Keychange Charity

# Keychange Charity Rosemary Mount Care Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Requires Improvement |
| 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 19 and 21 April 2016 and was unannounced.

Keychange Charity Rosemary Mount Care Home is a large, detached house situated to the east of Worthing town centre, with access to local shops, public transport and the train station. A large, bright, airy reception area with seating and a baby grand piano leads into a large sitting room and adjacent dining room. There is another smaller sitting room available for prayer and reflection and this room can also be used by families and visitors who require privacy. Bedrooms are of single occupancy and housed over three floors, accessible from a lift. Gardens surround three sides of the property. The home is registered for up to 29 people with a variety of health and mental care needs. At the time of our inspection, the home was at maximum capacity.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Generally, medicines were managed safely. We observed a senior member of staff administering medicines to people at lunchtime. The trolley was not always locked when left unattended and blister packs of medicines were left on top of the trolley. People were left to take their medicines in their own time and were not closely supervised by staff.

People told us they felt safe from abuse and harm. Staff had been trained to recognise the signs of potential abuse and knew what action to take. People's risks and environmental risks had been identified and assessed and were managed appropriately. Communication between staff regarding one person's care had not been effective, but this was promptly investigated and resolved. Accidents and incidents were reported by staff and appropriate action taken, with risk assessments updated as needed. There were sufficient numbers of staff on duty to keep people safe. Robust recruitment practices ensured that staff were vetted before they commenced employment.

Staff had been trained in all essential areas and were encouraged by management to take additional qualifications. New staff completed the Care Certificate, a universally recognised qualification. Staff had regular supervisions and an annual appraisal with their line managers. Staff had a good understanding of the requirements of the Mental Capacity Act 2005 and associated legislation and put this into practice. People had sufficient to eat and drink and menu choices were varied over a three weekly cycle. People were supported to maintain good health and had access to a range of healthcare professionals. The premises were well adapted for people with limited mobility and people could personalise their rooms in line with their preferences.

People were looked after by kind and caring staff. People and their relatives spoke highly of the staff and

were encouraged to express their views and to be involved in making decisions about their care. People were treated with dignity and respect. Where appropriate, documents relating to people's end of life care needs had been completed. People and their relatives were consulted about end of life wishes.

Care plans provided comprehensive, detailed information to staff about people's care and support needs and how they should be cared for. People were encouraged to be as independent as possible and relatives told us of the improvements their family members had made since they were admitted to the home. Handover meetings were organised between shifts so staff could update each other about people's care, their moods and health needs. A programme of activities was organised by an activities co-ordinator. People enjoyed the activities on offer and some people had 1:1 support with activities. Complaints were managed appropriately in line with the provider's policy.

The home was well managed and demonstrated good leadership at all levels. People and their relatives were asked for the views about the service provided and the quality of care, with positive results overall. Staff felt well supported by management and were asked for their feedback on the home. A system of robust quality assurance systems measured the quality of care delivered. A representative of the provider undertook quarterly monitoring visits which were used to drive continuous improvement.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

One aspect of the service was not safe.

On one occasion, the medicines trolley was unlocked and blister packs left unattended on top of the trolley when medicines were administered. In the main, people's medicines were managed safely.

People felt safe living at the home and staff had been trained in how to recognise signs of potential abuse; they knew what action to take.

People's risks were identified, assessed and managed appropriately. Accidents and incidents were reported and risk assessments updated as needed.

There were sufficient staff to meet people's needs and safe recruitment practices were in place.

### Is the service effective?

**Good**

The service was effective.

People received care from staff who had received all essential training.

People had sufficient to eat and drink and were supported with a healthy diet. They had access to a range of healthcare services and professionals.

Staff had regular supervision meetings with their line managers and annual appraisals.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act 2005 and put this into practice.

The premises were adapted to meet people's needs.

### Is the service caring?

**Good**

The service was caring.

People had formed positive relationships with staff. Staff supported people in a kind, warm and friendly way.

People were encouraged to express their views and be involved in decisions about their care. They were treated with respect.

