Nicholas James Care Homes Ltd

Edward House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 11 April 2016 and was unannounced.

Edward House provides accommodation for twenty-two older people, some of whom are living with dementia, who may need support with their personal care needs. On the day of our inspection there were eighteen people living in the home. The home is a large detached property situated in Burgess Hill, it has a communal lounge and dining room and a garden.

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

There was a lack of stimulation for people. Observations of an activity in the afternoon showed people enjoyed taking part in the activity and this provided a sense of fun and enjoyment. However this was the only activity or stimulation provided throughout the day and people spent most of their day sitting in their chairs with little to do. People and relatives both felt that the activities provided needed to improve. One person was overheard saying "I am sitting around all day and doing nothing." A relative told us "There could be more things to do I think, but I understand an activity co-ordinator starts next week so that should be good." This is an area of practice in need of improvement.

There were sufficient numbers of staff to ensure people's needs were met and their safety maintained. Staff had received induction training and had access to ongoing training to ensure their knowledge was current and that they had the relevant skills to meet people's needs. People were safeguarded from harm. Staff had received training in safeguarding adults at risk, they were aware of the policies and procedures in place in relation to safeguarding and knew how to raise concerns. People felt safe, one person told us "I don't think about it really so it must be safe."

Risk assessments had been undertaken and were regularly reviewed. They considered people's physical and mental health needs as well as hazards in the environment and provided guidance to staff in relation to the type of support people needed and the amount of staff required. People were encouraged and enabled to take positive risks. People's independence was not restricted through risk assessments, instead risks were assessed and managed to enable people to be independent. Observations of people assessed as being at risk of falls showed them to be independently walking around the home. Staff were aware of the importance of keeping people safe whilst not restricting their freedom. One member of staff told us "Keeping the residents safe is a priority but not to the exclusion of everything else". There were low incidences of accidents and incidents, those that had occurred had been recorded and were used to inform practice.

People received their medicines on time and told us that if they were unwell and needed medicines that staff provided these. People were asked for their consent before being offered medicines and were

supported appropriately, being offered a drink to take their medicine safely and comfortably. Medicines were administered by trained staff and there were safe systems in place for the storage, administration and disposal of medicines.

People were asked for their consent before being supported with anything. For people who lacked capacity, mental capacity assessments had been undertaken to ensure best interest decisions were made on their behalf. People who were deprived of their liberty had appropriate applications made to the local authority to ensure that they were not being treated unlawfully.

People had access to relevant external health professionals to maintain good health. Records confirmed that external health professionals had been consulted to ensure that people were being provided with safe and effective care. People's clinical needs were assessed and met and they received good health care from external professionals to maintain their health and well-being.

People were involved in their care and decisions that related to this. People were asked their preferences when they first moved into the home. Regular reviews ensured that staff were meeting people's current needs. Relatives confirmed that they were involved in their loved ones care and felt welcomed when they visited the home and knew who to go to if they had any concerns. There were various processes that people and their relatives could use to make their comments and concerns known.

People were treated with dignity, their rights and choices respected. Observations showed people being treated in a respectful and kind manner. People's privacy was maintained. When staff offered assistance to people they did this in a discreet and sensitive way. People confirmed that they were treated with dignity and their privacy maintained.

There was a homely, friendly and relaxed atmosphere within the home. People were complementary about the leadership and management and observations confirmed that the aims of the provider were embedded in staff's practice. Quality assurance processes were carried out to ensure that the quality of care provided, as well as the environment itself, was meeting the needs of people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The home was safe.

There were sufficient numbers of staff to ensure that people were safe. Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

People were able to take risks. Risk assessments recognised potential risks and provided guidance as to how these be minimised, whilst ensuring that people's freedom was not unnecessarily restricted.

People received their medicines on time, these were dispensed by trained staff and there were safe systems in place for the storing and disposal of medicines.

Is the service effective?

Good

The home was effective.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to health care services to maintain their health and well-being.

People were asked for their consent before being supported. The provider was aware of the legislative requirements in relation to gaining consent for people who lacked capacity and had worked in accordance with this.

People were happy with the food provided. They were able to choose what they had to eat and drink and were provided with support according to their needs.

Is the service caring?

Good

The home was caring.

People were supported by staff who were compassionate and kind.

People were involved in decisions that effected their lives and

care and support needs.

