Pilgrim Homes

Pilgrim Homes - Lady Anne Treves Memorial 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

Lady Anne Treves Memorial Home is a residential care home providing care and support for up to 21 people with age related conditions including dementia. The inspection took place on 30 November 2015. There were 16 people living at the home and two people having respite care on the day of the inspection. The provider, Pilgrim Homes, is a Christian charity that provides Christian care to people who are Protestant Christians. Accommodation was provided over three floors with stairs connecting all floors and a lift in situ.

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. People living at the home, relatives and staff all spoke highly of the registered manager.

Some people had medicines to be given as required and there were no guidelines in place for staff to follow to ensure that these were administered in a safe and consistent manner. This meant that people were at risk of not being given these medicines consistently and in accordance with prescribed instructions. Although there was a system in place for monitoring administration of medicines the registered manager had failed to identify gaps in recording. This was discussed with the registered manager who immediately took steps to review the procedures to ensure that there was proper oversight of the administration of medicines and stock control.

Some information was not updated in care records for example where a person's needs were changing rapidly the risk assessment and care plan had not been revised to illustrate the current situation, this meant that staff did not have the most up to date information to guide them when providing safe care. People were supported to be safe with systems in place to reduce the risk of harm and potential abuse. Medicines were stored appropriately and people received their medicines on time, one person said, "If I am in pain at all I just have to ask one of the staff for a tablet, I never have to wait." Staff were knowledgeable about the correct procedures to follow should they suspect abuse. Care records included assessments to identify and mitigate risks to individuals to ensure that people were kept safe without restricting their freedom.

Environmental risks were identified and managed appropriately, the maintenance officer said, "Resident's comfort and safety always comes first." People told us they felt safe, one person said "I have confidence in the staff, that makes me feel safe." Staff had been recruited through a safe and effective process, appropriate checks had been undertaken including character references and criminal record checks with the Disclosure and Barring Service (DBS) to ensure that staff were suitable and safe to work in the care sector. There were some vacancies in the staff team and staff told us they were under pressure sometimes. The registered manager told us she was recruiting to the vacant posts and used familiar agency staff to ensure adequate cover. The registered manager used a formal dependency tool to determine how many staff were required to keep people safe and meet their needs.

People told us they felt well supported by the staff, one person told us "The staff are wonderful really, they're all good at their jobs, I couldn't ask for better," a relative said, "We feel really privileged that our (relative) is here, they are absolutely brilliant." Staff told us that they had received a thorough induction before starting work, one member of staff said, "I was not new to care but the induction was very good." Training opportunities at the home were good, staff were supported to gain the appropriate knowledge, skills and competencies to perform their job role. People told us that they had confidence in the skills of the staff, one person said, "They always know what to do when they move me, I'm never worried." Staff were receiving support through regular supervision meetings and had annual appraisals to identify any areas of performance that could be improved.

Staff were working within the principles of the MCA and conditions or authorisations to deprive a person of their liberty were being met. Staff had undertaken recent training in this area and were able to demonstrate a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in peoples best interests when required.

People told us that they were supported to maintain good health and to have access to health care services. One person said "If I'm having any trouble they will always call the doctor or ask for the nurse to visit." Staff were proactive in ensuring that people received additional support from professionals when required to meet their care and treatment needs. People's dietary and nutritional needs were well supported. People told us that they enjoyed the food. One person said "I like the food here, they go to a lot of trouble to make it nice," Staff were knowledgeable about individual preferences and specific dietary requirements.

People and relatives told us that the staff were very caring, one person said "The staff here are all good, kind people." We saw many positive interactions between staff and people which emphasised the close relationships between them and demonstrated that staff clearly knew people well and understood their needs. People and their relatives had been included in the care planning process, this was evident from care records that were signed by individuals and /or family members and one visitor told us that she had been involved in planning her relatives care. We observed that people were offered choices and were supported to be independent whenever possible. We noted the calm atmosphere in the home and saw gentle interactions with staff giving people time to respond, showing consideration and treating people with dignity. One staff member said "Just because someone had dementia, it does not mean that they can't feel undignified if they are not treated with respect."

