Eleanor Palmer Trust

Eleanor Palmer Trust Home

Inspection report

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Ratings

Overall rating for this service	Good

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

This was an unannounced comprehensive inspection, to make sure the service was providing care that is safe, caring, effective, responsive to people's needs, and well-led.

Eleanor Palmer Trust Home, also known as Cantelowes House, is a 'care home'. The accommodation is purpose-built with passenger lift access to the first floor. People living in this care home receive accommodation along with nursing and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager, which 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.

The service is registered to provide accommodation for up to 33 people. There were 28 people using the service at the start of this inspection. The service specialises in the care of adults including those with dementia. It is operated by The Eleanor Palmer Trust, a voluntary organisation.

The service's registration was altered to allow nursing care in the Spring of 2018. However, the registered manager informed us that nursing care had not been provided in practice so far, and would not start until they were confident that aspect of the service could be successfully maintained.

At our last inspection of this service in September 2017, we found one breach of legal requirements. These was in respect of duty of candour following serious injuries to people using the service. The provider completed an action plan to show what they would do and by when, to address this breach and so improve the rating of the service to at least 'Good.' At this inspection, we found the necessary improvements had been made to addresses the previous regulatory breach. This has helped to improve the service's overall rating to 'Good.'

However, the rating for 'Is it Safe?' remains 'Requires Improvement.' This is because we identified some concerns about upholding infection control and health and safety standards. The lounge carpet was significantly stained, and the kitchenette near the lounge and some equipment used by people had signs of wear and tear. This compromised infection control standards. We also found one person being hoisted in a sling that was not the most appropriate for their needs. The service had not undertaken effective audits in these areas to identify and address these shortfalls. The registered manager sent us information during and after the inspection visits to show these matters were being addressed.

We have recommended the provider review and implement best practice guidance on infection control in care and nursing homes.

People using the service spoke positively about it, describing it as "wonderful" and "the best care home in the world" for example. Everyone said they would recommend it to friends and family. People's relatives and representatives provided similarly positive feedback.

There was a comfortable and engaging atmosphere at the service. Staff spoke in a positive manner about different people using the service, and had time for them. People were treated with kindness, respect and compassion, and were given emotional support when needed, sometimes from other people using the service.

The service provided people with a range of mental and physical stimulation. People were supported to develop and maintain relationships that mattered to them, and there were no restrictions on visitors.

People were supported have access to healthcare services and receive ongoing healthcare and nutritional support. This included through the proper and safe use of medicines.

The service enabled people to receive personalised care that was responsive to their needs. This was based on comprehensive initial assessments of people's needs and preferences, and regular reviews to ensure changes were taken on board.

The service provided sufficient numbers of suitable staff to support people to stay safe and meet their needs. Staff were trained and supervised in support of this.

The adaptation, design and decoration of premises generally supported people's individual needs to be met. Some improvements were being planned for.

The service was generally working within the principles of the Mental Capacity Act 2005 in terms of consent to care, but records of this were inconsistently kept.

The service had a positive and inclusive culture with a strong team ethic and effective leadership that achieved good outcomes for people. It worked in partnership with other agencies to support care provision and development.

The provider's governance framework and engagement with stakeholders helped to ensure sustainability and the development of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. This was primarily due to some weaknesses in infection control standards. We also found one person being hoisted in a sling that was not the most appropriate for their needs.

However, the service ensured the proper and safe use of medicines.

Sufficient numbers of suitable staff worked, to support people to stay safe and meet their needs.

The service's systems, processes and practices safeguarded people from abuse. It learnt lessons and made improvements when things went wrong.

Is the service effective?

Good

The service was effective. People were supported to have access to healthcare services and receive ongoing healthcare and nutritional support.

Comprehensive initial assessments of people's needs and preferences took place, to help ensure effective care outcomes.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support.

The service was generally working within the principles of the Mental Capacity Act 2005 in respect of consent to care, but records of this were inconsistently kept.

