Care for Veterans

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Care for Veterans is a residential care home providing personal and nursing care to up to 60 people, with physical disabilities and complex needs; the majority are wheelchair users. The home is divided into 3 separate units, each of which has separate adapted facilities. People admitted to the home are ex-service men or women, or have a direct relative who has served their country. At the time of our inspection there were 51 people using the service.

People's experience of using this service and what we found
People felt safe living at the home. One person said, "They have very good staff who are well-trained. They really look after me". People's risks, including environmental risks, were identified, assessed and managed by staff who knew how to support people safely. Staffing levels were sufficient to meet people's needs. People received their medicines as prescribed and medicines were managed safely. The home was clean and well-maintained. One person said, "This room is cleaned every day. They don't fall over on that. The standards are very high".

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Before people came to live at the home, they met with a member of the management team to discuss the type of support they required, and whether their needs could be met. People were supported by a range of health and social care professionals, including a team of therapists directly employed by the home. People's special dietary needs were assessed and catered for. One person said they had access to food and drink outside mealtimes and explained, "You can help yourself to fruit in the dining room. You can go along and help yourself". There were gardens and outside spaces which people could access. One person said, "I've been out in the garden. It's nice to see the squirrels".

People were looked after by kind, patient and caring staff who knew them well. One person said, "Staff are kind and caring, always, everybody". People were treated with dignity and respect and their independence was encouraged. Some people were part of a rehabilitation programme and had access to a range of therapies, to promote their independence.

Care was personalised to meet people's needs. Activities were organised, although these had been limited at the time of the inspection, due to an outbreak of COVID-19 at the home. Normally people had access to a wellbeing hub which offered a range of activities to suit people's interests. Complaints were dealt with in line with the provider's policy. If it was their wish, people could spend the rest of their lives at the home.

People knew the management team and could participate in residents' meetings where various topics were discussed, such as the quality of food on offer. One person said, "Senior staff come round and chat with me". Another person told us, "It's nice. I can go to staff with anything". A system of audits had been implemented to drive improvement.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (report published 13 July 2017).

Why we inspected
This service had not been inspected since 2017.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Care for Veterans on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Care for Veterans

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by an inspector, a nurse specialist and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Care for Veterans is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Care for Veterans is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people and 1 relative about their experiences of the service. We spoke with the chief executive officer who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with the registered manager, the head of clinical services, the head of human resources, 1 administration assistant, 1 chef, 2 registered nurses and 2 care staff.

We reviewed a range of records including 7 care plans and multiple medication records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has remained Good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse or harm. One person said, "Very safe. I'm not threatened. I like the staff. I've been in other homes and this is the best place I've been. They've helped me get better". A relative told us, "Yes, they keep an eye on her. If any injury appears, they deal with it. They keep a close and careful eye".
- All staff completed safeguarding training and knew what actions to take if they had any concerns about people's wellbeing. One staff member said, "It's ensuring I protect the residents' wellbeing, use the correct equipment and make sure it's checked before I use it. On abuse, there could be handling people wrongly, verbal, or financial abuse or neglect".
- Where incidents had occurred, the registered manager had reported these to the local safeguarding authority, and records confirmed this.

Assessing risk, safety monitoring and management

- Risks to people, including any environmental risks, were identified, assessed and managed safely.
- People were encouraged with their independence and in positive risk taking. One person said, "Yes, staff discuss any risks with me fully".
- We reviewed a range of risk assessments within people's care plans. For example, a diabetic care plan included the person's risks relating to infection and retinopathy, an eating and drinking plan reflective of diabetes, and involvement with a diabetic nurse. Another person had swallowing difficulties and was at risk of choking due to their health condition, and these risks had been identified and assessed, with detailed information for staff on how to mitigate these risks.
- Risks assessments within care plans were reviewed regularly or if people's needs changed.
- Staff had completed training in moving and handling. We observed staff supported people in a safe way. Equipment, such as hoists and wheelchairs, was serviced regularly to ensure it was safe to use and fit for purpose.
- Risks relating to fire safety and evacuation systems had been assessed. Regular testing of the fire alarms and fire evacuation practices were undertaken by staff. People had individual emergency evacuation plans.

