Rex Develop Limited

New Haven Care Home

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

The inspection of New Haven Care Home took place on 16 May 2016 and was unannounced. The home had not previously been inspected as it only opened in November 2014. It is a purpose built home to accommodate fifty people. It is divided into two units each with their own lounge, dining room and bathrooms. Each room has an en-suite shower room. On the day we inspected there were 31 people living in the home, with 11 of these living in the specialist dementia provision within the home.

The home has two registered managers who job-share. We spoke with both on the day of the inspection. 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 felt safe and this was a view endorsed by relatives who spoke of 'peace of mind'. Staff were able to identify possible signs of abuse or poor care and knew how to report such concerns. We observed staff to be observant during the day, noticing people's moods or agitation, and responding appropriately. The home reduced the risks to people of falls by pre-empting unsafe manoeuvres by people and managed people's level of distress to avoid the likelihood of altercations.

We saw staff respond promptly to people and because they were so vigilant meant that people had support as they needed it rather than having to wait too long for attention. The staff worked well together and had clear direction.

Medicines were administered, recorded and stored in line with requirements, and the home was pro-active in seeking reviews if they felt people's needs had changed.

Staff had received a comprehensive induction and their knowledge was developed through ongoing supervision and regular training. It was evident through the day to day interactions that staff knew the importance of seeking consent prior to offering any support and the home had effective capacity assessment tools in place to support this decision-making.

People were given plenty of drinks during the day to ensure they maintained a good level of hydration and had a positive and pleasant lunchtime experience where they engaged with each other well and received discreet support as needed. Access to external health and social care provision was requested and the advice received followed in practice and recorded in care records.

We observed staff to be kind, caring and patient, and often pre-empted people's needs showing that they knew and understood people well. There was a high level of awareness of how to support people living with dementia which was evident at all times. Staff paid due regard to respecting people's right to privacy and promoting their dignity through discreet support.

The home had an activities co-ordinator who showed initiative and drive, helping shape a programme of activities which were relevant and fulfilling for people. This was supported by pro-active staff who also engaged with people ensuring everyone received attention.

Care records were person-centred and reflected people's current needs, highlighting key pieces of information to ensure staff were able to be provide assistance at an appropriate level and in line with people's wishes. The home had managed complaints and compliments in a timely manner, paying due attention to any actions required.

The home had a friendly and welcoming atmosphere and people said they were happy living there. This was supported by comments from relatives and from feedback we reviewed.

Staff were supported by effective registered managers who had a sound knowledge of their responsibilities and a clear direction for the home to grow towards. This was reinforced by a robust quality assurance programme which identified issues quickly and ensured action plans were in place to remedy any concerns.

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 told us they felt safe and staff demonstrated an understanding of how to recognise and respond to signs of abuse.

Staff were actively supporting people through good observations and preventative interventions to limit falls.

We saw that people's needs were responded to promptly and that medicines were administered and stored correctly.

Is the service effective?

Good

The service was effective.

People were supported with their nutrition and hydration needs throughout the day and we observed mealtimes to be a sociable occasion.

The home adhered to the requirements of the Mental Capacity Act 2005 and people had access to health and social care professionals as needed.

Staff had received comprehensive training and were regularly supported in their roles through supervision.

Is the service caring?

Good

The service was caring.

Staff were attentive and empathetic, demonstrating positive examples of considerate and sensitive support to people.

People's consent was sought where needed and their privacy and dignity respected.

Is the service responsive?

Good

The service was responsive.

The home was supported by an activities co-ordinator who had established a good rapport with people which complemented staff's input.

Care records were personalised with appropriate levels of detail.

Complaints were handled effectively with positive outcomes and compliments recorded.

Is the service well-led?

Good

The service was well led.

The home was welcoming and had relaxed atmosphere. People spoke highly of the staff and managers, and staff also felt well supported.

We found evidence of a robust quality assurance process which identified issues that resulted in effective action plans. The registered managers were keen to learn and develop, which was a value promoted through the home.

