Abbeyfield Wey Valley Society Limited

Hatch Mill

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 26 January 2018 and was unannounced. This was the first inspection since the service registered with CQC in July 2016.

Hatch Mill is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hatch Mill accommodates 48 people in one adapted building, over two floors. One floor provides residential care and the other provides nursing care to people. At the time of our inspection there were 42 people living at the home. The home supported older people, some who had physical disabilities and long term medical conditions. Some people at the home were living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We identified shortfalls in record keeping that meant that clinical risks were not always accurately monitored. Plans on how to manage risks did not always contain enough detail to guide staff. The provider took action to address this immediately following the inspection. We made a recommendation for the provider to review their systems for monitoring individual clinical risks.

Care was planned in a person-centred way and care plans were regularly reviewed. Despite the shortfalls in record keeping for some risks, most individual risks were identified and managed to keep people safe. Staff routinely involved people in their care and met their preferences and desired routines. We received a large amount of negative feedback about the quality of the food on offer; we made a recommendation about the quality of the food on offer at the home.

People were involved in the running of the home and their feedback was regularly sought. Meetings took place to provide opportunities for people to make suggestions or give feedback and the provider conducted regular surveys. People's had consented to their care and treatment and staff had followed the guidance of the Mental Capacity Act 2005 (MCA). We made a recommendation about the documentation kept with regards to the MCA.

Staff had received training for their roles and told us that they felt supported by management. Regular supervisions and appraisals took place and the provider had systems of communication in place to enable staff to pass on important messages regarding people's care. Staff worked alongside healthcare professionals to ensure people's healthcare needs were met.

People received their medicines safely and in line with best practice. Nursing staff had support to maintain their clinical competencies and revalidate their registrations with the Nursing and Midwifery Council (NMC). The provider had effective systems and training in place to reduce the risk of the spread of infection and people lived in a clean home environment. The premises design was suited to the needs of the people who lived at the home.

Staff were caring and took an interest in people. Staff knew people well and found ways to improve people's lives and enable them to develop independence. People's wishes and preferences for end of life care were clearly documented and met. Staff provided care in a way that was respectful of people's privacy and dignity.

The provider had links with the local community and people benefitted from fund raising work that took place. Fundraising was used to develop the home and gardens in a way that provided people with restful spaces and areas to exercise in. The provider carried out regular audits to monitor the quality of the care that people received. There was a wide range of activities taking place at the home and people told us that they enjoyed these and could make suggestions in this area.

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 consistently safe.

We identified shortfalls in the monitoring of clinical risks that people faced.

Staff administered people's medicines in line with best practice. Staff understood their roles in safeguarding people from abuse and were trained in this area.

Infection control practices were adhered to reduce the risk of cross contamination. People lived in a clean home environment.

There were sufficient numbers of staff present to safely meet people's needs. The provider had carried out appropriate checks to ensure staff were suitable for their roles.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's nutritional needs were met but a high number of people were dissatisfied with the quality of the food at the home. We made a recommendation about improvements to the food.

Staff followed the legal process outlined in the Mental Capacity Act 2005. We made a recommendation about record keeping in this area.

Staff worked alongside healthcare professionals to meet people's needs. People lived in an environment that was designed and adapted to meet their needs.

Staff had received appropriate training and support for their roles.

Is the service caring?

Good

The service was caring.

People were supported by kind staff who knew them well.

Staff supported people in a way that promoted their independence and involved them in their care.

Where people had specific religious or cultural needs, these were identified and met by staff.

Staff supported people in a way that was respectful of people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People had access to a wide range of activities.

Care was planned in a person-centred way and reflected people's needs and preferences. People's wishes with regards to end of life care were documented.

The provider responded appropriately to complaints.

Is the service well-led?

Good

The service was well-led.

People were involved in the running of the home and their feedback was regularly sought.

Staff felt supported by management and the provider had effective systems of communication in place.

There was an ongoing plan to develop and improve the service. The provider conducted frequent audits and people benefitted from links with the local community.

Hatch Mill

Detailed findings

Background to this inspection

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

This inspection took place on 26 January 2018 and was unannounced.

The inspection was carried out by one inspector, a specialist nurse advisor 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.

Before the inspection we gathered information about the service by contacting the local and placing authorities. 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.