The adaptation, design and decoration of premises generally supported people's individual needs to be met. Some improvements were being planned for.

Is the service caring?

Good

The service was caring. There was a comfortable and engaging atmosphere at the service. People were treated with kindness, respect and compassion, and were given emotional support when needed.

The service ensured people's privacy, dignity and independence was respected and promoted.

The service supported people to make choices about their day-to-day care.

Is the service responsive?

Good

The service was responsive to people's care needs and preferences.

A range of mental and physical stimulation was provided at the service.

The service had systems in place to respond to people's concerns and complaints.

Is the service well-led?

Good

The service was well-led. It had a positive and inclusive culture with a strong team ethic that achieved good outcomes for people.

The provider's governance framework and engagement with stakeholders helped to ensure the development of the service.

The service worked in partnership with other agencies to support care provision and development.

Systems at the service enabled sustainability and supported continuous learning and improvement.

Eleanor Palmer Trust 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 unannounced inspection took place on 25 and 31 October 2018. It was undertaken by two inspectors, a specialist professional nurse advisor and an Expert by Experience, who spoke with people using the service and visitors during the 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.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also contacted the local authority and various community healthcare professionals who have a role at the service, for their views on the service. We received three replies.

There were 28 people using this service at the start of our inspection visits. During the inspection we spoke with 12 people living at the service, seven of their relatives and representatives, six care staff, two nurses, the administrator, the chef, the maintenance worker, the registered manager, and the Chief Executive Officer (CEO) for the provider.

During our visits, we looked at selected areas of the premises including several people's rooms, and we observed the care and support people received in communal areas including at meals. We reviewed the care records for eight people living at the service to see if they were reflective of the care people received. We also looked at personnel records of four members of staff. We reviewed some management records such as for health and safety, accidents and incidents, complaints, staff rosters, and quality audits, to see how the

service was run. We also requested further specific information about the management of the service from the registered manager during and after our visits.

Requires Improvement

Is the service safe?

Our findings

People told us the service was safe. Their comments included, "Everyone's careful", "All the doors and windows are locked at night" and "I feel safe enough." One person told us of having a "buzzer" by which to call for staff help if needed. People's representatives provided similar feedback. One told us, "I do feel he's safe, it gives me peace of mind." Another said, "They are always pleasant and careful with her."

At our last inspection, we found duty of candour requirements had not been formalised and documented in respect of two incidents of people being admitted to hospital with injuries. Whilst there was no suggestion those injuries were avoidable, this did not demonstrate a culture of learning from incidents to minimise the risk of reoccurrence. This meant the provider was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements had been made which addressed the breach. This was because, following significant injuries to people using the service, the service liaised with the person or their representative to apologise and provide an account of what happened. Investigations then took place, to establish what went wrong and what needed to occur to minimise the risk of reoccurrence to anyone at the service. This information was conveyed in writing to the person or their representative.

We found accident reports at the service paid good attention to monitoring people's welfare following the accident or to access treatment such as through GPs or hospitals. However, the reports did not clearly explain any plans to prevent reoccurrence, which the registered manager agreed to action. Nonetheless, staff could tell us of actions taken in practice. For example, where one person had a recent fall, their care plan had been updated to include the use of a sensor mat to alert staff if they got up at night. We found the mat to be in working order in their room. A community professional also told us the service acted to make sure incidents did not reoccur, such as through staff training and acquiring equipment to promote better care. We therefore concluded the service learnt lessons and made improvements when things went wrong.

The service has systems to protect people by the prevention and control of infection. Staff spoken with confirmed that gloves and aprons (PPE) were readily available and could describe good practice with regards to infection control. We saw staff using PPE appropriately throughout our visits. They also offered people wet wipes at lunch, to help ensure people had clean hands for the meal. The laundry was clean, orderly and fresh-smelling.