End of life care documents were completed appropriately and with the involvement of people and their relatives.

## Is the service responsive?

Good

The service was responsive.

People received support from staff in line with their documented care needs.

A programme of activities was organised for people.

Complaints and concerns were investigated and managed in line with the provider's policy.

## Is the service well-led?

Good

The service was well led.

People and their relatives were asked for their feedback about the service and the care provided.

Staff felt well supported by management and felt their views were listened to.

A range of quality assurance systems ensured that the quality of care was measured and continuous improvements were made. People, their relatives, staff and other professionals spoke highly of the service.

# Keychange Charity Rosemary Mount 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.

The inspection took place on 19 and 21 April 2016 and was unannounced.

An inspector and an expert by experience undertook this inspection. 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 at this inspection had expertise in older people and dementia care.

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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including three care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with five people living at the service and spoke with three relatives. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, two deputy managers, a shift leader, two care assistants and the cook.

The service was last inspected on 8 May 2014 and there were no concerns.

Requires Improvement

# Is the service safe?

## Our findings

Risks to people were generally managed appropriately and their freedom was supported and respected. People's risks were identified and assessed and risk assessments within care records contained information and guidance to staff on how to support people safely. Risk assessments had been drawn up in a range of areas, such as moving and handling, bathing independently, skin integrity, mobility and the use of bed rails. We looked at a risk assessment for one person relating to moving and handling. The assessment documented the equipment required to prevent falls: a sensor mat and bed rails. The assessment stated, 'Staff to ensure pressure mat is attached when [named person] is in room or in bed, to alert staff she is up and moving'. The vinyl flooring in the person's room had also been identified as a potential slip hazard. A relative told us about their family member and said, "Yes, she tries to get up on her own without the bell, but they have a sensor mat in place". Risk assessments were reviewed monthly and updated as needed. A member of staff said they would keep people safe, "By making sure everyone's risk assessed".

Three people had pressure ulcers and two hourly turns and turn charts had been completed by staff, to ensure that people's risks of skin break down was minimised. In addition, pressure relieving mattresses were in use. However, in one person's care plan, an entry in the daily notes on 20 April made by staff stated, 'Sore on anus area which has been bleeding. Red sacrum and sores around her bottom. Please observe and record'. It appeared that no follow-up action had been taken as to how this person's skin had been monitored as this had not been recorded within the daily notes. We drew this to the attention of one of the deputy managers, who immediately investigated our concern and reported back that the person's sore areas no longer posed a risk and had been managed safely. We discussed with the deputy manager and registered manager how communication between staff might be improved to ensure any monitoring identified was not overlooked.

In the main, people's medicines were managed so they received them safely. One person thought that staff managed their medicines safely and said that staff always gave them, "A glass of water to swallow pills with". Care staff were trained to administer medicines and competency checks were undertaken by senior staff at least twice a year. Training was refreshed yearly or as needed. An audit had been completed recently by the pharmacy who delivered and disposed of people's medicines. The audit had identified some action points and the registered manager had taken steps to address these. For example, people's allergies to particular medicines were to be reviewed and updated, with a copy sent to the pharmacy. Medication administration records (MAR) showed the medicines that had been prescribed for people and these were complete, with each entry signed by a trained member of staff. When medicines were administered to people as needed, (PRN), such as for pain relief, this was recorded appropriately. One person administered their own medicines and a risk assessment was in place; their medicines were kept in a locked tin in their room. Medicines were ordered, stored and disposed of safely.

