

Anchor Trust

Willow Gardens Care Home

Inspection report

Hampshire Lakes
Oak Leigh Square, Hammond Way
Yateley
Hampshire
GU46 7AG

Tel: 01252864700
Website: www.anchor.org.uk

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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

The inspection took place on 24 and 25 July 2017 and was unannounced. Willow Gardens Care Home is registered to provide accommodation and support for up to 36 older people some of whom may experience dementia. At the time of the inspection there were 26 people living there. The service is located on the first floor of the main building in one of the provider's retirement 'Villages;' which also provides independent flats and domiciliary care support packages for older people. The Village provides a range of amenities including: a wellness centre and spa, bistro, bar, library and delicatessen on the ground floor of the main building; which people living in the care home can also access.

The service had a registered manager. 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 told us they were safe within the service. Staff undertook both initial classroom based and annual on-line safeguarding training and understood their role in keeping people safe. Potential risks to people had been identified, assessed and measures put in place to manage the risks in a manner that did not restrict people's rights. For example, people were supported to go away on holiday. The environment had been adapted to meet people's needs. Processes were in place to ensure the equipment and premises were safe for people.

There were enough staff deployed to meet people's care needs. Robust recruitment policies and procedures were in place and relevant checks were made on staff's suitability for their role.

People received their medicines safely from trained staff whose competency to administer medicines had been assessed. Processes were in place to store people's medicines safely. When people were prescribed medicines that required special precautions staff ensured these were monitored by health professionals, for the person's safety.

People were cared for by staff who had undergone an induction to their role. Records confirmed staff had received supervision and an annual appraisal of their work to enable them to reflect upon their work and development. People were supported by staff who were encouraged and supported to undertake professional development, to enable them to provide people with effective care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Feedback about the quality of the meals provided was mixed. However, processes were in place to ensure people had regular input into the types and quality of the meals provided and their comments about meals were acted upon. Risks to people associated with eating and drinking were effectively managed.

Staff supported people appropriately to access healthcare services as required and professional's advice was acted upon to ensure people's welfare.

People told us staff were caring. Staff were heard to speak with people in a warm and friendly manner as they provided their care. They had a good understanding of each person's personal preferences about their care and how they liked to dress. Staff offered people choices about their care across the course of the inspection. They understood that people had the right to make their own decisions wherever possible. People's privacy and dignity was upheld by staff in the provision of their care. People or their families where relevant; had been consulted about their end of life care.

People said they or their relatives had been involved in planning their care. People's care plans were regularly reviewed with them. Staff had a good knowledge of each person and received updates about people's care during the staff shift handover. Staff had undergone dementia care training and the needs of people living with dementia were understood and met by staff.

The activities co-ordinator provided people with a weekly schedule of activities based on their suggestions and feedback from the resident's weekly meetings. People were provided with a range of activities, which ran in the morning, afternoon and evening, both in the service and in the community across seven days of the week to meet their needs for social activity and stimulation.

People told us that generally they had not needed to raise any complaints. However, if they had raised an issue verbally then it had been addressed at the time. Policies were in place for people to make formal complaints if required. Processes were in place to seek and act upon people's feedback about the service provided.

There was open communication and people told us they were informed about what was happening. People's care was based on clearly defined values and these were displayed by staff in their work with people. Inclusion was promoted both with relatives and with people living across the Village. Processes were in place to seek and act upon staff views and to recognise their work.

People and staff said the service was well managed. The registered manager had clear expectations of their staff and led by example. There was good communication between senior staff. The provider had a career development structure for care staff to enable them to develop their careers within the service. There were good links both within the service and externally to promote communication and the sharing of good practice.

Processes were in place to monitor the quality of the service provided and information about the service was analysed by the provider in order to identify any trends that required action for people.

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.

Processes, policies and staff training were in place to keep people safe from the risk of abuse.

Potential risks to people had been identified, assessed and measures were in place to manage them in a manner that did not restrict people's rights.

There were sufficient numbers of suitable staff deployed to provide people's care and robust safe staff recruitment processes were in place.

People's medicines were managed and administered safely.

Is the service effective?

Good ●

The service was effective.

People received effective care from staff who had the appropriate knowledge and skills for their role.

People's consent was sought in line with legislation and guidance and where people lacked the capacity to consent to decisions, legal requirements were met.

