in a timely manner, the registered manager described to us the action they took to analyse each incident. They showed us examples of outcomes of investigations; this included an accident where a person had fallen. The registered manager had reassessed the risk and implemented new strategies such as alarm mats to alert staff sooner to the person moving about their room. Staff were able to describe risks and supporting care practices for people. People with specific health care conditions had individualised risk assessments which staff were able to describe.

The registered manager ensured staff assessed the risks for each individual and recorded these They showed us an email the had sent to the heads of care and team leaders stating, 'There was an increase in people's falls in last month and identified three people who have had two or more. An action plan had been developed to address and reduce these. For example, installing activity monitoring systems, developing a UTI (Urinary Tract Infections) care plans and lowering the bed for another person at risk of falling from bed.

We checked a sample of risk assessments and found plans had been developed to support people's choices whilst minimising the likelihood of harm. The risk assessments included people's mobility risk, nutritional risk or specific health risks. One person's risk assessment detailed their assessed skin breakdown risk. The action plan detailed pressure mattress settings, repositioning frequency and nutrition support which should reduce the risk to the person of their skin breaking down or them acquiring a pressure wound. We saw that these actions were followed by staff.

People's medicines were well managed and they received them safely. One person said; I do get my medication when they are due", another person said that they are responsible for their own medicines and that are kept safely and securely for their own access. There was an appropriate procedure for the recording and administration of medicines. We saw medicines were stored securely. Each person had a medication administration record (MAR) chart which stated what medicines they had been prescribed and when they should be taken. We observed staff ensuring people had taken their medicines before completing the MAR chart to confirm that medicines had been administered. We looked at MAR charts and saw they were

completed fully and signed by trained staff.

People who were prescribed 'as required' medicines had protocols in place to show staff when the medicines should be given. The provider had in place procedures for safe disposal of medicines. MAR charts showed us the provider had completed PRN protocols for people. Where the PRN protocol was completed records showed us how staff knew to give PRN medicines and which affects staff should observe and report upon for example if a person had pain relief, why it was given and whether the person's pain resolved with the administration of the medicines.

The provider provided an easy reference guide for staff when people was prescribed warfarin, i.e. colour description of warfarin by dose of tablet so that staff would easily recognise which tablets the person was prescribed.

People said that there were enough staff deployed to meet their needs. One person said; "I do think there are enough staff about." Staff also said there were enough staff on duty. We saw people being attended to promptly. We heard care staff acknowledge people when they required assistance and phone colleagues to help people when needed. One person said "The staff do talk to me; you get anything you ask for." The provider used a dependency tool to assess that staffing levels were in place to meet the needs of the people. The registered manager said that the staff levels two care staff on each of the living areas, with two team leaders and two other floating care staff to support where needed. We checked the rotas for a four week period which confirmed the staff levels described by the registered manager were maintained.

Staff recruitment records contained the necessary information to help ensure the provider 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). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff members confirmed they had to provide two references and had a DBS check done before starting work.

There were emergency and contingency plans in place should an event stop part or the entire service running. Both the registered manager and the staff were aware and able to describe the action to be taken in such events.

Good

Is the service effective?

Our findings

People and relatives told us they thought staff were trained to meet their needs or their family member's needs. One person said, "The staff are helpful and knowledgeable", another person said; "They are always going to training courses."

The provider ensured that each member of staff undertook their personal induction. Staff had effective training to undertake their roles and responsibilities to care and support people. The induction process for new staff was robust to ensure they had the skills to support people effectively. This included shadowing more experienced staff to find out about the people that they cared for and safe working practices. Staff were trained before they started to support people and received regular on-going training to ensure their skills where kept up to date. Training was given based on the support needs of the people that lived at the home. One staff member said; "I received induction and then shadowed other staff until I was comfortable."

The registered manager ensured staff were suitably trained to meet the needs of people. One staff member told us the training was good and they had received dementia training and said the team leader observed their practice and as a result they had gone on a second moving and handling training course for confidence. Another member of staff said they had requested additional training and support to move professionally within their role. This had been done and they were now acting as care manager.

Staff said they had annual appraisals. Staff also had regular supervisions which meant they had the opportunity to meet with their registered manager on a one to one basis to discuss their work or any concerns they had. One staff member said "I had supervision last week, given a written record, discussion re team player, tasks, areas which weaknesses and strengths so can work with registered manager."