We observed medicines being administered to people by a senior member of staff during the lunchtime period. Medicines were administered from a trolley which was wheeled into the dining room. The member of staff wore a tabard which stated, 'Do Not Disturb' whilst they were administering people's medicines. We observed that the medicines trolley was not always locked when the staff member went to give people their

medicines. However, this was only when the staff member was giving people their medicines close to the trolley. Later, when medicines needed to be administered to people at the far end of the dining room, the member of staff locked the trolley, but had inadvertently left the rack of blister packs on top of the trolley. This may have occurred because the member of staff was nervous about being closely observed by us whilst administering medicines to people. The risk of anyone helping themselves to medicines left unattended was extremely small, but it is not good practice to leave a medicines trolley unlocked or medicines unattended. In addition, people's medicines were given to them in little pots and left with them, so they could take them a little later during the meal. The staff member allowed people the time to take their medicines and checked later to see that people had actually taken them. We discussed this with the registered manager later, who told us that staff knew people well and whether they could be trusted to take their prescribed medicines. Nevertheless, this posed a potential risk in that people could have disposed of their medicine, rather than taking it or people may have forgotten to take it.

People told us they felt safe and protected from abuse and harm. One person said, "I have been here three years and I used to be a carer myself. I know it is safe here". Another person told us, "All my time here, I have always felt safe". A third person said, "I've got a good family and I don't worry about anything anymore". A relative felt the home was safe and said, "I am in the business and I have absolutely no doubt my mother is safe here". Staff knew what action to take if they suspected abuse was taking place and had been trained in safeguarding adults at risk. One staff member named the different types of abuse that might occur such as institutional, physical and psychological. They described how they would support the person who alleged they had been abused and said, "I'd listen to them, write it down and report it to a more senior person". They explained that the registered manager would then raise an alert with the local safeguarding authority. Another member of staff said, "I'd report to the senior management" and told us they might also report their concerns to the Commission.

Accidents and incidents were reported by staff and eight incidents had been recorded for 2016, including some incidents relating to staff. The incident report forms showed the date the incident was investigated by a senior member of staff and any further action required. For example, one incident report form recorded the sudden onset of abdominal pain for one person, the GP was consulted, the person's urine was tested, pain relief prescribed, a urinary tract infection diagnosed and medicines prescribed for the infection.

Risks associated with the premises had been assessed and managed appropriately. Checks had been made by an external company and a water analysis log report included Legionella prevention, temperature recording, water quality and equipment. People had personal emergency evacuation plans in place which provided advice and guidance to staff about how to evacuate people safely from the building in the event of an emergency.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. On the day of our inspection up to six care staff were on duty and two deputy managers. The registered manager was supernumerary, but available to provide assistance with care if required. At night, two waking care staff were on duty and a senior member of staff was 'on call' if needed. The registered manager told us that staffing levels were assessed based on people's care and support needs. At busy times of the day, for example, when people needed assistance to get up in the morning, some day staff would come in a little earlier at 7.00 or 7.30am, while others started their shift at 8am. We looked at the staffing rotas and checked the staffing levels between 28 March through to the end of April 2016. Staffing levels were consistent across the time examined and confirmed the number of staff on duty. Staff we spoke with thought that staffing levels were safe and that the addition of staff to cope at busy times was helpful. A member of staff told us that they received notice of what shifts they would be required to work a month in advance. Some staff worked a mixture of day and night shifts.

Safe recruitment practices were in place. Before staff commenced employment, two character references were obtained, their identity checked and an application made to the Disclosure and Barring Service (DBS) to ensure they were of good character and safe to work in the care profession.

Good

# Is the service effective?

## Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. The majority of training was delivered on line through an external training organisation. Staff watched videos relating to the training topic and then answered a series of multi-choice questions which assessed their understanding of the subject. The staff training plan confirmed that all staff training was up to date in essential areas such as first aid, dementia awareness, fire safety, health and safety, infection control, safeguarding, medicines, moving and handling and food hygiene. Staff were encouraged to study for additional qualifications and one member of staff told us that they were hoping to be promoted to become a team leader, once they had achieved the appropriate qualification. They told us, "I always get a lot of support to move forward". Another member of staff said they had completed a National Vocational Qualification (NVQ) Level 2 in Health and Social Care and wanted to start an NVQ Level 3 soon. In the Provider Information Return (PIR), the registered manager stated, 'As a provider, we undertook the dementia pledge which made us look at where we could adapt our service. We will continue to monitor and review our audit. All staff, with the exception of those who are new, have received dementia care training'. The dementia pledge is about a service demonstrating a commitment to provide great dementia care.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics, a nationally recognised qualification. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. One member of staff talked about the induction they had received when they commenced employment. They told us they were halfway through completing the Care Certificate and that a senior member of staff assessed their progress. They had worked at the home for about three months and told us, "I really enjoy it. It's a lot to get used to". They went on to describe their induction and said, "I went round with the shift leader, went in [to people's rooms] when they did care". Induction also required new staff to read people's care plans so they understood people's care and support needs. New staff were also shown how to complete daily records of people's care. They said that their induction programme had been completed in a week. Volunteers were trained and supported and the home organised 12 week work shadowing placements for students from two local colleges.

