The Society of St James

St James Care

Inspection report

106-108 Radstock Road
Woolston
Southampton
Hampshire
SO19 2HU

Tel: 02380445310
Website: www.ssj.org.uk

Date of inspection visit:
04 May 2016
06 May 2016
18 May 2016

Date of publication:
08 June 2016

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

We carried out this unannounced inspection on the 4, 6 & 18 May 2016. St James Care provides accommodation and support for up to 16 people with mental health issues associated with alcohol dependency. The Society of St James provides support for people to manage their alcohol dependency safely and support people who are homeless. At the time of our inspection there were 14 people living at the home.

There was a new manager in post who was in the process of becoming registered with CQC. 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.

We found people's safety was compromised in some areas. There was no hand sink in the laundry as recommended by the Department of Health's guidance on infection control. However, the home had acted promptly and a sink had been installed while we were carrying on the inspection. The risks to people were minimized through risk assessments and staff were aware of how to keep people safe. However, risk assessments were not robust enough for people who smoked in their bedrooms. Relevant recruitment checks were conducted before staff started working at St James Care to make sure staff were of good character and had the necessary skills. However, there were unexplained gaps in staff employment histories.

There were enough staff to meet people's needs. Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. People were supported to receive their medicines safely from suitably trained staff and medicines were stored, administered and audited effectively.

Staff received regular one to one sessions of supervision to discuss areas of development. They completed a wide range of training and felt it supported them in their job role. New staff completed an appropriate induction programme before being permitted to work unsupervised.

Staff sought consent from people before providing care and support. The ability of people to make decisions was assessed in line with legal requirements to ensure their rights were protected and their liberty was not restricted unlawfully. Decisions were taken in the best interests of people.

People received varied meals including a choice of fresh food and drinks. Staff were aware of people's likes and dislikes and offered alternatives if people did not want the menu choice of the day. People were able to access healthcare services.

People were cared for with kindness, compassion and sensitivity. Care plans provided comprehensive information about how people wished to receive care and support. This helped ensure people received

personalised care in a way that met their individual needs.

The manager maintained communication with people through residents meetings. They consulted people about all aspects of the service and acted on their feedback. People were supported and encouraged to make choices and had access to a wide range of activities. The provider sought feedback through the use of quality assurance questionnaires and used the results to improve the service. The provider and manager used a series of audits to monitor the quality of the service.

A complaints procedure was in place. There were appropriate management arrangements in place and staff felt supported.

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.

There was no hand washing facilities in the laundry room to help reduce the risk of cross infection. However one was fitted during our inspection.

Recruiting practices were not always safe; there were gaps in people's employment histories. Risks were managed appropriately; however, risk assessments for people smoking in their rooms were not robust.

Staff knew how to identify, prevent and report abuse and medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff sought consent from people before providing care and followed legislation designed to protect people's rights.

Staff told us they felt supported and had regular sessions of supervision and received a wide range of training.

People enjoyed the food and felt they had choices. People were supported to access health professionals and treatments.

Is the service caring?

Good

The service was caring.

People felt staff treated them with kindness and compassion.

People were treated with dignity and respect and were encouraged to remain as independent as possible.

Is the service responsive?

Good

The service was responsive.

People received personalised care from staff that understood

and were able to meet their needs. Care plans provided comprehensive information and were reviewed regularly.

People had access to a range of activities which they could choose to attend. An effective complaints procedure was in place and concerns were listened to.

Is the service well-led?

Good

The service was well led.

People and staff spoke highly of the manager, who was approachable and supportive.

The service promoted the involvement of people and had strong links with the local community. There was a clear set of values and a vision for the service with people at the heart of it.

There were systems in place to monitor the quality and safety of the service provided. There was a whistle blowing policy in place and staff knew how to report concerns.

St James Care

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 the 4, 6 & 18 May 2016 and was unannounced. The inspection was carried out by two inspectors, an expert by experience in the care of people with substance and alcohol misuse and a specialist advisor in the care of people with substance and alcohol misuse.