Staffing and recruitment

- There was sufficient staff on duty to meet people's needs. However, we received mixed feedback from people about the availability of staff during the night or at weekends. One person said, "At night, there's only a few staff about. They have agency staff who don't know people well". Another person told us, "The staff support each other and they all chip in and help out. There is a good team spirit".
- We observed staff were attentive to people's needs and call bells were answered promptly. Staffing rotas

we reviewed showed consistent numbers of staff on duty. Staffing levels were assessed using a dependency tool, based on people's care and support needs.
● We asked staff if they felt they had time to spend with people. One staff member said, "At the moment, we're learning how to use the new care planning system, but I do spend time chatting with people. It's busy at the moment because of Covid. We do use agency staff and they work alongside experienced staff".
● Thorough checks had been completed to show new staff were recruited safely. We reviewed 3 staff files. Application forms, including employment histories, had been completed, and references had been obtained. Disclosure and Barring Service (DBS) checks had been received. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The registered manager said, "It's been quite difficult of late to recruit. You get the interest and then people don't even bother to turn up. We have quite a good rewards scheme here. We do use agency staff here and a set group of staff who come to the home; they're all reputable agencies".

Using medicines safely
● Medicines were managed safely.
● People told us they received their medicines as prescribed. One person said, "Yes, staff are very strong on that. They always explain any new medicine and you get it on time". Another person told us, "Staff bring it in the mornings and afternoons and when I'm in bed".
● We observed staff giving people their medicines at lunchtime. Staff were kind and patient with people. Staff completed training before being allowed to administer medicines, and their competency to do so was annually assessed. Medicines to be given at a particular time of day, for example before food, were given as prescribed. Medicines to be given as required (PRN) were recorded and PRN protocols had been completed.
● Medication administration records (MAR) contained information about people, their photographs and any allergies. MARs had been completed accurately by staff. Stock levels of medicines tallied with the balances recorded. Audits of medicines identified any concerns and were designed to address any shortfalls.
● Medicines were ordered, stored and disposed of safely.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
At the time of the inspection, a small number of people and staff had contracted COVID-19. The home was open to visitors, by appointment. Personal protective equipment such as disposable masks was available for visitors to use. Visiting took place in a partitioned area on the ground floor or through secure visiting pods. Visitors were required to undertake lateral flow device tests and receive a negative result before being allowed into the home.

Learning lessons when things go wrong

● Lessons were learned if things went wrong.

● The registered manager had set up a quality improvements group. Staff representatives from each department brought to the group an example of something that could be improved upon. They explained, "We can learn from other departments and share our learning across the board. For example, 1 staff member was checking fridge temperatures without knowing what the safe limits were, and what you need to do. This was an area we improved upon".

● Although safeguarding referrals had been made to the local authority when incidents occurred, these had not always been notified to CQC. We discussed this with the registered manager who then demonstrated their understanding that any alleged abuse needs to be notified, even if the incident did not meet local authority safeguarding criteria.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has remained Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before they came to live at the home. Initial enquiries were overseen by an administrator, then a member of the clinical team would complete an assessment, to include any therapy needs the person may have.
- One person said, "I was involved at first and my relative was involved too. It was very good. I was at a home before and they decided about end of life care and not being resuscitated, without talking to me. I was asked here, absolutely". Another person told us, "My relatives are involved at every stage".
- From our conversations with staff, it was clear they knew people well, including how they wished to be supported and cared for.