People were supported by staff to eat and drink sufficient amounts to maintain a balanced diet.

Staff supported people to ensure they maintained good health.

The environment had been adapted to meet people's needs.

Is the service caring?

Good ●

The service was caring.

People experienced positive and caring relationships with the staff who provided their care.

People were supported by staff to express their views and to

make decisions about their care wherever possible.

People's rights to privacy and dignity were respected and promoted by staff.

People had been consulted about their end of life wishes.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care that was responsive to their needs.

People were provided with a range of stimulating activities.

Processes were in place for people to make complaints and their feedback was used to improve the service.

Is the service well-led?

Good ●

The service was well-led.

The service promoted a positive culture that focused on the people cared for and was open and inclusive.

At all levels of the service there was good management and leadership.

Processes were in place to monitor the quality of the service provided and to drive continuous improvement to the service for people.

Willow Gardens Care 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 checked 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.

The inspection took place on 24 and 25 July 2017 and was unannounced. The inspection team included two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with nine people and three people's relatives. We spoke with six care staff, the activities co-ordinator, the deputy manager, the maintenance manager and the registered manager. Following the inspection we spoke with a community nurse and received feedback from a specialist nurse and a GP.

We reviewed records which included three people's care plans, three staff recruitment and supervision records and records relating to the management of the service. We also attended a resident's meeting, a staff shift handover, a head of department meeting and observed a medicines round.

This was the first inspection of this service which was registered on 4 March 2016.

Is the service safe?

Our findings

People told us they felt safe within the service. Their comments included: "Yes- the girls (staff) make me feel safe" and "Definitely- very safe."

Staff told us they had received training in safeguarding adults and if they observed anything they were concerned about they would report it to the manager. Records showed staff had undertaken the provider's mandatory annual safeguarding eLearning training. The registered manager told us staff also completed a one day safeguarding face to face training session when they commenced their role. Staff had access to relevant safeguarding policies, procedures and contact numbers. They could also seek advice from the provider's safeguarding team. People were provided with safeguarding information on the resident's information board. Although the registered manager had not needed to raise any safeguarding referrals to the local authority they understood their role and responsibility to do so.

People informed us potential risks to their safety were identified and well managed. A person told us "They are very good; make sure I am stable with my frame when I get up." Another person said "Oh yes it's very good. I have had a few falls but not since I came here."

Risks to people had been assessed in relation to their: skin integrity, mobility and falls, using recognised assessment tools. The measures to reduce any identified risks were noted: for example: how many staff people required to assist them, any equipment and interventions such as the application of topical creams (medicines applied to the skin) to prevent the breakdown of their skin. Staff had a good understanding of people's risks and ensured these were managed safely. For example, they knew who could only walk safely with their walking sticks and ensured these were provided. Staff were seen to gently guide and support people whilst they mobilised, to ensure their safety.

If people experienced a fall or incident, then this was recorded. A bodymap was completed to provide a record of the injury and any wounds were photographed so there was a record. Where required post-falls assessments were completed to monitor people for any signs that further medical intervention was required. Staff used a recognised reporting tool to ensure all essential information about the person was provided to the emergency services if they were called.

The registered manager told us that in relation to people exercising their rights to choice, "We try not to say no." Risk assessments were in place for outings. Records showed that when people went away on holiday, staff ensured the correct support was in place, to facilitate this safely.

Regular checks were completed in relation to: equipment safety, electrical and gas safety, water and fire safety as required. People had personal emergency evacuation plans in place in the event of fire. Written guidance was displayed for staff regards the actions to take if the fire alarm sounded whilst a person was bathing. Contractors on-site were accompanied by staff for people's safety. Processes were in place to ensure the equipment and premises were safe for people.

People told us there were enough staff to meet their needs. They said "Never have to wait for any assistance" and "There are usually quite a few staff around." Staff also informed us there were enough staff to provide people's care and that call bells did not ring for long periods.

People's dependency levels were assessed monthly to provide information about their staffing needs. The registered manager told us there were three staff shifts: an early, a late and a night shift. There was at least one professionally qualified team leader per shift and generally two on the morning shift. Staffing for each shift including the team leaders was: seven in the morning, five in the afternoon and three at night. People received consistency of staffing as there was no use of agency staff. Although some staff had left recently or were in the process of doing so, staff were being recruited. In the interim, vacant staff shifts were covered by existing staff to provide continuity for people.