Before the inspection, we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home and one family member. We also spoke with the provider's operations director, the manager, the kitchen manager and eight support staff members. We looked at care plans and associated records for four people, five recruitment files, accidents and incidents records, policies and procedures, minutes of staff meetings and quality assurance records. We observed how staff interacted with people whilst supporting them with a range of activities in the home.

We previously inspected the home in July 2014 when no concerns were found.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe living at the home. One person told us, "I feel safe while at the home." Another person said, "I absolutely feel safe." A third person told us, "The building is kept nice and clean and I have no concerns."

At our last inspection, the provider told us they were in the process of installing a hand washing sink in the laundry. However, we found this had not been completed. Staff told us they either washed their hands in the sluice sink or in the hand washing sink in the home's kitchen. Use of the kitchen sink risked spreading infection from the laundry into a food preparation area and onto any door handles or furniture they came into contact with en-route. We spoke to the manager about our concerns and by the end of our inspection the sluice has been removed from the laundry and a hand washing sink has been fitted.

Recruitment processes were followed that meant staff were checked for their suitability before being employed in the home. Staff records included an application form and a record of their interview, two written references and a check with the 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. However, there were a some unexplained gaps in the employment history of staff members. We spoke to the recruitment officer at the provider's head office who informed us that managers should go through people's employment history as part of their interview process and that this would be addressed.

A designated smoking area had been provided in the home, together with a covered outdoor area in the garden. However, two people chose to smoke in their rooms and smoking risk assessments were in place for these people. However, these were not robust and the safety measures designed to reduce the risk were limited to, "Regular health and safety checks, emptying the ashtray and bin, encourage [the person] to smoke in designated area." The risk assessment did not take account of the fact that one person regularly became heavily intoxicated, which increased the risk of fire being started by careless disposal of smoking materials. We discussed our concerns with the manager who arranged for a visit from Hampshire Fire and Rescue Service to seek further advice.

An effective system was in place for obtaining, storing, administering and disposing of medicines received into the home. One person told us, "My medication is always on time, and if I'm not here staff will come and find me." We observed part of the medicines round and saw staff followed best practice guidance by administering and recording medicines to people individually. Two people self-administered some of their medicines; an appropriate risk assessment had been completed and they stored their medicines safely. There was a clear process in place to help ensure topical creams were not used beyond their safe 'use-by' date. However, some hand-written entries in the medication administration records (MAR) had not been double-checked by a second member of staff to make sure they were accurate; also, some MAR charts did not include photographs of people to help ensure medicines were given to the right person. This was contrary to guidance issued by the National Institute for Health and Clinical Excellence (NICE) and could lead to medicine errors.

The manager had identified that two people who were prescribed sedatives had become more prone to falls in the evening. They had discussed this with the people concerned, who had agreed to take the sedatives once they were in bed. This was an appropriate response and had reduced the frequency of falls at the home.

Risks and harm to people were minimised through individual risk assessments that identified potential risks and provided staff with information to help them avoid or reduce the risk of harm. A staff member told us, "We minimise risks by managing people's alcohol limits and monitoring their medicines." Risk assessments contained detailed information about people's past and current risks, which were both physical and psychiatric, and were signed by the person. The manager had noticed that people were drinking the liquid hand sanitizer as it contained alcohol, and as a result had changed all the hand sanitizer's in the home to alcohol free gel.

Many of the people were dependent drinkers and received support around the management of their alcohol intake. We saw in people's care records each person had an agreement in place to support them to drink alcohol at safe levels. This included people's individual supply being controlled by staff as part of their agreement. This arrangement had been discussed with the individuals and they had agreed to this as part of their alcohol reduction programme and their agreement to live in the home. This helped to make sure people did not go into withdrawal whilst preventing them from becoming too intoxicated. This allowed people to drink controlled amounts of alcohol in a safe environment.