People's privacy and dignity was maintained and their independence was promoted.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

People did not have access to sufficient stimulation and activities. They spent large amounts of their time with little to do.

Care was personalised and tailored to people's individual needs and preferences.

People and their relatives were made aware of their right to complain. The provider encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Good

The home was well-led.

People and staff were positive about the management and culture of the home.

Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals, their opinions and wishes were taken into consideration in relation to the running of the home.

Edward House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 11 April 2016 and was unannounced. The inspection team consisted of two inspectors.

Prior to the inspection the provider had completed a Provider Information Return (PIR), this is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. Other information that we looked at prior to the inspection included previous inspection reports and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with seven people, five relatives, four members of staff and the registered manager. Following our inspection we contacted a health professional who visits people living at the home. We reviewed a range of records about people's care and how the service was managed. These included the care records for four people, medicine administration record (MAR) sheets, four staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service.

We spent time observing care and support in the communal lounges and dining areas during the day. We also spent time observing the lunchtime experience people had and the administering of medicines.

The home was last inspected in October 2013 and no areas of concern were noted.

Good

Is the service safe?

Our findings

People and relatives told us that the home was safe. One person told us "I don't think about it really, so I must be safe."

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing staff's suitability to work in the health and social care sector had been checked with the Disclosure and Barring Service (DBS) and their employment history gained. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Identity and security checks had also been completed and their employment history gained.

There were sufficient staff to ensure that people were safe and cared for. People and staff told us there was sufficient staff on duty to meet people's assessed needs and observations and records confirmed this. One member of staff told us "There are enough staff around I would say, It can be busy in the mornings but there are enough of us." Another member of staff told us "I have time to spend with the residents, so I don't have a problem." A relative confirmed this, they told us "We visit at different times of the day, always without staff knowing beforehand and there seems to be a lot of staff around. They're not running around either, they seem to have time to spend with people." People were happy with the levels of staffing. One person told us "Well, I don't wait for anything, the staff come straight away if I need them." People's individual care plans showed that a dependency tool had been used to identify their needs and the amount of support required. The registered manager confirmed that this was used to inform the staffing levels and told us that these were increased if people were unwell or needed additional support.

Staff had an understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. One member of staff told us "I would let my manager know if I suspected abuse, I'd whistle blow." Another member of staff told us "I find it sickening (abuse) I'd definitely report it to my manager." There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. (A whistleblowing policy enables staff to raises concerns about a wrongdoing in their workplace). Relatives told us that people felt safe when receiving support from staff. A relative told us "I have absolute confidence, I trust the staff to care for my relative well." Another relative told us "I think the care is good here and I have no concerns about the staff." People confirmed this, one person told us "Oh yes, staff are fine, I wouldn't stay if the staff weren't nice."

Suitable measures had been taken to ensure that people were safe but their freedom was not unnecessarily restricted. People were supported to take reasonable risks, and we observed people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. Risk assessments recognised people's physical and clinical needs as well as environmental hazards and were reviewed regularly. They took into consideration the risk, the likelihood of the risk occurring and the measures in place to minimise the risk. They identified the number of staff needed to assist the person and the necessary equipment that needed to be used. Staff confirmed that they found risk assessments

invaluable as they provided them with guidance about how to support people in a safe manner.

Staff were mindful of the importance of ensuring that people were safe, whilst ensuring their lives weren't unnecessarily restricted. One member of staff told us "Some of the people here are living with dementia, but we don't stop them doing what they want. We have safety measures in place but apart from that, it's up to them." Another member of staff told us "Keeping the residents safe is a priority but not to the exclusion of everything else." Relatives confirmed that people were able to be independent and take risks, yet their safety maintained. One relative told us "I've watched staff and they do intervene where necessary but they let the residents get on with it." Accidents and incidents were minimal. Those that had occurred had been monitored and practice changed as a result. For example, accident records for one person showed that they had slipped out of bed and sustained an injury on more than one occasion. In response to this the layout of the person's room and position of the bed had been reorganised to minimise the chances of this reoccurring.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks on equipment and the fire detection system were undertaken to ensure they remained safe. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. People's ability to evacuate the building in the event of a fire had been considered and each person had an individual personal evacuation plan.