However, we found the service was not always upholding infection control standards. The carpet in the lounge was heavily stained in places. The registered manager told us funding had been made available to replace the carpet, as cleaning equipment was no longer effective on the carpet. They sent us confirmation of the imminent date agreed for the replacement.

The small kitchen near the lounge had some infection control risks due to its poor state of repair. The plinth was notably damaged and chipboard was exposed; this surface is porous and may increase the risk of cross-infection. The kitchen work surface was very worn, making it difficult to keep clean. The inside of the fridge

was clean but some cracks were noted which compromised hygienic food storage. The registered manager told us this would all be addressed before the end of the year.

We noted occasional cracks to equipment people used, such as on a pressure cushion and two people's bed-rail buffers. We brought these to the attention of the registered manager, who arranged for immediate replacement.

Throughout the building, some radiator covers were chipped and peeling; and woodwork generally needed repainting to ensure that it was easy to clean. However, we also saw ongoing repainting to address these matters.

Bars of soap were sometimes observed in communal bathrooms and toilets which can be an infection control risk if shared. However liquid soap was also available and handwashing posters were seen.

The registered manager provided us with infection control audits after we drew their attention to our concerns. These helped identify, for example, that whilst staff received regular refresher training on infection control, that competency assessments were additionally needed.

We recommend the provider review and implement best practice guidance on infection control in care and nursing homes.

We saw that people in their rooms had call bells within easy reach which meant that they would be able to call for help when required. There were daily checks of suitable heating in the communal areas, and routine checks of safety risks around the service including in people's rooms.

There were a variety of risk assessments and subsequent care plans in place to recognise people who may need further support to keep them safe. These included for mobility and falls, nutrition, and skin care. There were risk assessments for where people had bed rails to help keep them safe in bed. Specific risk assessments were in place where one person self-medicated and another was at risk of leaving the service without the necessary support.

Where people needed hoisting between seats, care staff could state the specific equipment that person needed. They confirmed there were enough hoists and slings, and that all were in working order. However, we found one person was being hoisted in the wrong-sized sling, despite an appropriate care plan being in place. This put them at unnecessary risk of harm. This was immediately fixed when brought to the registered manager's attention. An audit was then undertaken to make sure correct individual slings were in place for everyone needing one.

In February 2018, the local fire authority informed us of satisfactory standards following their latest visit to the service. We identified no obvious fire safety risks during our visits. An external service of the fire alarm system was completed in May 2018. There were records of the service checking the fire alarm system, fire extinguishers, fire doors and emergency lighting. Fire drills also took place from time to time.

There were monthly checks on the water temperatures throughout the service. Staff told us of informal temperature checks when supporting people with baths, in case thermostats did not work properly. However, thermometers were not available in communal bathrooms which put people at increased risk of accidental scalding. The registered manager consequently agreed to buy designated thermometers for that purpose.

There were professional inspection certificates in place where appropriate, for example, for lifts and lifting equipment, electrical devices, and the water systems in respect of Legionella risk.

The service's systems, processes and practices safeguarded people from abuse. Staff spoken with demonstrated an understanding of what constituted abuse and the reporting procedures to follow. They were confident that any issues raised would be addressed appropriately by senior staff and managers.

Safeguarding information was not displayed on noticeboards in the service for the information of staff and visitors. The registered manager agreed to address this. However, the latest London multi-agency safeguarding procedures were available for reference in the service.

Records showed the service raised safeguarding alerts when there was evidence of mistreatment of people. Minutes from staff meetings indicated that safeguarding referrals were discussed together with incidents in the service, which demonstrated an open culture that aimed to minimise the risk of abuse. Along with positive feedback we received from community professionals, this indicated the service had robust safeguarding procedures.

Our checks of staff personnel files demonstrated that a robust recruitment process was in place and that appropriate pre-employment checks were undertaken. The service had systems for risk assessing any information of concern on the Disclosure and Barring Service checks of applicants. These are checks of police records and a list of people legally recorded as unsafe to provide care to adults.