Staff support: induction, training, skills and experience

- Staff were trained to work in a care setting. One relative said, "The staff aren't just well trained, they love what they do. They go above and beyond and they're always ready to help". One person said, "I can't fault the standards here. I'm better set up with my personal care here than anywhere else, I'm fortunate".
- New staff completed an induction programme, including mandatory training, when they came to work at the home.
- The majority of training staff completed was through eLearning. Some training was delivered face-to-face such as moving and handling, first aid, and basic life support. Training was overseen by the Human Resources Team who reminded staff when training was due. Staff had access to laptops at the home or could complete training in their own homes and at a time that suited them.
- Staff received regular supervision meetings with their line managers. One staff member said, "It's usually 1 of the supervisors or the nurse who does supervision. I also have a mentor if I want to discuss anything or have any concerns. We talk about how I'm feeling, whether any improvements are needed. I'm doing my NVQ3 at the moment and I receive lots of support. You can always ask for additional training on any topic if you want".
- The staff training matrix confirmed staff were up to date with their training.

Supporting people to eat and drink enough to maintain a balanced diet

- People's dietary needs were catered for and they were encouraged in a healthy diet. Where appropriate, and as part of their rehabilitation, people were supported to prepare meals and drinks in a specially equipped, accessible kitchen.
- We received mixed feedback about the food on offer. One person said, "The food is very good. I'm on a diet to lose weight so they give me fruit instead of puddings. They're supportive of the diet. The carers suggested I could lose weight". Another person told us, "The food's not bad. At times the meals are less

than good. They only have a small budget for food. The meal was good today though. They mostly remember my likes and dislikes".
● People's feedback about the meals on offer was gained through catering meetings held between staff and people.
● One chef demonstrated their understanding of people's special dietary requirements and said, "People that have allergies – these are listed in the kitchen. Any meals that need to be pureed, minced or moist, it's all highlighted. The menu has 2 choices, main is meat or vegetarian. There's an alternative menu as well, like jacket potatoes, omelettes, salad, sandwiches, etc".
● Catering staff had completed training on Internal Dysphagia Diet Standardisation Initiative (IDDSI) which classifies the different ways food and fluids should be prepared to suit people's specific assessed needs.
● As well as catering for people's clinical needs with regard to meal preparation, people's religious needs were also acknowledged and catered for. For example, one person could not eat pork, so kitchen staff prepared them chicken or fish instead, or the person might choose to have a vegetarian option.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People received support from a range of healthcare professionals, some of whom were employed at the home, such as physiotherapists.
● One person said, "I have asked to see a doctor, but they've got a nurse practitioner who comes in". Another person told us, "I have access to healthcare and I see a dentist for regular checkups". A third person told us, "I do physio every day here. I cycle on my legs. I build up my legs and I hope I will be able to walk again".
● The home was supported by a local medical practice who sent a nurse practitioner to visit people every second Tuesday. If people had an urgent medical concern, then staff could speak with a GP or specialist for advice.
● A team of therapists supported people as part of their rehabilitation. People had access to a gym area which housed various pieces of equipment to support people with their independence, aided by therapists.

Adapting service, design, decoration to meet people's needs
● The home was adapted to meet people's needs. One person said, "The services here are absolutely great. It's more like a caring hospital. It's not as luxurious as some other places, but it doesn't have to be". Another person told us, "The chapel's lovely. There's a very nice garden. I can go into the garden. They've got a greenhouse and they encourage gardening and growing stuff for the home".
● A kitchen for people's use had variable work surfaces and sufficient space to enable wheelchair uses to mobilise easily. A large dining room catered for wheelchair users and was accessible to all.
● Bathrooms and wet rooms included hoists to enable people with limited mobility to access baths or showers.
● A central hub area enabled people to engage in various craft activities such as painting or puzzles. A separate area had been cordoned off so people could watch television on a wide screen.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People's capacity to make specific decisions had been assessed.
- Where people lacked capacity to consent to their care and treatment, DoLS had been applied for to the local authority.
- Where people's relatives, or others, had been appointed to manage people's affairs on their behalf, copies of the Lasting Powers of Attorney were kept, so decisions were made lawfully and in people's best interests.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has remained Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People's diverse needs were acknowledged and catered for; they were supported by staff who knew their preferences. One person said, "Staff treat me very well, but they don't always have time to talk". Another person told us, "I'm very happy with the staff; they're kind".
- We explained to the registered manager that some people felt staff did not have time to sit and chat with them. They told us that with an outbreak of COVID-19 at the time of the inspection, parts of the home had been closed off. People were spending more time in their rooms to prevent the risk of infection. Staff were dedicated to working in the same part of the home through this outbreak.
- We observed staff supporting people in 1 part of the home. People were treated with kindness, by patient, caring staff.
- When asked how staff would treat someone with diverse needs, 1 staff member told us, "We have people of different religions. We have the church here in the grounds and Father comes in and chats to residents when he can. Every Thursday people can meet up and attend Mass. The home supports people of any religion or those who have none".

