Gracewell Healthcare Limited

Gracewell of Salisbury

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

This unannounced inspection took place on 7 and 8 August 2018.

This service has a dual registration which means there are two registered providers jointly managing the regulated activities at this one location. The service is subject to one inspection visit however, the report is published on our website twice, under each provider.

Gracewell of Salisbury is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates 63 people in one adapted building. At the time of our inspection 58 people were residing at the home. The service is in the city of Salisbury. Accommodation is arranged over three floors which are accessed via a lift. All rooms are en-suite and there are landscaped gardens.

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

At our last unannounced focused inspection in August 2016 we found the service was not meeting legal requirements. We found concerns relating to medicines management and records relating to incidents and accidents. At this inspection we found the necessary improvements had been made and we rated the service 'Good' overall.

Medicines were managed safely. Where appropriate people were supported to manage their own medicines. We observed staff administering medicines and found their practice to be safe. Staff had received training on medicines administration and had their practice observed to check for competence.

Accidents and incidents had been recorded in detail and action taken to minimise the risk of re-occurrence. There were opportunities for staff to discuss incidents and use reflection to learn any lessons. Risks had been identified and safety measures put in place to keep people safe from avoidable harm. All risk assessments were reviewed regularly. Care and support plans contained sufficient detail to support the staff to deliver personalised care.

The service had improved systems in place following falls. If people sustained a fall they were assessed by a nurse. If further medical advice or treatment was needed, this was sought. There were clear records of actions taken, and people were re-assessed as a precaution. Handover information was clear and up to date.

There were daily head of department meetings, regular team and 'resident meetings', where people and staff could share ideas. Minutes were kept and reflected on to make sure actions raised were closed. The service sought the views of people and their relatives, to try to improve the care and support.

Staff were recruited safely, and the required pre-employment checks had been completed. There were sufficient staff deployed to meet people's needs consistently. Gracewell of Salisbury had a consistent and experienced staff team who knew people's needs well.

Staff understood the different types of abuse and how to report any concerns. Training had been provided in a variety of topics and staff told us they felt well supported. Supervision was available, where staff could discuss any concerns, training needs or development opportunities.

The service was clean and free from unpleasant odours. We observed the staff used appropriate infection prevention and control good practice. The premises and equipment was maintained and serviced when required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's needs were assessed and where needed, referrals were made to healthcare professionals. Records demonstrated that people had access to services such as GP's, physiotherapists, speech and language therapists, district nurses and dentists.

The dining experience was person centred and inclusive. A 'whole home approach' was used, which meant there were ample staff available to offer people the support they needed. People had choice at the table which meant they could choose what they wanted when they saw the options. Snacks and drinks were available in different areas and people were encouraged to help themselves.

People told us they were supported by a kind and caring staff team. Privacy and dignity were maintained and people were supported to maintain their independence. There were no restrictions on visiting so people could have visitors when they wished.

Complaints were managed well and records demonstrated the action taken. People, relatives and staff thought the service was well managed with an open and transparent management approach.

People had the opportunity to record their wishes for end of life care, this information was in people's care plans. Where the service had provided end of life care the staff had worked with healthcare professionals to make sure people were as comfortable as possible.

There were comprehensive and robust quality monitoring systems in place. Audits were completed at service and provider level. Action plans were produced and the registered manager made sure the necessary action was taken where needed.

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 were recruited safely, as all the required pre-employment checks had been completed. There were sufficient staff deployed to meet people's needs.

The service was clean and well maintained. Staff followed good infection prevention and control processes.

Medicines were managed safely, we observed staff administering medicines and found their practice to be safe.

Risks had been identified and suitable safety measures were in place. These were kept under review.

Staff understood what abuse was and knew how to report any concerns. They were confident appropriate action would be taken.

Is the service effective?

Good

The service was effective.

New staff received an induction and training was available in a variety of topics. Staff received regular supervision and told us they felt supported.

The service worked within the principles of the Mental Capacity Act (2005) and staff told us how it applied to their work.