New Haven 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 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 16 May 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

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. This information was also used to assist with the planning of our inspection and to inform our judgements about the service. We also checked information held by the local authority safeguarding and commissioning teams.

We spoke with six people using the service and three of their relatives. We spoke with six staff including one senior carer, two carers, the deputy manager and both the registered managers.

We looked at six care records including risk assessments, three staff records, minutes of resident and staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Good

Is the service safe?

Our findings

We asked people if they felt safe living at New Haven. One person living in the home said "I feel safe when I'm with everyone. Safer than at home." We also checked staff's knowledge about safeguarding people from abuse. One staff member told us "I would report any safeguarding concerns to the managers." Another staff member said "I know the signs to look out for. I would be alert and intervene if I felt someone was at risk of harm. I would report any concerns to the managers and local authority if still concerned. We have the contact numbers in staff areas." This demonstrated the home had explained the policy well and staff understood their responsibilities.

The registered manager told us that if there were any safeguarding concerns raised they would complete a full investigation with suspending any implicated staff pending the outcome. This would be completed in conjunction with other relevant authorities as needed such as the local authority and police. If there was any learning from any such incidents this would be shared with staff through meetings and their individual supervisions.

We found the service had assessed risk and implemented necessary risk reduction methods in place including detailed moving and handling assessments, fire evacuation procedures and pressure care programmes for people. Each of these was focused on individual need and regularly reviewed. We spoke with staff about the use of bed rails and it was evident they understood the risks clearly. Risk assessments were in place to evidence why a piece of equipment had been provided. We found that falls risk assessments looked at general mobility along with specific medical conditions a person may have which posed a higher risk, considered their sight, medication and continence needs which are all factors affecting a person's risk of falling. They had then implemented control measures to ensure risks were minimised.

We observed staff assisting people to move with the use of equipment such as a stand aid. During the whole procedure staff provided reassurance and guidance to minimise distress to the individual. In one instance we heard staff say "Going down. We'll soon have you comfy, don't worry." On another occasion we heard staff discussing if the sling was the right size as we determined that people did not have their own slings. We asked a member of staff who advised us "Slings are not individual to people but we have one of each size on each unit. They are regularly washed." We saw in people's care records that it was recorded which sling was to be used according to the serial number and the correct one was used in the previous instance. Moving and handling care plans were very clear and detailed. However, we did discuss with the registered managers that people should have their own slings to limit the risk of infection and ensure that people always had the correct equipment as they had detailed in their care records. They agreed to address this as a matter of urgency.

Prior to lunch one person had stood up to move towards the dining table but without their zimmer frame so staff gently prompted the person to use it. This showed that staff had a good appreciation of the risk of falls and were observant in their practice, identifying and acting to prevent forseeable incidents. Staff were vigilant and clear in their support to people. We heard one staff member advise one person to stand up tall and put their weight on the zimmer frame prior to walking.

We saw the home completed monthly accident logs which specified who had been involved, the number of falls or injuries, the nature of the incident or accident and the action taken as a consequence. In one record we noted that a person who had fallen had had a sensor mat put in place and extra handrails, a referral to the physiotherapist and GP. This showed the home responded promptly and effectively to further limit the likelihood of further falls. The Care Quality Commission had been notified as required under the regulations.

During the day we observed staff being proactive in regards to pressure care relief by encouraging people to walk around with the necessary support. One staff member said "Let's stretch your legs." People responded positively and were happy to take short walks. Staff gave clear instructions to people "Make sure you've got your frame" and "Take your time, there's no rush." It was encouraging to see other people in the home supporting people to do this. We heard one person say "C'mon, You can do it, it'll do you good. Won't do you any harm."

The home had protective personal equipment in all communal bathrooms and the environment was visibly clean and free from odours. We saw the cleaning trolley regularly throughout the day. Staff we spoke with had a good understanding of infection control procedure and we saw appropriate action being taken when required. The home had recently had an external infection control audit completed in March 2016 and scored over 90%. They had a thorough audit process in regards to mattresses, slings, equipment and legionella prevention.