Staff were responsive to the needs of the people they were supporting. Care records were personalised and contained information about people's health and care needs, their personal life history and their preferences and wishes. Staff were able to demonstrate that they were knowledgeable about the individual details in people's care plans and we saw how this information was taken into account when providing care.

People were supported to follow their interests, one person said, "I love to knit and crochet and the staff bring in wool for me," For some people their Christian faith was important and they were supported to attend their local church. Others had volunteers from a local community church coming in regularly to visit and pray together. People were supported to attend devotions in the lounge area, and the registered manager told us that if some people could not come down to the lounge they could still be included through the use of speakers in their bedrooms.

The home had an effective complaints system in place to ensure that comments or complaints we responded to appropriately.

People, staff and visitors spoke highly of the registered manager, a staff member said, "The manager is very supportive." The ethos of the home reflected the Christian values of the provider organisation which included integrity, openness, honesty and that people should be treated with compassion, valued and respected. This was communicated to the staff through training and supervision. The registered manager had clear presence in the home, people knew who she was and said that she was approachable, with one person saying "She's a very kind lady."

The registered manager was committed to driving continuous improvement and involving people and staff in this process. Feedback on the service was collected through a variety of methods including through residents' meetings, questionnaires, reviews and individual meetings. This information was analysed to inform
improvements. There were quality assurance systems in place and these were being used to monitor and improve standards of care delivery.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of the full version of this report.

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.

Not all medication practices ensured that medicines were managed safely.

Risks to individuals were not always identified and plans updated to ensure people were cared for safely.

People and their relatives told us they had confidence in the staff and that they felt safe.

Staff had a clear understanding of the procedures for safeguarding people and recognised the importance of positive risk taking. Environmental risks were managed appropriately.

There were sufficient numbers of staff to keep people safe and meet their needs.

Is the service effective?

Good

The service was effective.

People were supported by staff who had received appropriate induction, training and supervision.

Staff had a good understanding of the MCA and were working within its principles. Conditions or authorisations to deprive a person of their liberty were being met.

People were supported to maintain their health and had access to appropriate health care services. People had enough to eat and drink in accordance with their preferences and needs.

Is the service caring?

Good

The staff were caring.

People and their relatives spoke highly of the caring nature of the staff.

Staff had developed positive relationships with people, knew

them well and understood their needs.

People were involved in decisions about their care and treatment and their views were respected.

Staff supported people to maintain their privacy and dignity.

Is the service responsive?

Good

The staff were responsive to the needs of the people they were caring for.

Care plans were detailed and personalised

People were supported to follow their interests and to maintain their faith.

There was an effective complaints system in place and people were encouraged to share their views about the care provided.

Is the service well-led?

Good

The service was well- led.

People and staff spoke highly of the registered manager and said that she was approachable. Her leadership was visible within the home.

There was a strong emphasis on a Christian ethos of the home and this was communicated effectively to staff and promoted in the day to day culture of the home.

There were effective quality assurance measures in place that were used to assess the quality of care and to drive improvements.

Pilgrim Homes - Lady Anne Treves Memorial 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 comprehensive inspection took place on 30 November 2015 and was unannounced. Three inspectors undertook the inspection. We spoke in detail with eight people who lived at the home, five staff members and the registered manager, two visiting relatives and a health care professional. We looked at areas of the building including people's bedrooms, communal areas and the lounge/dining area. We spent time sitting and talking with people, staff and visitors and observed the delivery of care and interactions between people and staff. We also observed a staff handover meeting and lunchtime medicines being administered. We looked at a range of care records, staff records, medication administration records (MAR), minutes of meetings, incident and accident reports and audits and quality assurance documents.