Staff told us that they received supervision with their line managers approximately every three months and an annual appraisal and staff records confirmed this. One member of staff referred to 'group supervisions' which were opportunities for staff to revise on training topics and to discuss these at the meeting. Staff meetings were held every four months. The minutes of a meeting held on 8 December 2015 showed that items under discussion were occupancy, confidentiality, laundry, training, infection control, medication administration records and senior managers.

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. Staff we spoke with had a good understanding of the MCA and their responsibilities under this

legislation. One member of staff said, "You can't assume someone has or hasn't got mental capacity. You support them in their mind to take the decision that's right for them". They went on to give an example of a decision taken in one person's best interests, with advice from the GP, relating to the withdrawal of their medication. Another staff member told us, "You can't always assume mental capacity, even if they make an unwise decision".

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. Some applications for DoLS had been submitted to the local authority for consideration and the majority of these had not yet been progressed by the local authority. The registered manager told us that they would always prioritise urgent applications for DoLS and that these would be considered promptly by the local authority.

The use of restraint was not used unnecessarily and one person's care record showed they had given their consent for the use of a safety belt to be used to support them safely in their wheelchair. Restraints were also used, with their permission, when they were using the bath or shower seat.

People had sufficient to eat and drink and they were encouraged to maintain a balanced diet. Menus were planned on a three weekly cycle and the home was in the process of changing from the winter menu to the summer menu. On the day of our inspection, two main lunch choices were available: sweet and sour pork with rice and prawn crackers or jacket potato with cheese and salad. People spoke positively about the food on offer. One person said, "I'm not a big meat eater, I like pasta and lasagne. The food's very good". Another person told us, "Food's very good and you get a choice every day of two things. I never remember what I've chosen, but I eat what's put in front of me!" People could choose a different menu option if they did not fancy the food presented to them at the table. A relative referred to their family member and said, "She enjoys the food".

We observed people as they sat down for lunch in the dining room, a room which had been recently redecorated. The tables were laid attractively with tablecloths and napkins. Staff were readily available to serve people with drinks or to provide other assistance. People could choose where they wanted to eat their meal and we observed staff taking meals to people in other parts of the home; the food was kept warm under a metal cover. One person told us, "I prefer to be on my own and not go to the dining room. All the carers are so kind to me and I cannot fault them". Breakfasts consisted of either a 'continental' choice of toast and cereal or a cooked breakfast was on offer three times a week. If people fancied something to eat between mealtimes, they could help themselves to a snack from a box in the sitting room, a cereal bar or chocolate biscuit bar. People were weighed monthly so that their weight could be monitored and any increase or decrease could be identified and managed. Special diets were catered for, such as for people living with diabetes.

People were supported to maintain good health and had access to a range of healthcare services and professionals. A district nurse visited regularly to deliver insulin injections and a chiropodist and optician also attended people at the home. On the day of our inspection, one person was receiving advice from a professional about their hearing aids. Another person described an occasion when they had developed a cough and staff had contacted the GP, who prescribed some cough mixture. They told us that their family supported them to attend hospital appointments, but that if they were not available, then staff would support them to attend. A relative confirmed that staff were, "Superb" at consulting healthcare professionals for their family member. A third person said, "We can have a chiropodist once a month and I

can get my hair done with the hairdresser every other week. When I ask for a doctor I can always get one quickly". People living with dementia had their medicines reviewed in October/November last year and, as a result, dementia care plans had been implemented and were in use at the local medical centre. Care plans contained records of when people had seen a GP or other healthcare professional. One person had regular blood tests recorded and diarised which were needed to monitor the dosage of a particular medicine for their health condition.