Where needed referrals were made to healthcare professionals to support people with their health needs.

Nutritional needs were met by a staff team who worked together to provide people with a positive dining experience.

Management had improved the dementia environment providing activity areas where people could engage as they walked by.

Is the service caring?

Good

The service was caring.

People were treated with dignity by a staff team who knew them well.

There were no restrictions on visiting, which meant people could have visitors at times that suited them.

Staff promoted independence as much as possible whilst providing people with compassionate care. People and their relatives told us they thought the staff team were kind.

Is the service responsive?

Good

The service was responsive.

There was a planned programme of activities supported by activity workers.

Complaints were well managed and documented to demonstrate action taken.

End of life care was provided by a team that sought guidance and support from healthcare professionals where needed.

Care plans were detailed and person centred. They were stored electronically and reviewed regularly.

Is the service well-led?

Good

The service was well-led.

There was an experienced registered manager in post who was supported by a team who appreciated their management style.

Staff told us they felt supported and were given opportunity to share their views at team meetings.

Quality assurance systems were established and robust. Audits were completed in a range of areas with action plans produced and shared with the staff team.

People's views were sought and used to make improvements.

Gracewell of Salisbury

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 7 and 8 August 2018 and was unannounced. The inspection was completed by two inspectors, a pharmacy inspector 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.

Prior to the inspection we reviewed information we held about the service. This included notifications the provider is required to send us by law about events that happen at the service. We also reviewed the information included in the provider information return. 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.

During the inspection we spoke with nine people, four relatives, the registered manager, deputy manager, 12 members of staff and one volunteer. The regional head of care and nursing director was present throughout our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at six care and support plans, four recruitment files and a range of other records related to the management of the service. This included quality audits, accident and incident reports and complaints records.

Following our inspection, we contacted eight health and social care professionals to ask for their feedback about the service, six responded.

Good

Is the service safe?

Our findings

At our last focused inspection in August 2016 we found the service was in breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns relating to medicines management and records following an incident or accident. At this inspection the required improvements had been made.

We reviewed people's medicine administration record (MAR) and found them to be completed in full, with the necessary guidance for staff to follow. At the end of each medicines round staff checked the MAR to ensure there were no administration gaps. They also completed daily stock checks on medicines to make sure the correct amount of medicines were available.

There were suitable arrangements for ordering, receiving, storing and disposal of medicines. Room and fridge temperatures were recorded daily to ensure medicines were being stored at the correct temperatures. The service had involved a pharmacist where needed, to advise on best practice when administering certain medicines. Staff had protocols for medicines prescribed to be taken 'when required' and they explained when medicines could be given. Whilst these were in place for all 'when required' medicines, some lacked people-specific details of when the medicine should be administered. We discussed this with the management during our inspection and observed they were amended to add in the detail required. We observed staff administering medicines during our inspection and found their practice to be safe. Records demonstrated that staff received medicines training and were assessed to check for competence.

Systems in place following falls had been improved. Accidents and incidents had been recorded in full and shared with staff who needed to know. Where people had sustained injuries, these had been documented, with any follow up monitoring completed by nursing staff. For example, one person had an unwitnessed fall resulting in an injury. Records demonstrated that follow up observations had been completed 24 and 48 hours after the incident. Management had investigated the fall and reviewed the person's risk assessment. Handover documentation was updated daily to make sure all staff were clear about any changes to people's needs.

We observed a daily 'heads of department' meeting. The clinical lead nurses for each floor were present along with the deputy manager. The registered manager chaired the meeting and discussed any events for that day, any complaints, concerns, incidents and accidents. If people had sustained a fall it was shared and all action taken discussed. Any changes to people's needs was also shared so this information could be communicated to the wider staff team.

The deputy manager completed an analysis following all falls to review the circumstances of the fall, actions taken and to review any learning. This process was included during the clinical governance meetings to involve all nursing staff. This made sure lessons were learned following incidents to improve the outcomes for people. The registered manager told us they encouraged the use of reflective practice following any incident, which encouraged staff to use reflection as a learning tool.

