Sue Ryder

Sue Ryder - The Chantry

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?	Outstanding ☆

Summary of findings

Overall summary

This inspection took place on the 2 November 2016 and was unannounced.

The service is registered to provide accommodation and nursing care for up to 31 people. On the day of our inspection there were 29 people living at the service.

The service provides nursing and personal care support to people who have a neurological condition, such as acquired brain injury or chronic neurological disease and including the care of people living with dementia.

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.

This service was previously inspected in October 2015 and was rated as 'Requires Improvement'. The provider sent us their action plan describing the action they would take to meet regulatory requirements.

At this inspection we found that improvements had been made. For example, staffing levels had improved. The provider had improved their system for logging all concerns and complaints. The employment of a new clinical lead had meant that staff received the support and clinical oversight they needed. Audits to check that people received safe and effective care had been further improved and managed effectively.

There was a positive, enabling culture in the service. Staff found innovative and creative ways of supporting people to overcome perceived limitations and enable people to take as much control over their own lives as possible. Discussions with the senior management team and staff demonstrated a passionate approach to looking at ways to improve the quality of the service provided.

Staff had extensive understanding of managing risks whilst supporting people to live their lives in a manner which promoted their independence, autonomy and choice with a view to enabling people to reach their full potential despite physical and emotional challenges. People were supported to access healthcare professionals when they needed them.

People were consulted and invited to be involved in the continuous planning to improve the service. For example, through their involvement in setting up and running their own committee meetings, dignity meetings and a regular review of their care and review of support plans.

Staff were caring and committed to providing quality care. People were treated with respect and their dignity was maintained. The atmosphere was friendly and there were positive, enabling relationships between staff and the people who used the service. Staff worked collaboratively as a team with their primary

focus meeting the neds of people whilst enabling them to maintain their independence.

There was a strong emphasis on person centred care. People were supported to plan their support, were involved in the pre-admission process and in the planning for all aspects of their care and received a service based on their personal needs and wishes. People's care was regularly reviewed with their key nurse and involvement of friends and relatives according to their choice.

People had positive relationships with their support staff who knew them well. There were enough staff available to meet people's needs and people were supported to follow a wide range of interests and hobbies including access and involvement in the local community.

Staff understood their roles and were well supported by the management team. Staff were encouraged to develop their skills further and provided with opportunities to access specialist training which provided them with the skills and knowledge they needed to meet the complex health and communication needs of the people they supported.

The cohesive management team demonstrated outstanding, strong values with a desire to learn about and implement best practice throughout the service. Staff were highly motivated and proud of where they worked. The provider managed to maintain sufficient numbers of qualified nursing staff which ensured continuity of care. The service had a positive culture that was person centred, open, inclusive and empowering. Links had been developed with other organisations that helped the service to develop best practice. The management team used effective systems to continually monitor the quality and the safety of the service with ongoing plans to provide for continuous improvement. The manager said that the vision was to care and support people to live as full a life as possible in spite of their experienced limitations and disabilities.

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.

Staff had been trained in recognising and responding to abuse. People were kept safe from harm and they had confidence in the staff to support them safely. People were supported to take positive risks and to live their lives as independently as possible whilst steps had been taken to protect them from avoidable harm.

Staffing levels were flexible and determined according to people's individual needs.

The provider operated safe and effective recruitment procedures which ensured that all satisfactory checks had been completed before staff started their employment. This meant people were supported by staff who had been considered suitable to work

The provider had safe and effective systems in place which meant people received their medicines as intended.

Is the service effective?

Good

The service was effective.

People received care and support that was based on their needs, wishes and preferences. Staff were skilled in meeting people's needs and received ongoing support with specialist training and their development needs monitored to ensure they delivered best practice.

People were encouraged to be independent, stay healthy and active.

The manager and staff had a good understanding of their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA). Consent to care and treatment was lawfully obtained.

Is the service caring?

Good

The service was very caring.

People were treated with dignity, kindness and compassion.

The staff and management team were committed to a strong person centred culture. People had positive relationships with staff that were based on respect for individuals and actively promoted their dignity. People were actively encouraged to express their views and were consulted on all aspects of care.

Is the service responsive?

Good

The service was responsive.

People were involved in assessing and planning their own care and were involved in the daily life of the service.

People were encouraged to maintain their independence and able to follow their own interest and hobbies.

