Anchorstone Services Limited

Anchorstone Nursing Home

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?	Requires improvement
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Anchorstone Nursing Home is situated in a residential street in Farnham, Surrey. The home is registered to provide care and nursing for up to 40 people, who are living with dementia. The home is made up of two houses joined together and care is provided across both buildings. Access to the first floor is by stair lift or passenger lift. Modifications have been made to the home to meet the needs of people that live there. At the time of our visit 35 people lived here.

The inspection took place on 08 July 2015 and was unannounced.

Everyone we spoke with praised the care and support they received from the staff and the registered manager.

One person said, “I don’t have any worries, I’m safe here and staff are brilliant.” A relative said, “This is very special place. They treat people as people. The staff have love for residents and relatives and I can’t speak too highly of them.”

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.

Summary of findings

People were not completely safe at Anchorstone Nursing Home. Not all risks to people's health and safety had been identified and managed. The assessment of the risk of harm to people from storage of hazardous substances, food hygiene and cleaning had not been appropriately managed by the staff.

Where people did not have the capacity to understand or consent to a decision the provider had not always followed the requirements of the Mental Capacity Act (2005). Decisions had been made for people without an appropriate assessment and review being completed. People told us that staff did ask their permission before they provided care.

Where people's liberty may be restricted to keep them safe, the provider had followed the requirements of the Deprivation of Liberty Safeguards to ensure the person's rights were protected.

People received their medicines when they needed them, and staff managed the medicines in a safe way. Staff were trained in the safe administration of medicines, however they had not had competency checks in line with best practice, and there were gaps and out of date information in medicine administration records.

Care and support documents did not always look at the person as a whole. There were gaps in care plans for people's personal history or personal preferences, although staff were able to tell us about them. Care plans were predominantly based on people's healthcare needs. Records of daily care did not always give enough detail to show that people received appropriate care and support. People told us that they had been included in the generation of their care plans, and involved in reviews.

The staff were kind and caring and generally treated people with dignity and respect. One person said, "The staff are brilliant they really know what they are doing here." We identified some issues with the actions of a small number of staff that could be improved, for example at meal times, and ensuring people had meaningful interaction.

There were enough staff to meet the needs of the people that live here, however we identified that the deployment of staff around meal times could be improved so that everyone received the support to enjoy their meals.

People enjoyed the food and were offered a choice if they did not like what was on the menu for the day. People had enough to eat and drink. The hydration of people was high on staff's priority as they understood how this could affect people's health.

People were supported to maintain good health as they have access to relevant healthcare professionals when they needed them.

Staff had a good knowledge of their responsibilities for keeping people safe from abuse. The provider had carried out appropriate recruitment checks to ensure staff were suitable to support people in the home. Staff received training to support the individual needs of people in a safe way. The provider carried out thorough recruitment checks to ensure staff were safe to support the people that live here.

People had activities that met their needs and the equipment and environment was personalised to the people that used it, rooms were all decorated in a different way to suit peoples tastes. The staff knew the people they cared for as individuals.

People knew how to make a complaint. Feedback from people was that the registered manager and staff would do their best to put things right if they ever needed to complain. A relative said, "The staff will sort out anything that is wrong and that goes along way for our peace of mind."

People and staff had the opportunity to be involved in how the home was managed, and the management listened and acted on what was said. The registered manager carried out a number of audits to check that a good quality service was being provided.

We have identified two breaches in the regulations. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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.

The provider had not taken appropriate measures to protect people from risks to their health and safety. Hazardous chemicals were stored in an accessible area.

Kitchen hygiene and cleanliness around the home needed to be improved.

People's medicines were managed in a safe way, and they had their medicines when they needed them. However information recording for medicines needed to be improved.

There were enough staff to meet the needs of the people; however these were not always deployed effectively around the home, for example during meal times.

People felt safe living at the home. Staff understood their responsibilities around protecting people from harm. Appropriate checks were completed to ensure staff were safe to work at the home.

Is the service effective?

Requires improvement

The service was not always effective

People's rights under the Mental Capacity Act were not always met. Assessments of people's capacity to understand important decisions had not been completed in line with the Act.

Staff received training to enable them to support people; however practice around checking competency of staff who gave medicines could be improved.

Records of peoples care did not always reflect that appropriate care and support had been given.

