# Pilgrims' Friend Society

# Framland

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

Framland is a 'care home' for elderly protestant Christians. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Framland accommodates 23 people in one adapted building. At the time of the inspection there were 21 people living at the service.

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.

People and their relatives told us people were safe living at Framland. Staff demonstrated they understood how to keep people safe and we noted that risks to people's safety and well-being were managed through a risk management process. We observed people's needs were met in a timely way by sufficient numbers of skilled and experienced staff. People were supported by staff who had been trained in the Mental Capacity Act 2005 and applied it's principles in their work.

People and their relatives were very complimentary about the staff and management at the home. They told us staff were kind, caring and compassionate. Staff members, including the management team, were knowledgeable about individuals' care and support needs and preferences. Visitors were welcomed at all times and people were supported to maintain family relationships.

People's health care needs were met and they had access to a range of healthcare professionals. Where required appropriate referrals were made to external health professionals, such as G.P's or therapists.

The provider had systems in place to receive feedback from people who used the service, their relatives, and staff members about the service provided. People were encouraged and supported to raise any concerns with staff or management and were confident they would be listened to and things would be addressed.

Staff told us, and records confirmed they had effective support. Staff received regular supervision (one to one meetings with their manager) and yearly appraisals. People were supported appropriately to eat and drink sufficient amounts to help maintain their health and well-being.

The provider had safe recruitment processes in place, which helped to ensure that staff employed were of good character and suited to the roles they were employed for. People's medicines were managed safely and kept under regular review. Infection control measures were in place to help reduce the risks of cross infection.

There was an open and inclusive culture in the home and people, their relatives and staff felt they could

approach the management team and were comfortable to speak with the registered manager if they had a concern. We saw evidence that arrangements were in place to formally assess, review and monitor the quality of care provided at the home.

## 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.

People told us that they felt safe.

Staff were aware of how to safeguard people from harm and were aware of potential risks and signs of abuse.

People and staff told us that there were enough staff available to meet people`s needs.

Staff administered medicines to people in line with their prescription.

### Is the service effective?

Good

The service was effective.

People were supported by staff who had been trained in the MCA and applied its principles in their work.

Staff had the training, skills and support to meet people's needs.

The service worked with other health professionals to ensure people's physical health needs were met.

### Is the service caring?

Good

The service was caring.

Staff were kind and respectful and treated people with dignity and respect.

People benefited from caring relationships.

The staff were friendly, polite and compassionate when providing support to people.

### Is the service responsive?

Good

The service was responsive.

Staff understood people's needs and preferences. Staff were knowledgeable about the support people needed.

People's needs were assessed to ensure they received personalised care.

There was a range of activities for people to engage with.

## Is the service well-led?

Good

The service was well-led

The registered manager demonstrated an in-depth knowledge of the staff they employed and people who used the service.

Arrangements were in place to formally assess, review and monitor the quality of care provided at the home.

The service had a culture of openness and honesty.

# Framland

**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 checked whether the provider was 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 18 December 2017 and was an unannounced inspection. This inspection was conducted by one inspector.

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 spoke with five people, three relatives, three care staff, one senior care worker, two kitchen assistants and the registered manager. We looked at six people's care records, five staff files and medicine administration records. We also looked at a range of records relating to the management of the service.

Good

# Is the service safe?

## Our findings

People told us they felt safe. Comments included, "No doubt about it, they look after me well here. I am safe and sound living here", "The staff keep an eye on you in here" and "I am very safe and well looked after here".

People experienced care in a safe environment because staff were aware of how to safeguard people from avoidable harm and were knowledgeable about signs of potential abuse. Staff were able to describe the process for reporting concerns both within the service and externally, if required. One staff member told us, "I would report my concerns immediately to my line manager. If I felt it was appropriate then I would also raise an alert with the local authority safeguarding team. Once I had done this then I would complete the SAF form". The SAF form was a form, created by the provider, that was completed by staff if they had any safeguarding concerns. This was then passed through the registered manager and then to the provider to ensure they had an oversight of any safeguarding concerns that had been raised by staff. We saw there was Information about how to report concerns, displayed in areas of the home, which reminded people and staff of the contact numbers they needed to report concerns. These additional systems demonstrated that the provider had taken appropriate action to help ensure that people were protected from abuse and harm.