Team leaders allocated staff to work in areas of the home. Staff told us that although they were allocated to one of the three corridors, they worked as a team to ensure people's needs were met. We observed staff worked well together, ensuring they knew where each other were and that people's needs were met.

Care records noted where people needed their call bell to be placed within easy reach; we saw people could access their call bells easily. The registered manager told us they monitored the call bell response times daily. Although these checks were not documented, they used them to review if call bells were being responded to in a timely manner. We reviewed a sample and saw that out of the 22 recorded 20 had been responded to in less than two minutes. Processes were in place to enable people to request assistance and these were monitored for people.

Robust recruitment policies and procedures were in place and relevant checks were made on staff's suitability for their role, including: their identity, references and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People confirmed to us that they received their medicines from staff as required. People had medicines care plans which documented their preferences with regards to how they took their medicines. There was written guidance for staff about how to determine if people were experiencing pain and therefore might require medication to ease it. People had topical cream charts to provide staff with visual guidance regards where to apply their topical creams to ensure this was done safely and effectively. People's medicine administration records (MAR) included a photograph and administration times for medicines. We saw that a person's allergy was noted on their MAR chart, to ensure staff were aware. We saw protocols were in place to provide guidance on the administration of 'as required' medicines. Staff had access to relevant guidance about people's medicines needs.

Staff told us they had undertaken medicines training and had their competency to administer medicines assessed, which records confirmed. We saw from records that where staff had made a medicines error they were required to complete two further safe observed medicine rounds and a competency test to ensure they were fit to continue to administer people's medicines.

Medicines were stored safely. There was a fridge to store medicines that required refrigeration at the correct temperature. The clinical room where medicines were stored was air conditioned to ensure people's medicines were stored at the correct temperature.

Controlled medicine records were clear and matched the stock held by the service. Controlled medicines are medicines which require a greater level of security. Regular audits of medicines were completed to

ensure they were safely managed for people.

We reviewed the MAR chart for a person who was prescribed a medicine that required monitoring by health care professionals ; we saw this had been completed. When people were prescribed medicines that required special precautions these were monitored by health professionals.

Is the service effective?

Our findings

People told us they felt the staff were well-trained. Staff received an induction to their role and staff new to care undertook the Care Certificate. This is the industry standard which staff working in adult social care need to meet before they can safely work unsupervised. Records demonstrated new staff underwent a six month probation to enable them to demonstrate their suitability for their role. People were cared for by staff who had undergone an effective induction to their role.

Staff were required by the provider to complete a range of essential training such as: moving and handling, dementia awareness, health and safety, fire safety, infection control and nutrition and hydration awareness, for example. The registered manager told us staff had a team leader allocated as a mentor whom they could speak with about any issues which staff confirmed. Staff told us they felt well supported within their role with regular training, supervision and professional development. Records confirmed staff had received supervision and an annual appraisal of their work to enable them to reflect on their work and development.

Eight staff had achieved a National Vocational Qualifications (NVQ) in health and social care at level three, while three staff were working towards this. Two staff were working towards NVQ level five. People were supported by staff who were encouraged and supported to undertake professional development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People had signed their consent to the care provided where they had the capacity to be consulted about their care. If people lacked the capacity to make decisions there was guidance for staff regarding how to support the person to make decisions. Staff had undertaken MCA training and were able to explain its application to their work with people. Staff told us how they supported people to make decisions about their care, for example, by showing them outfits to wear or the options available at meal times so they could decide.

The registered manager told us and records confirmed they had submitted eight DoLS applications for people. None of these had yet been processed by the supervisory authority, but records demonstrated the registered manager remained in contact with them regarding progress for people. Where DoLS applications had been made MCA assessments demonstrated how the decision to make the application had been reached and that their relatives or relevant parties had correctly been involved; a person's relative confirmed this consultation had taken place.

The stairwells and the lifts were accessed via keycodes. Where people were able to mobilise independently and had been assessed as having the capacity to manage them, they were provided with the code to ensure their freedom was not unnecessarily restricted.