People enjoyed the food and had enough to eat and drink. They had specialist diets where a need had been identified.

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

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

Is the service caring?

Requires improvement

The service was not consistently caring.

People told us the staff were caring, friendly and respected them; However we observed some interactions by staff that were not as caring and respectful as they should have been.

Summary of findings

The homes decoration and facilities in bedrooms were appropriate to meet people's needs. There was individuality to people's rooms which showed they lived in a caring environment.

Staff knew the people they cared for as individuals, and people were involved in how their care was given.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and gave guidance on the medical support needs that people had. They focussed on medical needs, but there were some gaps such as people's likes, and how they wanted to be supported.

People had access to activities that interested and were relevant to them.

People knew how to make a complaint and felt the registered manager and staff would do all that they could to address any concerns they raised. There was a clear complaints procedure in place.

Is the service well-led?

Good

The service was well led.

The registered manager carried out checks to make sure people received a good quality service.

People, staff and healthcare professionals were involved in improving the service.

People were complimentary about the friendliness and openness of the staff and the registered manager.

Anchorstone Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 08 July 2015 and was unannounced.

The inspection team consisted of two inspectors, a nurse specialist 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 authority safeguarding and quality assurance team.

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

During our inspection we spoke with 12 people, six relatives, a visiting health care professional, and eight staff which included the registered manager. We observed how staff cared for people, and worked together. We used the Short Observational Framework (SOFI) to try to understand the experiences of people we were unable to verbally communicate with. We also reviewed care and other records within the home. These included five care plans and associated records, three staff recruitment files, and the records of quality assurance checks carried out by the staff.

At our previous inspection in October 2013 we did not identify any concerns at the home.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe living at Anchorstone Nursing Home. They said this was because staff came quickly when they called and knew how to look after them. A person said, "I Don't have any worries, I'm safe here and the girls are brilliant." A relative said, "They look after people here and keep them safe." However we found that some areas of the home could be improved to improve people's safety.

People were not always kept safe because staff had not identified potential risks around the home. Cleaning fluids were found in an unlocked cupboard in a communal area which could be easily accessed by the people that lived here. Many of these people would not be able to understand what the liquids were. Items such as food were left out in the kitchen uncovered for long periods of time. These were exposed to staff walking by as well as plates with leftover food stacked up by them. These increased the risk of contamination that could then make people sick.

The risk to people from ineffective cleaning had not been addressed. The home was not consistently clean, and best practice was not always followed with regards to reducing the risk of infection. For example doors were seen with stains and spilled fluids (that had since dried) on them, window ledges were not consistently clean and there were cobwebs around light fittings and on ceilings. The home was difficult to keep clean as it was cluttered with equipment. For example people's wheel chair foot rests and other items were stored behind their armchairs which made it difficult to access. Kitchen cupboard doors had been removed which exposed the contents to the environment and possible splashes from cleaning fluids. The home did not have a sluice facility. This is a machine that hygienically cleans bedpans. Staff cleaned the pans with specialist wipes.

The issues with staff not identifying the risks to people's health due to poor hygiene practices in the kitchen and ineffective cleaning meant there was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good practice was seen with regards to care staff managing the risk of spreading infection when giving personal care. Hand sanitizers were available in communal areas as were soap and towels in en-suite facilities. Aprons and gloves were seen to be used by staff and available around the home. Staff washed their hands before and between tasks. Colour coded laundry bags were used to separate soiled laundry from general laundry items. Colour coded mops and buckets were seen to be used correctly and the domestic staff was fully aware of what colour should be used in what area.

There was a sufficient number of staff to meet the needs of people; however improvements could be made with how they were deployed around the home. People and relatives told us there were enough staff. During lunch we saw three instances where more support would have improved peoples dining experience. A person had to wait for staff to come and chop up their meal before they could eat it. A person who lived in their room had not had encouragement to eat their main meal, so only ate their desert. Their meal had also not been cleared away two hours after lunch had been completed. Another person had intermittent support from staff to prompt them to eat, but more supervision and assistance was needed to aid them to enjoy their meal. It is recommended that the registered manager review staff deployment around mealtimes to ensure people receive the support they need.

Appropriate checks were carried out to help ensure only suitable people were employed to work at the home. The management checked that they were of a good character, which included Disclosure and Barring service checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The management ensured that nursing staff were up to date with their professional membership by monitoring when their membership would lapse and making sure it was renewed in a timely manner.

