SHC Clemsfold Group Limited

Horncastle House

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

Overall summary

Horncastle Nursing Home provides accommodation for up to 43 people. It provides a service for people with nursing needs and for people with dementia. At the time of our inspection there were 35 people living at the home. The service had 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.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

People were protected by staff who knew how to recognise and report the signs of abuse. Staff had received regular safeguarding training.

Summary of findings

Safe recruitment practices were followed. Disclosure and Barring Service checks (DBS) had been requested and were present in all checked records. There were sufficient numbers of staff on duty to keep people safe and meet their needs.

People's rights were upheld as the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) had been adhered to. The registered manager had made DoLS applications for twenty seven of the people living at the home. Two applications had been authorised.

Staff had undertaken a comprehensive training programme to ensure that they were able to meet people's needs. New staff received an induction to ensure they were competent to start work.

People received enough to eat and drink. People spoke positively of the food and the choice they were offered. We were told " the food is excellent, if you ask for anything you get it". People who were at risk were weighed on a monthly basis and referrals or advice were sought where people were identified as being at risk.

Staff knew people well and they were treated in a dignified and respectful way. People's family and friends were able to visit and staff made them feel welcome.

People received care that was responsive to their needs and included information on their life history. The registered manager told us this information had been requested from people's family and friends. Staff understood the importance of knowing people's life history and told us how this could impact on how they responded when care was offered and how knowing this information could ensure that they delivered person centred care.

There was a schedule of planned activities which included exercise sessions, sing a longs, reminiscence sessions, puzzles and arts and crafts. On both days of our inspection we saw people taking part in the planned activities while other chose to spend time in the quieter lounge watching television.

Quality assurance systems were in place and were used to continuously improve the service. We reviewed the September 2015 infection control audit and saw that it had been identified that new pedal operated bins were needed. We saw that throughout the home pedal operated bins were now in place

Relatives spoke positively of the registered manager and told us "I'm delighted with the care, (registered manager) is absolutely lovely". We spoke with the registered manager about the vision and values of the home and were told "our aim is to create a homely environment and provide safe care. Care that is person-centred and responsive to people's needs".

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?
The service was safe.

Staff had received safeguarding training and knew how to recognise and report abuse

There were sufficient numbers of staff to make sure that people were safe and their needs were met

Risk assessments were in place and were regularly reviewed to ensure that they reflected people's current level of risk

Good

Is the service effective?
The service was effective.

People's rights were protected as the principles of the Mental Capacity Act and the requirements of the Deprivation of Liberty Safeguards (DoLS) were followed.

Staff had received training as required to ensure that they were able to meet people's needs effectively

People were supported to maintain good health and had regular contact with health care professionals

Good

Is the service caring?
The service was caring.

Staff were kind, caring and offered reassurance to people when needed.

People were treated in a dignified and respectful way

People and those that mattered to them were involved in their care

Good

Is the service responsive?
The service was responsive.

There were meaningful activities for people to take part in.

People received care which was personalised and responsive to their needs

Complaints were recorded and dealt with promptly.

Good

Is the service well-led?
The service was well led.

Quality assurance systems were in place and were used to improve the service

Staff felt supported and were able to discuss any concerns with the registered manager

Good

Horncastle House

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.

Before the inspection, we checked the information that we held about the home and the service provider. This included previous inspection reports and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We also reviewed feedback from healthcare and social care professionals. We used all this information to decide which areas to focus on during inspection. Two inspectors carried out the inspection.

Some people living at the service were unable to tell us about their experiences; therefore we observed care and support in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with two people, three relatives and we spent time looking at records. These included five care records, seven staff records, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints, quality assurance audits and other records relating to the management of the service.

During the inspection we spoke with the area manager, the registered manager, the chef, one registered nurse and two members of care staff. We also spoke with two health care professionals following our inspection. This was the first inspection of the service since a change to the provider's legal entity in November 2014.

