Woking Homes

Woking Homes

Inspection report

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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

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

Woking Homes is a care home for retired railway personnel and their families. People without a railway connection are also welcome to live there. It is a registered charity with a board of trustees. The home accommodates up to 51 people, some of whom were living with dementia or complex needs such as Parkinson's disease, and diabetes. At the time of our visit, there were 45 people living at the home. The home also provides end of life care. All of the accommodation is provided on the ground floor so that all facilities were accessible to everyone. People living at the home had access to a private indoor swimming pool.

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.

People and relative told us they were safe at Woking Homes. Staff had a good understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from harm.

There were sufficient numbers of staff deployed who had the necessary skills and knowledge to meet people's needs. Recruitment practices were safe and relevant checks had been completed before staff started work.

Medicines were managed, stored and disposed of safely. Any changes to people's medicines were prescribed by the person's GP and administered appropriately.

Fire safety arrangements and risk assessments for the environment were in place to help keep people safe. The service had a business contingency plan that identified how the home would function in the event of an emergency such as fire, adverse weather conditions, flooding or power cuts.

Staff were up to date with current guidance to support people to make decisions. Staff had a clear understanding of Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) as well as their responsibilities in respect of this.

The registered manager ensured staff had the skills and experience which were necessary to carry out their role. Staff had received appropriate support that promoted their development. The staff team were knowledgeable about people's care needs. People told us they felt supported and staff knew what they were doing.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk. People were supported to have access to healthcare services and were involved in the regular monitoring of their health. The provider worked effectively with healthcare professionals and was pro-active in referring people for assessment or treatment.

Staff treated people with compassion, kindness, dignity and respect. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's privacy and dignity were respected and promoted when personal care was undertaken.

People's needs were assessed when they entered the home and on a continuous basis to reflect changes in their needs. Staff understood the importance of promoting independence and choice. People were able to personalise their room with their own furniture and personal items so that they were surrounded by things that were familiar to them. People had the right to refuse treatment or care and this information was recorded in their care plans.

People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service people received.

People had access to activities that were important and relevant to them. People were protected from social isolation through systems the service had in place. There were a range of activities available within the home and the community.

People's care and welfare was monitored regularly to ensure their needs were met. The provider had systems in place to regularly assess and monitor the quality of the care provided.

People told us the staff were friendly and management were always approachable. Staff were encouraged to contribute to the improvement of the home. Staff told us they would report any concerns to their manager and felt supported by the management.

Senior management liaised with and obtained guidance and best practice techniques from external agencies, professional bodies and experts in their fields.

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.

People had risk assessments based on their individual care and support needs.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

There were sufficient numbers of staff deployed to keep people safe and to respond to their needs.

Medicines were administered, stored and disposed of safely.

Is the service effective?

Good

The service was effective.

People's care and support promoted their well-being in accordance to their needs. People were supported to have access to healthcare services and professionals were involved in the regular monitoring of their health.

Staff understood and knew how to apply legislation that supported people to consent to care and treatment.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

Is the service caring?

Good

The service was caring.

Staff treated people with compassion, kindness, dignity and

respect. People's privacy were respected and promoted.

Staff were cheerful and caring towards people.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit when they wished.

The service provided end of life care but at present there was no one receiving end of life care.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed when they entered the home and on a continuous basis. Information regarding people's treatment, care and support was reviewed regularly.

People had access to activities that were important and relevant to them. People were protected from social isolation and there were a range of activities available within the home and community.

People were encouraged to voice their concerns or complaints about the home. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service people received.

Is the service well-led?

Good

The service was well- led.

The provider actively sought, encouraged and supported people's and staffs involvement in the improvement of the service.

People told us the staff were friendly, supportive and management were always visible and approachable.

The provider had systems in place to regularly assess and monitor the quality of care and support people received.

Woking Homes

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.

We visited the home on 11 May 2016 and it was an unannounced inspection. The inspection was conducted by four inspectors.

We spoke to 18 people living at the home, two relatives, two visitors, four healthcare professionals, ten staff, the registered manager, catering manager, chief executive, chairperson and a member of the board of trustees. We observed care and support in communal areas; looked at six bedrooms with the agreement of the relevant person. We looked at nine care records, risk assessments, medicines administration records, accident and incident records, minutes of meetings, seven staff records, complaints records, policies and procedures and external and internal audits.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance team. We also reviewed records we held which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the home is required to send us by law.