People were assisted to take their medicines by trained staff. Safe procedures were followed when medicines were being dispensed. In order not to be interrupted the member of staff responsible for dispensing and administering the medicines wore a red tabard, this made everyone aware that they weren't to be disturbed, therefore minimising the risk of any medication errors occurring. People's consent was gained and they were supported to take their medicine in their preferred way. For example, one person was supported by staff to take their medicine, which was a tablet, on a spoon. Staff assisted the person by placing the tablet onto the spoon and into the person's mouth. People were asked if they were experiencing any pain and were offered pain relief if required, this complied with the provider's policy for the administration of 'as and when' required medicines. People confirmed that if they were experiencing pain that staff would offer them pain relief. Medicine records showed that each person had a medicine administration record (MAR) sheet which contained information on their medicines, these had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines.

Good

Is the service effective?

Our findings

People were cared for by staff who had received training and who had appropriate experience and skills to meet their needs. One person told us "Staff are very good, they know what they're doing."

Staff had completed induction training. The provider ensured that staff worked towards the Care Certificate. The Care Certificate is a set of standards that social care and health workers should work in accordance with. It is the new minimum standards that should be covered as part of the induction training of new care workers. As part of the induction process staff were encouraged to shadow experienced and skilled members of staff to enable them to become familiar with the home and people's needs and have an awareness of the expectations of their role. Staff told us that the induction training was useful and enabled them to feel more confident in their roles. One member of staff told us "My induction was fine, I shadowed other staff for over a week before I worked alone. I did quite a lot of training too." Another member of staff, who is employed by an agency but who regularly works at the home, told us "I work for the agency but the staff here were good and helped me to find my way around and get to know the residents."

Staff had completed essential training as well as courses that were specific to the needs and conditions of people, for example, courses for caring for people living with dementia. Some staff had undertaken additional training and held Diplomas in health and social care, or were working towards them. There were links with external organisations to provide additional learning and development for staff, such as the local authority, the local hospital and community nurses. Staff told us that the training they had undertaken was useful and enabled them to support people more effectively. One member of staff told us "I've done quite a lot of training since I started here, it has helped me a lot." One health professional who had supported staff to develop their skills when providing care to people, told us "I spent some time with the carers to support them to learn new skills and they were responsive to the advice."

Observations and discussions with staff further confirmed their knowledge and competence. Staff's interactions with people showed that the training undertaken was effective. Staff enabled people to express themselves and spent time with them, communicating in a respectful way, often sitting or kneeling beside a person when talking and listening to them, to minimise their distress or anxiety. For example, one person was becoming anxious and started to raise their voice at another person. Staff responded quickly and discreetly and competently diffused the situation, using distraction techniques to encourage the person to focus on something else. Staff spent time with the person, sitting alongside them talking about their interests and what they would be having for lunch. This interaction appeared to calm the person, they appeared to enjoy the conversation, responding with smiles and laughter. This demonstrated that staff were aware of how to support people who were living with dementia, that they were mindful of the importance of spending time with people, reassuring and listening to them.

People were cared for by staff who had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss people's needs and any concerns and were a chance for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions helpful and supportive. One member of staff told us "It's

good because I can say what I want." Another member of staff told us, "I think it's open and honest."

People's communication needs had been assessed and met. One person's care plan informed staff that the person could sometimes become verbally abusive to their family and provided guidance as to how this could best be managed. Another person's care plan informed staff that the person needed to wear glasses to enable them to see. Observations confirmed that the person was supported to wear these. Most people were able to communicate their needs well. However, some people had limited communication. It was apparent that staff knew people well, they were able to interpret and understand people's communication, ensuring that the person wasn't left feeling frustrated when trying to communicate with staff. People were encouraged to communicate with one another. Observations in the communal lounge and during lunch showed that people enjoyed having conversations with one another. Staff encouraged this by engaging in conversations with people about their interests and preferences, contributing to a friendly and relaxed atmosphere.

Staff handover meetings provided an opportunity for staff who had been working during the previous shift to pass on information about people's needs to staff working during the following shift. Observations confirmed that information related to the needs of people was passed onto staff and they were made aware of any changes in people's conditions. For example, changes in people's dietary requirements and their skin integrity. Staff told us that these meetings were helpful to them as they provided them with information so that they could ensure that people's care was consistent and effective.