Before the inspection we looked at the provider's website and information provided to us by the local authority. We reviewed the information that we held about the home including previous inspection reports and safeguarding concerns that had been made and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. This ensured that we had identified areas of possible concern to be looked at during the comprehensive inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR), this is because the inspection was undertaken at short notice. A PIR 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. Lady Anne Treves Memorial Home was last inspected in January 2014 and there were no concerns.

Requires Improvement

Is the service safe?

Our findings

People and visiting relatives spoke positively about their experiences at the home. One person said "I have confidence in the staff, that makes me feel safe," another person said "I do feel safe here, the staff know what I need and they are all very good, if I get a bit anxious they reassure me that I'll be alright," a third person said "If I ring the bell they come quickly, I know I'm safe here." Throughout the inspection we noticed people using their call bells and staff responded quickly to ensure peoples safety. However, despite the positive feedback from people, we saw areas of practice that needed improvement.

We observed a member of staff administering the medicines and we looked at the Medication Administration Records (MAR) for each person. Some people had been prescribed "when required" medicine. Good practice guidance for care homes produced by the National Institute for Clinical Excellence (NICE) states that these types of medicines, that may include variable doses, should have clear guidance for staff regarding when and how to use such medicine, what the expected effect will be and the maximum dose and duration of use. This information was not available in the care records which meant that people were at risk of not being given these types of medicines consistently and in accordance with prescribed instructions. For example, one person had been prescribed a number of "when required" medicines to manage their pain following a serious injury, however there was no guidance on the combination that could be given or how often. This could have resulted in an overdose and harm to the individual. Staff consulted were not aware of what was a safe combination of pain relief was for this person.

MAR charts showed that there was an unexplained gap for an antibiotic and it was therefore unclear whether the person had received the full course. A gap in another record identified that the stock of a medicine had run out, this meant that the person had not received their prescribed medicine for several days. There was no evidence that advice had been sought in the interim to establish any effects of not having this medicine. The member of staff was able to describe the procedure when a recording gap is discovered, however it was not clear what action had been taken subsequently to investigate what had happened and implement changes to prevent re-occurrence. Another record had instructions for a medicine that was administered through a patch; this stated that when changing the patch it should not be placed in the same area on the skin. There was no indication in the records of when and where each patch had been placed. We discussed our concerns with the registered manager who immediately took steps to review procedures to ensure that there was proper oversight of the administration of medicines and stock control.

Due to the concerns that we had regarding the proper and safe management of medicines and failing to ensure that there were sufficient quantities of these to ensure the safety of service users we found this to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to individuals were not always updated to reflect the current needs of people. For example one person's needs had changed significantly following a fall and they required support with care in bed, the risk assessment and care record had not been revised to reflect this so staff did not have the most up to date information to guide them when providing care. The situation for the individual was changing rapidly and

the risks associated with providing their care needed to be reviewed on a daily basis, this meant that staff were not provided with adequate information to ensure risks were mitigated and that care was provided safely. We discussed this with the registered manager as an area of practice that needs to improve. She said that staff were in the process of undertaking an audit of care plans and she was aware that senior care workers needed more time allocated to ensure that paperwork was current and updated in a timely way.

We asked staff about their understanding of risk management and keeping people safe whilst not restricting their freedom. One staff member said "We treat people like adults, but we do have to keep them safe." Care records included assessments to identify and mitigate risks to individuals, for example, one person's mobility had reduced over time and it was clear that the original risk assessment had been updated at regular intervals as the individual's mobility deteriorated. The most recent risk assessment included a manual handling assessment with clear instructions for staff in how to support the person to transfer with a standing hoist. Another example showed a person who had developed difficulties with swallowing. A risk assessment had been undertaken to reduce the risk of choking, with clear guidance for staff and a referral was made to a Speech and Language Therapist (SALT) for advice about introducing a soft diet.