People told us they felt safe at Gracewell of Salisbury. Comments included, "I feel very safe. The fact there are people around if something goes wrong is great", "I do feel safe, you take it for granted. All the doors and corridors are open but I feel safe", "Yes I feel safe, I have a drawer by my bed which I lock when I'm going out, but it doesn't worry me."

Risks to people's safety had been identified and appropriate plans put in place to reduce risks. Risk assessments were in place for a range of needs such as moving and handling, choking and skin care. People were supported to take positive risks such as managing their own medicines. Where people were supported to do this a risk assessment was in place recording the safety measures for staff to follow. One person told us, "I self-medicate, I keep my tablets in the locked drawer." Risk assessments were reviewed regularly and changes made if needed.

There were sufficient staff deployed to meet people's needs consistently. We observed there was staff available in all areas of the service. People we spoke with told us they thought there was enough staff. One person said, "I have a call bell, the staff come quickly when I use it." Agency staff were used at times to make sure staffing levels remained consistent. The registered manager aimed to make sure that where agency nurses were deployed, a permanent member of nursing staff was also on duty. This made sure there were always nurses on duty who knew people's needs.

Staff were recruited safely. The service completed all necessary pre-employment checks to make sure only suitable people were employed. This included a full employment history with any gaps in employment explored, employer references and an identity check. All staff had a disclosure and barring service (DBS) check prior to employment. A DBS check helps employers to make safer recruiting decisions and prevents unsuitable staff from being employed.

Measures were in place to safeguard people from the risk of potential abuse. Staff we spoke with told us about the different types of abuse and signs they look for. They told us they would not hesitate to report any concerns to the nurses or management and were confident that action would be taken. Staff were aware of the whistleblowing procedure. Whistleblowing is a process where staff report any suspected wrongdoing at work. They were aware that if needed concerns could be reported to external agencies, such as the police.

Where people experienced periods of distress which affected their behaviour, the nursing team worked together to find a positive approach. The registered manager told us they used a 'distressed behaviour tool' which supported the team to put in place plans to support people's behaviour. For example, one of the strategies to support distressed behaviour was to make sure the person had life history information in place. This would give staff background information about the person which might help them to understand people's current behaviour.

The service had comprehensive risk assessments for other areas of the service. There was an up to date fire risk assessment which had been completed by an external consultant. Each person had a personal emergency evacuation plan in place to support staff to help people out of the building safely in the case of emergency. There were detailed risk assessments for each cleaning chemical that was used at the service. The head housekeeper reviewed these and made sure the relevant chemical safety data sheet was also available.

The cleanliness of the service was well maintained. The housekeeping staff used cleaning schedules to record their work which was checked regularly by the head housekeeper. We found no unpleasant odours in any part of the service throughout our inspection. One person told us, "Housekeeping are pretty good. They would clean my room every day but I ask them not to." Another person said, "It's very clean here."

The service had been inspected in July 2017 by an environmental health officer from Wiltshire Council who had awarded the kitchen a 'five' rating. This meant that the kitchen had very good hygiene standards. Records demonstrated that staff completed food hygiene training. We observed that staff followed good practice in relation to infection prevention and control. They used personal protective equipment appropriately such as gloves and aprons. We also observed staff washed their hands when needed.

The equipment and premises were subject to regular safety checks and maintenance works were completed by external contractors. There were regular management meetings to review and monitor practice in all areas relating to health and safety.

Good

Is the service effective?

Our findings

People were happy with the food. Comments included, "The kitchen is pretty good and will do something else if you give notice", "Perfectly adequate for me", "We don't go hungry, the chefs are very good" and "The food is very good." Relatives could join people for meals. One relative who had eaten lunch told us, "Lunch is lovely."