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

As part of our inspection we spoke with the registered manager, the clinical lead, three nurses, one senior care staff, three care staff and the chief executive. We spoke with eight people and four relatives. We also observed the care that people received and how staff interacted with them. We read care plans for 13 people, medicines records and the records of accidents and incidents. We looked at records of complaints and the provider's surveys. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at four staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We also looked at records about food, activities and minutes of meetings of staff and residents.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the home. One person said, "When I fell I was helped immediately, I can ring the bell for anything I want." Another person told us, "They [staff] are eager to please." A relative said, "I feel confident about [person]'s safety."

People did not always benefit from accurate and up to date records. Despite people feeling safe, we identified shortfalls in record keeping that meant risk management plans were not always robust. Where clinical risks were identified, plans were not always implemented to monitor and respond to risk. For example, we identified two people living with diabetes and their records did not contain detailed information for staff about how to manage the risks associated with diabetes. For example, neither person's care plan contained information for staff on how to recognise a hypoglycaemic (low blood sugar) or hyperglycaemic (high blood sugar) attack. There was also no information for staff about when to record the person's blood glucose levels and the types of foods that could be offered to maintain a balanced diabetic diet. The impact of this was minimised because staff were able to tell us how they would identify changes in the health of people living with diabetes. Records showed that where changes in people's health and blood sugars had been noted, staff responded appropriately. The provider also showed us evidence that staff training in diabetes was up to date and they updated records following the inspection.

Another person had been identified as at risk of malnutrition due to losing weight and we noted that no food and fluid chart was being completed for this person. We identified two people with catheters and their care records did not contain information for staff on expected output and how to identify signs of infection. There was no monitoring of fluid input and output for both people with catheters in place. This further showed that there was a lack of monitoring and oversight of clinical risks. The provider took action to address these individual concerns after the inspection and submitted evidence of this. We will not apply a 'Good' rating to this domain until we have seen sustained improvements in this area.

We recommend that the provider reviews their systems for identifying and monitoring clinical risks to ensure accurate records are kept.

In other cases, risk assessments covered a variety of risks such as falls, pressure sores, nutrition and behaviour. Where staff identified risks the plans to implement them were appropriate. For example, one person was assessed as at risk of falls due to frailty and reduced mobility. To reduce the risk, staff supervised the person when they moved. The person had a walking frame and staff ensured it was near the person. Staff made sure the person had their glasses with them so they could see where they were going. Another person was at risk of developing pressure sores. This was because they were cared for in bed due to their condition. A plan was implemented and the person had an airflow mattress and was supported by staff to reposition regularly. Staff monitored the person's skin for signs of breakdown and applied prescribed creams. Staff were knowledgeable about these actions when we spoke with them and we observed staff supporting the person to move in line with this guidance.

Where incidents occurred, staff responded appropriately to keep people safe. Any incidents, such as falls or

behavioural incidents, were recorded and staff documented the actions that were taken. Records showed that staff took action to make people safe and to reduce the risk of a similar incident happening again. For example, one person had suffered a fall recently. In response, staff made sure that the person was safe and documented that they were not injured. The person's falls risk assessment was reviewed; additional actions were implemented to make sure the person's call bell was within their reach and to encourage them to drink fluids. All accident forms were signed off by management and an analysis was carried out to identify patterns or trends. This meant systems were in place to ensure that lessons could be learned should any significant incidents occur.

People's medicines were managed and administered safely. Medicines were administered by trained nurses or senior staff who had had their competency assessed. Nursing staff were observed administering medicines and they followed best practice. They washed their hands and checked tablets and dosage against people's medicines administration records (MARs) and confirmed people's identity before administering medicines to them. Medicines were stored securely and in line with the manufacturer's guidance. The provider carried out regular checks of the temperature of storage areas, to ensure the manufacturer's guidelines were met.

MARs were completed accurately with no gaps. Staff were observed signing MARs after medicines were administered and records were up to date. Where people had not been administered their medicines, staff recorded the reasons why. For example, one person had recently been in hospital and had not been administered medicines at the home because of this. The person's MAR made this clear and staff had used the correct codes to show the person was in hospital. MARS contained information on the medicines people were prescribed as well as any allergies.