People's medicines were managed and given safely. People told us they had their medicines when they needed them. The nurses showed patience and care when administering medicines to people. When administering the medications the nurse advised the person that it was their medicine and encouraged them. Staff effectively recorded when medicines had been given.

Medicines were stored and disposed of in a safe manner; however we noted that some improvements were needed with regards to how staff recorded when medicines were

Requires improvement

Is the service safe?

disposed of. The homes medicine policy referred to the requirement for signatures of staff and the disposal agency representative for returned medicine, this had not always completed in the logbook.

Medicines that were given as a variable dose did not always have the number of tablets given recorded on the Medicine Administration Record (MAR). Without accurate records it would be difficult to audit medicine stocks.

The allergies section in some MAR charts was blank. The staff said if it was blank then that meant the person had no allergies. This could lead to an error as the person may have an allergy, but staff had forgotten to record it.

Medicines were stored securely so that unauthorised people could not gain access to them. The temperature of the rooms that the medicines were stored in was monitored to make sure it stayed within the limits listed on the medicines labels. This was to make sure the temperature did not affect them.

People knew they could talk to staff if they had concerns for their safety. Staff understood their responsibilities in relation to safeguarding people. Staff were able to identify the signs of abuse and knew what action they needed to take should they suspect or see it taking place. Information for staff and others on whistle blowing was on display in the home. Where people had made an allegation the staff had referred this to the correct authorities. People and visitors were given information on how to report abuse. There was folder in the entrance to the home which gave details of the agencies that could be contacted if people suspected abuse was taking place.

Some assessments had been completed that identified risks of potential harm to people. Clear plans were in place to reduce the risk to people, for example falls. Staff followed the guidance that had been recorded in these assessments. These assessments covered individual risks to people, as well as risks around the home. For example the risk to people from the spread of infection was minimised as staff wore disposable gloves and aprons when carrying out tasks such as supporting people to eat, cleaning and providing personal care. Risk assessments covered the activities of daily living including mobility and falls, nutrition, MUST, skin integrity, as well as an additional assessment that covered dependency. Specific assessments for people that may have behaviour that challenged themselves or others were also in place. The care plans detailed the actions that staff need to take to address the risks. Staff were seen to follow these actions during the course of our inspection to keep people safe. Nursing care was also carried out safely and met the need of the people.

Equipment used to support people was regularly checked to make sure it was safe to use. Items such as hoists, fire safety equipment and specialist baths were regularly checked. People's care and support would not be compromised in the event of an emergency. Information on what to do in an emergency, such as fire, were clearly displayed around the home. These gave clear instructions on what staff were required to do to ensure people were kept safe. Each person also had a personal emergency evacuation plan which detailed the individual support they needed if the home needed to be evacuated.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA). They aim to make sure people in care services are looked after in a way that does not inappropriately restrict their freedom.

The staff did not always follow requirements to ensure that people's human rights where not compromised. Assessments of people's capacity were not based around a specific decision, but a general assessment that they lacked capacity to make a decision about living at the home. However no other assessments had been completed for areas of people's lives that staff made decisions for. For example where covert medicines were given the registered manager did not have a record of a mental capacity assessment to see if the person could understand why they needed their medicines, and what had been done to help them understand. There was not a record of who was involved in making the best interest's decision, other than a note signed by the GP to say it was in the person's best interests. Four people received covert medicines at the home. Mental capacity assessments had also not been completed when bedrails were used. This would be required to record that the person lacked the capacity to agree to them, and then who was involved in the best interest's decision. Bedrails are barriers put on the sides of beds to stop people falling out, but they also restrict the freedom of people.

Where people did not have the capacity to consent, the provider was not acting in accordance with legal requirements. This was a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples consent for day to day decisions were sought before staff gave care or support. One person told us, "They don't do anything on their own until they have asked me if they can do it." A relative told us, "They (the staff) encourage people to make decisions." The registered manager had an understanding of their duties under the Mental Capacity Act (2005) (MCA).

Some people's freedom was restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible. The care and restrictions provided by the staff matched with what had been authorised by the local authority.

People and relatives told us that care staff had sufficient knowledge and skills to enable them to care for people. A person said, "The staff are brilliant they really know what they are doing here." A relative said, "Everybody seems to know what they are doing."