The premises were well adapted for people with limited mobility or who were wheelchair users. The lift was a 'walk through' lift which meant that people did not have to turn around to exit the lift. Doors to communal areas were wide and there were wide sliding doors between the dining room and sitting room. Doors would open automatically when a button was pressed. We visited people's bedrooms, with their permission, and observed that people had lots of family photos and pictures on display. One person thought they had a nice bedroom and added, "I've got everything I need". The registered manager told us there was a rolling programme of redecoration and refurbishment. The dining room had recently been redecorated and refurbished and there were plans to replace vinyl flooring with carpeting in parts of the home. In the Provider Information Return (PIR), the registered manager documented the improvements that they were planning to introduce within the next 12 months. They stated, 'We are planning to improve our garden area by installing gated areas to enable people to use the garden independently whilst remaining safe and secure at all times'.

Good

# Is the service caring?

## Our findings

Positive caring relationships had been developed between people and staff. We observed staff bent or knelt down to speak with people at their level and that they had time to sit and chat. People confirmed that staff were kind, warm and friendly and one person told us, "The staff look after me so well and I'm grateful for the care I get here". A relative confirmed that staff were kind and caring and always had time to chat with people. A member of staff said, "It's about making a resident's quality of life better, or as good as it can be". Another member of staff told us, "We always try and have a chat, even if it's just walking down the corridor". People told us that they had formed friendships with other people at the home and we observed people chatting with each other and staff on the day of our inspection, about the Queen's 90th birthday. One person told us about the cake that had been made for their birthday. The registered manager said, "Life doesn't end just because you come into a care home". They went on to say, "The staff are caring and work really hard. When they do any kind of fundraising or celebrating, all the staff come in. They wouldn't do that if they were unhappy". A member of staff told us, "Everyone's friendly. We're quite lucky with the residents, they all get on well the majority of the time".

People were supported to express their views and were actively involved in making decisions about their care and support. We observed that staff consistently asked people for their permission before undertaking a particular task, for example, when helping people to mobilise around the home. People could choose what time they wanted to get up or go to bed each day and whether they wanted to have a bath or shower.

People were treated with dignity and respect and staff talked about the need for closing curtains and doors in people's rooms when assisting with personal care. One member of staff was a 'dignity champion' which required them to make a commitment to promoting people's rights to be treated with dignity and respect. They told us that being a 'champion' meant that they made other staff aware of how to treat people with dignity, especially new staff. A visiting member of the clergy told us, "Rosemary Mount treat their residents with great care and dignity and I see this now, just as when my mother was here". People confirmed they were treated with dignity and respect and one person told us, "Even the male carer. They try and make me more independent too".

Where identified as appropriate, 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) forms were in place for people. People and/or their relatives had been consulted about people's preferences and choices for their end of life care. DNACPR forms were kept in people's care records, which were easily identified as they were located in red folders, rather than black folders, which were used for other people who did not have DNACPR in place. Hospital passports had been drawn up for people which provided brief summaries about people's health conditions for hospital staff should they need to be admitted to hospital. Completed DNACPR forms and hospital passports were kept in a separate folder in the office for easy access when required in an emergency.

Good

# Is the service responsive?

## Our findings

People received personalised care that was responsive to their needs. People confirmed that, if they wished, they were involved in planning their care and care records confirmed this. One person told us they were involved in reviewing the information in their care plan. Another person said, "No not really. My daughter and son do that for me and my son signed it". A member of staff referred to people living at the home and said, "If they asked to have a look at their care plans they can". They also confirmed that relatives were involved in the review of their family member's care plan and relatives we spoke with corroborated this. A relative told us, "Overall it's very good. I was nervous about mum coming here. They've worked very hard to meet her needs" and gave an example of their mother having problems with continence, especially at night, so, "They put her in a room opposite the toilet".