We last inspected the service on 24 February 2014 where no concerns were identified.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe and secure at the home and with the staff who provided care and support. People told us, "I feel safe here.", "I feel very safe here."

Staff were aware of the signs and what to do if they suspected any abuse. A member of staff told us, "If I had any concerns I would not hesitate to speak to the manager." The home held the most recent local authority multi-agency safeguarding policy as well as current company policies on safeguarding adults. This provided staff with guidance about what to do in the event of suspected abuse. Staff confirmed that they had received safeguarding training within the last year. Easy to read information on identifying abuse and the action that should be taken was also freely available to people.

Risks to people were managed safely and in accordance with their needs. Risk assessments and any healthcare issues that arose were discussed with the involvement of social or health care professionals such as psychiatrist, GP or speech and language therapist. Where people were at risk of developing pressure sores there were plans in place to reduce this risk which were followed by staff. For example the involvement of the district nurse for the treatment of the wound, by using pressure mattresses or pressure cushions to alleviate and provide comfort to the susceptible areas. The information provided enabled care and support to be delivered as safely as possible.

There was information which identified where people were at risk of injuries due to diabetes, mobility issues or by exhibiting behaviour that challenged. This was detailed and provided information and guidelines for staff to follow when people were at risk. Action plans were put in place in accordance with people's care and support needs.

Where people had mobility needs or were susceptible to falls, information was recorded to help staff take action to minimise these risks. People had access to specialist equipment to aid their independence or to keep them safe such as large button telephones, wheelchairs, walking frames, hoists, specialist beds or bathing aids.

There was a system to manage and report incidents, accidents and safeguarding concerns. Members of staff told us they would report concerns to the registered manager. We saw incidents and safeguarding concerns had been raised and dealt with, relevant notifications had been received by the Care Quality Commission in a timely manner. Incidents were reviewed which enabled staff to take immediate action to minimise or prevent further incidents occurring in the future. We saw accident records were kept. Each accident had an accident form completed, which included immediate action taken. For example, one person had suffered a number of falls within a one week period. We saw on each occasion that the action points were being recorded and healthcare professionals had been contacted. Staff advised us that this person is now under the care of a physiotherapist and no more incidents of falls had taken place.

People lived in a safe well maintained environment. The communal areas and corridors were free from obstacles which may cause harm to people and enabled them to move freely around the home. Handrails

were placed throughout the home to support and aid people's mobility. Fire, electrical, and safety equipment was inspected on a regular basis. Specialist equipment such as wheelchairs, baths and showers was checked on a weekly or monthly basis to ensure they were safe and in working order.

Arrangements were in place for the security of the home and people who lived there. All entrances to the home was through a bell system managed by staff. We saw a book that recorded all visitors to the home.

There was a business contingency plan in place; staff had a clear understanding of what to do in the event of an emergency such as fire, adverse weather conditions, power cuts or flooding. The provider had identified alternative locations which would be used if the home was unliveable. This would minimise the impact to people if emergencies occurred. During the visit staff had to deal with an emergency situation, due to heavy rain fall, water had leaked into parts of the home and as a result part of the ceiling in a communal area had collapsed. Staff responded very quickly to the emergency, removing people from immediate harm, Staff remained calm and interacted with people explaining what was happening so people were aware of the situation. Arrangements were in place to curb the water flow into the home. All people were kept safe during this time.

Fire safety arrangements and risk assessments for the environment were in place to keep people safe. Each person had a personalised emergency evacuation plan (PEEP) that was regularly reviewed and staff carried out regular fire drills and evacuations so they knew what to do in the event of a fire. For example, one person in the home did have periods of confusion. Their PEEP stated that they must be reassured and escorted to a safe area. This showed that staff had information on how to support people in the event of an evacuation.