Good

Is the service safe?

Our findings

People were cared for by staff who knew how to recognise the signs of possible abuse. A visiting relative told us that they felt that their family member was "safe and well looked after". Staff were able to identify a range of types of abuse including physical, emotional and neglect. Staff were aware of their responsibilities in relation to keeping people safe. A member of staff explained that they would discuss any concerns with the registered manager and were confident they would take these seriously and respond appropriately. If they did not feel the response was appropriate they knew which outside agencies to contact for advice and guidance. The registered manager was able to explain the process which would be followed if a concern was raised.

Systems were in place to identify risks and protect people from harm. Risk assessments were in place to identify individual risks and these were reviewed monthly or sooner if needed. Where someone was identified as being at risk actions were identified on how to reduce the risk and referrals were made to health professionals as required. Staff were aware of how to manage the risk associated with people's care needs and how to support them safely. For example Waterlow assessments had been completed which measured and evaluated the risk of people developing pressure ulcers and how staff should monitor and mitigate this risk. We reviewed the handling risk assessment for someone who required assistance with transfers. The risk assessment detailed how many staff were needed for each transfer, what equipment and type of slings were needed. The risk assessment contained a photograph and description of the sling which was used to ensure that staff used the correct sling. We checked this person's room and saw there was also a photograph of the type of sling which should be used. This acted as a prompt and check for staff that they were using the correct sling. The risk assessment was reviewed monthly to ensure it reflected people's up to date needs.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely. We observed medicines being administered and saw that the staff who administered medicines did this safely. Staff confirmed that they were confident and understood the importance of this role. Medication Administration Records (MAR) were in place and had been correctly completed to confirm medicines had been given as prescribed. Each person had an individual record of how they liked to take their medicines. Medicines were locked away as appropriate and where they were required to be refrigerated, temperatures had been logged and fell within guidelines that ensured effectiveness of the medicines. We completed a random spot check of two people's medicines and they matched the records kept. Only trained staff administered medicines. Controlled drugs (drugs which are liable to abuse and misuse and are controlled by legislation), were stored securely in a separate locked cupboard fixed to the wall and were accurately recorded. Medicine which was no longer needed was stored safely ready for collection by the pharmacy.

Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all checked records. Staff files contained evidence to show, where necessary, staff were registered with appropriate professional bodies such as the Nursing and Midwifery Council. The Nursing and Midwifery Council regulate nursing staff and ensure professional standards. People told us that they felt there was enough staff and that they were responded to in a timely way. One person told us "my call bells' always in my hand and staff come if I ring". There were sufficient numbers of staff on duty to keep people safe and meet their needs. We reviewed the rota and the numbers of staff on duty matched the numbers recorded on the rota. Staff told us they felt there were enough staff on duty. There registered manager told us they used a dependency tool to decide on staffing levels and to ensure that staffing levels were adapted to meet the changing needs of residents. On the day of our inspection we saw that there were six care staff and two registered nurses working from 7.30am to 7.30pm. There were two activity staff on duty and the registered manager was on duty from 9-5pm. Cleaning, laundry and maintenance staff were also on duty during the day. We observed that people were not left waiting for assistance and people were responded to in a timely way. We looked at the staff rota for the past four weeks. The rota included details of staff on annual leave or training. Shifts had been arranged to ensure that known absences were covered.

Good

Is the service safe?

Good

Is the service effective?

Our findings

Consent to care and treatment was sought in line with legislation and guidance. 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 make 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. The registered manager told us that DoLS applications had been made for twenty seven people living at the service. Two DoLS applications had been authorised and others were awaiting decision. These applications included restrictions such as the use of wheelchair lap belts. DoLS protects the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority as being required to protect the person from harm. People were able to make day to day choices and decisions, but where decisions needed to be taken relating to finance or health, for example, then a best interest decision would be made for people who lacked capacity. A best interest decision is where care professionals and relatives would make a decision on the person's behalf, taking into consideration their needs and wishes. Where possible, the person would also be invited to the meeting.