People were protected against the risk of infection. The home environment was clean and smelt fresh. The provider employed housekeeping staff and we observed them cleaning the home throughout the day. Cleaning staff followed a clear routine that ensured all rooms and communal areas were cleaned regularly. Staff had been trained in best practice in relation to infection control and we observed staff using personal protective equipment (PPE) when providing care or serving food. Staff were also observed washing their hands before and after providing support to people. The provider carried out daily checks of cleanliness and there was a regular infection control audit at the home.

There were sufficient numbers of staff at the home to safely meet people's needs. The provider calculated staffing numbers based on the needs of people and we observed that the calculated levels were sufficient. People were responded to quickly by staff and they told us that staff spent enough time with them. In communal areas, we observed that staff were able to provide supervision to people to manage risks. For example, one person's risk assessments identified that they required supervision from staff to reduce the risk of falls. We observed that this person was given the required levels of supervision throughout the day.

Staff understood their roles in safeguarding people from abuse. Staff had received training in safeguarding adults and information on how to raise safeguarding concerns was displayed within the home. At the time of inspection, staff had not had to raise concerns with the local authority safeguarding team but we saw evidence of the provider working with social services where there had been a concern. There was a clear safeguarding policy in place and staff demonstrated a good knowledge of how to raise any concerns. One staff member said, "I'd report it immediately after making sure the person was safe. I could call police, safeguarding [team] or CQC."

People were protected from being supported by unsuitable staff because the provider carried out robust recruitment checks. Staff files contained evidence of references, right to work in the UK and Disclosure and

Barring Service (DBS) certificates. These are used to identify staff who would not be appropriate to work within social care.

The provider ensured the safety of the premises. Regular checks were carried out on the health and safety of the building and maintenance works were actioned where improvements were identified. The safety of the building in the event of a fire had been assessed. The provider had plans in place for in the event of a fire and equipment in place to support staff. Each person had an individual personal emergency evacuation plan (PEEP). PEEPS reflected people's needs and guided staff on how to best support them in an emergency. Staff were trained in fire safety and regular drills were conducted.

Requires Improvement

Is the service effective?

Our findings

We received negative feedback from people on the quality of the food that they received. One person said, "The chips taste like they are from a microwave and the roast potatoes are not well done." Another person told us, "The food is boring, not interesting. They hire the cheapest and the menu is not good." Another person said, "The quality of food is mediocre; it's like school dinners in 1947." Another person said, "The food is not all that marvellous, the vegetables are over cooked."

Whilst one person did tell us the food was 'reasonable' and another person told us that the food was 'ok', six of the people we spoke with gave us negative feedback on the quality of the food. The provider had recently started to use an external catering company that brought in food which was heated in the kitchen and served to people. People told us that since this catering company had been introduced, the quality of the food had fallen. We noted that there was a menu in place that offered choice to people and people told us they could always request an alternative. People dined together and received their meals promptly and we noted that there was a pleasant atmosphere as people dined. However, people told us that they were not satisfied with the quality of the meals that were prepared for them. People told us that food tasted like it had been frozen before cooking. They said that food tasted like it had been processed and lacked freshness. They also told us that food was not cooked to a good standard. The provider was aware of this feedback through their surveys and residents meetings. At the time of inspection, they were in the process of working with people and the catering company to make changes to the menu in response to the feedback. We will follow up on the impact of these improvements at our next inspection. Due to the high levels of dissatisfaction with the quality of food, we will not apply a 'Good' rating to this domain until this has been addressed.

We recommend that the provider reviews the food on offer to ensure the quality is satisfactory to people living at the home.

People's dietary needs were documented and met. Where people had specific dietary needs, these were listed in their care plans and met by the provider. For example, one person required soft foods due to difficulty chewing. This was documented in their care plan and the person told us they always received food in line with this guidance. Another person had celiac disease; this meant that they were allergic to gluten. This was documented in the person's care plan and the provider ensured that they had separate meals that were free from gluten. We noted that people living with diabetes had access to low sugar options that reflected their preferences.