People's feedback was mixed with regards to the quality of the meals; two people were positive; three felt it was alright and three would have liked to see improvement. A resident's survey had identified that food was an area that could be further improved. Processes were in place to ensure people had regular liaison with the chef and input into the meals provided. They were also provided with food tasting sessions to enable them to provide feedback on planned dishes. People's feedback had been acted upon with dishes removed or amended. In the dining rooms there were comments books, but we could not see any negative feedback in the book reviewed. Processes were in place to ensure people had input into the meals provided.

People's nutrition care plans noted their food preferences, portion requirements and where they liked to eat. It was noted whether people required support to choose their meals. People were provided with a choice of hot and cold snacks for lunch and puddings; the main meal was in the evening. Staff served the meals to people so they could see the options and choose what they wanted; if they did not like the options then alternatives were provided.

People's weight was monitored monthly and their Malnutrition Universal Screening Tool (MUST) score calculated. MUST is a screening tool to identify adults who are at risk from either malnourishment or being overweight. If required staff monitored people's food and fluid intake to enable them to determine if further action was required for the person's welfare. Where people had been identified as underweight the GP had been informed where required and their diet supplemented to increase their weight. There were nutrition and hydration stations located in the lounges. These provided a range of easily accessible snacks for people to access as they walked past. The chef was made aware of people who required a particular diet and this was provided to meet their needs. Risks to people associated with eating and drinking were effectively managed.

There was evidence people had either been visited by, or supported by staff to attend a range of health care professionals, depending on their wishes. These included for example: GP's, district nurses, psychiatrists, chiropodist, optician and speech and language therapists (SALT). Where professionals provided guidance this was disseminated amongst staff. For example, information about people's SALT guidance was shared with the chef to ensure they provided people with the correct diet. A community nurse told us staff acted upon the guidance provided to ensure people received effective care.

Although people were not living with advanced dementia, attention had been given to the environment. People had 'memory boxes' outside their bedrooms containing items of personal significance to them. These can be useful to people when trying to locate their bedroom. People living with dementia may walk around a service. At the end of the corridors, seating areas had been created so that there was a destination and an opportunity for people to sit and rest if required. Staff had identified that the lounge seats were too low for some people to get up from with ease, arrangements had been made for these to be replaced for people. The registered manager told us that where people required a shower rail to manage the risk of them falling these were fitted according to the individual's requirements and at the height they required for their needs. The environment had been adapted to meet people's needs.

Is the service caring?

Our findings

People told us staff were caring towards them. Their feedback included: "Staff sit and chat with you at night. They are very attentive, kind and caring." "Staff are very good." A relative told us "They have gone above and beyond what they need to do." Whilst another commented "They are extremely caring."

Staff were heard to speak with people in a warm and friendly manner as they provided their care. They greeted people as they entered the room and checked upon their welfare. They used humour and jokes where appropriate and laughed with people. We observed that once people had been served their lunch, some staff sat with them and ate their lunch. This enabled staff to share the lunch experience with people and to further develop their relationships with them in a social setting.

Staff were sensitive to people and did not rush them; they supported people at their pace. Staff told us "Management like us to sit with the residents." They also knew people's friendship groups and ensured they were able to choose to sit with their friends.

People's preferences about their care were noted, for example, regarding whether they wanted to be supported by male or female care staff. Staff told us there were always sufficient staff of both genders to meet people's preferences. People's preferred daily routines were also recorded, for example, in relation to going to bed. Staff knew whether people liked their door open or closed and whether the lights should be left on for them.

We saw that people were immaculately dressed and presented; a relative confirmed this was what they had also observed. Each person was dressed in accordance with their 'personal style.' Staff were able to tell us in detail people's dressing preferences and favoured items. For example, one person liked to wear a certain item at all times and we saw staff ensured this. Staff knew what jewellery and make-up ladies liked and how they wanted their hair.

People's care plans outlined if they had any communication needs and if so how these were to be met. If a person was living with dementia and struggled on occasions to communicate it was documented how staff could support them to do so. For example, by giving them additional time and space and talking about their past. We observed staff positioned themselves at the person's level when communicating with them to ensure they retained eye contact and did not bend over people. A relative commented that staff always addressed people by their name, so the person knew staff were about to talk to them.