Care plans provided comprehensive information for staff about people's care needs and how they should be supported. There was information on how to assist people with personal care. For example, one care plan documented, '[Named person] needs all assistance with washing and dressing each day. Goal/expected outcome: To enable [named person] to be independent where able and assistance to be given where needed'. Additional information about this person included, family communication, involvement in social activities, their personal history, mental capacity, moving and handling and behaviour. Where people had been assessed as at risk of displaying behaviour that might challenge, ABC charts had been completed. These recorded the Antecedent to the behaviour, the Behaviour itself and the Consequence of the behaviour. Advice had been sought about one person's behaviour from a GP and social care staff. Staff told us they would employ distraction techniques when this person became particularly agitated or distressed. One staff member talked about the person's refusal to accept personal care and told us, "If she still refuses, I'd get another member of staff to try". Care plans were audited and a checklist completed to ensure all necessary documents were in place including information on people's cognition, psychological state, physical, social and end of life wishes. Care plans were reviewed monthly or as needed.

People were encouraged to be as independent as possible. One person told us that they had difficulty walking when they were admitted to the home, but were now able to walk with a frame. A relative talked about their mother who was admitted to the home from hospital and unable to walk. They told us that their mother was not happy using a wheelchair and said, "But they've got her walking again". Where people received care in bed or chose to stay in their rooms, staff offered 'comfort rounds'. These were completed regularly by care staff to check on people's continence, repositioning in bed, hydration and that the call bell was within each. Staff signed when these checks had taken place and would also ask people if there was anything they wanted doing. When staff completed room checks at night, they pressed a button which recorded this had been completed on a database at the home.

Handover meetings were held for staff between each shift and we attended one handover meeting after lunch. People's care needs, their moods and behaviour and any visits or appointments were discussed. A member of staff explained they discussed, "Whether people have slept well and their moods, if people are feeling low". One person's care needs were discussed in relation to a urinary tract infection and input/output fluid charts were being completed. Another person with a loose tooth was offered a soft

pudding made up by the cook.

An activities co-ordinator organised activities for people on at least five days a week. On the day of our inspection, the co-ordinator was on annual leave, so care staff stepped in to organise an activity. People were asked if they wanted to do some colouring and pictures connected with royalty had been supplied, as it was the Queen's 90th birthday. People were also watching the television coverage of the celebration and of the Queen's life and family. The sitting room was decorated with red, white and blue paper chains and a singer visited in the afternoon to entertain people. The day's entertainment appeared to be enjoyed by everyone. One person said, "We like the singers who come in here for us". Another person confirmed they were happy with the activities on offer and said, "Sometimes we're invited in the kitchen to do cooking". A third person told us that outings out into the community did not occur frequently, but added, "I can go in the garden and out in the wheelchair". They said they tried to join in any activities on offer and referred to the baking they enjoyed saying, "Every Friday we make little cakes". We were shown the activities programme that had been organised for April 2016 and people could choose to do art, craft, cookery, tai-chi or board games. A film afternoon was organised for a Sunday afternoon with ice-creams.

Some staff had received training on motivating people to be involved in creative activities and experiences. The registered manager explained what a difference this had made to her thinking and improved her day to day working practice with people. People's spiritual needs were acknowledged and catered for; people could go to church or members of the clergy would come and visit. Records were completed by the activities co-ordinator which documented the activities that people had participated in, what they liked to do and any comments from people as to whether they had enjoyed the activity. Some people preferred to have 1:1 time with the activities co-ordinator rather than join in with group activities.

People's complaints and concerns were listened to and responded to in good time. Four complaints were received in 2015 relating to a lack of communication raised by a relative, medication issues raised by a relative, staff attitude to a relative, the laundry and availability of commode pots. Each complaint was clearly documented with the action taken by the registered manager to address these to the satisfaction of the complainants. The provider's complaints policy stated that all complaints should be acknowledged, investigated and responded to within 28 days and complaints were managed in line with this policy. People told us they would talk about any concerns they had with senior management. One person said, "I would go to [named registered manager and deputy manager]". Compliments were also recorded and we saw a file filled with 'thank you' cards and notes. For example, from students who had completed work experience programmes at the home had sent in their written thanks.