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.

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. The provider had complied with the requirements of the MCA. Where people could not make decisions for themselves the processes to ensure decisions were made in their bests interests were effectively followed. Detailed assessments of people's mental capacity for specific decisions such as not being able to go out on their own had been completed. Where people did not have capacity, their relatives who held a Power of Attorney confirmed they were consulted by staff and involved in making decisions for their family member, or advocate.

Staff had a good understanding of the MCA 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. One staff member said, "MCA is for people who are unable to make a decision about their health needs or money, but they may be able to

make a decision about what to eat or the choice between coffee and tea." 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.

People's nutritional needs were met. One person said; "The food it's very acceptable"" and a relative said "The chef is fantastic, lovely menu, well presented food."

People could help themselves to snacks throughout the day. Each living area had a small container which had chocolate biscuits, crisps and healthy alternatives in it. We asked a member of staff if there was any risk of people who had diabetes helping themselves to unsuitable snacks and was told they monitor the snacks that people have. Where some people had diabetes they knew what they should and shouldn't eat..

We observed lunch in one area. One person didn't fancy what was on the menu so the kitchen made sausages especially for them. The chef came around asking everyone if they liked the lunch. One person said, "It was nice, but it was a bit hard for me." The chef replied, "If you ever have any problems tell the staff and we will make you something else." There was chatter and easy-going banter during the lunch period. Staff were constantly checking if people had finished, wanted more or offering them a choice of pudding or drinks. Staff were very attentive.

One member of staff was assisting one person to eat and used appropriate methods to try and encourage them to eat. Throughout the time the staff member was smiling at the person and leaning forward to them at their level. They stroked the person's hand to keep contact with them and ensure they were engaged.

We saw a list in the kitchen of people's dietary requirements. The chef was able to identify those people who were on specialist diets. Staff told us, if a person had lost weight or staff reported a change in their dietary/fluid intake or a healthcare professional requested it, they recorded a three day food/fluid chart and always referred to GP if the person health deteriorated. They told us they offered the person fortified meals/drinks and this would be in progress until the GP reviewed them (if required). The chef manager told us they were involved, if the person was agreeable, when SaLT (Speech and Language Therapy) assessed a person's swallowing needs, so kitchen staff ensured the recommendations to minimise the risk to the person were put in action.

We sampled food and fluid charts for people who may be at risk of not having enough to eat or drink, where they were kept by people's rooms. Staff told us these were referred to as people's mini care plans. These 'mini-records' were kept in or by people's rooms for people who spent long periods in their rooms either due to their needs or because of their preferences. Records included the fluid charts and other records necessary to ensure people were kept healthy. We were told by the head of care that these records formed part of the overall recording for people.

The registered manager said that they promoted collaborative care (supporting people to access healthcare professionals and provide a person centred approach). Staff responded to changes in people's health needs quickly and supported people to attend healthcare appointments, such as to the dentist, doctor or optician. We saw, in individual care plans, that staff made referrals to other health professionals such as the (SALT)

team, the falls team, district nurse or the dementia nurse when required. One person said; "If I need to see the doctor, I only need to ask." We spoke to a visiting professional during our inspection who told us that staff made appropriate referrals in a timely manner. People medicines charts we looked at showed us the District Nurses managed blood monitoring for people e.g. where people had diabetes and needs blood glucose levels monitored. Staff told us the District Nurses attended any person receiving insulin for treatment of diabetes. Care staff at the service did not administer any injectable medicine.

Good

Is the service caring?

Our findings

One person said "They (staff) are so caring and kind." One visitor said "Staff are kind, caring, and compassionate throughout the home" and "If I needed to come into a care home I'd choose here." A relative told us their loved one "Thrives living at the home."

During the inspection we saw that staff took the time to listen and interact with people so that they received the support they needed. People were relaxed in the company of the staff, smiling and communicated happily often with good humour.

People looked well cared for, with clean clothes, tidy hair and were appropriately dressed. The atmosphere in the home was calm and relaxed and staff spoke to people in a caring and respectful manner. Staff were knowledgeable about people and their past histories. Care records recorded personal histories, likes and dislikes. Throughout the inspection it was evident the staff knew people well. Staff were able to tell us about people's hobbies and interests, as well as their family life. This information was confirmed when we spoke with relatives, or when they showed us their bedrooms, as decorations and items matched with what staff had said.