We found that people did not always have support from staff who had received appropriate competency checks in order to carry out their role. Staff that gave medicine to people did not have their competence evaluated on a regular basis. Medicines training for some staff were out of date. The manager had identified these issues and had a plan in place to correct them. This is important is it ensures that staff are working in a safe manner and in line with their training. During our observations staff were seen to give medicines in a safe way, so the risk to people was low.

It is recommended that the registered manager implement competency assessments on the staff that give medicines to ensure that best practice guidance in relation to legislation around administering medicines is followed.

Records of care given to people had gaps. For example one person was losing weight. There was a gap for three weeks within the record for the food and drink they had eaten. The assessment tool to check their weight had also not been updated for over a month. This would make it difficult for staff to monitor if they were giving the correct support to the person. Another example in the daily care notes referred to a person enjoying coffee and cake and that they ate well. However the food and fluid intake charts did not record this and the weight record book showed a significant weight loss over that period of time. The person had significantly declined and was now end of life care, but not all of the care records had been updated to show this.

A training plan was in place to ensure all staff had up to date skills to support the people that lived in the home. Where staff were behind in training there was a plan in place to correct this. Day to day information to give staff knowledge on specific care needs was discussed at staff handover meetings. Staff induction included a period of

Requires improvement

Is the service effective?

new staff shadowing a more experienced staff member; this also included agency staff that were used. Training was also arranged in response to new information and best practice, for example training on oral care.

Staff received regular one to one meetings with their manager in line with the provider's policy. They were able to discuss how they were doing in their role supporting people, and any issues they may have. Staff told us they felt supported by the registered manager.

People we spoke with were positive about the food they had. One person said, "I like the food here. It's good and I like the taste." All of them said they had enough to eat and drink. People's nutritional support needs were met by staff. These needs were identified by the use of an assessment. Where people had been identified at risk of poor nutrition or hydration staff took appropriate action. Examples included fortifying meals so they contained more calories where people were losing weight, or specialist diets to manage diabetes. People were given soft or pureed food in line with their nutritional requirements. Hydration was given a high priority at the home, as the registered manager and staff understood how it could affect people's health. People were offered drinks regularly and had access to drinks in their rooms and in lounge areas. There was only one choice of meal on offer at lunch and one resident hadn't touched their cooked meal. The carers noticed this and prepared his favourite sandwiches for him which he really enjoyed.

People received support to keep them healthy. The home had a close relationship with the local GP practice. People were also able to keep their own GP if they chose. Where a need had been identified, such as a person becoming ill, the appropriate agencies were consulted to ensure that person was supported to get well. Ailments such as pressure sores were managed effectively and people received the correct care and support to make them better. People also had access to a range of visiting health care professionals such as psychiatrist, podiatrist and the Community Matron. In addition the home had two qualified nurses on throughout the day to supervise care delivery and give support to staff.

The design and decoration of the home was good at promoting peoples independence, and meeting their mental health needs. Systems such as clear signage had been put up around the home. Toilet doors and toilet seats had been colour coded in line with best practice guidance for supporting the people that lived here, most of whom lived with the experience of dementia. Handrails around the home were painted in a different colour to the walls so they would be easier to see and use and would help to reduce the risk of falls.

Requires improvement

Is the service caring?

Our findings

People told us that staff treated them with dignity and respect, the care was good and that it was delivered by kind staff. A person said, "Staff are lovely, very kind and caring." A relative said, "Staff are very caring and they really know my family member well."

The feedback from everyone was positive about the caring nature of staff at the home. However our observations did not always show this to be the case. Due to lack of storage space around the home people's bedrooms had been used as storage areas by staff. For example one room was found to have a number of wheelchairs, walking frames and other items that did not belong to the person in their room. Improvements over lunch could also be made. A person was saying they did not want to eat anymore, but the staff assisting them to eat did not acknowledge this and kept trying to give them food. On another occasion a carer walked up to a person and without a word placed a large spoonful of food in their mouth and walked away. We also heard staff speaking to a person in a childlike way that did not promote their dignity when assisting them with their meal. During our observations in the lounge one person had little interaction with anyone for nearly an hour and when staff did speak to them it was only to ask if they wanted another biscuit.

We recommend the registered manager reviews with staff the best practice around treating people with dignity and respect.