There was sufficient numbers of staff deployed to keep people safe. People we spoke to had different views on the staffing levels at Woking Homes, however they all felt safe and cared for by the staff at the home. One person told us, "Staff were good and came if I ring my bell." Another person told us, "I can just go into the corridor and usually find a staff member." The consistent staff team were able to build up a rapport with people who lived at the home. This enabled staff to acquire an understanding of people's care and support needs. We saw people were supported in line with their risk assessments and what was in their care plan. We noted on the day of our visit, that people's needs were met promptly; this included those who chose to stay in their room and called for assistance. The staffing rotas were based on the individual needs of people and did not fall below the minimum staffing levels the registered manager had determined as being needed to support people safely. All the staff we spoke with enjoyed working at the home and said they felt there were enough of them to undertake their roles well.

There was a call bell system in place; the system was easy to use and accessible to people so they could alert staff if they needed support. We observed there were call bells in communal areas as well as in people's bedrooms. During our inspection peoples call bells or requests for help were responded to quickly.

Staff recruitment and selection systems were in place and followed to make sure suitable staff were employed to work at the home. All applicants completed an application form which recorded their employment and training history and went through a selection process. The provider ensured that the relevant checks were carried out as stated in the regulations to ensure staff were suitable to work with adults at risk. We saw from the records that staff were not allowed to commence employment until satisfactory disclosure and barring checks and references had been received. The registered manager provided similar information which is obtained about agency staff working at the home to ensure they are safe to work at the home. This showed that checks were carried out to ensure that people were cared by staff who were safe and suitable to provide support.

Medicines were managed and stored securely. There were appropriate arrangements in place for the storage and recording of medicines. All medicines coming into and out of the home were recorded and medicines were checked and recorded at each handover. Any changes to people's medicines were prescribed by the person's GP.

People received their medicines on time, as prescribed and given by competent staff. Only staff who had attended training in the safe management of medicines were authorised to give medicines. Staff attended regular refresher training in this area. Upon completion of training, managers observed and assessed staff's competency to administer medicines before they were authorised to do this without supervision. When staff administered medicines to people they explained the medicine and waited patiently until the person had taken the medicine.

Arrangements were in place to accurately record medicines administered. We checked medicines records and found that a medicines profile had been completed for each person and any allergies to medicines recorded so that staff knew which medicines people could safely receive or which ones to avoid. The medicines administration records (MAR) were accurate and contained no gaps or errors. A photograph of each person was present to ensure that staff were giving medicines to the correct person. There was guidance for people who are on PRN [as needed] medicines. Records included details about the amount of these medicines people were given and the reason for the administration of the medicine.

Good

Is the service effective?

Our findings

Relatives and people told us they felt staff were well trained and had sufficient knowledge to deliver effective care. A person told us, "It is lovely here never any problems" Another person told us, "Staff are very good here."

There were qualified, skilled and experienced staff to meet people's needs. For example we observed staff when they were helping people to move around the home or assisting them when transferring from a wheelchair to a chair and this was done effectively and according to best practice. The provider promoted good practice by developing the knowledge and skills of new staff required by the Care Certificate to meet people's needs. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Training was delivered in different formats such as online learning, DVDs, training courses and certificated learning workbooks. All new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. The registered manager confirmed that they would use agency staff to cover absences and try to ensure the same agency staff attends to ensure consistency and reduce the disruption to the home. An agency member of staff told us, "They have shown me around and I will be working with someone who knows the home today."

Staff confirmed they had received training and that they had sufficient knowledge to enable them to carry out their role safely and effectively. Staff provided us with information about people's care and support needs and how they met these. The PIR, provider's records and training certificates confirmed that all staff had received mandatory training such as safeguarding adults; person centred care; dementia awareness; nutrition and hydration; challenging behaviour; health and safety and infection prevention and control and Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff had received appropriate support that promoted their professional development. Staff told us they had regular meetings with their line manager to discuss their work and performance. Documentation confirmed that three monthly supervision and annual appraisals took place with staff. For example, each supervision session had a theme that was recorded and notes showed that staff were discussing these to identify training needs as well as to fill in gaps in their knowledge. To support and promote professional development the provider had agreed to pay for a member of staff to attend Qualifications and Credit Framework (QCF) Management in Health and Social Care level 5 training course. We also noted that staff were able to raise concerns during their supervisions, they were recorded and actioned. Management observed staff in practice to review the quality of care delivered and any observations were discussed with staff with the aim of improving the care they offered to people.