People's health needs were met. People received support from healthcare professionals when required, these included GPs, chiropodists and opticians. On the day of our inspection people were visited by a chiropodist. There were weekly GP visits for some people and records confirmed that people had access to external health care professionals when required. Health professionals told us that the home responded promptly to people's health needs. One health professional told us "Staff are aware of individual residents needs and seem to respond quickly and efficiently to any problems." One person told us "If I need to see a doctor they will do it straight away."

People had a positive dining experience. Staff recorded meal choices on a whiteboard and showed us photographs of food that could also be used if people required further assistance to understand the food that was available to them. For people who had been assessed as being at risk of malnutrition, food and fluid charts were completed to monitor people's daily intake and foods were fortified with cream and milk to increase calorie consumption. People were provided with choice. Observations showed staff asking each person what they would like for their meal. People were able to choose where they had their lunch. Some people preferred to sit in their arm chairs with small lap tables, others chose to sit at the main dining tables. Tables had been laid with condiments, napkins and cutlery and contributed to a pleasant environment for people to eat their meal. One person commented about the dining experience, they were overhead saying to staff "What a posh show, lovely napkins."

Staff discreetly monitored people to ensure that they were able to eat their meals and offered support to them when required. Observations showed two people having difficulties eating their meals, staff recognised this and asked "Would you like me to put some more gravy on your dinner so it is softer to eat." The person agreed and was then able to enjoy their meal. Another person, who was having difficulty eating peas with a knife and fork, was told "If you find it easier to use your spoon, then don't worry, use it. I'll get you another spoon." Results of a recent survey sent to people's relatives, confirmed that people had received appropriate support with their nutrition and as a result had gained weight, records confirmed this. One relative commented 'My relative is safe in this home, they're eating so much better now.'

Observations showed people were encouraged to have regular drinks of their choice throughout the day. One person, who had just finished their cup of tea, was asked by staff "Did you like that? Would you like another one?" Records of a recent staff meeting showed that staff had been advised to be mindful of the importance of ensuring that people had plenty to drink, particularly in warmer weather. It stated 'It is very important that residents are given plenty of fluids and ice lollies during the hot spell we are having, they can become very dehydrated. It is our job to make sure they are well hydrated.'

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had arranged for mental capacity assessments to be undertaken for some people, was aware of DoLS and had made the necessary applications. Observations showed that consent was gained before staff supported people. One member of staff, who was supporting a person to eat their meal, was heard saying "Is it alright if I help you with your dinner?" Staff showed a good understanding of MCA and DoLS and the implications of this for the people that they supported. One member of staff told us "We always assume people can make decisions for themselves unless we know otherwise." Another member of staff told us "We have a few people here with DoLS. It is because they don't understand risk and need to be kept safe."

People told us that staff were respectful and always gained their consent before offering support. One person told us "The staff wouldn't dream of doing things without asking first." Another person told us "I like to make decisions for myself, I won't have it any other way and the staff know that." Relatives confirmed that people were asked for their consent. One relative told us "Our relative has dementia so we need to make the big decisions. Staff always ask us and they keep us informed every step of the way."

Good

Is the service caring?

Our findings

People were cared for by kind, caring and compassionate staff who appeared to know them well. One relative told us "The staff are very good, they're very patient and caring and treat people as people. Sometimes it makes me cry they are that caring." Staff told us "I suppose it's about treating them like our own family. It helps that the home is small and we get to know them really well."

People were encouraged to maintain relationships with each other as well as with their family and friends. Observations showed one person, who was celebrating their birthday, being visited by family. The person enjoyed time with their family and were able to enjoy opening their presents and cards. Observations later in the day, showed staff and people singing 'happy birthday' to the person whilst presenting them with a cake that their relatives had brought in to share. People told us that they could have visitors at any time and observations confirmed that relatives were welcomed. Staff appeared to know the relatives well and were seen passing on information to them regarding their loved ones care. Relatives confirmed that they felt fully involved in their loved ones care and could approach staff if they had any questions or queries relating to it. One relative told us "We are always kept up to speed with what is going on. The manager wouldn't make a big decision about their care without asking us first."

People's differences were acknowledged and respected. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Care plan records for one person informed staff that the person liked to look smart and took pride in their appearance, wearing certain items of jewellery and having their hair styled. Observations confirmed that the person had been supported to maintain their identity, wearing their jewellery and carrying their handbag with their possessions in.