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 so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were protected because staff followed the guidance of the MCA. People's care records contained evidence of mental capacity assessments that were used to assess people's ability to make specific decisions. Where people were unable to make decisions, best interest decisions were documented. For example, one person who was living with dementia was assessed as being unable to make the decision to stay at the home. A best interest decision was recorded that involved staff, the person's GP and their relatives. It was decided that it was in the person's best interests to stay at the home so an application was made to the local authority DoLS team. We did note one instance where a person was receiving their medicines covertly. Staff told us they had been assessed as lacking the mental capacity to consent to receiving their medicines, but the mental capacity assessment and best interest decision were not on file. The decision had been signed off by the person's GP but not the pharmacy. This was important because a pharmacist could advise on how to best administer the medicine covertly. The impact of this was minimised due to the person not always receiving medicines covertly, and records showed the person usually accepted their medicines. After the inspection, we received evidence of a mental capacity assessment and best interest decision involving the pharmacist.

We recommend that the provider ensures that the correct legal process is followed wherever people receive their medicines covertly.

People were supported to meet their individual healthcare needs. People's care plans documented any medical conditions that they had and any input from healthcare professionals. For example, one person was under the care of the community mental health team (CMHT) and their records contained information on their behaviour, which was used by the CMHT to make decisions about the person's medicines. People's records contained evidence of regular visits from the GP. The home had links with a local GP practice and we saw the GP visiting people on the day of our inspection. One person was being seen by the GP due to changes in their mood and energy levels. Staff had noted concerns the day before our visit and the GP had attended the person the next day. We also saw evidence of people being seen regularly by dentists, podiatrists and opticians.

The design of the premises was suited to people's needs. The provider took into account people's needs when redecorating and refurbishing parts of the home. For example, a toilet had recently been redesigned in line with best practice in relation to dementia care. The walls were brightly coloured with a matt-finished floor. This was designed to support people to recognise the toilet area and overcome visual impairments that people could develop as part of their dementia. There was clear signage throughout the home, using pictures, to ensure people could orientate themselves. Corridors and communal areas were wide and allowed room for people to access the home using wheelchairs. The home was well lit for people with visual impairments and corridors were kept clean and free from clutter to reduce the risk of people falling.

People were supported by staff that were trained to carry out their roles. Staff told us that they had access to a range of training courses and that these supported them in their roles. One staff member said, "My most recent training was on health conditions where we learnt about diabetes and Parkinson's." Staff completed mandatory training courses such as health and safety, safeguarding and infection control. The provider kept track of these and records showed that staff were up to date. Staff told us that they received an induction before starting work. They told us that they completed training courses and also shadowed experienced staff members before working on their own.

Staff also received training specific to the needs of the people that they supported, such as dementia

training. The provider encouraged staff to complete the Care Certificate. The Care Certificate is an agreed set of standards in adult social care that staff are trained to. The majority of staff had also been trained in further qualifications, such as Qualifications and Credit Framework (QCF). QCF is a further qualification in adult social care. The provider encouraged the completion of additional courses by giving staff an increase in pay when courses were completed. Staff also received regular one to one supervisions and appraisals where they could discuss their performance.

People received a thorough assessment before coming to live at the home. Assessments seen captured people's needs and how they related to their medical conditions. People were asked about their preferences and their backgrounds at assessment and the information was added to their care plans. Assessments were always completed before people came to live at the home, which enabled the provider to make a judgement about their ability to meet that person's needs as well as prepare staff and equipment to meet the person's needs.

Good

Is the service caring?

Our findings

People told us that they were supported by caring staff. One person said, "[Staff member] is great, she got me out of bed this morning." Another person said, "I've never had a bad carer." Another person told us, "'I do like it very much. They [staff] are very kind and very caring." A relative told us, "We are made feel part of the community, part of a family."

During the inspection we observed pleasant interactions between people and staff. In the morning, one person living with dementia had become lost and asked staff where they were supposed to be. The staff member said, "I get muddled in the mornings too, let go over here." The staff member took the person's hand and led them to their room. In the afternoon, staff chatted with a person about a visit from the GP, which they told us they were worried about. This appeared to put them at ease. Throughout the day we observed staff coming down to people's eye line to speak with them and using appropriate touch to reassure people.

People were supported by staff who knew them well. Staff were able to give us information about people's needs and backgrounds whenever we asked them. People told us that they were supported by consistent staff that they had time to build a rapport with. Rotas showed that a regular staff team supported people and there was low use of temporary agency staff. The provider told us they focussed on staff retention with their systems for rewarding and developing staff and this had meant people benefitted from consistency. People's records contained information about their backgrounds and staff had a good knowledge of these. For example, one person had an interest in rugby and we observed staff talking to them about that. The information was in their care plan, along with where they were born and their family background and career. Another person worked in a hospital in their working life and staff knew this about them when we spoke with them.