The service provided sufficient numbers of suitable staff to support people to stay safe and meet their needs. People and their representatives told us this was the case. Staff spoken with stated that staffing levels were adequate to meet people's needs. Some long-term agency staff were being used in the service which had helped create stability during a significant period of change at the service.

The registered manager informed us the service now had a nurse working at all times. There were also six care staff in the morning, four during the afternoon and evening, and two at night. Ancillary staff were additionally employed so that care staff did not have to routinely take on domestic duties. Three weeks of recent staffing rosters confirmed that these staffing levels were maintained.

The service ensured the proper and safe use of medicines. People told us their medicines were supervised and well managed. One person said, "I can get pain killers." We saw medicines being administered in a kind and professional manner. For example, staff asked people if they needed any as required pain relief (PRN) and checked they had swallowed their medicines prior to signing the medicine administration records (MAR). PRN protocols and pain management scales were in place and the nurses were confident on how to use these.

Medicines were managed and stored safely. Medicines trolleys and the clinical room were clean and had people's medicines stored in an orderly manner. Temperatures were logged daily with nothing adverse noted.

Recent MAR had been consistently signed against. We saw no gaps in people's charts where medicines had been signed as administered. Topical medicine administration charts were also consistently signed. This indicated that people received their medicines as prescribed.

Medicines for disposal were logged in the destruction book and all entries had been countersigned. Controlled medicines were stock checked weekly. We checked three people's controlled medicines and we

found stocks matched recorded quantities.

Records showed the service undertook regular medicines audits, to check systems were working safely. Audit reports from the supplying pharmacist also confirmed the appropriate medicines standards were being maintained at the service.

Good

Is the service effective?

Our findings

People praised the service and told us they would recommend it to others. Comments included, "I love this place", "This place is lovely, very calm, everything is wonderful", "I do recommend to other people, the place is nice" and "The best care home in the world, I'm 100% satisfied." People's representatives were similarly complementary of the service. They told us, "I am very satisfied", "It meets my relative's needs well" and "I do recommend it to other people."

The service assessed people's needs and choices so that care and support was delivered in line with standards to achieve effective outcomes. The registered manager told us people's representatives were initially invited to visit the service. The registered manager then met the prospective person, wherever their location, to assess their needs before offering a placement in the service if they felt the person's needs could be met. These processes all contributed to people's individualised care plans.

The whole service worked in co-operation with other organisations to deliver effective care and support. Community professionals told us this was the case. Weekly manager reports demonstrated ongoing liaison with community healthcare professionals in support of people's different welfare needs. We were generally able to find that the service was following the guidance provided by community professionals. For example, one person was being weighed on a more frequent basis following dietitian advice. Someone else was using an adapted cup following the input of a speech and language therapist. Where someone had had a period in hospital, there was a recovery plan for them back at the service, to help staff them give effective care.

The service supported people have access to healthcare services and receive ongoing healthcare support. Nursing staff displayed good working knowledge on both medicine and physical care management. The service had systems for monitoring aspects of people's health and welfare such as whether they were becoming at risk of constipation. People's care records showed when and why a GP had been called and the outcome of the GP visit. Records also showed when other healthcare professionals such as the district nurses, opticians, and the chiropodist saw people.

People were supported with pressure area care appropriately. The service had equipment in place for this. Records and staff feedback show two people had been discharged from district nursing care following community-acquired pressure ulcers. Staff could explain how they supported people in relation to those needs, for example, by making sure the person wore a dressing for protection during transfers between seats.

One person was admitted for hospital treatment during the inspection. When we spoke with a nurse it was clear help had previously been sought in a timely manner. For example, antibiotics had been commenced as soon as they were prescribed and ready.

There were specific care plans in place for some people's physical and mental health conditions such as for skin care. However, for some other people care plans lacked detail on what the person's specific needs were and how the service would address this. This included for management of diabetes, Parkinson's Disease and

depression. On our second day of visiting, we saw that several people's care plans, including their care plan summaries, had been broadened to address this.