Supporting people to express their views and be involved in making decisions about their care

- People were encouraged to express their views and to be involved in all aspects of their care.
- One person said, "Staff are kind and empathic. I've had personal problems and they've been very supportive. They haven't taken sides, but they show me that they want to take care of me".
- We asked staff how they would involve people in decisions about their care. One staff member said, "We talk with people and get to know the residents, their likes and dislikes. We go round with the menus, so they have a choice every day of what they want to eat. I know who wants a shower and when. You just get to know people".

Respecting and promoting people's privacy, dignity and independence

- People were treated with dignity and respect and their independence was promoted.
- One person said, "My privacy and dignity is maintained at all times. Staff knock and wait for me to answer. Well, they don't always wait, but that's all right. They cover me up in towels when I'm in the shower". Another person told us, "I've got a sign up saying to come in after they've knocked and I've said, 'Come in'. I've never had it had happen here that someone has come in without knocking".
- Staff described how they would maintain people's privacy and dignity. One staff member said, "I would close the doors, and cover people with a towel I would check with people that they want to receive personal care. There is a sign we put on the door when we're giving personal care".

● People were encouraged to do as much as they could for themselves. A team of therapists supported people in this way, and people had access to various facilities that enabled them to be as independent as possible.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Good. At this inspection the rating has remained Good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received personal care that met their needs and in line with their choices and preferences.
- A staff member explained their understanding of personal care and said, "It's the person first, respecting their wishes and their way of doing things. Just talking to people and getting to know them. The more you get to know the person, the easier it is for them to know their wishes will be respected and things are done the way they want".
- Care plans were in the process of being changed over from one electronic system to another. Staff were still in the process of ensuring all the information within care plans was current, and receiving training on how to operate the system. The care plans we reviewed showed people's personal histories had been included. From our conversations with staff, it was clear they knew people well.
- One person said, "I've travelled a lot and staff ask about the places I've been to".

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were met. One person used a specialist piece of equipment into which they typed what they wanted to say and the computer spoke the words. Another person wore hearing aids which helped them, although they were able to lip read as well.
- Staff communicated with people in a warm and friendly manner, showing caring attitudes to everyone; we observed people enjoyed talking with staff. Relationships were good across staff teams. Staff appeared to enjoy their work, including housekeeping staff, who were cheerful and busy.
- Information could be provided in any format according to people's needs and preferences. For example, some people preferred information to be in an easy-read format.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- A variety of activities and pursuits were available to people throughout the day, although these had become restricted due to the outbreak of COVID-19 recently within the home.
- A wellbeing hub provided a range of activities for people, although this was not in use at the time of the inspection because of the infection risk. Where possible, staff were engaging with people in their own rooms

with some activities on a 1:1 basis. The hub included a large-screen television for people to watch, art and craft, board games, word games, and chair-based activities. There was a computer suite where people could use laptops or tablets to stay in touch with relatives or friends around the world. A Valentine's dance had proved a popular event with people and staff.

● Some people commented on the trips they had taken outside the home. One person said, "We had tickets to Twickenham for the rugby. We went in the mini bus last year. It was lovely and a complete change of scenery". Trips to commemorate Armistice Day at the Cenotaph were taken up by some people.