People's care plans contained risk assessments, which included risks associated with moving and handling, falls, medication and pressure damage. Where risks were identified plans were in place to identify how risks would be managed. For example, one person was at risk of pressure damage. The person's care record gave guidance for staff on the use of pressure relieving equipment and the need to carry out frequent observations. This person's care record gave clear guidance for staff to report any changes to the person's skin integrity to healthcare professionals. Staff we spoke with were aware of this guidance and told us they followed it.

One person had restricted mobility and was at high risk of falling. The person's care record gave guidance for staff on how to support them effectively whilst moving around the home. For example, the number of staff needed to transfer the person to their walking aid and the number of staff needed to support the person whilst they used their walking aid. During our inspection, we observed staff following this guidance. Throughout the transfers, staff were observed talking with the person to help reassure them.

Accidents and incidents were recorded and regularly reviewed to ensure any learning could be identified, discussed and shared with staff to reduce the risk of similar events happening. For example, following a number of incidents that involved a person struggling to come down the stairs in the home. The registered manager and staff explored the issue further and identified that the person did not have appropriate footwear to manage this task safely. The registered manager made a referral to the Care Home Support Service (CHSS). As a result CHSS recommended more suitable footwear for this person, which the registered manager sought. Following this incident the registered manager and staff carried out a review of people with mobility difficulties to ensure they had appropriate footwear to use the stairs more safely. The impact of this was that there were no further incidents.

People who were assessed as being at risk of malnutrition had accurate and up to date Malnutrition Universal Screening Tools (MUST) in place and were supported by staff, who were aware of these risks and what action to take as a result. During our lunchtime observations, we saw staff supporting one person, identified as being at risk of malnutrition appropriately.

People received their medicine as prescribed and the service had safe medicine administration systems in place. We observed staff administering medicines to people in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given. One person we spoke with told us, "They give me my medicine, they are very meticulous".

Where people had been diagnosed with specific conditions, extra monitoring was in place to ensure people received their prescribed medicines, which ensured their condition was managed safely. Care records included guidance for staff on what action to take if people developed symptoms related to their medical conditions. Medicines were stored securely and in line with manufacturer's guidance.

We observed, and staffing rotas confirmed, there were sufficient staff to meet people's needs. The manager used a 'dependency tool' when carrying out initial assessments on people's care needs. This enabled the manager to calculate the right ratio of staff against people's needs. We saw that this was reviewed regular by the management team. On occasions where staffing levels had not been achieved the registered manager had taken appropriate action to access additional staffing.
During the day we observed staff having time to chat with people. Throughout the inspection, there was a calm atmosphere and staff responded promptly to people who needed support. One person told us "I've never had any concerns about staffing; they have always been around when I have needed them". A staff member said, "I have no concerns about our staffing levels. Put it this way I have never walked away from a shift feeling stressed".

Safe and effective recruitment practices were followed to help make sure that all staff were of good character and suitable for the roles they were employed for. We checked the recruitment records of five staff and found that all the required pre-employment checks had been completed prior to staff commencing their employment. This included a completed application form, two written references and disclosure and barring check (DBS).

People were protected from the risk of infection. The premises and the equipment were clean, and staff followed the provider's infection control policy to prevent and manage potential risks of infection. Colour coded equipment was used along with personal protective equipment (PPE). PPE equipment, such as aprons and gloves were available and used by staff. 'Staff were aware of infection control guidance and were prepared to challenge visitors when they entered areas, such as the kitchen, where there was a risk of the spread of infection.  One staff member said, "Sorry but we need to ensure we reduce any risks of cross contamination". Equipment used to support people's care, for example, wheelchairs and hoists was clean and had been serviced in line with national recommendations.

Good

# Is the service effective?

## Our findings

The people and relatives we spoke with told us staff were knowledgeable about their individual needs and supported them in line with their support plans. A relative said told us, "They really know mum and her needs".

People's needs were assessed prior to their admission to ensure their individual care needs could be met in line with current guidance and best practice. People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, where people had been identified as having swallowing difficulties, referrals had been made to Speech and Language Therapy (SALT). Care plans contained details of recommendations made by SALT and we saw staff following those recommendations.

People's care records contained a 'hospital passport'. These documents contained important information about people that could be passed to professionals in the event of an emergency or planned transition to another healthcare provider. They reflected how each person wished to receive their care and support. For example, people's likes dislikes and what was important to them when receiving healthcare. This system supported people to experience a comfortable transfer, if the guidance in the hospital passport was followed.