The provider was proactive in encouraging feedback from people and responded to any concerns, promptly and to the best of their ability to people's satisfaction.

Is the service well-led?

Outstanding

The leadership and management of the service was outstanding.

People and their relatives, were actively involved in developing the service.

Staff understood their roles and were well supported by the senior management team. Staff received regular, planned performance reviews which were linked to the provider values and behaviours. There was effective overall clinical monitoring of the service. Nursing staff had access to regular clinical supervision and support to update their clinical skills and knowledge.

The service worked effectively in partnership with other organisations to promote best practice and improve the lives of people who used the service.

There was a strong emphasis on continual improvement and best practice which befitted people and staff. There was a range of quality and safety audits which identified potential areas for improvement of the service. The culture was open and inclusive where feedback was encouraged.

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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 inspection took place on the 2 November 2016 and was unannounced.

This inspection was carried out by one inspector, a specialist nurse advisor 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. The Expert by Experience had experience of providing care and support for an older person.

We reviewed the previous inspection report to help us plan what areas we were going to focus on during our inspection. We looked at other information we held about the service including statutory notifications. This is information providers are required to send us by law to inform us of significant events.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Some people living at the service were unable to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we spoke with nine people who were able to verbally express their views about the quality of the service they received and four people's relatives. We observed the care and support provided to people and the interactions between staff and people throughout our inspection.

We looked at records in relation to eight people's care. We spoke with the registered manager, the head of care, three nurses, the cook, one activities coordinator, a cook and seven members of care and domestic staff.

We also looked at records relating to the management of medicines, staff recruitment, staff training and systems for monitoring the quality and safety of the service.

Prior to and during our inspection we spoke with stakeholders such as the local authority and health care professionals. Stakeholders were complimentary about the leadership of the service and the timely response to people's changing health care needs.

Good

Is the service safe?

Our findings

Risk assessments for the environment had been developed and were regularly reviewed with the changing needs of the people who lived at the home in mind. The manager collated information on untoward incidents and accidents and used this information to plan for monitoring trends and planning to meet care needs. All incidents were recorded and an outcome based plan was included to minimise the risk of future occurrence.

Staff had been provided with clear guidance to enable them to mitigate the risks to people's welfare and safety. Where risks had been identified, a 'what you need to do to keep me safe' plan was put in place and provided staff with guidance on how to manage and mitigate these risks. For example, when using moving and handling techniques and equipment, the risk of developing pressure ulcers, dietary intake, accessing the community and responding to and monitoring epileptic episodes. Risk assessments had been reviewed regularly and actions described with regards to changes. Each person had a personal emergency evacuation plan (PEEP) in their plan of care. This gave guidance to staff to ensure people's safety was protected during the evacuation of the building in the event of fire or other emergency.

Staff had extensive understanding of managing risks whilst supporting people to live their lives in a manner which promoted their independence, autonomy and choice with a view to enabling people to reach their full potential despite physical, cognitive and emotional challenges. People were encouraged to raise concerns about their safety in regular resident meetings and in individual care review meetings with support where necessary. This ensured that everyone regardless of their needs or the strength of their voices was supported to have their say. A relative told us, "I can see they have a dedicated team here. They do everything they can to make sure the residents are safe and comfortable."

Risk assessments have been completed for people mobilising around the service. These included falls risk assessments and risk management guidelines to prevent the risk of falling. Risk assessments supported positive risk taking. Moving and handling plans described for staff safe techniques to follow and we observed safe moving and handling manoeuvres as described in these plans. We saw that people with complex physical limitations were supported to access hobbies and interests such as sailing, support to attend football matches and horse racing.

Staff were aware and confident in how to escalate any concerns they might have in relation to protecting the safety of people and aware of how to identify those at risk of abuse. One member of staff told us, "All staff receive safeguarding awareness training and everyone knows what to look out for and how to escalate concerns." Staff had been provided with guidance in risk assessments and training in awareness of how to protect people from the possible risk of harm or abuse. Staff told us they were aware of their responsibilities to report any allegations or safeguarding concerns to the manager and local safeguarding protocols that were in in place and were aware of how to access information to enable them to report to the local safeguarding authority for investigation.

Staffing levels were flexible according to individual needs. Everyone we spoke with told us there was

sufficient staff available during the day and night. One person said, There is always enough staff around when I need them, there is always two to lift me into my wheelchair and they do it gently, I feel safe."