Staff demonstrated that they had a good understanding of the procedure for the safe administration of medicines. Whilst administering they wore a "do not disturb" tabard throughout the process and locked the cabinet between administering medicines, showing that they understood the importance of remaining focussed on the task. They were attentive and patient throughout the process, taking time to explain to people what the tablets were for and ensuring they had a drink. They demonstrated a thorough knowledge of people's medicines and their side effects. People told us that they received their medicines on time, comments included, "If I am in pain at all I just have to ask one of the staff for a tablet, I never have to wait," and "They are always on time with the medicines, I never have to ask."

MAR charts included information about allergies and body charts to show where creams should be administered. There were medication guidelines in place for staff and these included instructions on the use of homely remedies. Medicines prescribed with a variable dosage were managed well, for example where someone had warfarin the dosage changed regularly following blood tests and this was clearly documented. One person was receiving medication covertly (that is without their knowledge or permission), this was documented clearly with guidance for staff to try alternative methods first and to only give covertly as a last resort. There was evidence that the GP and family members had been included in the decision making process and there was a letter from the GP approving the decision.

People were supported to be safe, with systems in place to reduce the risk of harm and potential abuse. All but five members of staff had received recent safeguarding training and the registered manager told us those who were yet to undertake the training would be prioritised. All the staff we spoke with had received safeguarding training and were able to demonstrate a sound knowledge of the correct procedures to follow should they suspect abuse, including referral to the local authority safeguarding team in line with the provider's policy. One staff member said " I'm sure abuse wouldn't happen here, but I would know what to do," another said, "I've had training and I know that abuse is more than harming someone it can be about poor care too." Staff said they would report any concerns to the registered manager and we saw evidence that the registered manager had reported safeguarding concerns to the local authority appropriately.

There was a procedure in place for recording incidents and accidents and staff were aware of this and recorded appropriately. One accident record described a person having fallen in their bedroom when trying to stand unaided. As a result of this, the falls team had been consulted for advice and the care plan was updated to include more regular checks by staff until a pressure mat could be introduced; the person and their family had also been included in this process. We noted that the registered manager had also

undertaken a risk assessment for a member of staff who had sustained a serious injury; this was recorded in the staff record and detailed the duties that the staff member could undertake safely.

Risks associated with the environment and equipment were identified and managed appropriately. There was a dedicated maintenance officer who undertook regular checks throughout the building, such as testing electrical items, monitoring water temperatures, maintaining and installing equipment, for example bed rails, and liaising with maintenance contractors. There were comprehensive monitoring records to support this work. The maintenance officer described how they ensured the comfort of people living in the home, saying "Residents comfort and safety always comes first, I have a list of things to do, but I prioritise safety, for example, call bells. If something goes wrong I will come in at any time to make it safe."

Staff had been recruited through a safe and effective process. Appropriate checks had been undertaken, including character references and criminal record checks with the Disclosure and Barring Service (DBS) to ensure that staff were suitable and safe to work with people.

We asked people if they felt there were enough staff on duty, one person said "I think so, they are a bit short of staff sometimes, but you don't generally have to wait long for someone to come." A visiting relative said, "The staff are always busy, but I wouldn't say they are seriously short of staff, they always take time to chat to my (relative) and to me when I visit." Staff had mixed views, one said "Yes, I think we have enough staff on duty, but we do need agency staff," another said, " We have some new residents and we need more staff now," a third staff member said, "We do have an extra staff member in the afternoon, but I don't thinks it's enough." We spoke to the registered manager about these concerns, she told us that there were some staff vacancies and she was recruiting to fill them. She told us that a formal tool was used to calculate safe staffing levels taking into account the changing needs of people living at the home. We looked at the staff rota for the previous four weeks and found that staffing levels had been consistent across this period. Vacant shifts were covered by existing staff and agency staff, and the registered manager told us that where possible they used agency staff that were familiar with the home and people living there. We noted that there had been additional pressure in recent days, as two people had recently moved to the home for respite care and a new permanent resident had arrived. The registered manager acknowledged this had stretched the staff team, but mentioned that a new member of staff was starting their induction training that day, which would help to relieve the pressure.