The service supported people to eat and drink enough and maintain a balanced diet. Feedback on food and drink was generally positive. People's comments included, "The food is very good and fresh" and "It's not bad but it's not brilliant." One person said, "It means so much to have biscuits at 7:30." A representative told us, "He is very fussy about what he eats, but he likes the food here."

Staff knew the signs of dehydration and prevention strategies, and made sure people had drinks across the day. Some people's food and fluid intake was monitored in writing, in support of meeting their nutritional needs. Records and feedback indicated one person no longer needed this as their weight had increased as planned.

People were provided with a choice of two home-cooked meals for lunch. Staff sat beside some people during meals to provide support and interaction. The support was at people's pace and in an encouraging manner. Most people ate well and appeared to enjoy their meals. The mealtime experience was calm and pleasant.

The chef told us of meeting new people and their representatives, to understand their food needs and preferences. They also checked with people at residents' meetings and from being present at meals. They were aware of who had specific diets such as vegetarianism or via dietitian advice. This was recorded on guidance notes in the kitchen.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We found the service was generally working within the principles of the MCA, but that records of this were inconsistently kept. People told us staff usually asked for consent first. We saw staff seeking consent from people about the care being offered. Staff spoken with demonstrated some understanding of the implications of the MCA for their day to day work, for example, that some people's capacity for making decisions could fluctuate. They told us of respecting people's decisions but where they judged the person may still need care, of trying to reassure and persuade people without pressurising them, or trying different staff with whom the person may engage.

One person told us of going for local walks with staff support. Another said, "My daughter can take me out in her car for shopping or lunch." Someone's representative told us, "He has total freedom; he can go out for lunch with us." However, records showed DoLS were in place for some people that authorised a restriction on their freedom. The registered manager also showed us evidence of where applications for DoLS had been made for some other people but with no outcome as yet.

There were two cases where people's DoLS authorisations included conditions that the service as "managing authority" was required to act on. However, there were no direct records in response to this, nor

a care plan recognising those conditions and the action to be taken. The registered manager's grid by which to oversee that DoLS applications had been appropriately made did not refer to any conditions. However, they sent us an updated grid explaining actions taken in response to each condition before our second day of visiting. They undertook to ensure these were kept under periodic review.

People's care files showed there was assessment of everyone's capacity to make informed decisions about a range of aspects of their care. However, the documented process showed the four-stage assessment occurred before the various decisions were considered, which did not make sense as people can have different capabilities in respect of different decisions. Where best interest decisions were needed when someone lacked capacity for a specific decision, there was no record of how the decision was made except for evidence of family involvement. The registered manager showed us revised forms at our second visit by which to bring these assessments more in line with MCA principles.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support. People were positive about the skills and knowledge of staff. A visiting representative of someone told us, "They are definitely well trained." Another commented on there being "capable" staff.

Staff stated that training was helpful and equipped them for their roles. One spoke of being supported to take a national vocational qualification (NVQ) at level 3 in care. The registered manager told us of acquiring NVQ training resources through liaison with national training organisations.

The registered manager explained that induction for new staff took place over 13 weeks. It included face to face training on fire safety and the moving and handling of people, along with many online courses. Records and training certificates confirmed this occurred, and that staff were provided with regular refresher training.

Staff told us of receiving regular developmental supervision and annual appraisals, which records confirmed. The registered manager told us staff were asked to self-assess their performance and developmental needs as part of the appraisal process before meeting him to agree on outcomes.

The adaptation, design and decoration of premises generally supported people's individual needs to be met, but some improvements were being planned for. There was a homely lounge and dining area where people tended to spend their time. Air conditioning units had been installed in the lounge to better regulate the temperature of the room. At the entrance to the building there was a smaller seating area with access to books, magazines and tactile resources that some people used. The service also had a large room upstairs for communal activities and meetings if needed.