Good

# Is the service well-led?

## Our findings

The home promoted a positive culture that was person-centred, open, inclusive and empowering. People told us that residents' meetings took place. One person confirmed this saying, "Yes, we do, and if you want to put a point over you can". They went on to describe the subject areas that could be discussed, such as the food and decoration of the home, adding, "The handyman is very good". We looked at the minutes of a residents' meeting held on 1 March 2016 which showed that menu choices, activities and visitors had been discussed. The registered manager said that people could contact her at any time to discuss any issues they wanted to raise. A relative confirmed that relatives' meetings also took place approximately three times a year. Relatives were in regular contact with the senior management staff through visits, telephone, email or via social media, which was useful for families who lived abroad. Questionnaires were sent out to people and their relatives. The last survey had been sent out in March 2016 and the responses were analysed. People were asked for their views about activities and entertainment and what, if anything, they would like to see added. Fourteen responses had been received and people stated they would like to play Bingo, have more quiet games and more music which had been noted and implemented.

Good leadership was visible at all levels and the home was well managed. Members of the management team were freely available and operated an 'open door' policy. We observed that staff treated each other with respect, warmth and humour and that staff's views were listened to and acted upon. Staff were also asked for their feedback about the home and the last survey was completed in February 2016 with positive results. We asked staff if they felt the home was well managed. One staff member said, "Yes, definitely. I wouldn't have stayed as long otherwise". Another member of staff said, "Staff are treated alike by the manager". A third member of staff told us they felt well supported and were confident to discuss any concerns they might have. The deputy managers were very supportive of the registered manager and the registered manager felt that staff had helped her to build a team together. The registered manager felt the provider supported her too and said, "They're not here every week, but I can call at any time". They added that they received support from the registered managers from the provider's other homes. In the provider's Statement of Purpose, it recorded: 'Our aim – To create communities with a Christian ethos that are well led; where staff are enabled to give the best of care, that is responsive and person-centred, in an environment which makes people feel safe and supported'. From our observations and conversations with people, relatives and staff at inspection, it is our view that the home had met this aim.

Robust quality assurance and governance systems were in place to drive continuous improvement. The operations manager of the provider visited the home at least every quarter and recorded their findings in a 'quarterly visit record'. The operations manager's visit included a walk around the home and site, discussions with people living at the home and any visiting friends or relatives. The operations manager also received copies of all statutory notifications and reviewed accidents or incidents, which were then discussed with the registered manager. At the last visit, follow-up items from the preceding visit were also addressed and these related to recruitment and retention of staff, staffing levels relating to increased occupancy and the development of the management team. Where issues had been identified, steps were taken and improvements made. In addition to the audit undertaken by the operations manager, there was a range of internal audits undertaken such as daily cleaning schedules, weekly environmental cleanliness

checklists, bedrail audits, equipment checks, health and safety, care plan audits and feedback from health and social care professionals who were involved with the home. A GP had stated, 'Manager is fully aware of all the clients and well informed. Staff are fantastic during all routine rounds'. A registered nurse had commented in January 2016, 'Fantastic residential care home' and a dementia specialist had written, 'Residents appear happy here'. We asked people what was 'good' about the home and one person said, "Well everything really, the atmosphere and meeting people". A relative told us, "The care is really, really good".

We asked the registered manager about their understanding of the regulation, 'Duty of Candour', Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation is about ensuring that providers are open and transparent with people who use services and others, in relation to care and treatment. This includes informing people about any incidents, providing reasonable support, truthful information and an apology when things go wrong. The registered manager told us, "We have a duty to report to you [the Commission]. It's about being open and honest". They went on to talk about the importance of informing relatives, investigating any issues and reporting back.

The registered manager referred to their role at the home and told us, "It's challenging at times trying to meet all the requirements constantly, but I still enjoy it".