Independence was encouraged. People told us that staff were there if they needed assistance but that they were encouraged and able to continue to do things for themselves. One person told us "I can do a lot of things for myself but if I need the help it's there." Observations showed people being encouraged to maintain their skills and independence. People were involved in their care. Records showed that people had been asked their preferences and wishes when they first moved into the home and that care plans had been reviewed in response to people's feedback or changes in their needs. Observations confirmed that people were asked their opinions and wishes on a daily basis and staff respected people's right to make decisions. Staff explained their actions before offering care and support. People told us that staff treated them with respect and that they took time to talk, explain information and listen to their needs. The provider recognised that people may need additional support to be involved in their care and explained that if people required the assistance of an advocate then this would be arranged. (An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.)

People's privacy and dignity was respected. Information held about people was kept confidential, records were stored in locked cabinets and offices. Handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained. People and relatives

confirmed that they felt that staff respected people's privacy and dignity. One relative told us "I think that is a top priority for staff, I've never seen anyone treated other than in a dignified manner." Observations of staff interacting with people showed that people were treated with dignity and respect. For example, when discussing information of a personal nature staff spoke quietly and sensitively with people, asking if they needed assistance in a sensitive and tactful way. One person, who was living with dementia, was beginning to show signs of increased anxiety whilst having their lunch. A member of staff recognised this and discreetly sat alongside the person and talked with them quietly, engaging them in conversation until they were calm and able to continue eating their lunch. Staff had undertaken training in relation to maintaining privacy and promoting dignity and showed a good understanding of this. One member of staff told us "We try to treat people as we would like to be treated." Another member of staff told us "I think we always try to put people first and treat them well."

Results from a recent survey sent to people's relatives confirmed that staff were kind and caring. One relative had commented, 'Staff treat my relative well, with a smile and respect.'

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed when they first moved into the home, care plans showed that the person and their relatives had been encouraged to be involved in both its development and review. People confirmed that they were involved in decisions that affected their care. One person told us "Yes, they're very keen on that. I do feel that my opinion matters." However, we found an area of practice in need of improvement.

The Social Care Institute for Excellence (SCIE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being and reduce the risk of social isolation. The provider was mindful of this and in the service user guide provided to people when they moved into the home, it stated, 'We focus on activities, taking into account your interests, skills and experiences, personality and medical conditions.' However, observations found that this was not implemented in practice.

The activity coordinator had recently left employment and the home had recruited another member of staff who had not yet started. Records of residents meetings, when an activity coordinator was in post, showed that people had been supported to access a wide range of activities. These included visits in the local area, pantomime performances, musical entertainers and PAT dogs (Pets as Therapy) that visited the home. Observations showed some people enjoying taking part in group activities, such as throwing and catching the ball and exercises. There was lots of encouragement and praise offered and it provided people with some fun and interaction. However, this was the only stimulation provided throughout the day and although some people received visits from family and friends, most people spent a large amount of their day sitting in their armchairs or walking around the home, with little stimulation. One person was overheard saying "I am sitting around all day and doing nothing." Records of a residents meeting showed that when the activity coordinator was in post, people were asked what activities and interests they'd like to pursue. One person had asked for some puzzles and had commented "Something to kill the boredom." Relatives confirmed that there was a lack of activities for people. One relative told us "There could be more things to do I think, but I understand an activity co-ordinator starts next week so that should be good." This is an area in need of improvement.

SCIE guidance states that person-centred planning is a process for continual listening and learning, focusing on what is important to someone now and in the future and acting upon this in alliance with their family and friends. The provider was working in accordance with this. On admission to the home each person had their individual health, medical and social needs assessed and individual care plans were devised to meet people's needs. Care plans were comprehensive and contained detailed, specific information about the person's health needs, abilities, preferences and support requirements, informing staff of how to support the person in their preferred way and in accordance with their needs. Staff told us that for people who were unable to fully communicate their preferences in relation to their care needs and requirements, that they used feedback from relatives and health professionals as well as observing the person's abilities. This enabled them to build a picture of the person's needs and preferences and devise their care plan.

In addition to the information in people's care plans a document titled 'This is Me' was completed. This identified the person's interests, hobbies and employment history and provided staff with an insight into people's lives before they moved into the home. Staff told us that this was helpful and provided them with useful information that helped them to care for people in a way that was specific to them. Observations and people confirmed that people received personalised care according to their needs and preferences. People were asked if staff treated them in a person-centred way. One person told us "I would say so yes, If I want something the staff will provide it and if I don't want to do something, they respect that too." Relatives confirmed this. A relative told us "Without doubt, the staff know the residents so well and fit around them." Staff showed a good understanding of person-centred care and implemented this in practice. One member of staff told us "Each aspect of each person's life is different, we have that in mind." Another member of staff told us "Well, this is their home, so they're in charge. We treat people as people."