Staff displayed people's art work on the walls. There were pictures displayed of activities people had participated in across the previous month and photo albums of events held at the service. Staff also supported people to choose pictures to create their own scrap books of their experiences and activities which they had enjoyed at the service. These were used to both document people's daily lives and as a resource and prompt for discussions with people. Staff valued people as individuals and respected and celebrated their achievements and experiences.

People's bedrooms were personalised to their tastes. People were able to bring and display items and pictures that were of personal significance to them. Staff ensured these were placed within easy reach and sight of people; this was especially important if the person experienced poor sight to ensure they could see them.

People told us they or their families were involved in making decisions about their care. A person told us "They talk about my needs and explain what they think will help me." Another person commented "My son makes any decisions for me, we speak to staff together." A relative told us staff were keen on their loved one having choices and that they now had "More choices" than when they were at home.

People's records reflected their right to have choice and control over their lives; which staff were instructed to support wherever possible; there was written guidance about how they should achieve this. For example, a person's care plan noted they liked to make their own choices and that where they struggled to achieve this staff should look at how they could support them to do so.

Staff were observed to offer people choices about their care across the course of the inspection. A staff member told us "There are a lot of choices here" and "We don't tell them what to do they tell us." Staff consulted people about decisions, for example, checking if people wanted the TV or radio on rather than just making an assumption about their wishes.

People told us staff upheld their privacy and dignity in the provision of their care. A person commented "Yes I do need help with showering. They always keep my door closed and keep me covered." Another person said "They always knock before coming into my room, they are polite and never rude."

Staff were able to describe how they ensured people's privacy and dignity was maintained. Staff were observed to knock on people's bedroom door before entering and await a reply. Where required people had a continence care plan which outlined to staff how their needs should be met. Staff were observed to support people discreetly and sensitively where required with either their continence needs or their dignity. Staff ensured people's personal care was provided in private.

People had a key to their bedroom where they wished to have one. Housekeeping staff were heard to request a person's key from them and to check if they wanted their bedroom cleaned. This ensured the person's permission was sought and their privacy maintained.

People or their families where relevant had been consulted about their end of life wishes and preferences which were documented. This ensured staff had guidance in place regards people's end of life care wishes. A specialist nurse informed us people had received good end of life care.

Is the service responsive?

Our findings

People told us they or their relatives had been involved in planning their care. Their comments included "Yes they did involve me," "Yes definitely" and "My son and I did it together."

The registered manager told us either they or the deputy manager completed people's initial assessment along with a team leader. As part of the assessment people were invited to come in and have lunch, this enabled staff to assess people's reaction to the environment. A relative told us their loved one had been admitted in a crisis and they had found staff to be supportive of the family at this time and not just their loved one. Staff then reviewed people's care plans on a monthly basis or more often if required. People and their families confirmed they were involved in regular reviews of their care.

The registered manager informed us care staff sat with people to explore their life history and spoke to families, which records confirmed. For example, staff had obtained a person's biography from their family to provide a detailed account of the person's background. People's aspirations for the future as well as their past had been noted. The registered manager told us of a trip that a person wanted to undertake and that staff were looking into supporting them to do this. Staff sought, understood and used people's background and aspirations to plan their care.

At the start of each shift, staff received a handover of information about people. For example, in regards to their general health and welfare and any issues that required addressing for the person. Staff responded to any identified issues for people, for example, by putting a re-positioning chart in place for a person in response to emerging concerns about their skin integrity and monitoring another person's fluid intake. They also ensured that feedback from professional's regards people's care was shared with relevant staff to ensure they received the care they needed.

The registered manager told us that although the bedrooms on Blossom corridor accommodated a number of people living with dementia, it was not segregated from Bluebell and Emerald corridors. People were able to move freely between the three corridors and lounges. If people were accommodated on Bluebell or Emerald corridors but then diagnosed with dementia, then they were not moved to a bedroom on Blossom corridor, but remained in the security of the environment within which they had already become familiar. Staff all underwent a day's face to face dementia training and therefore had the knowledge to meet people's behavioural needs.

People had behavioural support care plans where required and where possible their families had been contacted for information and guidance. Records demonstrated staff had applied the guidance provided to support them in managing people's behaviours when these had challenged staff. There was guidance for staff in regards to how to manage specific behaviours associated with dementia such as 'sundowning,' which is when people may become more agitated in the early evening. Staff were able to tell us how they worked with people's more challenging behaviours. Staff had access to clear and individualised guidance to enable them to support people appropriately.