When asked in their 'Provider Information Return' what improvements the provider planned to introduce within the next 12 months that would make the service safer? They told us they planned to improve on their response times to call bells. This involved installation of a new call system being installed with regular audits and that this work was ongoing.

Everyone we spoke with told us that there was sufficient numbers of staff to support them to access regular outings into the community. During our visit we saw people going out for a walk locally and strolling in the grounds accompanied by staff. People were supported by staff to access facilities available in the service, such as a day care service if they chose to attend.

We saw an example of rotas where staffing levels had been increased beyond the usual ratio to support people where one to one care was required to meet people's complex needs.

People's medicines were handled safely and according to the provider's policy and procedure.
Staff had received up to date training in handling medicines and were able to tell us about safe practice. Staff understood what certain medicines were prescribed for, the effect they had on people and the importance of keeping medicines under review. People's medicines were stored safely and securely. Room and fridge temperature checks were carried out daily with records maintained.

People's medicines, including controlled medicines, were stored safely and there was a system for the ordering, receipt and disposal of medicines. Staff told us they received updated training in medicines management and also the use of specialist equipment. Staff competency for administering medicines was assessed at two yearly intervals. Medicine errors were recorded on a monitoring system, investigated to ensure that lessons were learnt and people were protected.

Care plans described the medicines prescribed, any risks identified and how people chose to take their medicines. People told us they received their medicines as prescribed and pain relief when required and in a timely manner when requested. Where people were prescribed as and when required pain relief medicines and were unable to verbally communicate their needs, staff had recorded guidance which described for them potential indicators of pain such as facial expressions and body language which may indicate a person was uncomfortable and experiencing pain.

We observed one person tell a nurse that they were in pain. The nurse encouraged the person that this was likely related to their mobility needs and may subside during their physiotherapy sessions that was about to commence. The person was reassured that they could review their pain after the session and would be supported to access the pain relief if this was required. Later in the day this person told us that after their physiotherapy sessions they no longer required pain relief and had been satisfied with the nurse's earlier suggestion.

For people where medicines were administered directly into their stomach via a percutaneous tube, there was clear guidance for staff in care plans. This meant that staff were provided with safe procedures for the administration of their medicines and care to ensure the cleaning of the tube entry site.

We found clear guidance for staff on the administration of insulin for people diagnosed with diabetes. Where people with diabetes were a risk of developing other health related conditions care plans provided clear guidance in the case of fluctuating blood glucose levels and evidence of regular access to podiatrists and

opticians.

We observed staff to administering medicines to people in a safe, timely manner and according to people's preferences. People were offered their pain relief at the time of medicines administration and encouraged to inform staff if this was required at any time in between.

Medicine administration charts were signed following administration of people's medicines and did not contain any gaps. Where medicines had not been administered appropriate codes were used to describe the reasons for this. This showed that people received their medicines as intended by the prescriber.

The service recruited staff in a way that protected people. A review of staff recruitment files showed us that application forms had been completed which identified any gaps in applicants previous work history. Checks were in place from the Disclosure and Barring Service (DBS) to establish if staff had any criminal record which would exclude them from working in this setting. References and DBS checks had been confirmed before staff started working at the service.

Good

Is the service effective?

Our findings

The service provides support for people with neurological disabilities requiring a skilled multi-disciplinary team. Interdisciplinary team working had been introduced to ensure that people's individual goals were planned and regularly reviewed together by the whole team on a weekly basis. The team included at these meetings consisted of; the head of clinical care, lead nurses, senior nurses, nurse assistant's, neuro physiotherapists, occupational therapists and therapy assistants. People and their relatives were invited to inter disciplinary review meetings but were also offered a less formal meeting with the lead nurse for those who were not comfortable with a formal meeting, preferring a less formal setting.

People consistently told us that they were happy with the care they received. People and their relatives told us they received support from staff who they described as skilled, experienced and knowledgeable in the roles they were employed to perform. One person told us, "The staff are trained well. When I am helped into the hoist they do this sensitively and appear skilled in this. I feel safe with them." A relative told us, "The staff are very able and skilful. They discreetly provide care with the minimum of fuss which helps [relative] feel safe and secure." Another told us, "I have no criticism of any of the staff they appear capable and able to support my [relative] well."