Doors were being painted at the time of the visit. The registered manager explained that it was intended that they would be painted a bright, contrasting colour which may be helpful for people with dementia. It was also intended that people's names, room numbers and significant pictures would be put on the doors once re-painted, to aid orientation. For people who regularly used wheelchairs to get around the home it was intended that their names would be at eye level on the door. It was positive to see this work in progress.

Some areas of the home needed refurbishment. We have highlighted these matters under 'Is It Safe?' due to the potential infection control risks they present. One person also told us they could not use the garden due to the "uneven pathway" which we saw could trip people up. The matter had been highlighted in recent trustee reports. The registered manager told us that significant work was needed there to make the garden sustainably safe and useable. This was being investigated, with a view to having it fully available by next summer.

Good

Is the service caring?

Our findings

The service ensured that people were treated with kindness, respect and compassion, and that they were given emotional support when needed. People described staff as "familiar", "hard-working", "nice", "kind" and "gentle." Comments included, "The staff are smashing, we talk and laugh" and "They're never cheeky or rude; always smiling." People's representatives were similarly positive. Their comments included, "The staff are really good", "Staff are friendly and easy to talk to" and "Very nice staff, nice atmosphere."

Positive and caring interactions were observed during our visits. For example, one staff member drew the curtains a little in the lounge to protect someone from the very bright sunlight coming in. Where another person was coughing, staff checked on them and provided fluids. Staff had time for people and showed an interest in what people had to say.

Staff spoke in a positive manner about different people using the service, for example, describing one person as "highly intelligent" and how they responded to them accordingly. One staff member told us of staff "genuinely building trusting relationships with each and every resident." The registered manager told us of some staff choosing to visit one person in hospital and encouraging them to regain some independence they had temporarily lost and which their family reported they were not motivated to regain. We met that person during our visit and saw them to have regained motivation and independence.

There was a comfortable and engaging atmosphere at the service. One person told us, "Everyone here's happy." A relative said, "The atmosphere, especially in the lounge, is light hearted and the staff are often laughing, which is very nice to see." A staff member commented, "The home has a real 'family' feel which is often commented on by visitors." There was a pleasant atmosphere during our visits. People engaged with staff and enjoyed the activities provided. Several visitors were present and positive relationships with staff were observed. There were a few cats at home in the lounge that some people enjoyed. We also saw people using the service chatting amongst themselves and providing others with emotional support, indicating there was also camaraderie amongst some of the people using the service.

A community professional told us the service recently provided a comforting remembrance service for the family and friends of someone who had passed away after using the service. They said it was evident that staff knew the person very well, were sad for their passing, and that a collection of photos of the person in the service was given to the family. The registered manager told us people's representatives had been very appreciative of this. We saw a 'thank-you' card sent in from the family of another person who had recently passed away. It praised the care the person received and the assistance the service provided following the person's death.

The service ensured people's privacy and dignity was respected and promoted. People and their representatives told us this was the case. One person said, "I can have my door open or shut and they always knock." Another said staff were "absolutely respectful." We saw staff knocking on bedroom doors, and closing curtains and doors before personal care. They also tended to talk with people at their eye level, therefore sitting with them rather than standing over them.

People told us they had regular access to a bath or shower if they wished. People's daily hygiene records indicated they were regularly supported with personal care where needed. Staff confirmed that people were supported to have a bath or shower when they requested one or as a minimum every five days. There were oversight charts that staff used to help make sure people received that support regularly. We saw staff to discreetly work together to support people to receive personal care when needed.

People were well dressed and presented from the start of our visit. This indicated that, where needed, staff had supported people with their appearance. People's representatives confirmed this was the case. One said, "He always looked shaved and clean when I visit." Another told us, "She is always looking clean and her clothes are spotless." The service had laundry facilities and systems, to help people keep their clothes clean and presentable. We also saw some people to be offered napkins for lunch, to help keep their clothing clean.