There were enough staff to meet the needs of the people and keep them safe. One person told us, "I feel there are enough staff both day and night." Another person said, "All of us have buzzers in our rooms and staff always respond quickly." A family member said, "I think there are plenty of staff here; staff are always ready to talk to me at any time." We observed that staff were available to support people whenever they needed assistance. People and staff told us they felt the number of staff was sufficient to look after people's routine needs and support people individually to access community activities. One staff member told us, "Occasionally it can be busy in the evening, but one [staff member] does the medicines while the other spends time with people." They said they had time to take people out, for example a staff member was supporting one person to go to the cinema on the first evening of our inspection. They said, "So long as there are two [staff members] in the home, then we can take people out." Another staff member said, "There is a senior on duty till about 18.30 or a manager. Then [management responsibility] gets handed over to the Operational Security Team (OST) as well as a manager being on call, who can also go out and look for people or if any incidents occur we can call for help and they are only a phone call away."

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. One staff member told us, "We follow procedure for reporting to management and make sure it is well documented, while making sure the person's wellbeing is the top priority." We viewed referrals that staff had made to the local safeguarding authority. We saw these were appropriate and correspondence between safeguarding staff and staff at the home showed there was a healthy working relationship, and exchange of information, which helped safeguard people effectively. The manager had identified a person who was at risk of financial abuse by family members. They had sought support for the person from a lay advocate and had alerted the person's care manager to the risk.

Arrangements were in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire and fire safety equipment was maintained appropriately Fire evacuation bags containing emergency equipment and information was kept in the home. These included details of the support people would need if the building had to be evacuated. Safety checks were conducted regularly of gas and electrical equipment.

Good

Is the service effective?

Our findings

People who lived in the home appeared happy with the care and support they received. One person told us, "Care has been immaculate; I fell in love with place. Where I was before I didn't like it and they couldn't give me 24 hour care, which they do here." Another person said, "Staff are always helpful at night, with snacks, hot drinks or to talk with."

Staff had received training in the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework to 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.

Staff were clear about the need to seek verbal consent before providing care or support and we heard them doing this throughout our inspection. People's consent to care and treatment was sought in line with legislation. For one person this was supported by a very detailed best interest decision as in the morning they were able to walk to the shops independently, and plans and risk assessments were in place to support them. But when they were intoxicated it was not safe for them to walk to the shops on their own and needed staff support. The manager explained the process and how she had been proactive in getting the best interest decision in place for the person.

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 was being met. DoLS had been authorised for one by the local authority. Most staff were aware of the support required by people who were subject to DoLS to keep them safe and protect their rights, however there was some confusion with a couple of members of staff on DoLS. We spoke to the manager about our concerns. They said they had recently talked about DoLS and best interest decisions in staff meeting and handovers and agreed to speak to staff and check their understanding.

New staff completed a comprehensive induction programme before working on their own. Arrangements were in place for staff who were new to care to complete the Care Certificate. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate support to people. In addition, the manager had supported some experienced staff to work towards the care certificate in order to build their confidence and gain recognition for their skills.

Experienced staff had completed refresher training in the provider's mandatory subjects. Some care staff had obtained, or were working towards vocational qualifications, and all senior staff had achieved level three qualifications in health and social care. The manager told us, "I'm aware staff need a lot of support at the moment. I think personal development is so important, we'll look for all suitable courses."

Care staff received regular supervisions. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. These had led to individual training plans being developed for each staff member to support them in their work.

A staff member told us "Supervisions are regular. We discuss everything; who we're working with, how we're getting on, our strengths and weaknesses." They said additional training had been promised in the use of the provider's computer system, but they were still waiting for this to be delivered. The Operations Director told us the person who was due to deliver this training was on sick leave, which had caused it to be delayed.