Staff had undertaken appropriate training to ensure they had the skills and competencies to meet people's needs. Staff spoke with us about the range of training they received which included safeguarding, food hygiene and moving and handling. Staff records reviewed confirmed that all staff training was up to date. Staff told us that some training such as safeguarding was classroom based while other courses where completed through the provider's e-learning system. New staff undertook a comprehensive induction programme which included essential training and shadowing of experienced care staff. Staff had completed the provider's induction checklist which involved staff familiarising themselves with the layout of the building, fire safety procedures, policies and procedures and reading through care plans. New members of staff had a review of their performance after the first month, three months and six months. There was a formal supervision and appraisal process in place for staff and action which had been agreed was recorded and discussed at each supervision meeting. Staff received supervision three times a year and also had an annual appraisal. They received supervisions and appraisal minutes which detailed what had been discussed. Nursing staff were supervised by the registered manager and care staff were supervised by an appointed registered nurse. Staff confirmed they had regular supervisions and told us they found these helpful. They discussed the people they supported and any areas of personal development to ensure staff skills and knowledge in caring for people.

People were supported to maintain good health and had access to health professionals. One relative told us "(named person) had a cough and the next day they phoned to tell me the doctor had been". Staff worked in collaboration with professionals such as doctors and the falls prevention team to ensure advice was taken when needed and people's needs were met. People's care records contained a section which detailed the contact which had been made with the health care professionals such as the GP and noted advice and guidance which had been received. A health care professional told us that " any recommendations made were accepted".

The Malnutrition Universal Screening Tool (MUST) tool was used to promote best practice and identified if a person was malnourished or at risk of becoming malnourished. People who were at risk were weighed on a monthly basis and referrals or advice was sought where people were identified as being at risk. People's hydration needs were met and we saw people were offered regular hot and cold drinks throughout both days of our inspection. One person told us "I've always got a drink by my side, cordial or Ribena". A relative told us "when we go she's always got cups of tea and something to eat".

The chef had details of people's dietary needs including soft food diets kept within the kitchen and ensured that all kitchen staff were aware of any changes to people's diet and recorded. People told us they had enough to eat,

Good

Is the service effective?

enjoyed the food and were offered choices. If people did not want the planned meals the chef would make an alternative. One person told us "the food is excellent if you ask for anything you get it. I asked for eggs and bacon and what turned up? Scrambled eggs and bacon." Another person told us "I don't like sausages or mashed potatoes and they make sure I don't get them". We observed a lunchtime meal and saw that people had enough to eat and drink and were offered support when needed. Staff offered people a choice of cold drinks. People were served their choice of meal. People's meals appeared hot and appetising. There was a menu on each table which detailed the choices available. Christmas music was playing the background while people enjoyed their lunch. Staff encouraged people to eat and offered to refill drinks. Staff were seen cutting people's food into smaller pieces when needed. When needed, people also used plate guards to allow them to remain independent with eating. Where people needed assistance with eating we saw that this was done at an appropriate pace. Staff sat beside the person and spoke with them to make sure this was a pleasant experience and asked the person when they would like more food. Meal checks were carried out twice a week and people were asked for their views on the menu choices. The chef told us that if the feedback on a meal was negative he would take if off of the menu. From the meal check documents reviewed the feedback on the food was mainly positive.

Good

Is the service caring?

Our findings

People's relatives spoke positively of the caring manner of the staff. We were told "the staff are very friendly, it's just like a family" and "when we hear staff talking to people they're always friendly and lovely. A lot of the time they don't know that we are there and can hear". Healthcare professionals also spoke positively about the caring manner of staff and told us "all the staff were friendly, welcoming and appeared caring. When talking with staff and through observation they all demonstrated a good knowledge of the residents that they cared for". Staff took time to support people and ensured they did not feel rushed. A relative told us "I have never seen anyone be less than patient and caring". We saw a member of staff support someone to walk from the dining room through to the lounge area. They made sure the person had the equipment they needed to walk and encouraged them to walk slowly and take their time. We saw staff spend time speaking gently and kindly to someone who had recently moved to the home and was upset. Staff offered reassurances they were safe and encourage them to take part in the morning's activities.