People's human rights were protected. People's care plans detailed whether people had capacity to make decisions, this was reviewed on a regular basis as people's capacity could vary from time to time. Staff obtained consent before carrying out any tasks for people. We heard staff ask people if they would like to come with them so they could help them. Staff had received training in what the Mental Capacity Act (MCA) 2005 was about, and how they needed to put it into practice. The MCA is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions

such as medical treatment as well as day to day matters. For example for one person who has developed confusion they had been referred to the mental health team. This person had chosen to manage some of their health needs themselves. The care plan contained clear information for staff on how best to prompt and encourage this person to maintain independence with this particular need. We saw that it had been risk assessed and staff recorded daily that this person was managing the need. This showed us that the home is allowing people to make choices about their care and independence is being encouraged where it can be balanced with risk.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Nobody at the home was currently being deprived of their liberty. We spoke to a staff member about what they would do if someone developed dementia at Woking Homes and became at risk of wandering or wishing to leave. They staff member said, "If they wish to leave, we would think about mental capacity. If they have capacity we would work with them to help them to leave." This demonstrated that staff had an understanding of the mental capacity act and how it would be applied in practice to protect people from unlawful restrictions.

People told us they enjoyed the food at the home. One person told us, "The food is excellent here." Another person told us, "Lovely meals." A third person told us, "I look forward to my dinner." People were involved and consulted about the creation of the menu for breakfast, lunch and tea. The chef prepared and cooked all of the meals in the home. There was a choice of nutritious food, snacks and drink available throughout the day; an alternative option was available if people did not like what was on offer. The PIR stated that the provider had requested and received a nutritional document containing allergens and nutritional content of all meals cooked by their kitchen staff, which we were interested to see. Kitchen staff showed us the recipe book they have recently completed. This information would assist staff to work with healthcare professionals, such as dieticians, when planning menus for people who may have special dietary needs in the future. Staff confirmed that a dietician was involved with people who had special dietary requirements.

Lunchtime was a social occasion; the dining room was large to comfortably accommodate everyone who lived at the home. People were able to choose who they sat with and some people enjoyed their lunch together in the dining room, the lounges or in their room. People sat in groups and engaged in conversation with each other and staff. There was also a separate table for visitors to sit so people could sit with their visitors without disturbing other people's seating arrangements. Staff offered people different sized portions and people could select their own vegetables.

People were supported to have their nutrition and hydration needs met. We saw staff assisting people to get ready for lunch, at a slow and steady pace, they were not rushed. People who were able to eat independently were prompted and encouraged to do so. Where people needed support, they were supported by a member of staff. We saw people who needed one to one support being given it. Throughout the meal we observed staff interacting with people and asking them about the food. Throughout the day people were encouraged to take regular drinks, to ensure that people were kept hydrated.

People felt their health needs were being met by the service. People had access to healthcare professionals such as the GP, district nurse, dentist, chiropodist, dietician, physiotherapist, and speech and language therapist. A visiting healthcare professional told us, "Staff always undertook anything she asked and were good at undertaking instructions." Another healthcare professional told us, "I have no problems with the home or the staff." We saw from care records that if people's needs had changed, staff had obtained guidance or advice from the person's doctor or other healthcare professionals. People were supported by

staff or relatives to attend their health appointments. Outcomes of people's visits to healthcare professionals were recorded in their care records. Staff were given clear guidance from healthcare professionals about people's care needs and what they needed to do to support them.

People's bedrooms were personalised with pictures, photographs and items of religious sentiment and personal interest. Individual bedrooms had doors with letter boxes and door knockers, people were able to lock their room. The home was split into different units which were painted in different colours and flooring. Communal areas such as toilets and shower rooms had signs to describe the room. Areas of the home painted in different colours helped those living with dementia to move around the home and to find their rooms, toilets and bathrooms. The home had a large garden which people used for relaxation, planting plants and growing vegetables.

Good

Is the service caring?