People told us they liked the food and were able to make choices about what they had to eat. One person said, "The food is excellent and always fresh, and if I don't fancy what's on the board [a staff member] will cook what I like." The kitchen manager told us, "Yesterday I was requested to cook bangers and mash for today, as they wanted something normal." They also told us they "try to keep variety and nutrition in planning meals."

People received varied and nutritious meals including a choice of fresh food and drinks. There was a choice of two hot meals at lunch time and a choice of puddings. Staff were aware of people's likes and dislikes and offered alternatives. For example we observed one person come down for lunch later in the afternoon and ask the kitchen manager "What's for lunch?" the kitchen manager told them what it was and knew they wouldn't want it, so had prepared them a peri peri chicken and salad. The person was very pleased with this outcome and it showed that staff were aware of people's likes and dislikes. People were supported to eat and drink and maintain a balanced diet. The kitchen manager was a member of a diabetic forum and received regular emails and recipes to support people living with diabetes.

People had access to health and social care professionals. One person told us, "Staff remind me of my health appointments as I forget, and will accompany me if I ask." Another person said, "Staff always accompany me to hospital, GP and dentist appointments." A third person told us, "Staff have been great; I have a lot of hospital appointments next month and they have been sorting it out. They look after my health and look after me; care is fantastic." Records showed people were seen regularly by GPs, social workers, optician's and district nurses. While we were at the home an optician had visited. We observed staff members supporting people by encouraging eye tests and trying on spectacles.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. One person said, "Nothing is too much trouble. It's difficult to come to terms with people who care." They also told us, "Staff go that little bit extra to make sure you're happy, really caring and helpful." Another person said, "Staff are polite and well-mannered. If I want something the staff will always get me whatever I want; no concerns." A family member told us, "Staff are very caring and always talk with the people living here; couldn't be in a better place."

Staff respected people's privacy and dignity. One person told us, "Staff treat me with dignity and respect." Another person also told us, "Staff treat me with dignity and respect; no concerns." We observed care was offered discreetly in order to maintain personal dignity. People's privacy was protected by ensuring all aspects of personal care were provided in their own rooms or in bathrooms around the home. Staff knocked on doors and waited for a response before entering people's rooms. One person told us, "All staff are good at knocking on doors and waiting for a response."

The home had appointed a member of staff to act as the home's dignity champion. A dignity champion's role was to challenge poor care practice, act as a role model and educate and inform staff working with them. We spoke to the dignity champion for the home who told us, "I attend meetings every three months with other dignity champions from other homes. We share experience, so I can bring good ideas back into the home and share best practice with staff to improve the quality of life for people living at the home."

Staff built up positive relationships with people. Staff spoke about their work with passion and spoke about people warmly. One staff member told us, "I love working here; the residents are the best thing. It's nice to get to know about them and the situation they were in."

Staff understood the importance of promoting and maintaining people's independence. A staff member told us, it's not a regime here; we try to promote and encourage a style that suits everybody." One person told us how they sometimes helped out in the kitchen and reported that this was "a great pleasure" for them as they used to love cooking.

We observed care and support being delivered in the communal areas of the home and saw good interactions with people. Staff were kind and compassionate; for example, we observed a person being encouraged to have something to eat and drink, as they had not wanted breakfast. We also observed a person asking staff for money and being treated with patience and understanding throughout. People were supported in an unhurried way and staff kept them informed of what they were doing.

People's care records included information about their personal circumstances and how they wished to be supported. When people moved into the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. One person told us, "I was involved in my care plan." Comments in care plans showed this process was on-going.

If people wished to have additional support to make a decision they were able to access an advocate.

Information about advocacy services was available to people. The manager informed us that people living at the home had access to various advocacy services, including lay advocates.

We observed caring behaviour in staff interactions with people, which demonstrated person-centred care in their familiarity with each person, and the ease of communication. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it. When staff discussed people's care and treatment they were discreet and ensured conversations could not be overheard.

Good

Is the service responsive?