One person we spoke with said "I think there's enough staff. They do work very hard." We spoke with a relative who told us "There are always enough staff on duty." Another relative said "Staff are always available." We also asked staff if they felt there were enough. One staff member said "I used to do a lot of shifts together but not so much now." However, another staff member was about to start eight twelve hour shifts in a row. They were aware that recruitment was ongoing and we did raise the wellbeing of staff with the registered managers who acknowledged the heightened risks of no time off for staff. The staff member did stress it was their choice to do this as they preferred to work rather than use agency staff who did not know the people in the home and that the registered managers had tried to dissuade them. Staff were supported to take regular breaks during the day.

We asked the registered managers how they determined staffing levels. They told us they used a dependency tool which based levels on a person's need. If this need increased and a person required more support they had the authority to increase staffing levels as necessary. They spoke with us about the gradual development of the size of the staff team which was in line with increasing the occupancy of the home. Both registered managers said they implemented a strict absence policy and staff could only return after having a return to work interview.

We looked at staff recruitment records and saw the home followed a rigorous and consistent process. References were checked and gaps in employment history discussed with each person at interview. Disclosure and Barring Service (DBS) Checks were carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at how medicines were administered within the home. Records were thorough and contained a signature sheet identifying which staff were authorised to administer medication. Each person's record had an outline front sheet with their name, date of birth and room number, GP details, any allergies highlighted in red and their photograph. If a person was prescribed PRN (as required) medication there was an appropriate protocol in place which identified when the person should be offered this medication and how often. It was recorded at what time the person had received such medication, thus limiting the likelihood of receiving medicines too close together.

We checked stock levels and these all corresponded with the information on the Medicine Administration Record. Running stock totals were maintained for PRN medication and these all tallied. We checked the treatment room and found that fridge temperatures were checked but there were some gaps which had been identified on a recent audit and this had been followed up with the necessary staff. Diary records were kept of key information such as needing to re-order medicine or a change in a prescription which was then transferred onto the person's own record. Controlled drugs were stored as required under the Misuse of Drugs Act 1971 and records matched stock levels.

We asked one of the staff who administered medicines to explain the process they followed. They advised us that information was obtained at the start of each shift to ensure any changes were known. They then always checked the person's record, identity and stock levels of medicines prior to removing the tablets from the blister pack to avoid wastage or error. They told us no one was on covert medication.

The home completed thorough medication audits which identified staff's training needs. All staff had received refresher training in September 2015 and were assessed for their competency. Each audit identified any issues and then developed areas for improvement with action points. These were shared with all staff who signed to say they had read and understood the concerns. The most recent audit had referred to 'booking in' procedures, stock ordering and checking countdown sheets. All of these areas were noted by the member of staff we spoke with showing that learning was shared.

Good

Is the service effective?

Our findings

One person said "Oh, everything is fine here. I like it. The food is nice as well. I can have whatever I want." Another person said "The food here is lovely and I'm faddy. If I don't like summat, they'll do me summat else." A further person said "The food delicious. A little bit of what you fancy does you good. I always get the food I fancy." We observed the cook asking people what they would like for their tea. One relative told us "The food is good and people get plenty of drinks."

We saw that tables were set with cloths, flowers and napkins and saw a noticeboard with the day's menu on it including breakfast choices. It also referenced foods to avoid if a person was on particular medication. We heard staff asking people if they would like some more breakfast. At lunch time we observed people being offered condiments and appropriate assistance such as cutting up food or alternative cutlery. People were offered a choice of dessert and allowed the time to make their choice. Lunchtime was a sociable experience with lots of banter and laughter between people and staff in each of the dining rooms.

We observed in the dining room in Rose Court that people were waiting sometime for food to be served from the heated trolley despite there being staff available. It appeared that the task of serving fell to one carer but they were otherwise occupied initially which meant people had to wait. People's preferences were recorded on a sheet which the carer who was serving followed but people were asked just prior to serving their meal if this was still their choice. During the wait for the food people were offered a range of drinks and staff interacted well. One staff member asked someone if they would like cranberry juice "as I know you like that?"