Good

Is the service effective?

Our findings

People told us they felt well supported by the staff, one person told us, "The staff are wonderful really, they're all good at their jobs, I couldn't ask for better," a relative said "We feel really privileged that our (relative) is here, they are absolutely brilliant."

Staff told us that they had received a thorough induction before starting work. One member of staff told us, "I was not new to care but the induction was very good," another said "I had a chance to shadow staff and get to know people." A new member of staff was working their first day during the inspection. They told us they were clear about their role that day, which was to spend time with a new resident to help them to orientate and to get to know the building. They said they were enjoying the opportunity to be able to spend time getting to know someone. The registered manager told us that all new staff were expected to complete the Care Certificate. This certificated training provides new health and social care workers with basic awareness of 15 care standards to support them to work within the care sector.

Staff said that the training opportunities were good. There was a wide range of training available in subjects relevant to the needs of the people they were supporting. Staff appeared well trained and competent in manual handling techniques. We observed staff interactions with people throughout the inspection and saw that staff were confident and competent in their roles. For example, a number of people were supported to transfer from wheelchair to comfy chairs in the lounge area before and after lunch, we saw staff completing these manoeuvres in a safe, professional and skilful way. They were talking to people throughout, explaining what was happening and reassuring them. We also saw people being assisted to stand themselves and supported to walk using a frame, and other people being repositioned to ensure their comfort. People told us that they had confidence in the skills of the staff. One person said, "They always know what to do when they move me, I'm never worried," and a relative said "I have no doubts about the abilities of the staff here, I know my (relative) is in good hands."

Records confirmed that supervision and yearly appraisals had been undertaken or was planned for every member of staff in the line with the home's policy. Supervision is a formal meeting where staff members can discuss training needs, reflect on their practice and receive support from their manager. Supervision should be a useful tool for managers to address performance issues and provide support to staff members as well as gaining an insight into the challenges they face. Supervision is one aspect of staff development together with induction, training and support that enables staff members to be equipped to support the people they care for effectively. Staff said they had received recent formal supervision, or a yearly appraisal. Staff told us they found these meetings helpful, one staff member said, "If I had an issue I wouldn't wait for supervision, because I can go to the manager at any time, but it's still good to know you have that time set aside to talk and the manager does listen." Each shift had an identified shift leader, usually a senior care worker who would oversee the staff on a daily basis. The manager and deputy also undertook a regular walk -about which gave them the opportunity to observe staff practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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 or authorisations to deprive a person of their liberty were being met. Staff had undertaken recent training in this area and were able to demonstrate a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in peoples best interests when required. Some staff told us about the implications of DoLS for people they were supporting. One staff member told us, "The MCA is about protecting people's rights and the main thing is that we all have mental capacity unless it is proven otherwise."

People's care records confirmed that people were asked to give their consent to their care, treatment and support and there were signed consent forms on peoples' care files. We observed that staff frequently checked that people were consenting to care. For example, before commencing to move someone using a hoist, staff were heard to ask, "Would you like us to move you into the chair now? I think you'll be more comfortable," they waited for the person's consent before commencing with the manoeuvre. The care record for one person showed that their mental health was deteriorating and a mental capacity assessment had been undertaken. As the condition worsened staff were required to monitor regularly and this had been recognised as a possible deprivation of liberty, as the individual was under continuous supervision and unable to consent to this. An appropriate DoLS application had been made and granted and the staff continued to monitor the person's capacity with the use of a post DoLS authorisation check list.

People's dietary and nutritional needs were well supported, and people told us that they enjoyed the food. One person said "The food's good, we often get a roast dinner at lunchtime, or fish and chips. That's my favourite," another person said "I like the food here, they go to a lot of trouble to make it nice," a third person told us "I like the desserts, I have a sweet tooth and they are really good." A visiting relative said that they were impressed with the choice and variety of the food and thought that it always looked good.