People were supported to maintain their independence. One person told us, "They [staff] let me get on with things." People's care plans reflected their strengths and areas in which they were able to support themselves. One person required minimal support to mobilise with their frame. Their care plan recorded that they liked to walk up and down the corridors with their frame to develop strength and confidence. We observed the person doing this during our inspection and staff provided verbal encouragement to the person. Another person's care plan recorded that they were able to attend to their own oral care and could attend to some personal care tasks themselves. A staff member knew this when they described the person's needs to us. We noted there was a washing line in the garden of the home. The registered manager told us that one person who was living with dementia liked to hang their clothing on here. They told us that staff then discreetly took the clothes and washed them before returning them to the line for the person to take down.

Staff involved people in their care. People told us that they were given choices in different areas of their care. One person said, "Most of the carers know who I am and I am included in activities." People had regular meetings where they were asked about food and activities at the home. Minutes of a recent meeting showed that people had been involved in decisions about Christmas celebrations and a bonfire night party. People

were routinely offered day to day choices. We observed staff giving people options at lunch time as well as with drinks throughout the day. Staff demonstrated a good understanding of how to promote people's day to day decisions. A staff member told us, "We support [person] who has advanced dementia but really enjoys choosing her outfits each day."

People were supported to maintain their religious and cultural needs. One person said, "The minister comes every fourth Thursday." People's religious needs were captured at assessments and where people had particular cultural or religious needs, these were documented and met. Some people living at the home were practicing a Christian faith and they had regular visits from the church to the home where services were conducted. We also noted another person was regularly supported to attend their church to maintain links with this community. Relatives were welcome to visit the home whenever they wished. We observed a number of relatives coming to see people during our inspection. Relatives spoke highly of the home and told us that they had a good rapport with staff and management.

Staff were respectful of people's privacy and dignity. People's care was provided in a way that promoted their privacy and their dignity. Staff were observed knocking on people's doors and waiting for permission before entering. Where personal care took place, this was done discreetly and privately. Staff demonstrated a good understanding of how to promote people's privacy and dignity when providing care. A staff member told us, "I always tell people what I'm doing and ask if it's ok. [Person] uses a 'thumbs up' to let me know."

Good

Is the service responsive?

Our findings

People told us that they liked the activities on offer at the home. One person said, "Yesterday there was a Burns night celebration." Another person said, "They spend some money on the garden." A relative said, "There's a very good programme of outings in the summer. They go to Wisley Gardens, boat trips on the Thames and the garden centre. There are opportunities to volunteer."

There was a programme of activities on offer at the home and these reflected a variety of interests. In their PIR, the provider told us they offered, 'chair Pilates and Zumba.' They also said, 'Weekly activities include bingo, card games, word games, scrabble, dominoes and crosswords.' Our findings supported this. We saw evidence of arts and crafts activities, outings, exercise and entertainment taking place at the home. Activities were discussed at meetings and people were given opportunities to make suggestions and give feedback. Regular events took place at the home which benefitted people who found it difficult to go on outings. At the time of inspection, people and staff were planning events for Valentine's Day and Chinese New Year. The home also used charitable funding to improve the home environment and gardens to provide spaces people could rest and interact with. For example, there was a Japanese garden at the home with plants and water features to provide people with an easily accessible outside space. Plans were also underway to develop a sensory walk for people living with dementia to have space to walk with sensory items to interact with.

People received person-centred care. One person said, "I am very pleased with treatment I get here." Another person told us, "I get a hot bath and bubbles. All I need is a duck." People's care plans listed their needs and what was important to them. For example, one person liked to wear a particular colour of clothing and this was listed in their care plan. We met this person on the day of inspection and they were wearing clothing that matched their preferences. Another person liked to get up early and this information was recorded in there are plan. Daily notes records showed that the person got up at the time they wished to each day. Care plans covered a lot of information on people's preferences with regards to food and activities and routines and staff were knowledgeable about these.

People received sensitive and appropriate end of life care. People's wishes and preferences were recorded with regards to end of life care. People told us that they were asked about this sensitively and the information was recorded. For example, one person did not wish to go to hospital if they became unwell and this was made clear in their care plan. Information on when to contact relatives was also clearly documented. Where people had specific requests for after they had passed away, these were also recorded. For example, one person wished for their body to be donated to medical science and this was in their care plan.