Our findings

The atmosphere in the home was calm and relaxed during our inspection. Staff showed kindness to people and interacted with them in a positive and proactive way. People were happy and laughing whilst enjoying being in the company of staff. People spoke fondly of staff which would indicate that they have a good rapport with them. One person told us, "The staff are great. I can have no complaints about the staff at all." Another person told us, "The staff are super, they remember the little things that I forget." A third person told us, "The staff are all so kind."

Staff understood the importance of promoting independence and choice. A person told us, "I like to have a shower every evening before I go to bed." Another person told us, "I like to have breakfast in my room and then read my daily paper." Information recorded confirmed this happened. People were able to personalise their room with their own furniture and personal items so that they were surrounded by things that were familiar to them. People had the right to refuse treatment or care and this information was recorded in their care plans. Guidance was also given to staff about what to do in these situations. We saw people refuse support from staff and staff respected their decision, people were offered an alternative option which some people accepted whilst others did not.

Staff knew about the people they supported. They were able to talk about people, their likes, dislikes and interests and the care and support they needed. For example, at lunch we heard one of the staff spending time having a conversation with two people who had lived in a similar area to them in their working lives There was detailed information in care records about people who self-medicated, highlighted people's personal preferences, and also what constituted as a good or bad day for people, so that staff would know what people needed from them. Staff knew people's personal and social needs and preferences from reading their care records and getting to know them. Care records were reviewed on a regular basis or when care needs changed so staff had the most up to date information.

Staff approached people with kindness and compassion. Throughout our visit we observed good caring practice between people and staff. Staff always spoke to the person when supporting them, this was done in a respectful and friendly manner. For example, one person was being supported to the dining room and used a walking aid. The member of staff, when half way to the dining room, asked the person if they wanted to stop for a rest. The person responded, "No I am fine to carry on thank you."

Staff called people by their preferred names. Staff interacted with people throughout the day. When attending activities, listening to music and watching television, at each stage staff checked that the person was happy. Staff spoke to people in a respectful and friendly manner.

Privacy and dignity was respected and people received care and support in the way they wished. Staff understood the importance of respecting people's privacy and dignity and treating people with respect. Staff were seen to discreetly advise people when they required attention to their personal care and this was always provided in private. People were not kept waiting for assistance with personal care. We observed that staff knocked on people's doors and waited for an answer before entering. A member of staff explained, "I

look at people like they are part of my family."

People were involved in making decisions about their care. We observed that when staff asked people questions, they were given time to respond. For example, when being offered a drink staff did not rush people for a response, nor did they make the choice for the person. Relatives, health and social care professionals were involved in individual's care planning. Staff were knowledgeable about how to support each person in ways that were right for them and how they were involved in their care.

People were protected from social isolation with the activities, interests and hobbies they were involved with. Relatives and friends were encouraged to visit and maintain relationships with people living at the home. Relatives said they could visit whenever they wished and that they were made welcome by staff. One relative told us, "The staff is very welcoming to us as visitors. We are always made welcome." People confirmed that they were able to practice their religious beliefs, because the provider offered support to attend the local religious centres. We saw that religious services were held in the home and these were open to those who wished to attend. This demonstrated that care and support was provided with due regard for people's religious choices.

The home provides an end of life care service. End of life care is support for people who are in the last months or years of their life. End of life care should help people to live as well as possible until they die, and to die with dignity. At present there was no one receiving end of life care at the home. The registered manager told us they have a good working relationship with the GP, district nurses and the Palliative Care Team which enables them to provide the appropriate care.

Good

Is the service responsive?

Our findings

People told us they were happy with the support they received. One person told us of an incident where a person was coming into their room at night, they told us, "I have my call bell close by to ring for help when it happens. I also have a key to my bedroom door and I lock it when I leave the room." The registered manager confirmed that staff know how to support both people to alleviate their anxieties and reduce reoccurrences. A visitor told us, "[Friend] is having her hair done, which she loves. They come and collect her so she doesn't miss out." They went on to say "She is able to do a lot of things that she likes to do, where she needs help they are very good at helping her."

We saw that pre- assessments were carried out before people moved into the home and then were reviewed once the person had settled into the home. The information recorded included people's personal details, care needs, and details of health and social care professionals involved in supporting the person. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. This information was used to ensure people's needs could be met prior to them moving in and then develop care and support in accordance to people's needs.