Staff were able to describe people to us and why they were living in the home. When asked about treating people with respect, dignity and privacy, one member of staff said, "I am always chatting to them and I make sure I keep areas covered when I am doing personal care because it must be embarrassing for people." They added, "When I get out their clothes in the morning, I say, "What do you think about wearing this?" and let them decide." Staff told me people could stay in bed in the morning if they wished and they did not have to get up at a certain time.

Another staff member said, "It's dependent on the resident, but we must provide person-centred care." They added, "People who are living with dementia you need to know their history so you can talk to them about that and gradually get them back to the present."

People were given information about their care and support in a manner they could understand. A staff member said, "We support people to make daily choices about what they wear, what clothes and items to buy in the shops; I will show them the item. I know people, they communicate through facial expressions, body language or noises." Information was available to people around the home. It covered areas such as local events, newsletters from the provider and which staff would be on shift. Information was presented using pictures and easy to understand text, for example the staff on shift used staff pictures, so everyone could see who would be supporting them in their home. Information such as staff on shift, calendars, menus and activity planners were all current and up to date, so gave good and correct information to people.

People's rooms were personalised which made it individual to the person that lived there. Relatives told us they were free to visit when they chose to.

We saw positive interactions between staff and people. Staff were very caring. We heard the activities co-

ordinator chat to people. They were talking about the book club one person has set up and how the posters were now displayed. We saw staff support people to walk at a suitable pace. For example, a district nurse was taking a blood sample and the staff member escorted the person back to their room to have this done. We watched staff walk slowly beside the person at their preferred pace. A staff member said one person had liked to work with their hands before they moved into the home and at times they became agitated and frustrated. Staff had thought about how to distract the person and purchased items for then to hold to see if these were an effective way of keeping this person occupied.

Staff addressed people nicely. One person came out of their room in her overcoat with a handbag (and slippers). We heard a member of staff say, "Hello, the First Lady – how are you?" Staff took an interest in where the person was going and chatted to them. Two other people came through with mugs to the kitchenette to make a cup of tea and staff greeted them and supported them to make their drink. People could be independent. We saw one person help themselves to some water and take it back to their room. Staff chatted away to people. We heard staff talk to one person about football and general chit chat going on whilst staff were bringing people tea or sitting in the lounge with them.

We asked people and family members if they had been involved by the staff in their care or the care of their relative. They confirmed that were included and kept up to date by the registered manager and the staff at the home.

Good

Is the service responsive?

Our findings

One person said, "There is loads to do here."

There were lots of varied activities going on. New clubs had started in the home which was set up and run by people who lived there. For example, a pub club, book club and gardening club. The next project was to establish a 'chapel' where people can go to for peace and reflection.

We heard staff during the morning trying to encourage people to attend activities. One staff member said, "It looks good down there. In fact I'd like to join in. Why don't you try it and if you don't like it you can always come back." Other staff were helping people to cook some cookies and painting.

The activities co-ordinator told us since they had started in December 2015 they were getting to understand people's likes and dislikes. This was through talking to people and monitoring attendance at activities. They had carried out a lot of research into suitable activities for people living with dementia and worked with other co-ordinators at Anchor homes to share good practice ideas. They felt external outings needed to improve, but was pleased with the support they were getting from management to organise new activities. I looked at the activities records and could see that people attended activities or received one to one's from the co-ordinators.

One person said that choirs entertain at the home and was pleased that a bar had been built in one of the lounges. There was a regular pub quiz that they had helped organise which was very popular . We heard one staff member say, "Are you going to the church service?" When people responded that they weren't, the member of staff said, "Okay what shall we do then?" and proceeded to get out the skittles and encourage everyone to have a go.

Before people moved into the home an assessment of people's needs was completed with relatives and health professionals supporting the process where possible. This meant staff had sufficient information to determine whether they were able to meet people's needs before they moved into the home. Once the person had moved in, a full care plan was put in place to meet the needs which had earlier been identified. We saw these were monitored for any changes. Full family histories were drawn up so that staff knew about a person's background and were then able to talk to them about their family or life stories.

Staff were responsible for a number of people individually which meant they ensured people's care plans were reviewed on a regular basis. We read that reviews were undertaken and staff discussed with people their goals. A staff member said they got to know what people wanted, including what time they wanted to get up and how they liked to spend their day. Staff said they had handovers when they first came on duty. This was an opportunity for staff to share any information about people. A visitor told us, "Staff anticipate (the) person's needs…"respect (person) with dignity."