Mealtimes were social and inclusive. There was a choice of food for each mealtime and special diets were catered for by a kitchen team that knew people well. The team at Gracewell of Salisbury had participated in an internal 'Enriched Dining in memory care' project. This aimed to improve the dining experience for all the home but particularly for people living with dementia. Staff had taken time and thought to make sure tables were well presented with tablecloths, napkins and flowers. The deputy manager told us that some people had attempted to eat flowers that were on tables. The service sought alternatives rather than remove floral displays. They used fresh herbs instead. This made sure people were not put at risk but also not discriminated against due to their needs.

People were able to choose their meal at the table. This meant that people could visually see the options plated up, they could smell the food and then make their decision. Mealtimes were relaxed and unhurried because there was sufficient staff available to provide support. The service adopted a 'whole home approach' to mealtime provision, which meant all staff regardless of their role helped where appropriate. The chef regularly served meals and was supported by hospitality staff who took the lead in serving and clearing away. This gave the nursing and care staff time to sit with people and focus on the support they needed to eat their meal.

People received person centred and dignified support. Staff spoke to people at the table and made the experience a social activity. Conversations heard were about families, visitors and activities. People appreciated the support they received from staff. One person told us, "The carers always come and say if they think you should be having more. They keep an eye on you."

People's needs were assessed in line with best practice guidance to make sure the service was effective in meeting their needs. For example, the service used a Malnutrition Universal Screening Tool (MUST) to assess people's needs in relation to nutrition. There were monthly nutrition meetings where the chef and the nursing staff met to discuss people's needs. The chef prepared specialist diets, such as fortified meals to boost people's calorie intake. One person told us they were having additional calories, they said, "They are giving me extra to build me up." Records demonstrated the number of people losing weight between June and July 2018 had reduced.

Timely referrals had been made to healthcare professionals so people could have appropriate support to meet their health needs. One healthcare professional told us, "The clinical lead is very good at contacting me for advice and we have a very good system of email between us." People told us they could see healthcare professionals when needed. Comments included, "[Staff] would send for the doctor if needed", "A nurse practitioner comes in once a week. You can ask for an appointment to see the doctor and they take

you to the surgery" and "I was going to the exercise classes, but now the physio has given me my own exercise programme and the physios visit me every week."

Staff were trained and supported relevant to their roles. Training was available to all staff in a variety of topics such as manual handling, fire safety, equality and diversity and dementia pathways. Staff told us they enjoyed the training and could always ask for training to boost their skills. One member of staff said, "I like learning, I like to learn something new." New care staff completed the care certificate. The Care Certificate is a set of 15 standards that care workers are expected to complete to make sure they can demonstrate the right skills, values, knowledge and behaviours to provide quality care. One member of staff told us, "Everything has been explained to me, but if I don't know I will as the nurses a question. They love being asked questions."

Specialist training was available for nursing staff to maintain their clinical skills such as wound care and catheterisation. The provider offered specialist dementia training for the dementia leads in all services. The deputy manager had completed a six-day enhanced dementia training course and was planning to cascade learning to staff. Training was also available to relatives. The service had provided dementia awareness sessions as well as introductions to the electronic record keeping system. Some relatives had raised concerns about using this system, so the registered manager reassured them by offering training on how it was used.

Staff regularly met with their supervisor to discuss any concerns, training needs or good practice. Staff we spoke with found the supervision meetings to be supportive. One member of staff said, "I feel supported here, I can speak to someone if I need help. In my supervision I can talk to my supervisor about any problems I may have." There was opportunity for staff to achieve work based qualifications such as the health and social care diplomas.

Gracewell of Salisbury had been purpose built to meet people's needs. The corridors and doorways were wide enough to easily accommodate wheelchair access. There were chairs placed in some corridors to make sure people had a place to sit and rest if needed. There were communal areas that were bright and inviting. There was garden space with seating and shade for people and their visitors to use.

The registered manager and deputy manager had made improvements to the dementia environment by completing a 'Nostalgia floor improvement project'. They had created various activity areas around the environment to support people to engage as they walked by. For example, at one end of a corridor there was a baby's crib, a moses basket and dolls. We observed people interacting with dolls, which gave them comfort. Tables had rummage boxes on which people could delve into and interact with a variety of objects, such as musical instruments. We observed staff use these items to interact with people as they walked by, which resulted in positive social interactions.