Staff received a variety of training to support them in the roles. External accredited organisations were utilised to deliver training based on best practice. Nursing staff told us they were provided with opportunities to update their clinical practice and development. For example, in caring for people with complex medical health conditions. One nurse told us, "I feel safe as a registered nurse here. Things are done properly they don't cut corners. There is no pressure put on you if you are not sure how to do something but they support you with the right training where needed. We get lots of specialist training such as; Tracheostomy, up to date training on suction catheters, syringe driver training and administering medicines via a percutaneous endoscopic gastronomy (PEG) (a means of receiving nutrition through the stomach wall when people cannot take food). We recently had training in grading pressure ulcers and receive regular updates with safe moving and handling." A senior carer told us, "Good practice is embedded into the training we receive. We have performance reviews at least four times a year where we are assessed according to the behaviours and values of the organisation. We are set goals and plan training. There is a behaviour framework such as; working together, honesty and integrity and delivering outcomes. These are discussed and we are measured against these. This gives us clear boundaries to work within. As a senior carer I am supported to improve my skills and knowledge. I have access to training such as; care of people who have had a laryngectomy (removal of the larynx and separation of the airway from the mouth, nose and oesophagus), oral suction and leadership courses. I love my job. We work well together as a team for the good of the people we support."

Newly employed staff told us about their induction which included a period of shadowing a more experienced member of staff. All of the staff we spoke with confirmed that they had received regular one to one performance review meetings with their line manager.

Staff confirmed that they had received training in understanding their roles and responsibilities with regards

to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Care records showed us that people who lacked mental capacity had an assessment carried out so that any decisions made regarding their health and welfare where they lacked capacity would be made in their best interests. Applications for authorisation with regards to the deprivation of liberty safeguards for people where their freedom of movement may be restricted to keep them safe, such as those requiring constant supervision had been referred to the local safeguarding authority and reviewed when required.

Staff described the creative ways they used to assess people's consent to care and treatment where they had limited mental capacity and lacked verbal communication. One staff member told us , "I use short, closed questions and look for body language which indicates I have been given consent when providing personal care or assessing a person's choice with planning for involvement in activities." Another told us, "Because people are with us for such a long time, we get to know what they like and can treat them as individuals but we still ask them what they want as they change their minds often, as they have a right do so."

One person told us they believed that their condition had improved since they moved into the service. They said, "The staff ask what I would like and before they leave ask me if there is anything else they can do for me."

One person had been assessed as requiring a pressure relieving mattress but had objected to this as it affected their sleep. There was evidence that their capacity to make decisions had been assessed and their best interests considered in line with the Mental Capacity Act 2005.

People were supported to have enough to eat and drink and maintain a balanced, nutritious diet. However, we received mixed views about the quality of the food and the mealtime experience. One person told us, "The food is good for the majority of the time, you can't please everyone. My only complaint is we sometimes have to wait a long time to be served our meal. Your main meal comes along but when you have finished this you sometimes have to wait a long time for your dessert." Another told us, "The food is good, and we have plenty to eat but the dining experience leaves a lot to be desired."

Menus had been developed following consultation and involvement of people who used the service. The cook attended meetings with people to ascertain their views. The registered manager told us that they were working to respond to people's views raised at resident committee meetings.

Discussions with kitchen staff demonstrated they had a sound understanding of people's complex health needs including the people who following specialist advice from speech and language therapists had been assessed as requiring prepared textures to their food to avoid choking risks. The cook in charge on the day of our visit told us, "We double check everything to make sure we don't give the wrong consistency to people to avoid the risk of choking."

The catering team demonstrated a sound knowledge of action they would take to fortify foods for people who had been assessed as at risk of losing weight. They described how they would fortify foods to increase their calorific content. For example, "We add as many nutrients as possible, such as full cream milk, cream shots, butter to potatoes along with cream and prepare milk shakes with additional milk powder."

We observed the lunch time meal. We noted that meals arrived slowly with some people waiting for up to 45 minutes for their first course to arrive. Other people were eating their pudding whilst others were still waiting for their main meal. There was a lack of preparation with no place settings made and adaptive aids such as plate guards and slip mats provided before people sat and started to eat their meal. People arrived

supported by staff at different times but some people arriving later were served before others who had arrived before them and left waiting for some time.