Individual care plans contained information which related to people's preferred name, allergies, family

history, personality, the social activities they liked doing and their care needs. There were also details about how they wished to be looked after if they became unwell. Staff showed us a file which recorded people's weights. People were weighed regularly and staff calculated people's body mass index (BMI), so they could check people remained at a healthy weight. We saw that one person had lost weight and staff had referred this person to the GP for a dietician referral and to the SALT team for further guidance on managing the weight loss and nutritional needs. One staff member said they felt the care plans were, "Pretty easy" to understand and they said they felt they understood the care someone needed by reading through them.

People told us they knew how to make a complaint if they needed to. One person told us "I've no major complaints but I'm sure they would respond to a grumble." We saw how the registered manager had dealt with previous complaints and had identified improvements or actions that needed to be taken. For example for more activities, this has now been embedded in the home and the home has a full social calendar. The complaints policy was displayed in the foyer and each person had a copy of it in their service user guide. There was a, 'We welcome feedback' poster on the noticeboard on one floor and a complaints policy. A staff member said if a person or relative had a complaint they would support them to go to the team leader. Another staff member said, "All complaints should be investigated thoroughly and the outcome out in the open. Everything should be put in writing."

People felt they had a say in how the home was run. People told us that they remembered filling out a survey and one person said; they had attended a residents meeting; People and relatives said "There is a resident's meeting every month and relatives meet every two months" and "They do try to resolve issues brought up at the meeting." One person stated they wanted to go on holiday to the seaside, the registered manager was looking into this.

Good

Is the service well-led?

Our findings

The home had a registered manager. People and relatives we spoke with all knew who the registered manager was and felt that they could approach them with any problems they had. One person said "I find the manager a nice, competent person." A staff member said, "It's (the home) pretty well put together. I wouldn't mind coming here myself."

We observed that the registered manager interacted well with people. An external healthcare professional said "The registered manager is approachable." The registered manager was walking about the corridors on the ground floor in the morning talking to people and speaking to them by name. In the afternoon he was seen talking to people on the second floor and there was a friendly rapport between them..

Staff were positive about the management and the support they gave to them. They told us they felt supported and could go to them if they had any concerns. One member of staff said "This role was totally new to me and it's a lot more involved than I thought with a lot more responsibility. But there is always someone to ask or to help. The manager is very approachable and he comes around the home."

Staff meetings were regularly held and minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. Best practice guidance was discussed during these meetings and any concerns that staff had. For example discussions around the handover forms and the need for daily care documenting. Staff told us they attended staff meetings and felt comfortable to speak up in these.

The registered manager told us about the missions and values which staff were aware of. Staff we spoke to understood and followed the values to ensure people received kind and compassionate care. This was implemented during the staff induction process and reviewed regularly. We saw that the values were promoted in the 'Residents Guide', which anyone wanting to find out about the home or who lived there could read.

One member of staff said when new staff started they received training on the aims and objectives of the service. It was then up to senior staff to monitor them to ensure they put these aims into practice. Any issues identified would be covered in an individual supervision session. This helped develop consistent best practice and drive improvement. A member of staff said the ethos of the provider was checked through supervision and observation. They said they would always observe staff to see if they were doing their job safely and reliably. They added, "Things have improved a lot. This is down to the new manager and also staff through meetings and staff now knowing what is expected of them." They said the manager was, "Straightforward and good at motivating staff." They told me the manager taught by example, for example always having a smile on his face."

The registered manager told us about the systems they used to ensure the delivery of high quality care. We saw the quality assurance systems in place were robust. We saw evidence of audits for health and safety, care planning, medication and infection control. This enabled the registered manager to identify deficits in best practice and rectify these. The registered manager explained that regular health and safety meetings

and staff meetings were held. The minutes of the meetings were recorded and made available to all staff. Best practice guidance was discussed during these meetings including communication skills and care plan reviews. This showed that the registered manager was continually assessing the quality of the home and driving improvements.

We saw on the wall a poster that said 'We listened to your feedback'. It showed feedback from people and the actions of the staff. For example: people said they would like a sheltered area in the garden. The staff organised a Gazebo which is in place. People said they would like raised flower beds in garden. The staff and registered manager organized these and people who struggle to kneel down or are using wheelchairs can now enjoy gardening.

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