We spent time observing the care practices in the communal areas and saw that people's privacy and dignity were maintained. Staff knocked on people's doors before entering and made sure they were happy for them to enter the room. We spoke with staff about how they ensured people receive care in a way that promoted their dignity. A member of staff told us "We make sure the door is closed, the curtains are pulled and put on the do not disturb notice. We explain what we are going to do to gain consent". The registered manager told us that treating people with dignity is an area which was discussed at staff induction, ongoing training and at staff meetings to ensure this value was embedded in staff practice.

People were involved in the decisions about what care they received and in their decisions about daily routines. People told us "if you don't want to get out of bed they don't make you. Although they do encourage me to get up". Staff encouraged people to make choices in their daily life such as about what clothes they would like to wear. They told us that when supporting someone to get dressed they would offer a selection of outfits and ask the person which they would prefer to wear that day. People were offered a choice of how they would like to spend their day and what they would like to eat. During our inspection we saw that staff knelt down when talking to people so that they were are the same eye level and repeated questions when needed. A member of staff told us "communication is the most important thing". Staff spoke with people and gained their consent before providing support or assistance. We spoke with staff about how they communicated with people who were unable to communicate their wishes verbally. They told us they would watch their facial expression and gestures to understand their views. If someone refused their assistance they would respect their decision but would return later and offer support again.

People's rooms were personalised with items such as ornaments and family photographs. Staff spoke with us about their focus on delivering person centred care and the importance of understanding people's life history. A staff member spoke with us about how they found out the likes and dislikes of someone who had recently moved to the home and how they used this information to reduce any upset the experience when settling into the home. They told us "how can you care if you don't know the person".

Family and friends were able to visit without restriction. Relatives were made to feel welcome and felt comfortable discussing any changes or updates to the care their relative received. Throughout our inspection we saw relatives visit and spend time with their family member in the lounge and dining area. Staff members knew who relatives were there to visit and family members appeared comfortable speaking with the staff on duty.

Good

Is the service responsive?

Our findings

People received care which was responsive to their needs. Care plans included information and contact details for people's key relationships. They also included information on people's health and social needs. Care plan's contained information on people's life history. The registered manager told us this information had been requested from people's family and friends. Relatives told us that the registered manager had spent time with them discussing their family member's life history. One relative told us "they spoke to us about mum's life history; they made thorough notes on everything". Staff understood the importance of knowing people's life history and told us how this could impact on how they responded when care was offered and how knowing this information could ensure that they delivered person centred care.

We reviewed a care plan and saw it detailed the person's preferred night time drink and that they like to settle in bed early but would not fall asleep until later. Where appropriate people had Do Not Attempt Resuscitation (DNAR) orders in place at the front of their care plan. A DNAR is a legal order which tells medical professionals not to perform cardiopulmonary resuscitation on a person in the event of cardiac arrest. Where people displayed behaviour which may be challenging they had care plans in place which detailed what behaviour may be displayed and how staff should respond to this to reduce the likelihood of the person becoming upset. However we saw that one person within the home was distressed and displaying behaviour which may be challenging. We reviewed this person's care plan and saw they were staying at the home temporarily while a permanent placement was sought. They had lived at the home for two weeks. This person's care plan did not contain information which detailed how best to support them if they displayed behaviour which may be challenging. We discussed this with the registered manager who contacted the person's social worker for an update on the future plans. They also contacted the GP to request that they visit and assess the person's physical health. People's care plans were reviewed monthly or sooner if needed. We reviewed a care plan and saw that their eating and drinking assessment had been reviewed monthly and it was identified that the person was at risk of malnutrition. The additional support which the person required was detailed, their weight was recorded monthly and a MUST review was in place. A MUST is a malnutrition universal screening tool which is used to identify people who may be at risk of malnutrition.