People were supported by kind and caring staff. We had very positive feedback from everyone we spoke with about the caring nature of the staff. A person told us, "They really look after me here." Relatives were given a warm welcome by staff. Staff spoke to them in a caring and supportive manner. They gave them the latest information about their family member, but nothing of a confidential nature due to the proximity of other people. A relative said, "Anchorstone is like a family to me. It's a very special place. They treat people as people. The staff have love for residents and relatives and I can't speak too highly of them."

People's rooms were personalised with family photographs and ornaments, and were also decorated differently. This made the room individual to the person that lived there. People's needs with respect to their religion or beliefs were met. Staff understood those needs and people had access to people and services so they could practice their faith.

People were involved when staff provided support. Staff asked people if they wanted to get up out of bed, and when they said they wanted a lay in, staff respected this. Staff asked peoples' opinions, and encouraged them to make decisions and as far as possible, accommodated their wishes. Information was available to keep people orientated on the day/time of year, as well as keeping them informed of what was going on around the home. Festive celebrations were carried out over the year, such as Red Nose day, the Queen's birthday and St Patricks Day. People had been involved in the organisation of these events by making decorations.

People were supported by staff that demonstrated patience and care towards them, whilst involving and enabling them. During the morning a cake/biscuit decoration activity was going on. The staff member organising the class supported residents with this activity to become involved and assisted them when it was evident they needed it. After the activity there was the visual results of what they had achieved, some brightly coloured decorated biscuits. This promoted a sense of achievement in people. Throughout the day we heard staff explain what was happening during medication rounds, hoisting and wheel chair transfers. Staff maintained eye contact and listened to peoples' wishes.

Staff knew the people they cared for. People and relatives confirmed that staff knew who people were as individuals and what their needs were. Staff were able to tell us about the people and their relatives, for example there histories, even though this information was not always documented in the persons care plan.

Where people did not have anyone to help them understand decisions, an independent mental health advocate had been used. This meant they were supported by an impartial person to ensure any decision made were in their best interests.

Staff understood the importance of protecting people's privacy and dignity. They showed this by responding quickly when people asked to be supported to the toilet. People were also appropriately dressed and looked clean. When people were assisted to move this was carried out by

Requires improvement

Is the service caring?

staff who had been trained and who knew how to maintain people's dignity throughout the procedure. The staff explained what was going to happen and reassured the person during the hoist. Staff knocked on bedroom doors before going into people's rooms. Curtains were closed and doors closed when care was being delivered and all bedrooms had en-suite facilities, so people could be washed in their own rooms.

Good

Is the service responsive?

Our findings

People told us that they were happy with the level of care provided by the staff. The care plans and other care documentation such as risk assessments were regularly reviewed by staff to ensure that the information was up to date. One person said, "I'm not really involved in my care plan, but staff do what I want and I am happy as I am." Relatives commented that staff were very good at keeping them updated with the health of their family member, and they could look at the care plan if they wished. One relative said, "We are involved in the care plans and the reviews. Staff always involve us."

Care planning documents gave a good level of information to staff on how to care for people. The care plans included information and guidance to staff about how people's medical care and support needs should be met. There were some gaps in recording about the likes and choices of people in the care plans; however staff were able to describe these likes and choices when asked. Care plans were safely stored and each person had an individual file. Within the care plans were the individual assessments conducted prior to people being admitted. The pre assessments contained some good information about that persons care needs including mobility, falls, nutrition and mental health issues. The files had individual sections for ease of locating information. The home uses the document "This is me" which is a tool to provide staff with a picture and background of the resident.

People received care and support as it had been detailed in their care plans.

People had access to a wide range of activities. One person said, "There's a lot to join in with if you want. I love it when the dog comes in and I really enjoy having my nails done."

Another told us, "I enjoy going out on the trips." An activities person was employed at the home, and spent all their time working with people to give them activities that interested them. They had done away with a schedule of activities and instead asked people on a daily and weekly basis what they would like to do. This worked well as people had access to varied activities over the day which they found interesting and stimulating. One person told us how they were enabled to continue with their particular hobby that they had before they came to live at Anchorstone.

People's independence was promoted by staff. Throughout our inspection staff encouraged people to mobilise on their own. Staff never rushed people. Equipment was provided to help keep people independent, such as specialist plates and cutlery so people could feed themselves. Portable call bells were used in this home and these provide people with greater independence as they could move around with them.