We observed the lunchtime meal, it was a social occasion with about 15 people in the dining room. People were heard to say, "What a lovely meal" and "Thank you for such nice food." The meal was served by the staff on duty including the maintenance officer who said that they enjoyed helping out at meal times, to ensure that people got their food quickly, so that it was still hot. Their support was clearly enjoyed by the people they were supporting and we observed much banter and laughter. There was a choice of drinks offered and plated meals were served according to what the individual had chosen the day before. Many people at the home were living with dementia and had short term memory loss, they could not remember what they had chosen, or had changed their mind since they ordered the meal. For example, one person had ordered a meal with mashed potato, but when it arrived they said they didn't like mash so it was removed.

Staff were knowledgeable about individual preferences and specific dietary requirements including those requiring special diets. We observed there was good communication regarding changes to people's diets, including following advice from health care professionals. For example, at coffee time a member of staff was seen to be offering one person a choice of biscuits that were different from the others, they told us this was because the person needed to have a gluten free diet and care records confirmed this. We noted that a vegetarian meal was available for one person and portion sizes were varied according to people's needs, for example one person was known to have a big appetite and was served a larger portion. Some people

required a soft diet and pureed food. We saw that meal components were kept separate and food temperatures were tested before serving. People's care records included the use of a Malnutrition Universal Screening Tool (MUST). This is used to identify and assess if adults are at risk of being malnourished or obese and supports monitoring of these risks. As part of this process people's weight was regularly recorded and people with special dietary needs were assessed by external professional such as speech and language therapists. Fluid charts were kept to monitor people's fluid intake and ensure that they did not become dehydrated.

People told us that they were supported to maintain good health and to have access to health care services. One person said "If I'm having any trouble they will always call the doctor or ask for the nurse to visit," and "I was quite poorly, they (staff) called my GP straight away." Another person said, "I was really struggling one morning, and they were so attentive to me making sure I wasn't in any pain, they called the doctor very quickly." Care records showed that staff were monitoring people's health and well- being and made appropriate referrals to health care professionals if concerns arose. We saw numerous examples of this, including involvement of consultant psychiatrists, physiotherapists, community nurses, GP's and SALTs. Staff were able to demonstrate a good understanding of people's health needs, for example one staff member described how they monitor a person who has diabetes, "We have to keep a close eye on their weight and we help them to manage the illness through diet and medication, if their mood changes or they tell us they don't feel well, we note it down, because that can be an indication that something's not right. I would call the doctor if we're worried." We spoke to a visiting health professional who told us that the advice and guidance they gave was understood and followed by the staff. One person had suffered a fracture as a result of a bad fall and the registered manager had sought advice from the falls team regarding updating the manual handling assessment. In order to implement their recommendations the staff had to be trained in the use of a different type of hoist sling.

Good

Is the service caring?

Our findings

People and relatives told us that the staff were very caring. "They are all such caring people, I don't want for anything," and "It's very nice here, they have made me feel very welcome, I will come again," and "The staff here are all good, kind people."

We observed that people who were less able to communicate were at ease and comfortable around the staff, for example one person displayed positive body language when approached by a particular member of staff, smiling and holding out their hand. The registered manager told us that all staff were trained in the Christian ethos and values of the provider, Pilgrim Homes, and that staff were expected to exhibit the practices and attitudes described within the ethos including valuing people, respecting their dignity and treating people with compassion. We saw many positive interactions between staff and people which emphasised the close relationships between them and demonstrated that staff clearly knew people well and understood their needs. For example, one person was in considerable pain when they moved, a staff member spent time reassuring and comforting them until they were able to make them more comfortable. They spoke in a calming tone and explained exactly what they were going to do and continued to offer reassurance whilst they adjusted their position. The person was responsive to this and became calm and relaxed. They were clearly at ease with the member of staff and a trusting relationship was evident.