We found that people's weight was monitored regularly and records were up to date. The registered managers advised us that no one was currently nutritionally at risk. One person who had been losing weight due to a hospital admission was now gaining it again due to regular monitoring and support from staff.

Staff told us that handover notes were completed at the end of each shift with key details of each person's experience. They told us they found these helpful as the notes provided prompts so they knew what to look out for on each shift. This ensured effective communication between shifts to ensure the continuity of care for people using the service.

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 so that they can 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.

The home had assessed each person's mental capacity and assessments had been signed by the person where they had capacity. The process looked at how a person was to be supported with their communication needs, and who had the authority to make decisions on their behalf if they lacked capacity. It also considered if an advocate was required and followed the two stage test as detailed under the Mental Capacity Act 2005 with the person's answers recorded. This information then resulted in a best interest decision where it was decided a person lacked capacity to make a specific decision.

One staff member told us "I understand the importance of seeking people's consent. If I think someone's rights were not being upheld I would report it to the senior." The home had two authorised DoLS in place and were in the process of requesting two more. The entrance to the home was locked so we asked the registered managers if people had the keycode. They told us people can ask for it if they wish to leave and people are happy for the doors to be locked as they feel safer. The registered managers were very aware of the need to continually re-assess people's capacity and also of the importance of asking at different times of the day to ensure a balanced decision was reached.

We spoke with people asking them if they felt staff were knowledgeable. One person said "I don't miss a trick in this place. I reckon the staff know what they are doing. I see everything. If I didn't like anything I'd let them know about it." Staff told us they received regular supervision and training. One staff member said "I've been here a year and had a lot of training when I first started. I now have supervision every three months." The registered managers advised us that induction training can take up to four weeks, longer if necessary. This was then followed by a full week of shadowing shifts which could also be extended if needed.

Another member of staff told us "The training is OK; it's a mixture of interactive learning and booklets to complete." This staff member said they felt enabled to challenge decisions if they didn't agree with them if they feel this was not in the person's best interests. The registered managers allowed staff time to complete training and were strong advocates of the use of external training bodies in addition to in-house resources.

We found that all staff had received supervision and an appraisal every two months since the start of the year. We looked at the training matrix and found this was up to date. Staff had accessed training in first aid, fire safety, moving and handling, infection control, safeguarding, advocacy, health and safety, food hygiene and dementia awareness. Some staff had also been on training for end of life care, managing falls and mental capacity and DoLS in addition to more specific conditions such diabetes. The registered managers advised us they were currently preparing a training programme around the Care Certificate. This is a set of minimum standards for all social care workers to adhere to and they should be trained on this during their induction.

One person we spoke with told us they were waiting to see the nurse. The nurse arrived mid-morning and spent some time talking to the senior care staff about how people were. This was conducted discreetly and it was evident that information was current. We saw in people's care records all visits from external health and social care professionals were noted with key information from the visit.

We spoke with the visiting nurse who informed us that staff were responsive to their views and always very pleasant. They said "Staff know everyone and are very attentive. They listen and respond." The only minor issue they raised was that perhaps they could sometimes be a bit more prepared for when the nurse was visiting so that people were ready to see them in a private area as this could make the visit take a long time otherwise. In care records we noted the home was quick to seek further advice if required. We noted in one record concerns about someone having hallucinations and a GP visit had been requested and their advice

followed. All visits from health and social care professionals were logged.

The environment was well signposted although some of the signs blended into the wallpaper due to their neutral colours. The home had made innovative use of the wallpaper in one part of the home as it was a drawing of a road sign and this had been illustrated with directions to the reception area and lift. There were chairs in communal areas offering people the opportunity to rest and ornaments on the windowsills all added to the homely atmosphere. The grounds outside were extensive with a summer house and level access. We saw this space being used during the day.