People's needs were regularly reviewed. Care plans contained evidence of regular reviews to identify any changes in needs or preferences. Where changes were identified, these were actioned by staff and care plans were updated. For example, where one person's behaviour had changed they were referred to their community psychiatric nurse and they made changes to their prescribed medicines. The person's care plan was updated to include increase checks on the person and more time spent with staff. Records of daily

notes showed that this change was being actioned by staff.

Complaints were responded to appropriately by the provider. There was a complaints policy in place that informed people and relatives of where to go if they had any concerns. The policy was displayed at the home and people and relatives were reminded at meetings. There had been three complaints in the last 12 months and records showed that the provider had investigated complaints and responded, ensuring complainants were satisfied with the response.

Good

Is the service well-led?

Our findings

People told us that they thought the service was well-led. One person said, "They [management] are very caring; they fix it." Another person said, "If I don't like something I tell them and they take it on board."

The provider regularly sought people's feedback. Regular meetings took place where people provided their feedback on the food, activities and the home environment. Minutes of meetings showed that people provided feedback and this was responded to. For example, at a recent meeting one person had expressed positive feedback for a musical activity, and this had been added to the schedule. We saw evidence that people had discussed changes to the food at a recent meeting. The provider was involving people in meeting the catering team and making changes to menus. We will follow up on the impact of these improvements at our next inspection.

Staff felt supported by management. One staff member said, "The place has a good atmosphere and the support from [registered manager] and [clinical lead] is immense." The registered manager and the clinical lead were accessible to staff and they were observed working alongside staff on the day of inspection. Staff had a weekly meeting with management to discuss people's needs and any important messages to pass on. Records showed that changes to one person's health had been discussed at a recent meeting and the person was then seen by the GP on the day of our visit. Regular staff meetings took place where important messages were passed on and staff had opportunities to make suggestions to improve the lives of the people that they supported. A recent meeting had been used to discuss activities and processes for ensuring people's hospital appointments are recorded in a timely manner. The provider had also been accredited with a Gold award in Investors in People (IIP). IIP is an accreditation framework for employers and the Gold award demonstrated that the provider valued staff and provided them with high levels of support and recognition. Staff spoke highly of the provider and told us that they felt valued in their roles. The provider had recognition schemes in place to reward good practice and develop staff. Staff also told us that management was supportive of their personal lives and allowed flexibility with working patterns wherever possible. We noted that a large number of staff had worked at the service for a long time which demonstrated that they felt valued.

The provider carried out regular checks on the quality of the care that people received. There were a variety of audits in place and these covered areas such as health and safety, infection control, documentation and medicines. The provider had a board of trustees and every three months a trustee visited the home and carried out a holistic audit. Records showed that these audits were person-centred and used observations of care, people's feedback as well as checks of the environment and records. The provider also carried out a regular survey of people and relatives and feedback was used to identify improvements at the home. For example, in the last survey a relative had requested additional goals be added to a person's care plan and this had been addressed.

There was an ongoing plan to improve the service for people. Actions identified from surveys and audits were added to an action plan that the provider kept up to date and recorded actions taken. The provider had regular meetings with trustees and senior managers from other locations where they discussed

improvements and initiatives. We observed a meeting taking place on the day of inspection. Management discussed improvements to the training on offer to staff and assessing competencies. The provider had brought training in-house to improve the training and make it more accessible for staff. The provider sent CQC a PIR before the inspection. The PIR was detailed and contained information about improvements that the provider intended to make. We found that improvements the provider had told CQC about had been actioned by the time of our visit. For example, staff had regular 'hot topic' meetings to discuss important topics around care delivery and these were being carried out by the time of our visit.

The provider had links with the community and relevant organisations. The provider had a presence at local events, such as a recent carnival where they were awarded 'Best in Show'. The provider put on events to fundraise and recent fundraising events were being used to fund the new sensory garden at the home. We saw evidence of the provider working alongside relevant agencies such as social services, community health services and GP to ensure people's needs were met.

The provider was aware of the responsibilities of their registration. Providers are required to notify CQC of important events such as allegations of abuse, deaths or serious injuries. Where appropriate, the provider had submitted notifications to CQC when these events occurred.