People and relatives knew how to raise a concern or make a complaint. Copies of the home's complaints procedure were clearly displayed at strategic points around the home. People and relatives said they were able to raise concerns and that they would be listened to, and their issues would be addressed. Complaints and comments had been dealt with effectively by the registered manager to the satisfaction of the person who made them. Records of complaints were kept and reviewed by the manager and the provider. One relative said, "We are involved in the residents and relatives forums. They do listen and act on what we say, or explain why they can't do what we have asked." People who had had minor issues said that these had been resolved quickly. This showed the complaints and feedback systems were effective at meeting the needs of the people.

Good

Is the service well-led?

Our findings

Peoples care records were not always detailed or completed to show that they had received appropriate care and support. From our observations and speaking to people we found that care and appropriate support had been given, it was purely an issue with staff recording what they had done.

Accident records were not always fully completed. A person had sustained a head injury from a fall the evening prior to our inspection. The staff had completed an accident form, but had not completed it fully. They had also not recorded essential information to show that the person's health was monitored to ensure it did not deteriorate. The first recorded checks were not completed until 12 hours later when the day staff came on shift. Following any head injury close and regular observations must be made in case of further complications. Staff we spoke with were able to tell us when the accident had happened and we saw the person received appropriate support during our inspection. This showed that the accident had been discussed in detail at a staff handover meeting, even though the documentation had not been completed.

There was a positive culture within the home between the people that lived there, the staff and the registered manager. We saw many friendly and supportive interactions. Staff confirmed that the management in the home were open and approachable. One staff member told us that this was their first job working with people living with dementia and they had been supported by the registered manager and their deputy.

The staff were very helpful, open and receptive when areas for improvement were identified during the inspection. During the inspection the registered manager and team leaders had a visible presence around the home. They talked with people and relatives and gave advice and guidance to staff to ensure people were happy and received a good standard of care. People knew them well and told us that if they were passing by they always stopped for a chat. People told us that the management was approachable and caring. Staff had a clear understanding of the values of the service, to treat people as individuals and find out about the person.

The registered manager ensured that various groups of people were consulted for feedback to see if the service was meeting people's needs. People and relatives were included in how the service was managed. Regular residents and relatives meeting were held. The last meeting with relatives discussed the latest survey that had been completed and how the registered manager would use the information. Families were also asked for their feedback about the service, and given information about the new Care Act and updated Safeguarding procedures. The residents meeting discussed people's views on activities and issues around the home. A record was kept of the actions that came as a result. These had been reviewed by the staff and action taken, for example staff prepared 'Mocktails' (non-alcoholic Cocktails) in line with what people had requested in the meeting.

Staff had group meetings where they were given feedback about the service, such as areas that needed to be improved. They were also able to give their opinions and ideas about improvements. One staff said this made them feel valued and part of the team, "I stay here because of the team work." Staffs opinion about the service was also sought by the use of a survey. Staff said they felt supported by the registered manager. Feedback from health care professionals was also sought. The outcome of the surveys were generally very positive and graded good or very good for most aspects of our service. All of this gave the registered manager a good understanding of what people felt about the service.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. We had received notifications from the registered manager in line with the regulations. This meant we could check that appropriate action had been taken.

The registered manager and staff kept up to date with best practice information in order to provide care to people. Staff regularly attended the Farnham Dementia Café to look at different initiatives and advice given on how to look after people who live with dementia.

Quality assurance checks were carried out by the registered manager and other senior staff to ensure a good quality of care was being provided to people. The registered manager also undertook unannounced visits out of hours to check on how well staff supported people, and if any improvements were required. The results of audits and performance reports were discussed with the provider. The provider carried out a monthly quality assurance visit and

Good

Is the service well-led?

various aspects of the home were checked. The audits by the manager had been effective at identifying some of the issues we had raised. For example they had identified that practical competency was not routinely checked for staff that gave medicines to people after their initial and follow up training. Some of the issues that were identified i.e. medication records /documentation had been identified through an audit conducted by the newly appointed regional manager, and a plan was in place to address the issues.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.** The provider had not done all that is reasonably practicable to mitigate the risks to the health and safety of the people that lived here.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for Consent** The provider had not ensured that where people were unable to give consent they had not followed the requirements of the Mental Capacity Act 2005.