People who wanted to mobilise independently were enabled to do so. Staff provided reassurance or minimal support where appropriate. There was equipment such as spouted cups by which people could drink by themselves. Some people told us of having keys to their rooms. Staff told us of encouraging people's independence.

The service supported people to develop and maintain relationships that mattered to them. People told us the service enabled them to maintain contact with friends and family, and of good visiting arrangements. People's representatives told us of no restrictions on visiting times. They were also kept informed of forthcoming events at the service or if their loved one was unwell or injured. One said, "They call me whenever my mum isn't well." The registered manager told us of supporting one person to visit their partner in another care establishment. Visitors to the service were observed to be welcomed and seen to be comfortable in their relationships with staff.

The service supported people to make choices about their day-to-day care. This was evident in practice as people were asked for their consent before care was offered. Choices were provided where possible, for example, at mealtimes. Records showed people and those close to them were encouraged to contribute to the assessment and planning of their care, which people's representatives confirmed to us. However, the registered manager confirmed the service did not yet have a formal process for involving people and their representatives in reviewing their care. They agreed to implement this, to help ensure people's views on their care continued to be checked on.

Good

Is the service responsive?

Our findings

The service enabled people to receive personalised care that was responsive to their needs. People told us this was the case. One person said, "I think I get most of what I need; I have good support." Another told us, "Yes they help me if I ask them." A representative said, "Staff know residents well."

Staff we spoke with new people's different needs and preferences, and in some cases were aware of life histories such as people's previous occupations and daily routines. One staff member said the registered manager emphasised the need to "walk with" each person, meaning to understand the person's reality and respond accordingly. One person was therefore enabled to deal with paperwork and help with staff interviews; another to go for supported walks locally as they often tried to leave the premises.

People had individual care plans in place that reflected many of their care needs and preferences, for example, for personal care, mobility, night care and medicines. Each section was usually kept under monthly review. These had enough detail on whether needs had changed or remained the same. There was also a summary care plan that provided the most important information by which new staff could quickly provide personalised care.

The service supported the communication needs of people with a disability or sensory impairment. Good communication is key to reducing feelings of frustration of not being understood. There were specific care plans in place for each person on their communication needs and how to support this, for example, if the person was hard of hearing. A staff member explained how they supported a person whose speech was slow. They told us, "It's important to be patient and give them time to respond."

People's support needs around culture and faith were identified in their care files. Staff showed awareness of these. For example, a staff member told us one person liked to pray and had a particular routine regarding this. The registered manager told us ministers for certain religions continued to visit people and hold services.

The service provided people with a range of mental and physical stimulation. One person told us, "There's always something going on." Another explained they chose not to join in activities, but read the newspapers that were delivered. A relative said, "My husband enjoys the activities; he loves music." A community professional told us the service supported people to engage in a local art exhibition. Activities information was displayed in the lounge. There were photographs from this year on display near the building's entrance. These demonstrated how people were supported to access and enjoy a range of activities.

We saw people engaging well in activities provided by the service. For example, a staff member engaged most people in the lounge by reading out phrases but omitting the last word. The activity was inclusive as some phrases were directed at individuals to answer. During the day staff spent time chatting to people to help keep them socially stimulated. A musician entertained as planned during the afternoon of our first visit. People were singing along, laughing and smiling. A few people danced with staff.

The service had systems in place to respond to people's concerns and complaints. People and their representatives generally told us they had no concerns of complaints about the service. Comments included, "We've had no complaints to make", "We never had any issues" and "If I have any issue I could contact [the registered manager]."

The complaints folder indicated that the last formal complaint received by the service dated back to July 2016. The registered manager stated that there had been no recent complaints. However, they showed us an email of informal concerns being raised by someone's family that had been resolved as far as possible. They commented that their open-door policy meant that any concerns got dealt with promptly.