Staff had access to information about people's care and support needs. The home used an electronic system which all staff had access to. Electronic care plans that we looked at were being reviewed regularly and the electronic format allowed for daily notes and health observations to be inputted and accessed very easily and quickly. The electronic care plan system had a function where a one page summary can be quickly printed off for healthcare professionals or paramedics if someone is admitted to hospital. This sheet contained allergy advice, medical history and contact details to ensure a smooth transition in care for hospital admissions.

Staff were able to build a picture of the person's support needs based on the information provided. Care plans contained personalised information to ensure people received care and support in accordance with their needs and preferences. Any changes to people's care was updated in their care record which ensured that staff had up to date information. For example, one person that we spoke to told us that they enjoyed spending time alone reading the newspapers and chatting to people. This person's care plan clearly stated these were their interests but also contained information relating to what staff might want to talk to this person about, including their previous work on the railway.

Staff were quick to respond to people's needs. Documentation was in place to identify, monitor and review people at risk of injury when being helped to move by staff; people who at nutritionally at risk; people who are susceptible to developing pressure sores and people who self-medicate.

Staff were knowledgeable about the techniques to use to when people were distressed or at risk of harm. Information was recorded in people's plans about the way they would like to be spoken to and how they would react to questions or situations. During the inspection we observed people's behaviour and how staff responded to help them calm down.

Staff told us they completed a handover session before each shift which gave them the opportunity to share information about any changes to people's needs. This may be a change in people's medicines, healthcare appointments or general messages to staff. Daily records were completed to record each person's daily activities, personal care given, what went well, what did not and any action taken. This ensured that staff had up to date information relating to people's care needs.

People confirmed that they took part and enjoyed the activities in the home and outside in their community. One person told us, "They are very good at providing activities." Another person said, "They do something every night here." A third person told us, "I join in lots of the things here." Another person told us, "I love music, they have singers and music nights here." The activities on offer covered a range of interests and needs. Activities included music, arts, storytelling, physical exercise and trips out of the home. They also have a licensed bar which is the location of 'Pub Night' every Thursday night which was popular with people. We saw photographs of outings or events people had attended. We observed a timetable of activities on a board which was in an easy read format and on the day of the inspection observed some activities taking place. Staff encouraged people to engage in activities and offered a variety that catered to people's needs and interests.

The service employed an activities coordinator. The activity co-ordinator told us, "We always accommodate things they'd like to do. I always meet with new residents and ask about their interests and ask for ideas and things." They advised us that people had input into what they would like to do and management were always supportive of setting up new activities. For example, in the bar area there was a wide screen TV where sport was shown. There was a list of fixtures advertised for the week ahead for example a league football game, darts, Rugby, and the Invicta's Games. This was appreciated by people living in the home. In some of the communal areas there was sensory equipped which created sensations that could assist relaxation, or stimulate people's senses. A member of staff told us, "They love this room, it is so peaceful." The range of activities that suited each person meant that people were less likely to experience social isolation.

People and their relatives were made aware of the complaints system. People told us they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be addressed. A person told us, "Standards are good but if I wasn't happy with something, I would certainly make a complaint." A relative told us, "I generally e mail the manager if I have any concerns and she will manage this." They went onto say "One day [family member's] room was a tip and I asked them to clean it and they did." There were various ways that people could voice their opinion about the service. For example discussing the issue with staff, the manager or at the resident's meetings. People had their comments and complaints listened to and acted upon. The service had received and responded to complaints received during the last twelve months. Complaints, both verbal and written were recorded and actioned. Details of the outcome of the investigation and feed back to the person were also recorded. When people first moved in there was a copy of how to complain provided in the resident's guide which people kept in their rooms.

Staff told us that they were aware of the complaints policy and procedures. Staff we spoke with knew what to do if someone approached them with a concern or complaint and had confidence that the manager would take any complaint seriously. The complaints procedure was displayed throughout the home in an easy read format. This provided information about how and who to make a complaint to. It included the timescales for responding and investigating complaints. Contact details for the CQC, Surrey Adults Social Care Team and board of trustees were included.

Good

Is the service well-led?