Good

Is the service caring?

Our findings

One person said "I forget most things. I just can't rely on my memory, that's why I need the staff here. They help me when I most need them." Another person told us "The staff are marvellous. Nothing is too much trouble." One relative said "Staff are always very friendly and welcoming." In the relative satisfaction survey it was noted "the carers are all very kind" and in a review "Care is second to none, nothing is too much trouble. Thoughtful staff."

Throughout the day we observed staff to be kind when interacting with people. They spoke to people in a caring way as people were sitting in the lounge. One staff member asked "Would you like some fresh air? Let's open a window" upon people saying yes. Just before someone was due to be assisted from a dining chair into a more comfortable armchair the staff member said "[Name] when you're in your comfy chair, I'll make you a fresh cup of coffee." Another staff member demonstrated a positive rapport with people by joking with them asking "Are you wanting me to do a handstand?" A further staff member said to someone who was trying to get to the toilet, "Hang on, I'll help you."

We observed staff chatting to people. One person asked "What's happening?" The member of staff replied "We're all having a sit down together. You look tired. Are you feeling OK?" A bit later on the same person was becoming distressed saying "I've no idea what's going on in this place. How long have I been here? No one tells me anything round here." A staff member went and sat with them and said "This is your home [name]. You live here. You have your own room, like a flat, it's lovely." The person was then given a drink and biscuit and settled down. The staff member remained with them for a while reminiscing with them. This demonstrated that staff had a good understanding of how to support people with dementia, offering reassurance and social stimulation.

Staff were quick to intervene when people started to squabble. They were able to separate people effectively and discreetly by diverting their attention. We found staff's conversation was appropriate to the people in the home. They talked about how many children they had had and where they used to live. Staff also reminded people who might be coming to see them and what people had done the previous day, supporting them to recall when they struggled rather than just provide the answers.

Someone became quite distressed in the afternoon but staff were quick to provide reassurance. Staff responded by saying "You're here so we can make sure you're alright." The cook brought round some ice lollies and put their arm around the person "Don't worry, you're at home, you're OK." A little later they complained their back was hurting so a member of staff brought them a cushion asking "Is that better?" We observed one staff member painting people's nails chatting to each person while doing it. All staff we observed were seen to be motivated, smiling and gave attention to people when they needed it rather than just when supporting with care tasks.

People's care records contained signed agreements for photographs and the use of CCTV in communal areas.

We saw that people had signs on their door which said "I may be in, I may be out. Please knock before you find out." We heard one person ask for assistance to the toilet but the only member of staff was with someone else. However, the staff member turned around and acknowledged the person's request saying "Yes OK. I'm coming." Two members of staff then came over and were very patient and gentle, assisting the person to stand and giving clear direction as to how to move safely.
People were dressed smartly wearing jewellery and had their hair done. Walking frames were accessible and people were wearing their glasses and hearing aids.

We asked the registered manager if anyone had an advocate but no one had at the time of our inspection. However, all staff knew about the importance of seeking an Independent Mental Capacity Advocate (IMCA) if a person lacked capacity and had no official representative.

Good

Is the service responsive?

Our findings

People spoke highly of the activities co-ordinator as they had "local knowledge and knows the residents." People told us about local walks, garden centre visits, a trip to the Wildlife Park and local pubs and social club, film shows, arts and crafts, weekly bingo and coffee afternoons. There was evidence of regular visiting entertainers. We also saw that a local history group had been set up as a response from people in the home as it was discovered that three people had written local history books. We found people animated discussing how times have changed, the local area including the shops that used to exist, who worked there, who had gone to work with whom and how everyone had to walk everywhere. This level of stimulation is crucial to engage people with memory impairment and showed the home was aware of how to support people effectively.

We observed the activity co-ordinator working around the home during the day. They began in the Poppy Suite with a quiz showing people photographs of film stars to prompt conversation and recall. They followed this with a catchphrase quiz which people seemed to thoroughly enjoy. Conversation flowed between people about the price of fish and chips, jobs they used to do and local places. People were engaged really well and joined in the conversation.