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. Assessments of capacity had been completed where appropriate, where people lacked capacity best interests' decisions had been made involving relevant people and professionals where needed. Staff we spoke with had received training on the MCA and could tell us how it applied to their work. The deputy manager had made pocket sized cards for the staff with the five principles of the MCA on one side.

People can only be deprived of their liberty so that they receive care and treatment when this is in their best

interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The service had applied for appropriate DoLS authorisations. Where they had been granted the registered manager had notified us and met conditions.

Good

Is the service caring?

Our findings

People told us they were happy with the staff and that they were caring. Comments included, "The caring staff are very good", "You couldn't be better looked after", "They [staff] are very nice indeed here" "They [staff] are all marvellous" and "I think the staff are charming and helpful when I need them."

We observed kind, caring, and compassionate social interactions between people and staff. Staff took time to talk to people, to sit down with them and listen. One person was not able to get comfortable in their seat. A member of staff took time to place a cushion in the right place and they went and got a blanket to make sure they were not cold. A relative told us, "They do a very good job at looking after [relative]." A healthcare professional told us that they often saw and heard compassionate care when they visited. They said, "I overheard a nurse talking to a resident in a compassionate, sensitive and respectful way. It brought tears to my eyes how kind she was, so respectful."

Staff knew the people they were supporting well, and they responded to people's needs in a timely way. One person told us, "The care here is very good, without exception the staff are very kind. If possible, they make anything happen." One relative told us that they thought staff were kind, they said, "[Relative] is very happy here and smiles at all the staff." Another healthcare professional told us, 'I often observe staff taking time to have meaningful interactions with the residents living at Gracewell of Salisbury and this shows me that the care culture has progressed far past a task focused approach'.

Another relative described the "wonderful atmosphere" in the home and felt people were treated with kindness and dignity. Staff told us how they made sure people's privacy and dignity was promoted when providing personal care. Examples they gave included making sure people were covered with towels, not talking over people and closing doors and curtains where appropriate. They also told us how they always knocked on people's doors before entering rooms. We observed staff did this during our inspection. Healthcare professionals we spoke with also confirmed that if they were visiting a person, staff knocked on the door before entering the room.

We observed staff were respectful when speaking with people. The staff addressed people by their choice of name. When communicating with people staff made sure they were on the same level as the person, they held people's hands where appropriate and smiled. They did not contradict people or tell them they were wrong. For example, one person told a member of staff they had not had anything to eat for hours. We had observed this person eating a few moments before. The member of staff did not contradict this person and tell them they had already eaten. They asked if they were hungry and got them a drink and some more snacks. Another person wanted to bring a doll into the dining room, the staff supported them to do this and made sure the doll was next to the person. This action helped the person to be relaxed whilst eating their meal.

One person told us they needed to use a hoist to transfer due to mobility difficulties. They didn't enjoy the experience but realised it was necessary. They told us that the staff tried to make the activity more enjoyable by continually communicating with them throughout. They said, "The staff tell me all the time what I need to

do. They say to put your hand on there and they tell me when I am going to go up." Staff told people what was happening around them. People in wheelchairs were asked before they were moved, people were told when it was lunchtime and what activity was going on and where.

People were provided with a continuity of care by an experienced team. Some staff had worked at the service since it opened five years previous. Staff we spoke with told us they enjoyed their jobs. Comments included, "I love it here, I love talking to the residents and I love helping people", "This is a happy home and a beautiful home" and "I love my job". Staff told us they liked working with people and wanted to make a difference. A healthcare professional told us, "I find it to be a happy atmosphere, all the staff are friendly and there is lots of singing and laughter."