Our findings

People we spoke to told us they were happy with the management and running of Woking Homes and that issues were dealt with swiftly and without problem. One person told us, "I am very happy with the management and the staff." Another said, "Yes, the manager's nice."

People were involved in how the home was run in a number of ways. People's feedback was positive and stated that they were well looked after and encouraged to form positive relationships between healthcare professionals, staff and people. There were 'residents' meetings for people to provide feedback about the care provided. We saw minutes of the meeting where people discussed issues regarding their home, staff, the people and environment they lived in, food and activities. For example, a person had requested bubble and squeak added to the breakfast menu which had been implemented.

Staff were involved in the running of the home. All the staff we spoke with enjoyed working at the home. Staff told us regular staff meetings were held and they felt they could make suggestions and that these were listened to. Staff had the opportunity to help the home improve and to ensure they were meeting people's needs. Staff were able to contribute through a variety of methods such as staff meetings and supervisions. Staff told us that they were able to discuss the home, quality of care provided, their training needs, job role and any changes in people's care needs. The PIR provided information about the improvements being made which we were able to verify this during the inspection. For example team leaders had identified problems with trying to ensure all duties and tasks were fulfilled during the morning. This issue was presented to the board of trustees to consider. As a result a new staff position of a care administrator was created and implemented. Their role is to contact people's G.P's, chase prescriptions, and arrange appointments and transportation. Staff told us that this has proved to be invaluable to the team leaders with regards to being able to spend time care planning and doing reviews with residents.

The senior management of the service and the board of trustees understood the key challenges, risks and concerns. Information gathered was through a variety of meetings and feedback obtained from the registered manager, staff, relatives and people. For example the Chairperson told us that due to the increase in people using walking frames and the need to have them near the table for easy access; the provider is looking to extend the dining room to create more space. We saw minutes of a board of trustees meeting February 2016 and issues discussed included Fit and Proper persons for Trustees and Directors, resident's dependency levels, medication errors, Trustees monthly visits, and internal controls policy. One of the issues discussed at a board meeting was the extension of night staff's working hours to assist with the transition of care and support by staff from the day and night shifts. This has been implemented with the agreement of staff. Where staff performance was brought into question, managers reviewed and implemented their disciplinary procedures and took appropriate action.

Staff had a clear vision and set of values and these were discussed with people when they moved into the home. For example, people were given information on what they could expect from the service and staff at Woking Homes.

Senior management liaised with and obtained guidance and best practice techniques from external agencies and professional bodies and experts in their fields. We saw the service liaised with Dementia Friends, and Health Innovation Network regarding a Dementia case finding tool for care workers. The home had also consulted the Environmental Health Agency and the local authority Environment officer and followed best practice when the home had an outbreak of vomiting and diahorrea. The arrangements put in place enabled the home to minimise the risk of harm to people and improve their care.

The home took a key role in the local community and is actively involved in building further links. People from the local community used the home's swimming pool facilities on a regular basis. This also gave people the opportunity to meet and interact with people living at the home.

The registered manager had notified the Care Quality Commission (CQC) about a number of important events which the service is required to send us by law. This enabled us to effectively monitor the service or identify concerns.

There were a number of systems in place to ensure staff assessed and monitored the quality of care provided to people living at the home. Staff told us they conducted regular spot check on rooms to check on the condition of the room in relation to health and safety needs. People's care and welfare was monitored on a regularly basis to make sure their needs were met within a safe environment. Monthly audits were carried by the management team regarding people's care and support needs such as management of medicines, accidents and incidents and infection control. The senior management team and the board of trustees conducted monthly audits linked to Regulations such as staffing, person centred care and dignity and respect. The findings from the audits were collated and an overall action place was in place that monitored that timely actions were taken to drive improvements.

We saw records of accidents and incidents that had occurred and an analysis of the falls was carried out by the registered manager. The analysis identified a number of issues and as a result recommendations and learning outcomes were made. We noted that action taken was recorded. For example where people were identified as being susceptible to falls; they had access to specialist equipment such as sensory mats which alert staff to potential risk.

We looked at a number of policies and procedures such as environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing. The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated their knowledge regarding these policies and procedures. The policies and procedures were reviewed on a regular basis. This ensured that people continued to receive care and support safely.