One person we spoke with was keen to attend church but said they had not been able to. They told us "the one thing that is most important to me in the whole world, more important than money, is my God, my church. They all know me in my church and it would be a comfort." We spoke with the registered managers about this and they advised us that they would make a member of staff available so this person could attend.

Staff supported a couple to be together during the day but had rooms in different parts of the home due to their differing care needs. Staff told us they have different routines as one person likes to get up early and the other prefers a lie-in but they enjoy being together during the day.

We looked at care records which were indexed for easy reference. At the beginning of each file was a sheet indicating which staff had read the file and when. Key information was at the front of the file such as how a person was to be moved, their preferences, weight and a body map showing if there were any injuries or marks. In one record it was noted "[Name] likes to look nice and smart each day….likes to be involved in social activities and really enjoys tennis." In another "[Name] will choose their own clothes. Likes to wear earrings and jewellery, likes make up and nails to be nice and well kept."

People's dependency levels were scored showing whether they needed more or less support from staff based on their mobility, dexterity and level of communication, and any equipment or pressure relieving support was logged. People's files contained an emergency evacuation plan in the event of a serious incident which reflected their specific needs.

Care plans were written in a person-centred manner and focused on promoting the person's independence. Assessments were initially undertaken which resulted in a care plan. These assessments were all reviewed

monthly and care plans amended as required. Care plans assessed what a person could do for themselves, what need they had, what the intended outcome was and how it was to be met. This provided a clear structure for staff to follow and helped promote the person's abilities.

There were care plans for all aspects of someone's care needs such as behaviour, medication, personal hygiene, nutrition, oral care and sleeping. In one file we saw evidence of a person's mental health being monitored and the link with their medication regime. There was evidence of regular medicine reviews. Communication needs were assessed with references to people's eyesight and hearing. People's preferences for their leisure time and interests were also recorded. Where a significant event had occurred, such as a fall, this had been logged in the file and the care plan amended as required. If other health professionals were involved such as a district nurse this was also recorded along with their specific advice and this helped shape the care plan.

We found there were some gaps in recording in people's daily notes but upon speaking with the registered managers were shown detailed daily log reports in a separate file. The registered managers agreed to review this duplication of records following our inspection to avoid the likelihood of missed information. The daily reports were divided into morning, afternoon and evening sections and looked at all aspects of a person's care regime including food and fluids, skin integrity and behaviour. Entries were based on a mix of observation and care delivery.

People's rooms were personalised with their own objects such as photographs, ornaments, pictures and blankets.

One relative said "I know the complaints procedure." We saw only two complaints had been made in the home, both in 2015. These had focused on meals and both had been addressed in a constructive manner.

The home had an extensive selection of 'thank you' cards and letters of appreciation on display in the reception area. Comments included "It is difficult to express in words our gratitude and thanks to all of your staff for the level of care you gave to [name]" and "A big thank you for making [name's] final years happy and cared for." There were also copies of reviews received which included "I cannot praise staff at this home enough; they attended to [name's] needs and requirements with 100% attentive loving care….Staff go over and above what is required not only to ensure [name] is cared for but to make them feel loved and respect their feelings."

Good

Is the service well-led?

Our findings

One person told us "You won't find much wrong with this place you know." One relative said "I am very happy with all the care, staffing levels and the home. I have no concerns." Another relative told us "I have peace of mind and trust the staff." A further relative said "Staff are wonderful….Everyone is friendly and welcoming."

There was a positive and relaxed atmosphere in the home throughout the day. We observed people waving to each other across the lounge and before lunch many people were admiring each other's newly painted nails.

We asked staff if they felt supported. One staff member told us "The home is well managed. All staff get on together – there is a great team effort." Another member of staff said "This home is good enough for my family. I think it is very well run. The management are all good here." A further member of staff said "I'm very happy. I think people get very good care here. This is due to the staff team who are very good and morale is high."