We also saw that one person who had been identified at being at risk of choking had a detailed care plan around how staff should support this person with meals. This information had been update in the care plan following an assessment by the speech and language therapist. The care plan advised that only staff with the appropriate training should support this with task and that they were to ensure that the person was alert and support in a fully upright position. The care plan also detailed which stage thickener the person should receive and that staff should ensure this was given in small single sips only. The care plans also contained guidance about the pace the person should be supported with eating.

Some people were living with dementia and we saw that care plans contained detailed information on how staff should communicate with people. One communication care plan stated that the aim for this person was to ensure that their needs, wishes and preferences were to be understood by staff. The care plan stated that staff should "approach him in a calm and friendly manner, speak clearly and slowly and maintain eye contact". The care plan also reminded staff to observe for non-verbal cues which may convey pain or discomfort.

Daily records were kept for each person which recorded which care the person had accepted or refused, what they had eaten and drank, and if there had been any changes to their mood. This ensured that the person's needs could be monitored and any changes responded to as needed.

People had pressure relieving mattresses in place to reduce this risk and maintain their skin integrity. People's care plans contained information on the correct setting for the pressure relieving mattress. The registered manager told us that this was set based on people's weight and height and was reviewed when needed.

People's social needs were assessed and their care plan contained information on what hobbies and interests they had taken part in before moving to the home. Health care professionals told us "the activities staff were very enthusiastic when carrying out activities and when talking about what they were planning, they were observed encouraging all residents to participate in the activity

Good

Is the service responsive?

sessions". Copies of the activities schedule were available throughout the home so that people could see what was on that day and what they would like to take part in. The activities timetable included exercise sessions, sing a longs, reminiscence sessions, puzzles and arts and crafts. We saw that one person's social care plan had been reviewed and updated as staff had found out that the person enjoyed classical music. The care plan reminded staff to ensure that the radio was on and classical music was playing in the person's room. There were two lounges, one was the activities lounge which was used for group activities such as quizzes and the other was a homely decorated lounge which was quieter and people used this are to relax and spend time with staff or watch television. This ensured that people had the option of spending time taking part in group activities or they could chose to spend time in a quieter environment.

Staff told us they find out about people's likes and dislikes by gathering life history information from people's family and friends. When people chose to spend more time in their room, activities staff would visit their room two or three times a week and offer social activities there. A relative told us that "the staff try to get mum involved as much as she can, sometimes she has a go at some colouring". Staff spoke with us about one person who spent most of their time in their room and told us "(named person) I will spend time talking to her or we put on some music and listen to that". The minibus was used for trips outside of the home. Trips had been arranged to the beach in the warmer weather and recently to the local pub for lunch. There were planned activities throughout the year for events such as Christmas and people and their families had taken part in the summer fete in the garden of the home. This ensured people had opportunities for social interaction and stimulation to meet their social and emotional needs.

People and relatives we spoke with told us they had never had a reason to make a complaint but felt that the registered manager would respond appropriately. There was a complaints policy in place and the registered manager told us how they would respond to a complaint. They would document the concern, respond promptly and ensure that the person or relative was kept informed throughout. We reviewed the written records relating to complaints and saw that the registered manager had responded in line with the policy and recorded the details of the complaint, the action taken to resolve the complaint, who was informed and if the complaint was resolved. Staff demonstrated an understanding of how to deal with a complaint and told us they would take a note of the complaint and pass this on to the registered manager.