Our findings

People were involved in developing their care, support and treatment plans. One person told us, "I am very much involved in my care plan and have seen and signed it; my opinions were listened to." Another person said, "I'm aware of my care plan, but I don't want anything to do with it." A third person told us, "I go through my care plan with my key worker and they help sort everything out for me."

People were involved in their care planning and care plans were reviewed monthly by the manager or their key worker. All the people living at the home had a keyworker. A keyworker is a member of staff who is responsible for planning that person's care and liaising with family members. A staff member told us responsibilities included supporting them to attend medical appointments, getting new clothes, talking through things, supporting them to claim benefits and allowances, and "looking at and talking through every aspect of their lives".

Care plans were comprehensive and detailed, including physical health needs and mental health needs. Each person had individual support arrangements and agreements in place about when, where and how much alcohol they would consume during the day. Staff were aware of these, but were flexible in the way they applied them in order to meet the needs and wishes of people at a particular time. For example, a staff member said people were allowed to bring alcohol into the home up to 5%, but they were never allowed to bring spirits in. They said, "They would be taken away and destroyed in line with their contracts."

A handover meeting between staff at the start of each shift helped ensure that important information was shared, acted upon where necessary, and recorded to ensure people's progress was monitored. We observed the handover meeting on the day of our visit; staff provided a detailed description of how each person was feeling, what they had done, eaten and enjoyed (or not enjoyed). This was beneficial for people; for example, we observed staff passing on essential information about a person who had gone out. Staff were advised to keep a note of the time they returned and if they were not back at a certain time to follow the home's procedures for a missing person. This demonstrated how much the staff respected and were concerned for people's wellbeing.

People had a range of activities they could choose to be involved in. One person told us, "I like the group activities in the house." Another person said, "We have movie nights three times a week which I enjoy." People were able to choose what activities they took part in and suggest other activities they would like to complete. For example, a staff member told us, "One person was planned to go to the cinema on Saturday night to see a movie they wanted to see, but was too intoxicated so we have arranged for tonight and they are happy with this." Another staff member said, "We had a women's group today for the ladies; we had the staff and taxi ready to go, but they had changed their minds and didn't want to go, but we will still keep trying."

'Residents meetings' were held every quarter and minutes from a meeting in February 2016 showed that people discussed the opportunity to have some baby chicks and watch them hatch. People were shown the leaflet about it and agreed to keep the chickens afterwards. They told us they were looking forward to fresh

eggs and to caring for the animals. One person said, "I saw the chicks hatch and crack the shell to come out; it was an amazing experience."

While we were at the home we observed a residents meeting taking place. People were asked if they wanted to chair the meeting, but they declined and it was chaired by the manager. A community garden project was discussed; a nationwide supermarket had agreed to provide the garden with a makeover, where a team of workers would attend for the day and reform the garden by providing new decking and garden furniture. The project team had visited the home in the morning and discussed ideas with management. The manager shared the plans with people at the meeting and they were asked for ideas. Suggestions were made as to locations for the chicken run and the vegetable patch, and the plans were changed accordingly. Another person suggested a water feature and the manager agreed to pursue this.

People praised the quality of the food and discussed activities they wished to pursue. People commented on how they enjoyed the steak they had received from the FareShare scheme yesterday. FareShare is an organisation that saves good food destined for waste and sends it to charities and community groups who transform it into nutritious meals for vulnerable people. The manager asked for ideas on days out, as there were plans in place to share a mini-bus with another care facility. Discussions took place as to the various ways this could be utilised and the idea was popular among people.

People knew how to complain or make comments about the home and the complaints procedure was prominently displayed. One person told us, "We only have to ask and are always answered." A family member said, "If I have any concerns I will ask and will get answers and be sorted" The home had received three formal complaints in the last year. Records showed these had been dealt with promptly and investigated in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

The home had a new manager at the service who was in the process of becoming registered with CQC. People and staff felt the home was well run. One person said, "Management are a good package, everything is written down. No complaints whatsoever. I only have to knock on the office door and staff always have time to talk." Another person said, "I'm happy here and I have no concerns." One staff member told us, "The manager is very approachable". They added, "Morale is good and the place is well-run". Another staff member said, "Management are supportive and have an open door policy."