There were adequate numbers of staff available to support people with their meals. Staff assisted people to eat at their own pace and encouraged them with their meal with explanations of what they were eating where this was required. However, there appeared to be a lack of deployment of staff to provide consistent support to people, who required one to one with eating their meal. This meant that whilst one member of staff supported a person with their main meal a different member of staff later supported then with eating their pudding. We discussed our findings with the management team. They told they had already received feedback from people who used the service via meetings and surveys and were in the process of looking at ways to improve the meal time experience for people.

Care records showed that a nutritional assessment had been carried out for each person and their weight had been checked and monitored regularly. Where people had been identified as at risk of losing weight appropriate referrals were made for specialist advice from dieticians and speech and language therapists where people experienced swallowing difficulties or deemed to be at risk of choking. For example, one person had lost a significant amount of weight in a short period of time. They were referred to their GP and dietician for specialist advice which was followed. One person had been assessed by a specialist nutrition nurse to enable them to administer their own nutritional intake independently.

People were supported to have access to a variety of health and social care professionals if and when required. For example, GP's, dentists, opticians and podiatrists as well as advocacy support. A weekly GP surgery was conducted within the service. People had access to tissue viability specialists where advice was required in the prevention and treatment of pressure ulcers. Access to specialist equipment was provided appropriate for the needs of individuals. Where people chose not to have staff physically reposition them as required regularly, specialist beds were provided which would automatically reposition people, gently, without the need for staff to physically intervene. This one person told us supported their need for privacy.

There was evidence that people had their blood pressure, blood glucose monitored and weight measured regularly and this had been recorded accurately with action taken in response to any concerns identified.

Visiting health professionals told us that staff were effective in their roles. One told us, "I visit weekly and the team provide a list in advance of people who require a visit with a description of their health concern." They gave examples of when nurses raised concerns about people's health and following GP advice supported people appropriately according to advice given.

The log of contacts with health and social care professionals evidenced that care and support had been delivered as stated in the care plan. One person had been visited by the dentist on the day of our visit and required additional support with x-rays before dental treatment could commence. We noted nursing staff liaised with the hospital and logistical arrangements were made to support this person with appropriate information recorded to their daily records and the communication diary.

People had information in relation to their health care needs within a hospital passport and emergency transfer recording system. This provided important information including their personal preferences and complex care needs in a concise format, should they require admission to hospital.

Good

Is the service caring?

Our findings

People and their relatives were consistently positive about the caring attitude of staff. They told us staff were friendly and treated them with kindness. One person said, "The staff are lovely and help you." Another said, "I am quite happy here. The staff are lovely and always treat me with respect. They look after me well and they have a great sense of humour."

One relative told us, "I have heard other people call out for help and staff attend to them promptly. The staff are polite and caring, very caring." Another told us, "Staff are kind and caring. [Relative] is totally dependent on them and when they move [relative] that are so gently. They do a wonderful job and work so hard."

We observed people who became anxious and distressed supported by staff who remained calm and treated people in a compassionate manner. For example, one person was observed to become distressed and refused assistance with eating their lunch. A staff member, knelt beside the person making good eye contact, spoke gently reassuring them. The person responded well and became calmer allowing the carer to support them. Another person was observed to be supported by staff in a reassuring, supportive manner whilst explaining what they were doing whilst conducting a moving and handling transfer. We observed another person being supported into a recliner chair using an electric hoist; staff support this person to maintain their dignity ensuring their legs were covered with a blanket. Staff were kind, reassuring and a gentle explanation was given throughout the manoeuvre.

It was evident from our observations and from what people and their relatives told us that there was a person centred culture within the service. A relative told us, "When my [relative] arrived at here they were confused and hitting out. Staff were very kind, spent time talking to [relative] and telling [relative] what they were doing. [Relative] has improved so much and I am so grateful to them. I am reassured that when I leave here after visiting [relative] is looked after well. If there is a problem they will always contact me." One member of staff told us, "We work according to the needs of people and encourage them to express their wants and needs. I think we provide a good service but are always looking for new ways to improve."