Resident meetings were held once a month. Relatives told us that if they were unable to make the relative meetings the registered manager kept them up to date on any changes when they visited the home. We were told "(registered manager) made it clear if we want to discuss anything we just have to say, she's very approachable and very hard working". Topics discussed covered the care people received, food, laundry and the activities provided. Relative meetings were held quarterly. We reviewed the minutes from the December 2015 relatives meeting and saw that topics of discussion included requests to submit life history information, the new carpets being fitted and the Christmas party. The registered manger also told relatives that there would also be three days in each month that would be drop in days and relatives were encouraged to visit the registered manager and discuss anything. The minutes also noted that notepads were now in people's rooms to improve communication for staff and relatives. A relative spoke with us about the notepads and told us that they found them helpful as they could leave notes about non urgent matters such as new items of clothing which they had brought in for their relative and stored in the wardrobe. This ensured clear communication and timely response to any concerns or changes.

Good

Is the service well-led?

Our findings

Quality assurance systems were in place to regularly review the quality of the service provided. There was an audit schedule for aspects of care such as medicines, care documentation and infection control. We reviewed the September 2015 infection control audit and saw that it had been identified that new pedal operated bins were needed. We saw that throughout the home pedal operated bins were now in place. Accidents and incidents were recorded by the registered manager. The area manager for the home also reviewed this information and this was sent to the provider so that patterns or trends could be identified and action could be taken to reduce the occurrence of any of these events. Environmental risk assessments were also carried out and there were personal evacuation plans for each person so staff knew how to support people should the building need to be evacuated. There were weekly, six monthly and annual health and safety audits to ensure the safety of staff and people. We reviewed the weekly health and safety audit and saw that this checked on areas such as the flooring, the staircase, general cleanliness and storage. We saw that the registered manager had identified and issue with the carpet on the landing on the health and safety audit carried out on the 13 November 2015 and also the 20 November 2015. This issue was resolved by the 27 November 2015 and a new carpet was in place.

Regular staff team meetings took place to allow staff to communicate their views about the care provided and any concerns about individual people's care. Staff told us that the registered manager was approachable and they felt comfortable raising any concerns which they had. Staff were aware of the safeguarding and whistleblowing policy and told us they would report this to the registered manager if they had concerns. The registered manager made sure that they had regular contact with the nursing and care staff to ensure that they were aware of any concerns about staff practice or areas which need further development or training. The registered manager had regular contact with the area manager and told us that they felt well supported by senior manager and were able to discuss any challenges which the service may face. They also attended manager meetings arranged with registered managers from the providers other homes. The registered manager felt that these were helpful as they had the opportunity to discuss issues with other managers and share good practice.

Relatives spoke positively of the registered manager and told us "I'm delighted with the care, (registered manager) is absolutely lovely". We also reviewed thank you cards which the home had received and one comment read 'I just wanted to say a very big thank you for all the care and love you showed mum over the last few months.' Another read 'I just wanted to say thank you for taking care of nana and for all the support you have shown us over the last year'. Health care professionals spoke positively about the registered manager and told us they were "receptive to the input and information shared. They were appreciative of the feedback and information given. They demonstrate a good working relationship and were supportive to staff". We observed that people had a good relationship with the registered manager. During the lunchtime meal one person was upset and the registered manager spent time reassuring and comforting them. One staff member told us "I'm well supported by (registered manager). What she wants we follow, she's a good leader and supports her staff". Another member of staff told us they felt supported by the registered manager and felt that the staff worked well together. They told us "as a team we are working really well".

Relatives were asked for feedback once a year through a survey and people were asked for feedback twice a year. We reviewed the resident's survey from October 2015 and saw that their response was positive. We reviewed the relative's survey from November 2015 and read one comment which read 'all staff members very friendly and helpful. We are very pleased with the care mum receives'.

We spoke with the registered manager about the vision and values of the home and were told "our aim is to create a homely environment and provide safe care. Care that is person-centred and responsive to people's needs". Staff shared the vision of the registered manager and told us "we specialise in elderly and dementia care. People are really taken care of. The care is safe, responsive, caring, effective and well led". Another member of staff told us "we focus on person centred care".