There was an open and transparent culture in the home. The previous inspection report and rating was displayed prominently in the reception area. The provider notified CQC of all significant events. Visitors were welcomed and the home had built strong links with the community. These included links with local supermarkets through the 'FareShare' scheme which donated food; for example, we saw a supply of rib-eye steaks in the kitchen that had just been received. Links had also been developed with drug and alcohol treatment services; for example, some of these provided activities as diversion therapies that people had accessed, such as fishing and farm work. Other activities could be accessed through links with local sports associations. One of the local universities had provided a student to work with the home and the provider on a marketing project; and a local school had donated Christmas presents through a shoebox appeal. There was a whistle blowing policy in place and staff were aware of it. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations.

However, the provider did not have a duty of candour policy in place to help ensure staff acted in an open way when things went wrong. A person who fell, causing a serious injury was given information about the incident, but a letter was not sent to the person as required. We discussed this with the manager who agreed to develop a suitable policy.

The Operations Director told us the provider wanted to specialise in "Working with people who are older, problematic drinkers who have mental health or cognitive difficulties." They added, "We aren't looking to change [people's lifestyles] but are about managing harm in the way they choose to live." They said they aimed to do this "by stabilising the amount people drank which opens up opportunities for thinking about change and rebuilding relationships with families and friend." They recognised that "recovery is a journey, not a destination" for people.

The provider had a clear vision and set of values which encouraged the philosophy of placing the person in the centre of all the care they received. The provider's values were: "Everyone is of worth and has the capacity to change". The Operations Director said the values were communicated to staff "by managers leading by example and by ensuring that staff understood what is expected of them". They said they were "proud of the level of staff retention and of their ability to work with a client group who are marginalised and vulnerable".

Staff we spoke with were committed to this approach and clearly understood the provider's objectives and values. Staff meetings were held once a month and minutes showed these had been used to reinforce the

values, vision and purpose of the service. One staff member told us, "We can email management with any agenda items as well as given opportunities at the end of meeting." Another staff member said, "We are asked for ideas to bring up in the meetings, and made aware of when it us due."

The manager informed us they kept up to date by attending provider forums every three months to share best practice with other providers, attending safeguarding meetings and completing and updating training. The manager told us, "Most important is that I am approachable and set a good example." They added, "I share my experiences as I have a lot of alcohol and substance knowledge as well." The manager received regular supervision and annual appraisal from the Operations Director. They told us they felt "supported and well-valued by the provider and were being supported to gain a level five qualification in health and social care."

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. These included audits of medicines, care plans, safeguarding, finance, and health and safety. For example suitable arrangements were in place to manage small amounts of money on behalf of people; comprehensive records were maintained and audited on a regular basis by staff at the provider's head office.

The Operations Director worked across the Society's homes and services and said they acted as a "conduit for learning and transferring best practice between services". They said they did spot checks and looked at the processes used in the home and would "look at tools to do a full audit of the home within the next quarter".

There was a process in place to enable the manager to monitor accidents, adverse incidents or near misses. This helped ensure that any themes or trends could be identified and investigated further. It also meant that any potential learning from such incidents could be identified and cascaded to the staff team, resulting in continual improvements in safety. The manager told us, "I always reflect after an incident, what we could do better next time. We use lots of reflective practice and debriefs on all our incidents." One staff member told us, "The manager is very good; I had an incident and they were checking if I was okay and needed to have a chat. She's a breath of fresh air."

The home carried out annual quality assurance surveys with people. The most recent of these were sent out in November 2015, eleven responses were received and showed people were satisfied with the food and enjoyed the activities. For one person, their response indicated they wished to do more gardening; we saw photos of them doing gardening and a greenhouse had been purchased for the garden.