Staff explained that they would report a complaint made by people or their representatives to the nurse of the manager. However, we noted the service was not displaying a complaints policy or procedure, by which to inform people and their representatives of what to do if concerned about any aspect of the service. The registered manager agreed to action this.

The registered manager told us the service was not currently admitting people needing end-of-life care, but that where possible they continued to care for people whose needs were now palliative. This was confirmed by one person's representative who told us, "They had a meeting a few weeks ago about her palliative care." The registered manager spoke of liaising closely with district nurses and hospice teams in these instances, to make sure that specialist support and equipment was in place when needed.

Where people had a formal Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) document in place, this was easily available at the front of their care file for when needed. Their files included some information on their end-of-life wishes if they were happy to discuss this, for example, on arrangements for final days including family and religious considerations. The registered manager told us this was reviewed with people and their representatives if their needs increased.

Good

Is the service well-led?

Our findings

The service's registered manager had been in that role for around eighteen months. Their registration indicated they had appropriate capability, qualifications and experience. They retained a long-established nursing registration.

People provided positive feedback about the service's management in terms of visibility and approachableness. Comments included, "The service is very well managed and everyone here is very helpful", "The manager is approachable" and "We see the manager every day." A representative told us, "I know the manager" and explained they had had no concerns to raise. Another said, "I think the service is well-led. The manager is very approachable. I liked what he said and his attitude during our initial conversation and interview." A community professional also reported on the management team being open and transparent, acting on recommendations, and providing good leadership.

The service promoted a positive and inclusive culture that achieved good outcomes for people. Staff said they recommended it as a place to work. This was because they felt supported in their roles, for example, through supervision, staff meetings, and the approach of managers and colleagues. They said the registered manager had an open-door policy. One said the registered manager was "very fair; he pulls you if you need pulling, but lets you know if you've done well." Another described the staff team as "fantastic."

The registered manager told us of recruiting and supporting staff "who want to be here." They felt staff now trusted him enough to let him know if mistakes had been made as these were learnt from. During our visit, we noted that a few extra staff arrived voluntarily, to support and participate in the inspection process. This reflected that staff took pride in their work.

The provider's governance framework ensured that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. The registered manager continued to send weekly summary reports to the provider. These reported on key indicators at the service such as occupancy, accidents, developing or resolved health matters relating to people using the service, and staff training and progress. Ongoing audits of certain aspects of the service such as for accidents and incidents fed into this.

There continued to be regular trustee and director visits, to check on service standards through observations and discussions with those present. Guidance on what to check had been recently updated for their visits. The latest report made positive observations on the care provided, but identified that some environmental improvements were needed such as for the garden area.

The provider engaged with and involved stakeholders in the development of the service. A meeting for people's representatives last took place in April 2018. Minutes showed relevant topics were covered and that there had been positive feedback about the service amongst the many attendees. The registered manager told us another meeting was to be imminently organised.

People and their representatives were invited to fill out a satisfaction survey earlier this year. The results of this showed overall satisfaction amongst the 18 respondents, with many stating the service was "very good." It was particularly evident from this that people using the service and their visitors were being treated well by everyone employed at the service.

Systems at the service enabled sustainability and supported continuous learning and improvement. Although the provider had successfully gained registration to operate the service as a nursing home earlier this year, the registered manager explained that this would not occur in practice until they were sure systems and the staff team especially the new nursing staff could meet people's nursing needs. In the meantime, the service now had a waiting list for unoccupied rooms, and so the registered manager could ensure places were only offered to those whose needs fitted with what the service could offer. The registered manager told us of further plans for the service environment and staff training, to continue to develop the service.

The service worked in partnership with other agencies to support care provision and development. A community professional told us this was the case, which had helped make sustained improvements to the atmosphere and effectiveness of the service. The registered manager spoke of working in partnership with the local authority. They showed us a positive report from that organisation's contact monitoring team's visit in July 2018. The registered manager also responded positively to our inspection process such as through sending information on request or in response to where we identified ways the service could improve.