We observed the breakfast table was laid with pots of tea and condiments. The registered manager told us this was to support people's independence in helping themselves. Staff then served people the hot breakfast options. People's care plans noted the areas of their care they were independent with and where they required assistance. For example, although a person might be capable of dressing themselves they might require monitoring whilst they did this to ensure they did not fall. A person confirmed to us they dressed themselves and staff just came to check on them as they finished. This enabled them to retain their independence in this area.

People told us there were enough activities about which they were consulted. A person told us "There are lots of activities every day and we go out too. We have a meeting every week and we can give suggestions of what we want to do." Another person told us "Plenty of activities if you want something to do. Every day the girl (staff) often asks what we would like to do, we go out for lunch and visits, walking in the garden."

The activities co-ordinator provided people with a weekly schedule of activities based on their ideas and feedback from the resident's weekly meeting. Some activities ran in regular slots such as the twice weekly exercise class held in the Village's wellness centre, coffee sessions in the bistro, the weekly visit to the service by a dog, the hairdresser and the weekly excursion to a 'knit and natter' community group. Other additional activities took place such as: cocktail afternoons, themed weeks on topics such as the seaside and visits from external groups which included; 'Creative minds' who deliver fun and therapeutic art sessions to care homes and 'Mad science' in response to peoples' feedback. In addition there were regular activities such as: games, bingo, craft, walks, films and pamper sessions. The service aimed to provide two excursions per week for people and these were facilitated by the maintenance staff from the Village, who were allocated to drive the minibus for 10 hours per week for the service. People were provided with a range of activities, which ran in the morning, afternoon and evenings, both in the service and in the community across seven days of the week to meet their needs for social activity and stimulation.

In addition to group activities; people's needs as individuals were met, for example, staff visited people who spent time in their bedrooms. The activities co-ordinator was supported in their role by two volunteers and an additional one was being recruited. This widened the scope of activities that could be provided to people. In addition staff occasionally brought in their children to meet with people under supervision and a young person was observed to support people in a card making activity, which people clearly enjoyed.

People told us that generally they had not needed to raise any issues or concerns. However, if they had raised a concern verbally it had been addressed at the time. The provider's complaints policy outlined how people's complaints would be responded to and the actions people could take in the event they were not satisfied with the handling of their complaint and the outcome. The registered manager told us one written complaint had been received. Records showed this had been investigated in accordance with the provider's complaints policy and a written response provided as required.

Records showed there were weekly residents meetings and quarterly relatives meetings to seek people's views; which people and relatives confirmed. People were encouraged to provide their feedback of the service on a recognised industry internet site and positive feedback was provided. In addition people had sent the service a number of cards complimenting the service provided. In October 2016, 14 people completed a national satisfaction survey. Overall the service scored above average, but the registered manager had noted areas where further improvements could be made such as in relation to food and laundry. In response, they now met weekly with the chef individually, in addition to the daily head of department meetings to identify any issues and the chef also met directly with people. Records showed staff had reported people were unsettled with their lunch so in response the registered manager had held an additional meeting with the chef on 17 May 2017 to discuss this for people. The service displayed a 'You said,

we did' board to demonstrate to people how their feedback had been acted upon. This showed that people had wanted a pottery class and in response 'Creative minds' had been booked for people. Processes were in place to seek and act upon people's feedback about the service provided.

Is the service well-led?

Our findings

People told us there was open communication and that they were informed about what was happening. Their comments included "Yes from the top down" and "The manager is very good, we are kept informed." A relative told us "Very open, constantly on the phone. I have a good rapport with the staff."

The provider's values were for all staff to be: personally accountable, reliable, respectful, honest and straight forward. The registered manager told us and records confirmed that the staff interview process assessed whether applicants displayed the values they were seeking. Those who did not display them were not recruited; this ensured that only staff who shared the provider's values were appointed. Records showed people were also involved in staff recruitment to ensure their views were represented. Staff told us the values were further explored during the induction process. The registered manager informed us and records confirmed that where staff behaviours had not been in accord with the provider's values and expectations, staff had brought this to their attention and relevant staff management processes had been followed. People's care was based on defined values and action was taken to ensure these were displayed by staff in their work with people.