We found evidence of regular staff meetings where key information from audits was shared such as the importance of weighing people on admission to the home to be able to track their wellbeing and the documentation of all accidents. In the most recent meeting discussions had occurred about the shared responsibility for engagement in activities by all staff with people in the home which we observed during our inspection. Staff were reminded of their specific roles as keyworkers which meant they were responsible for monthly reviews of care plans and audits, and the focus on seniors giving clear direction to care staff was emphasised strongly. We observed this in practice. Minutes evidenced discussions between staff about core areas of practice such as moving and handling and medication.

The home produced a quarterly newsletter which included photographs of service users enjoying activities, details of recent events including people's birthdays and staff information. They were very accessible in large print and nicely presented. They also included family recipes which was information shared by people in the home. Forthcoming events were listed, some of which we saw evidence of having taken place.

We found evidence of residents and relative satisfaction surveys which were issued annually. Comments were very positive. The home scored 100% in all areas including the environment, views were listened to and meals. The issues were around laundry and awareness of keyworker. These were assessed in depth and action plans were drawn up as a result of the findings to address any areas needing improvement. Comments included "absolutely satisfied", "very well cared for" and "no complaints yet. Perfect."

There was a full display of all staff members and their photographs including one noted as 'Employee of the Month'. This was a position voted for by people living in the home and other staff colleagues because of their contribution. The registered managers were keen to promote this as it demonstrated the value placed on a good staff team and the employee always received a small token of appreciation.

The home had detailed minutes of Residents' Meetings. Four had been held in 2015 and one so far in 2016 with another scheduled for 2 June 2016. Attendees were listed with a third of the people living in the home having attended. Specific requests were recorded such as 'salmon and wine' for dinner, increased contact with local schools, and suggestions for trips out.

There were also minutes of Relatives' Meetings again held regularly. Discussions from the previous meeting had included the opening of a new part of the home, amendments to breakfast options such as people's preferences for a full English on Tuesday and Saturdays with a caveat that this could be amended if people chose.On the noticeboard in the reception area of the home was the agenda for the next Relatives' Meeting to be held on 1 June 2016. This included feedback from the recent survey, suggestions for future activities, introduction to new staff and keyworkers, care plans and reviews and any complaints or issues that needed addressing.

The registered managers told us they completed daily walk arounds at the service to check the environment and observe staff's practice but this was not documented. However, the Operations Director did complete a monthly visit which was recorded in depth. This looked at documentation and practice issues, notifications to CQC and all internal audits such as care plans, medication, pressure care, safeguarding and accident analysis. We saw all these were completed in addition to mattress and infection control audits which were completed by the housekeeper. Records evidenced deep cleans including shower heads and legionella checks. Action points were logged such as ensuring care plan audits reflected actions being taken if issues were identified. One example was in relation to weight loss where the Operations Director requested evidence of who had been contacted about this and how the home had responded.

We asked the registered managers what the values of the home were. They told us "To deliver person-centred care however people wanted to be supported. It's what we're here for. We work with staff to monitor and improve support and make things happen." They said they were strong advocates of promoting people's independence and ensuring they went out into the community as often as possible. They advised us of one person who enjoyed returning to where they used to live to meet their friends and join in activities.

The registered managers said they strove to ensure people were safe, well cared for by competent staff and they 'wanted it to be the best home it can be'. They told us they were supported by the director who was very responsive. They were very aware as the home was growing how important it was to avoid complacency. We asked them how they would do this and they said "To be continually present and observant, especially with new staff ensuring they had necessary support." They said they would also utilise monitoring of feedback, complaints and external audits to help shape the direction of the home and identify issues early. This promotion of good practice was reinforced by regular training and supervision of all staff and frequent meetings with evidence of lessons learnt from incidents.

All equipment and the premises were appropriately checked as required under then Lifting Operations and Lifting Equipment Regulations (LOLER) requirements. The home had also checked all slings, handling belts and slide sheets in addition to the gas and fire alarm ensuring that they were only using equipment that was safe to use.