People and their relatives told us they were supported to maintain their dignity and independence. Rehabilitation was a key focus for the service through interdisciplinary goal setting to support and enable people to return home if this was their choice to do so. One person with an acquired brain injury, previously unable to stand, eat independently, no verbal communication and hoisted for all transfers but had a goal to return home to their family. This person had been supported through 'slow rehabilitation' to be able to stand independently, eat independently and had been supported with several home visits along with an occupational therapist with a plan to be able to return home. Another person admitted to the service and as a result of a complex health condition was unable to walk. As a result of a programme of planned physiotherapy they were now walking independently. This showed us that people had been actively involved in their treatment and care to achieve their desired goals.
The service had its own residents committee which met regularly and provided people with the opportunity to input into the development of the service. We saw from a review of meeting minutes that people were involved in discussing ideas for menus, activities and access to personal monies held for safe keeping as well

as nominations for staff awards. One of the outcomes of these meetings was a decision for a separate dignity meeting to be held, chaired again by people who used the service where people could discuss more personal issues to them. Actions from these meetings were agreed and communicated to staff designated as dignity champions. These appointed staff attended bi-monthly staff dignity meetings where issues raised by people were taken forward for staff attention and actions implemented and reviewed.

People had been encouraged to decorate their rooms to their preference as well as encouraged to influence the communal environment through decoration. People and their relatives told us there was an open visiting policy with social interactions with relatives and friends encouraged and supported by staff.

There were effective systems in place to enable people to receive dignified and pain free end of life care. Where required people had end of life care plans in place that described individuals preferences, such as their preferred place of death. Anticipatory medicines were requested when a person was identified as nearing the end of their life. Anticipator y drugs are medicines that are used to manage people's symptoms including control of pain at the end stage of life in support of a pain free, dignified death.

The service had recently secured Burdette Trust funding to lead a new education programme to implement a personalised approach to end of life care based on human rights, 'What matters to me'. The manager told us, "The explicit aim is to increase awareness of how human rights can be used to aid decision making, effect change and ensure compassion and dignity are at the heart of personalised care."

Good

Is the service responsive?

Our findings

People received consistent, personalised care and support. They and the people that mattered to them had been involved in identifying their needs, choices and preferences and planning for how these should be met. Care plans were reviewed regularly and had been signed by those able to do so. One person told us, "I see my care plan and agree to it before my husband can sign it as I am unable to."

A service planning assessment had been completed prior to people moving to the service. This included a comprehensive assessment of people's health and wellbeing needs. We noted that this information had been used in planning their health care and support needs. As well as up to date information provided in people's care plans there was a notice board in each person's room which contained important information about their care including exercises prescribed to improve their health and wellbeing.

Care and support plans described how best to support people with little or no verbal communication and described how staff should look for body language that would indicate pain and to interpret facial expressions for assessing people's responses in promoting their rights to choice. One person had a laryngectomy which resulted in severely limiting their ability to verbally communicate. Their care plan contained specific guidance for staff in how to support them person to communicate their needs wishes and preferences.

There was an 'All about me' section in the care plan that gave staff a concise overview of the person including occupation, leisure interests, relationships and preferences for daily living. This was written from the person's perspective. A section of the care plan was dedicated to decision making. We found that an assessment of mental capacity had been completed. Where appropriate there was documentation for lasting power of attorney and family carers had been consulted in relation to health and wellbeing planning and support. People and their relatives had been asked about their preferences for end of life care and funeral arrangements, this was clearly documented in the care plan.

There were risk assessments and care plans in place for people living with health conditions such as epilepsy and diabetes. Plans included proactive care and support to manage complex health conditions as well as contingency plans, should the condition deteriorate. For example, one person's care plan linked urinary tract infections with increased risk of seizures. Guidance had been provided for staff with instructions for ensuring the person had enough to drink and regular screening to identify infection as early as possible. Another person living with Parkinson's Disease and diabetes had been assessed by a neurologist and a falls risk assessment including management guidelines were available for staff to follow. There was guidance for the administration of insulin and contingency care planning for fluctuating blood glucose levels. There was evidence that this person and others had received regular foot care from a podiatrist, particularly important for people with a diagnoses of diabetes. This showed us that people received personalised care that was regularly reviewed and responsive to their needs.

We observed during a staff handover meeting, staff were provided with health and wellbeing updates in relation to each person who used the service. Staff were verbally reminded as to whether or not people had

a 'Do Not Attempt Resuscitation' (DNACPR) agreement was in place. A handover meeting log was designed to aid as an easy reference in the event of an emergency to enable staff to have access to information in deciding people's choice as to whether or not to be resuscitated. Nurses conducting the handover meeting checked to ensure that all staff understood the information presented and staff were given the opportunity to ask questions. Staff were reminded to check if people were in pain so that pain relief could be offered.