Independence was promoted as much as possible. There were 'hydration stations' available on all the floors. People and their visitors could help themselves to drinks, biscuits, crisps and fruit. People told us and we observed that these areas were well used. People could get up and go to bed at times that suited them, there was no set routine. One person said, "They are very good here, I get myself up when I want to and have breakfast in my room." There was a small shop in the front reception where people could go and buy items such as toiletries, sweets and tissues.

People were encouraged to personalise their rooms by bringing in their own small items of furniture, hanging up their own pictures and personalised decorations. The lower ground floor rooms had doors onto a small patio area and the garden. People had personalised this area by adding their own garden furniture and plants.

The service recognised the importance of people maintaining key relationships with family and friends. There were no restrictions on visiting times. People's relatives and friends could visit at any time of the day or night. One relative told us, "The staff know me well now and address me by my name every time." Another relative told us, "I'm in most days and they let me know what's going on." Another told us that they appreciated the staff supporting their relative with activity such as medicines and personal care. They told us this meant, "We have quality time when we visit as that [personal care] is taken care of."

Relatives we spoke with told us they had no concerns with communication between them and the service. The registered manager told us they had identified relatives that preferred to receive email updates. They emailed relatives the service newsletter and any other important information. One relative told us, "I like the constant communication. I can email them and get a response immediately." Another relative told us they appreciated being contacted following any incidents. They said, "[Relative] has fallen here. They [staff] ring me every time."

The service had received many compliments about the care. Following an event at the service one member of the public had written to the staff, 'It was obvious to me that all the residents looked very much at home and gave the impression of a well-run and caring home'. A relative had written, 'To all the wonderful carers for looking after my mum, a big thank you'. Another relative had written to thank the staff for organising an event, 'It was so nice for mum and I to share with everyone and we know a lot of hard work went into organising it and making it special. Thanks to you all'.

Records were stored securely with only authorised personnel able to access them. Electronic records required individual log-in's and passwords to access them. Staff handovers were held in areas where the door could be shut, so conversations were not overheard.

Information was available on notice boards around the service on how to access local advocate services.

Advocates are independent people who can speak for a person when they are no longer able to communicate their needs.

Good

Is the service responsive?

Our findings

People told us they could access activities at the service if they wanted to. Comments included, "There's something going on all the time. I don't go often, I like to just read", "I like to go to the activities on the whole" and "There's a lot of activities if you want to join in".

Every Monday people were given an activity plan of what was going to be available for the week ahead. People confirmed this happened weekly, one person said, "Every Monday we get an up to date activity list." We saw that the programme was varied and included activities such as games, puzzles, art and craft and exercises. The activity plan for the week was also available on notice boards around the building. People were encouraged to share their views on activities, what they wanted and what was not so enjoyable. Minutes from 'resident meetings' demonstrated that activity provision was consistently on the agenda.

Activity areas available in the dementia environment had been arranged according to people's needs and life history. For example, by one person's room, we saw there was a stand which had cleaning related equipment such as feather dusters, cloths and a dustpan. This had been placed near this person's room as they used to manage a bed and breakfast and enjoyed cleaning. The deputy manager told us this person would often dust in the corridors, taking pride in keeping the area clean.

Management at the service were keen to support people to try therapeutic activities. One project which had recently started at the service was the introduction of Tai Chi. The registered manager told us that people had been asked to volunteer for a six-week programme. People were measured at the start for their abilities in relation to muscle strength, flexibility and balance. They had commenced a weekly session of Tai Chi which is a gentle exercise aiming to improve muscle strength, flexibility and balance. Once the course was completed people would be measured again to determine any improvement. People told us they were enjoying being part of this project. One person told us, "This morning I have been to Tai Chi, it's really good. I enjoy the exercises."

Technology was used to provide people with opportunity to engage. There was an interactive electronic table which used computerised programmes (apps), that included audio and visual effects. There were various apps to choose from depending on people's needs, wishes and abilities. One member of staff told us they often used the 'balloon experience' with a person. In addition to music being played, balloons would float across the table. The person could touch the balloons which would then pop. This provided an activity the person both enjoyed and succeeded at. Music therapy was provided one day per week. The therapist used an app to provide music for a variety of reasons which included engagement, calming and as an activity. Music therapy was available as a group and on a one to one basis.