People and their relatives had been included in the care planning process; this was evident from care records that were signed by individuals and /or family members. One visitor told us that she had been involved in planning her relatives care and that staff kept her well informed about any changes. People's choices were respected, for example two people had come into the home for a period of respite and they had expressed a desire to share a room. This request had been accommodated. The staff were focussed on supporting people to express their views and we observed that people were offered choices and were supported to be independent whenever possible. We observed that care had been taken to support people with their appearance, indicating that staff had time to support people appropriately and to maintain their dignity. Staff were attentive and anticipatory of people's needs, for example at meal time staff were consistently offering people more drinks, further gravy, supporting people who needed help with their meal and encouraging people to do as much as they could for themselves. One staff member noticed that someone didn't have their slippers on their feet properly and asked if they could help put them on properly, demonstrating awareness for their dignity and safety. People were seen to be called by the name they preferred, and there was a high level of engagement between staff and people throughout the day.

We noted the calming atmosphere in the home and saw gentle interactions with staff giving people time to respond, showing consideration and treating people with dignity. We saw staff knocking on people's doors and waiting before they entered and talking to people in a discreet way regarding personal care needs. We noted that people's dignity was also considered in care planning and records, for example one person's care record described how they liked to "walk with purpose" as opposed to wandering.

When transferring people using a hoist we saw how staff were careful to ensure people remained covered to protect their dignity. Staff were patient and repeated information several times for some people who

appeared confused. People's personal information and records were kept securely in locked cabinets. The registered manager said that maintaining people's privacy and dignity was an important aspect of the homes ethos. She said a number of bedrooms previously did not have a lockable cupboard and these had been replaced to ensure people could maintain some control over their possessions to improve their privacy. A "dignity tree" was displayed on the wall in the lounge area and people had been encouraged to say what was important to them, and their comments were written on leaves attached to the tree. Some comments included, "please listen to me," "leave me alone," "I want to be respected," staff told us that this helped to remind them of people's individuality. One staff member said "Just because someone had dementia does not mean that they can't feel undignified if they are not treated with respect."

Good

Is the service responsive?

Our findings

Staff were responsive to the needs of the people they were supporting.

Care records were personalised and contained information about people's health and care needs and associated risks, their personal life history and their preferences and wishes. The information was detailed including for example, the clothes that people preferred, favourite foods, things they disliked, their interests, past hobbies and occupations. This detail helped staff to understand what was important to the people they were caring for. The registered manager said that changes were being made to make the care plans clearer as they were difficult to navigate and although there had been progress they were "not there yet."

We attended a staff handover meeting, the purpose of the meeting was to ensure that staff coming on duty were aware of any changes and to share information to ensure good continuity of care. Discussions were appropriate and relevant and focussed on the individual needs of people, including updates from visits involving health or care professionals and other relevant information relating to care needs. We asked staff members about how they provide personalised care, they said, "It's putting the residents at the centre of everything we do," and "We give care that is for the person, we fit around them." Staff were able to demonstrate they were knowledgeable about the individual details in people's care plans and described how this information was taken into account when providing care. Some examples they gave included, knowing that someone particularly disliked wearing trousers and that someone else preferred to drink water not blackcurrant squash. Another person was very active and staff knew to look for signs that he was hungry and to offer snacks between meals.

People said they were supported to follow their interests. One person said, "I love to knit and crochet and the staff bring in wool for me," another person said "I enjoy singing, they (staff) are going to take me to the Brighton College for their carol service." These interests were recorded in their care plans. The home had an activities co-ordinator who was responsible for arranging activities and ensuring that people had access to activities that were personalised to their interests; these were recorded in their care records. For example, a person had an interest in gardening, their activities care plan showed they would be supported to access the garden as often as possible and to grow some plants. For the majority of people their Christian faith was important and they were supported to attend their local church. Others had volunteers from a local community church coming in regularly to visit and pray together. During the afternoon we observed people attending a devotional session where people were encouraged to request particular passages that were important to them and a member of staff read from the bible. People were seen to be deriving comfort from this and the session was conducted in a sensitive dignified manner. The registered manager told us that if some people could not come down to the lounge they could still be included through the use of speakers in their bedrooms. A visitor told us that their relative had dementia and had been displaying aggressive behaviour when they first moved to the home. They said that staff had worked hard to identify the triggers for this, and had arranged to decorate the bedroom in the same colour scheme as the person had in their flat. She said this really made a difference and the person became more settled and less agitated. She said "I have total admiration for the staff here, they are so considerate, they try anything to help people to feel at home here."