People told us that despite their complex health care needs they were supported to lead meaningful and interesting lives as much as they were able. They said they were enabled to be involved in activities of their choosing. One person said, "I like playing chess. Staff play along with me as do some others who live here."

Activities organisers worked closely with nurses and therapists to assess risks and support people to take part in enjoyable activities of their choice and planning to enable people in accessing the community. We saw that people with complex physical limitations were supported to access hobbies and personal interests such as sailing, support to attend football matches and horse racing. The service had links with 'Active Lives' a charity which provided a gardening project. One person said, "We go out and take part in gardening where we plant seeds and grow vegetables."

The service had developed links with local schools who visited the service and provided entertainment. Links with the local university and YMCA supported work experience opportunities.

On the morning of our visit, an external entertainment group were performing a "Swinging Sixties' pantomime. This was well attended by people. One person told us, "Things like this make the day enjoyable." Another told us, "We recently went on a trip to Felixstowe and had fish and chips. It was a great day out and to top it we had ice cream on the sea front."

People told us the work undertaken by activities coordinators was greatly appreciated. We enjoy lots of chair exercises which help keep you fit, basketball and skittles. Activities staff told us, "We have a music session at least once a week which is very poplar and weekly outings on Tuesday when we go out to Ipswich. Some people have access to specialist music therapy which provides therapeutic support for people with very limited communication skills." A relative told us, "My [relative] has music therapy which they respond very well to. It is a vital resource for them."

We noted from activity plans for individuals, planned according to people's needs, choices and preferences that people had access to physiotherapy sessions, art therapy and regular outings into the community. The art therapy assistant told us that the, "Arts therapy project was designed to support people who require psychotherapy to express themselves in a trusting, safe environment."

The service employed a high number of volunteers who supported people in accessing trips out into the community, to drive the minibus and befriending people.

At or last inspection we found that whilst formal complaints were logged and a clear audit trail provided there was a further need to evidence responses to informal concerns and suggestions. At this inspection we found that the provider had implemented a system to log all informal concerns and suggestions with actions described in response. Only one formal complaint had been received since the last inspection.

People were actively encouraged to give their views and raise concerns or complaints. The senior management team viewed concerns and complaints as part of good indicators as to where work was needed to provide improvement of the service.

People's feedback was valued and people told us the responses to the issues they raised were dealt with an open and transparent manner. For example, people were supported to have their own committee meetings that met on a monthly basis as well as monthly general residents meetings. One of the outcomes from the monthly residents meetings was that people said they would like to hold a bi-monthly 'dignity meeting'. With people's permission we attended the dignity meeting which took place on the day of our inspection. People told us that these meetings gave them the opportunity to talk about more personal dignity issues that they specifically wanted to express and action taken to address. For example, one of the issues raised was that people said they would like staff to be reminded of the needed to wait after knocking on the door of their rooms before walking in. From this meeting actions were agreed and then communicated to staff at their bi monthly dignity meetings.

People had access to clear information about how to raise concerns and complaints. There was a written procedure available throughout the service on notice boards. There was a suggestion box in the reception area, available to enable people to log any suggestions and concerns easily and anonymously if they chose. Satisfaction surveys were regularly carried out which assessed people's experience of the care they received. To enable people easier access to take part in this survey, electronic tablets had been provided. Responses received were formulated into reports which described actions with planning towards improvement of the service.

Outstanding ☆

Is the service well-led?

Our findings

People told us the service had systems and processes in place to enable them to be heard and action taken in response to their views. There was a strong sense that the lines of communication between people, staff and senior and management were open, enabling and supportive. One person told us, "The management team is very supportive of us. They are always available if you need them. They know what we need." Another told us, "In any organisation there is always things that you could find that need attention and so there always is things you could say need to improve. However, here we can openly discuss those things that bother us and we do and we are listened to."

External health professionals told us, "There is consistency and continuity of nursing staff. We find the management open and transparent. They provide a good service to people" and "They effectively manage people with severe and complex health care needs. The nursing staff are of high quality, friendly and efficient. We work well with them as a team of professionals and they have an effective way of escalating concerns to us which benefits the people who live their well."

One relative when asked to describe the culture of the service said, "It is a positive place. I have been impressed by the services they provide. I think the management team know what they are doing and they support people to their best of their ability. They care." This showed that the management had promoted a positive inclusive culture.