Trips out to places of interest were organised following discussion at 'resident's meetings'. One person told us, "There are outings. Recently there was a boat trip." On the second day of our inspection a small group of people were supported to visit the local cinema to watch a film.

People's religious needs were met by visiting clergy. The activities worker told us that they tried to cater for

all religions, so at present there were three different faiths represented at the home. One person told us, "There was a church service last Sunday. A retired vicar comes once a week to give communion."

People were assessed prior to moving into the service by the registered manager and/or the deputy manager. This process aimed to make sure the service was suitable to meet people's needs. The assessment was the start of the care planning process. People had their own personalised care plans that were stored electronically.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People's needs in relation to any sensory loss such as hearing or sight impairment had been recorded in their care plan. There was information available to people in large font and the registered manager told us other formats would be sourced if people required them. The service had trialled pictorial information such as picture menus but found this was not effective. The registered manager and chef told us showing people the menu options on a plate worked for people currently living at the service.

Care plans seen detailed the support the person needed with regards to their needs such as communication, continence, skin care and mobility. Where a need was identified, goals were recorded as well as the actions required to meet that need. Where people had specific health needs, such as a urinary catheter and diabetes management there was appropriate plans in place. The plans were detailed and gave staff information about how to provide appropriate care and support. For example, people who required wound care had clear and concise records demonstrating assessment, treatment and evaluation. There was input from an external tissue viability nurse if needed so their expertise could be added to the care plan. Records showed that people had regular care reviews and where appropriate relatives were involved.

Where required, the staff team monitored some people's nutritional intake, fluid intake or positional changes. These actions were recorded at the time of delivery, on an electronic system which was available on walls around the service. Whilst the service was making sure that people had the care and support they needed it was not always easy to monitor. For example, positional changes might be recorded on a mobility record, a continence record and a turning record. Looking at these individual records you would see all the action taken but this could be time consuming. We discussed this with the management during our inspection. They told us they would review the electronic system to look at how they could make monitoring easier.

End of life care had been provided. People had the opportunity to record their wishes for their end of life care in their care plans. The service involved healthcare professionals where needed to make sure people got the care they required. This included making sure people's pain management was reviewed. The registered manager told us that family members were welcome to stay with their relative if needed and requested at the end of their life. One healthcare professional told us they believed the service provided end of life care that was responsive. They said, "The staff have such a good rapport with families and know people so well, this is really important for good palliative care."

Relatives had written to the service to thank them for the end of life care that had been received. One relative wrote, 'I would like to say how I and my family so much appreciated all the care and kindness shown to [relative] since we came here and particularly in his last few days'.

Complaints had been recorded with copies of any investigation and correspondence. All complaints received had been closed within timescales set by the provider. The complaints procedure was available to

people and they told us they knew how to complain. One person said, "If I had a concern I would wait until the senior carer comes on or I might go upstairs and moan at the office." Nursing staff we spoke with showed an awareness of the importance of reporting complaints. One nurse told us, "When we get complaints, we put things right."

Good

Is the service well-led?

Our findings

People and relatives told us they were happy living at Gracewell of Salisbury. Comments included, "I feel very fortunate to be here", "It's ok here, the staff are very nice" "I have no grumbles at all" and "I'm extremely content." One relative told us, "It's very good here, excellent." Another said, "It's excellent, especially the staff. They are most helpful."

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. One healthcare professional told us, "The staff at Gracewell of Salisbury appear happy and the leadership is strong."

Morale amongst staff we spoke with at the service was good as the culture was open and inclusive. Staff told us they felt supported by colleagues and the management. Comments included, "My team is amazing, we all get stuck in and help each other", "The manager is supportive and makes it friendly here", "We work as a team here, we listen to each other" and "The management here are lovely, they are always talking to the residents and the other day when it was warm they came around and offered everyone an ice-lolly."