Care plans identified people's skin integrity and their risk of developing pressure ulcers was assessed using a Waterlow Scoring Tool. This took into consideration the person's build, their weight, skin type and areas of risk, age, continence and mobility. This assessment was used to identify which people were at risk of developing pressure ulcers. For people at increased risk of developing pressure ulcers, care plans provided guidance to staff informing them of how to support people to minimise the risk of skin breakdown. For example, one person's care plan showed that they were at a very high risk of skin breakdown. Staff had been advised to encourage the person to maintain their mobility, ensure that the person was sitting in a comfortable position when sitting in their chair and to encourage the person to regularly access the toilet facilities, ensuring that their skin was clean and dry. Observations showed staff implementing this.

People's risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk and they were weighed each month to ensure that they were not losing any more weight. Care plans provided guidance and observations showed that the advice given had been followed. People were supported to have food and drink that was prepared according to their needs and in sufficient quantities. For example, one person, who had been assessed as being at high risk of malnutrition, was supported to have regular drinks and snacks throughout the day. Care plan records for the person advised staff that the person preferred smaller portions and their meals served in a bowl so that they could eat independently. Observations showed that this was implemented and staff were observed sitting alongside the person offering encouragement and praise whilst the person was eating.

People's needs were reviewed on a regular basis and support changed as a result. Care plan records for one person, who was a diabetic, showed that following a review of their care, with the involvement of the diabetic team, it had been agreed that the person no longer needed to be supported to monitor their blood glucose levels so frequently. Staff had been informed of this in the person's care plan and records showed that it had been implemented.

The provider had a complaints policy, this was clearly displayed on the notice board and within the service user guide which was given to people when they first moved into the home. Complaints that had been made had been dealt with promptly and in accordance with the provider's policy. The provider encouraged feedback from people and their relatives during the regular resident and relative meetings. People and relatives told us they felt comfortable to raise and discuss any issues and told us that they would speak with the manager if they had any concerns.

Good

Is the service well-led?

Our findings

People and relatives told us that the home was managed well and were complimentary about the management team. One person told us "The manager does a good job."

The home was part of a wider organisation; the provider had a number of homes throughout the South. As part of the support provided by the provider the registered manager was visited on a regular basis by the operations director and area manager. The management team consisted of a registered manager, two deputy managers and two team leaders. A health professional who visited people at the home told us "I think the home is well-led and generally has a happy staff team which can only benefit the residents."

The provider had a philosophy of care that stated 'We aim to provide all our service users with a safe, secure, relaxed home-like environment, where their care, well-being and comfort are of prime importance. The philosophy of care was embedded in the culture of the home and the practice of staff. There was a friendly, warm and homely atmosphere and a positive culture. People appeared to be at ease, happy and comfortable. One person confirmed this and told us "It's a home from home."

Regular meetings took place for people, relatives and staff, providing them with information about the home and for them to have an opportunity to share their ideas, suggestions and concerns. Staff confirmed that there was an open and transparent culture and ideas and suggestions to improve the care provided were welcomed. One member of staff told us "There is an open door policy."

Annual quality assurance surveys were sent to people's relatives to gain their feedback. These contained complimentary comments which demonstrated that people and relatives were happy with the care people received. Comments from one survey said 'An excellent friendly home, with excellent staff, we are happy with all aspects of care.' Another commented 'A small friendly environment which works well. All staff are excellent and very supportive at all times for which we are very grateful.' Regular audits also took place to enable the registered manager to have oversight of the processes in place to identify what was working well, or if there were any trends or areas of improvement required.

There were links with external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local authority, local hospital and integrated response team. (The team provides advice, training and information for care homes that provide care to older people.) The registered manager had ensured that links with other home managers within the organisation were maintained, they attended regular care home manager meetings where issues of best practice were discussed and shared. The home was also a member of the National Care Homes Association and worked closely with external health care professionals such as the GP and district nurses to ensure that people's needs were met and that the staff team were following best practice guidance.

The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight

of these to ensure that appropriate actions had been taken.