The provider worked in partnership with other organisations to implement best practice with a strong emphasis on continually striving to improve the quality of care people experienced. The service had implemented a rehabilitation project which involved workshops for staff to benchmark the service against British Society Rehab medicine Guidelines for Specialist Nursing Homes. As a result the service had developed pathways of care which recognised slow stream rehabilitation, complex disability management and neuro palliative care. Outcome measurement tools had been developed, such as; nursing dependency tool, functional independence measures and rehabilitation complexity scoring. This project also involved rolling out training for staff in principles of rehabilitation. The service is linked to the East of England Rehabilitation Network with staff attending training events.

The manager told us that this year there had been a strong focus on developing a rehabilitation model both through working internally promoting this from within the staff team, providing training as well as working with external stakeholders and commissioners of services. The manager said they recognised the importance of educating other professionals where there is limited understanding, raising further awareness of the needs of people with neurological conditions.

The senior management team had developed good working relationships within and outside of the organisation. For example, working with Ipswich hospital and a wider stakeholder group of clinicians in support of the rehabilitation project and support people with their endo of life care. There were also positive relationships developed with community groups that benefitted the people who used the service.

Staff morale was high. Staff interacted well with each other and demonstrated positive team working. One member of staff said, "The management team is always available when you need them. Because they know the resident's well they know what we need to look after them well. We get the equipment and support we need." Another told us, "Staff like working here, we work well as a team and the training opportunities are good. We have recently been provided with walkie talkies. These have helped to improve communication and we can respond quicker to people's needs."

Action was taken to drive improvements when this was required. For example, where staff had previously expressed a disconnection with the senior management team, a new initiative had been developed whereby people who used the service and colleagues could nominate a member of staff who they felt had demonstrated care in line with the behaviour framework. We saw examples of these nominations. Staff engagement events had been organised such as mini Olympics, craft day and other fun themed events brought staff together and built a team working culture. A staff awards ceremony had been organised where members of the organisations executive team attended as well as representatives from the CCG presented awards. People who used the service nominated individual staff members across categories such as person centred care, driving quality improvement, volunteer contribution and leadership. This award was presented by a person who used the service and nominated as the chair of the residents committee.

Staff understood the organisations values and philosophy. And these values were underpinned in staff practice. Staff understood their roles and responsibilities, they were encouraged and supported to develop professionally and they told us that mistakes were acknowledged and acted on in an atmosphere of mutual respect. Staff were supported to improve their practice across a range of areas as they were provided with specialist training to enable them to meet the complex health care needs of people. Performance reviews were linked to the organisations overall vision, values and philosophy. These were people focussed and provided boundaries for staff in relation to desired behaviours and performance measures linked to person centred care

The service had held 'investors in people' accreditation for 10 years. The manager told us that as a result of this and feedback from staff surveys they had been working at reinforcing the behaviour framework and developing leadership skills within the team as well as looking at innovative ways of engaging staff and demonstrating how valued they were. This had been achieved throughout working together as a team to agree behaviours expected and reinforcing these through performance management system.

There was a thorough and effective quality assurance system in place. In addition to the formal complaints procedure the organisations clinical quality monitoring team visited the service regularly to assess people's views.

The registered manager and staff team were proactive in seeking ways to involve people in planning for improvement of the service. The culture of the service was enabling and supportive of people. Lines of communication were strong and clear and a number of communication methods were used according to people's needs. People were at the heart of the service. Regular meetings including care reviews were held with people and their relatives to discuss the quality of the care provided. Improvements to care were made as a result of these meetings for example in relation to providing one to one support, activities and menu planning. We saw that quality improvement plans were developed which evidenced planning to respond to concerns with actions planned with timescales.

Other management audits included the monitoring of health and safety including fire safety and moving and handling equipment. Pressure ulcer and infection control audits when identifying shortfalls evidenced planning of action required, the person responsible for taking forward the action and a due by date for

completion. Incidents and accidents were analysed including falls monitoring. The service had a quality improvement plan which demonstrated learning from incidents, audit and inspection.

The registered manager and staff told us that the results of audits and the outcome of dignity meetings led by people who used the service were discussed in staff meetings and all staff were made aware so that any shortfalls were addressed to improve the overall quality of the service. Staff and people we spoke with told us that identified improvements were implemented immediately. Plans for improvements and progress towards achieving them were also openly shared with people who lived at the service in meetings. People told us they were kept informed, updated, consulted and agreed that they had a strong influence on the way the service was delivered.