Staff were clear about their roles and responsibilities. Staff we spoke with respected the boundaries that their role worked within. Care workers were understanding of when they needed to refer to a nurse. One member of staff told us, "I am clear about what I do, if a person falls we call a nurse, they will come and assess the situation." Nurses could go to the management if they needed. One nurse described the support they received as, "Excellent; from the manager and above."

Team meetings were held regularly and minutes produced. The registered manager told us that they found meetings for each group of staff more effective than larger general staff meetings. Staff felt better able to voice their view when attending a meeting with their colleagues in their teams. For example, housekeepers met regularly as a team, activities met as a team and care staff met as a group depending on what floor they worked. Heads of department attended quarterly regional meetings with their peers. This enabled staff to share practice with their colleagues who worked at the provider's homes in the local region. Staff we spoke with told us they found this supportive and informative.

The provider values were known by staff we spoke with. August was used to promote the provider values by providing staff with a T-shirt to wear in the warmer weather. The T-shirt had the values listed on the back. The registered manager told us it was an opportunity to re-visit the values and remind everyone of what they were. The deputy manager had produced small pocket-sized cards for all new staff to carry. On one side was the providers values, this also helped to remind staff of what they were.

Staff were rewarded with various awards organised by the provider. There was an employee of the month award which was decided at a home level. The heads of department voted for who they believed deserved the award monthly. The provider held an annual awards ceremony called 'The Heart and Soul Awards'. Staff

could be nominated by people, relatives and colleagues for doing 'above and beyond' what was expected of them in their role. In 2018 two members of the team at the service had won this award. They attended a ceremony, awards dinner and were given their award at a presentation.

The service gained feedback from people and their relatives in a variety of ways. In the front reception there was a suggestions box which anyone could use to write comments and leave for the service. This could be done anonymously if people wished. The provider used surveys to formally gather feedback from people, relatives and staff. There were regular 'resident meetings' and separate 'relative meetings'. The registered manager told us that people had requested not to have relatives at their meetings so this wish was respected. One person told us, "We have a group committee meeting every month. The chef, nurse, chief carer, anyone who is involved come. [Staff] does the secretarial notes. It's all done above board and we get a copy of the notes."

On a board in the front reception was a 'You said – we did' board. This outlined feedback gathered and what the service had done in response. For example, a member of staff had said they found their feet got wet when supporting people to have a shower. In response the registered manager bought shoe covers for all staff to use when doing this activity. A person told the kitchen they didn't like the chips. The chef changed the method they used to cook them to ensure they were crispier.

The service worked in partnership with various professionals and community groups. A local dementia support charity told us that they held carers support meetings at the service. The facilities were provided free of charge so that families of people with dementia both in the community and at the service could meet. The meeting was chaired by a worker from the dementia charity. A quarterly professionals meeting was held at the service. This was a forum to share best practice and local information.

Quality monitoring systems were in place and robust. The registered manager and deputy manager told us they completed a full night visit every three months to check practice at night. They also did early morning visits so that they could observe and listen to practice. There were various internal audits completed and action plans produced which monitored safety and quality of service. The regional head of care and nursing visited regularly to complete quality monitoring across the service, they produced a report which was shared with the staff team. They were also available to people, relatives and staff for support and guidance if needed.

Whilst the service completed audits which gave an overview of quality and safety at the service there were also practice specific audits for areas such as medicines and continence. The quality assessment tool for continence was detailed and covered availability of incontinence aids, odour in toilets, service plans, staff training, whether staff were discussing people's continence in communal areas, and resident's experience. This robust quality monitoring meant the service was continuously looking to improve in all areas. The management told us about their plans to continue to improve the environment and the outside areas. There were plans available to outline the development of a sensory garden. This would support people with sensory needs to better enjoy the outside space.

The local authority quality assurance team had recently completed a service monitoring visit. A report was produced which demonstrated that they had not found any concern. They high-lighted the many areas of good practice which had been observed.