The home had a complaints policy and an effective complaints system was in place to ensure that comments or complaints we responded to appropriately. There were no outstanding complaints at the time of the inspection. The registered manager said that she tried to encourage people and relatives to make complaints as this was a useful tool for making improvements. She said that they have regular meetings for residents and their relatives and these were usually well attended. Notes from the last two meetings showed that people were supported to contribute and expressed their views. The registered manager said that not everyone was comfortable to speak at these meetings and she made time to meet with people individually to gather their views. People told us they would be happy to raise any complaints, one said "The manager is very nice, I would have no hesitation in speaking to her if I had any complaints."

Good

Is the service well-led?

Our findings

People, staff and visitors spoke highly of the registered manager, staff members said, "The manager is very supportive," and "The manager is great, I think we all know where we stand." Another staff member said, "I think the place is well run, we (staff) all get on really well."

The Registered Manager told us that the ethos of the home reflected the Christian values of the provider organisation which included integrity, openness and honesty and that people should be treated with compassion, valued and respected. This was communicated to the staff through training and supervision. There were policies in place to support openness including a whistleblowing policy that staff were aware of. The registered manager had notified CQC about significant events, this ensured that we were informed about areas of concern and we monitored that actions had been taken to keep people safe. Links with the local community had encouraged staff to work in partnership with health colleagues, developing professional relationships that supported good practice. For example a visiting family member told us about how their relative had been transferred to the home from hospital. they said, "The hospital staff told me they were impressed with the response that they had from the home. The staff here made sure everything was in place, all the equipment, everything. Staff went up to the hospital to visit and it was really reassuring ."

The registered manager had clear presence in the home, people knew who she was and said that she was approachable. One person said, "She's a very kind lady." Staff were aware of the lines of accountability and who to speak to if they had any concerns. The registered manager undertook a daily 'walk about'. She used this as an opportunity to talk to people about the care they were receiving and to observe staff performance. The registered manager said that she made notes during this process and this had become a useful tool for reflection with staff either in supervision or staff meetings.

The registered manager was committed to driving continuous improvement and involving people and staff in this process. She sought feedback on the service through a variety of methods including through residents' meetings; staff meetings; questionnaires; reviews and individual meetings and through the complaints process. This feedback was analysed to help drive developments in the service. For example, a questionnaire was given to people living in the home and their relatives, as well as professionals who were involved with people living in the home. The results contributed to the development of an action plan for improvements. For example, the registered manager explained that communication between staff was identified as an area for improvement and as a result the time for staff handover was changed to ensure that staff had adequate time within their shift to pass on relevant information. This had resulted in a noticeable improvement in terms of how information was exchanged between staff. An audit undertaken by the Local Authority contracts team had also identified some areas for improvement and the registered manager had included this information in an action plan with clear timescales for completion. The registered manager said that she had been aware of the issues from her own auditing process and this was work in progress.

There were quality assurance systems in place and these were being used to monitor and improve standards of care delivery. Monitoring of incidents and accidents had shown a high number of falls or near misses were occurring in the evening, when people were tired and particularly during the period when some

staff were having their break. To respond to this, the times for the staff break were changed to ensure more staff were able to be around to support people. This had resulted in a reduction in incidents during the last month which was a positive outcome for people. Another positive change had been the introduction of a tea cook, this meant that more staff were available to support people and this had been found to have a very positive impact for people and staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users were not always protected against risks associated with the unsafe use and management of medicines.