Improving care quality in response to complaints or concerns

● Complaints were logged and managed in line with the provider's policy. We reviewed 1 formal complaint that was currently being dealt with. Some complaints were dealt with straight away by staff. One person said, "I've never had to make a complaint really, but if I've raised issues, they were extremely good at addressing them". Another person told us, "We meet regularly with the management team. Anyone can go along. There was an issue 1 day about the quality of the food. It was recognised and dealt with before it was brought up at the meeting".

End of life care and support

● People could live out their lives at the home, if this was their wish.

● Advanced care plans recorded people's wishes and preferences for staff to follow.

● Some people had 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) documents within their care plans. These showed when it would not be appropriate to resuscitate a person due to their medical history and significant health concerns.

● A staff member explained the training they had completed on end of life care. They told us, "It's hard, but you know you've given the person your all, made them comfortable and supported their families. We try and give the best care possible".

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has remained Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The culture of the service was promoted by the management team to enable people and their relatives to be involved in all aspects of the service.
- When asked about the culture of the service, 1 person said, "They see the residents as their priority".
- In the past, the service was viewed as a hospital-type setting with a clinical focus. The registered manager explained how they hoped to change the perception of the home being a, "Nurse-driven culture. What we are trying to do is to change this, but nurses can be quite protective of what they do".
- Duty of candour responsibilities had been met as needed. Duty of candour is the requirement for the registered provider and registered manager to act in an open and transparent way with regard to the provision of care and treatment to people.
- The registered manager explained how any issues could be escalated as needed and information shared with departments within the home, so these could be learned from.
- The registered manager had a reasonable understanding of their responsibilities and regulatory requirements. There was a concern about the lack of reporting of some allegations of abuse and we discussed this with the registered manager. Whilst these incidents had been reported to the local authority, they had not always been notified to CQC as required. However, no-one had been harmed as a result of this, and the registered manager had made safeguarding referrals to the local authority as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives were encouraged to give their feedback about the home.
- Residents' meetings were organised and records confirmed people attended these. For example, a meeting held in January 2023 showed COVID-19 guidelines were discussed, heating, accessibility outside, and a new residents' handbook.
- One person said, "The meetings are open. They can't provide all that people ask for, but the managers give all the information they can possibly give without breaking confidentiality". Another person told us, "They don't do anything I don't understand. They were doing some building work and they had to make a noise. They explained that and I fully understood".
- Any characteristics protected under the Equality Act 2010 were identified, acknowledged and catered for. For example, staff who could struggle to understand information and training because of dyslexia, were

supported in a variety of ways, such as 1:1 support and coloured overlays for laptop screens. Staff were generally positive about working at the home. One staff member said, "I absolutely love it here, the staff and the residents; I'm happy here. I don't have days when I don't want to work. I love my job and seeing people smile when you walk into the room".

● Staff meetings took place, although some staff were not always able to attend if they were on duty. However, minutes were available. One staff member felt the staff meetings could be quite overwhelming and suggested smaller staff meetings within each unit of the home. We fed this back to the registered manager.

Continuous learning and improving care

● A range of audits identified areas where action was required to drive improvement.

● Incidents and accidents were reported and analysed for any patterns or trends, so steps could be taken to prevent similar events from reoccurring.

● A 'continuous improvement file' recorded any informal concerns raised by people. For example, occasions when people had questioned staff's attitude towards them. Another issue related to concerns about the lack of joined-up care for 1 person, so a multi-disciplinary professionals' meeting was organised.

Working in partnership with others

● The home worked with a range of health and social care professionals. Referrals for people to be admitted to the home came through the local authority or continuing health care.

● A team of therapists were employed directly by the home and liaised with others such as GPs, dieticians and speech and language therapists.

● The registered manager was a member of various fora and engaged with other registered managers to share information and seek advice. They told us, "During Covid, being a member of a West Sussex group was good and we linked with other managers. We also used social media to share information with other homes".