Joint activities and events were arranged for those living in the service and those living in the Village. This enabled people to mingle across the community. In addition to the provider's dementia training, an additional training session had been arranged with a local nurse. People's relatives had been invited to attend this with staff, offering them the opportunity to train with staff and to develop their knowledge for people. There was an attitude of inclusion with people's relatives and across the Village.

Staff told us "There is an open culture. We are encouraged to raise issues as they arise." They also said there is a "Good team." Staff's views were sought through the monthly staff meetings. They were also asked for their ideas with regards to any areas of the service which could be improved for people. The registered manager told us staff had been sent to other of the provider's services, which staff confirmed, to enable them to make links and experience other services. Staff had been asked for their feedback through the provider's staff 'Pulse survey.' This had identified which areas were working well and those that required improvement, such as staff feeling valued. The registered manager had discussed with staff how these areas were to be addressed. There was an in-house recognition award, 'Star of the month.' This award was voted for by people, their families and staff, a small gift was then presented at the staff meetings. Processes were in place to seek and act upon staff views and to recognise their work.

People told us the service was well managed. Their comments included "Everything runs very well," "Very open and transparent, very well managed." A relative told us there was an open door policy and that they could speak with the manager at any time. They said any minor issues they had raised were quickly resolved.

Staff told us the service was well managed and that that management were visible on the floor. A staff member told us "Management are nice. I feel I can go to them with anything."

It is a condition of registration with the Care Quality Commission (CQC) that the service has a registered manager in place. There was a registered manager registered with CQC to manage the service.

The registered manager told us they were clear with staff about their expectations and standards and that they led by example. They told us they greeted people each morning and went on the floor at lunchtime which we saw; we observed people greeted them warmly and obviously had a good rapport with them. They also accompanied people on one of their weekly outings to the community. This provided people with the opportunity to meet with them informally. They informed us that they and the deputy manager worked some weekends, which records confirmed, this enabled people and their relatives to have access to management out of usual office hours.

There were good links between senior staff with team leader meetings, a daily head of department meeting, weekly meetings with the chef and monthly and quarterly health and safety meetings in addition to good links with staff from the Village. The registered manager attended a monthly meeting with other home managers and the District Manager to share best practice and lessons learnt.

The provider had a career development structure for care staff. The registered manager told us they had recently promoted care staff to the role of team leader to ensure they were supported with their development within the service. Senior staff were supported to undertake management qualifications, to equip them with the required knowledge and skills to progress within the service.

A specialist nurse held regular clinics with staff to support them and to share good practice. Staff also attended the Frimley Park Care Home Forums to keep themselves abreast of best practice and to enable them to network and link with other local providers. There were good links both within the service and externally to promote good communication and the sharing of good practice.

People's care plans were audited 48 hours after people's admission and then again after a month to ensure they contained all of the required information. Records showed that 11 people's care plans had been audited in May 2017 as part of the on-going care planning audit programme. Where issues were identified these had been addressed, for example, a person's nutrition care plan had been updated with new information. There were monthly infection control audits and staff audited medicines within the service monthly. This included reviewing a sample of peoples' medicine administration records to ensure there were no gaps or errors. Stock checks were also completed on packaged medicines to ensure the correct stocks were held. The provider's pharmacist had last audited their medicines on 9 February 2017 and no issues were identified. In addition the registered manager completed a monthly health and safety check of the service. Any actions identified from the audits completed were incorporated into the service action plan, to ensure any required actions were undertaken for people.

Any accidents or falls people experienced were entered onto the provider's electronic recording system; these were then reviewed by the registered manager the provider's safeguarding team and the District Manager to ensure any relevant actions had been taken to reduce the risk of a repetition for people.

The registered manager completed a weekly report for the provider. This covered: safeguarding's, complaints, infections, pressure ulcers and notifications made to CQC regarding events. This information was the used to produce a monthly trends report for the provider's quality team to enable them to identify any trends that required action. The registered manager also completed a quarterly report for the provider based on the CQC five key questions, this resulted in an action plan that the District Manager then reviewed and signed off during their monthly audit of the service. Processes were in place to audit, monitor and drive improvements to the quality of the service provided for people.