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People were supported by staff who had been trained in the MCA and applied its principles in their work. Where appropriate people's care plans contained capacity assessments. Where decisions were made on people's behalf, we saw evidence that the service followed the best interest process. For example, some people lacked capacity in making decisions to have their annual flu vaccination. We saw evidence of how the service had included people's families, G.P's, legal representatives and followed the best interest process to ensure that people received their vaccinations.

Staff we spoke with had a good understanding of the Act. One staff member told us "The act is there to protect people who may lack capacity to make safe decisions. A change in a person's capacity could be down to a decline in their dementia, or it could be more short term for example they may have a UTI (Urinary Tract Infection). But we need to be sure that it is a capacity issue in that the person may have made an unwise decision. Just because a person makes an unwise decision does not mean they lack capacity". Another staff member said, "Just because a person lacks capacity in one thing does not mean they lack capacity in everything". We saw staff routinely sought people's consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found the home was meeting the requirements of DoLS.

Records confirmed people were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff completed training, which included safeguarding, MCA, moving and handling, infection control, medication, first aid, health and safety, medication, dignity in care and nutrition. One staff member told us, "I like the training". Another staff member said, "The training helps us to refresh on things we do, it supports us to give consideration and to make improvements on how we do our job".

Newly appointed care staff went through an induction period. This included training for their role, shadowing an experienced member of staff and having their competencies assessed prior to working independently with people. One staff member told us, "I felt supported throughout my induction".

Staff were supported effectively through regular supervision, which is a one to one meetings with their manager and yearly appraisals. Staff told us they felt supported by the registered manager and the provider. One staff member told us, "The provider is fair and we can ask for help whenever we need it". Another staff member said, "I feel supported 100% by [registered manager]".

Staff told us and records confirmed that staff had access to further training and development opportunities. One member of staff we spoke with told us, "We can ask for additional training any time we want and [registered manager] will get it for us". In communal areas throughout the home was up to date national guidance, reminding staff of to ensure best practice was followed when delivering care. For example, national best practice on reducing the risks of flu outbreaks. We observed staff following this practice.

Prior to people eating their meals they were supported in line with their religious preferences and needs. For example, a Christian prayer was said before people started with their meals. We saw how people were given a choice as to whether or not they would like to say the prayer or have a member of staff say it. During our inspection people asked if a specific member of staff could say it. One person said, "Oh please can [staff] do, She does it so beautifully". The staff member happily carried out the request. People told us they were happy with the food they received. One person told us, "We get more than enough to eat and it's always very good". Another person said, "The food is very good and if you don't fancy it you can always have something else instead".

People were offered a choice of meals three times a day from the menu. Staff advised us that if people did not like the choices available, an alternative would be provided. At lunchtime we observed that a person had changed their mind and asked for something different. Care staff responded to this and brought the person a meal of their choosing. This demonstrated that people were involved in decisions about what they ate and drank.

Menus were displayed in the home's dining area and staff assisted people with their choices. During our observation of the lunchtime meal we noted that people were offered a choice of drinks. People had access to and were offered drinks throughout the day. Where people required special diets, for example, pureed or fortified meals, these were provided by kitchen staff, who clearly understood the dietary needs of the people they were catering for. We found that people with specific health problems, such as diabetes had the correct guidance in place for staff to deliver effective treatment. Records confirmed that staff followed this guidance.

We observed that the environment was suitable to meet people's needs and there was a homely feel about the service. One person told us, "It's the little touches that make it homely". We observed parts of the home had reminiscence tables, which were set up with items from past years. This followed good practice guidance for helping people to be stimulated. This is because talking about the past can bring up happy memories and good feelings, and is proven to particularly support people who may be feeling down. Rooms we observed had been personalised and made to look homely.

The service worked closely with healthcare professionals such as, G.P's, occupational therapists, dieticians, physiotherapists and other professionals from the care home support team. To ensure that people received effective care. Where healthcare professionals provided advice about people's care this was incorporated into people's care plans and risk assessments. For example, where people had been identified as at risk of falls referrals had been made to CHSS. Care plans contained details of recommendations made by CHSS and we saw evidence that the service followed these recommendations.

Good

# Is the service caring?

## Our findings

People told us they benefited from caring relationships with the staff who supported them. Comments included, "The care is excellent here", "The staff are very good and kind", "I couldn't wish for a better place", "We love it here" and "The staff are amazing". A relative told us "We are more than happy with the care here".

Throughout the day of the inspection, we noted there was good communication between staff and the people who used the service and saw that staff offered people choices. For example, we observed a staff member asking a person, "Would you like some music on today". The person replied, "Yes please", the staff member then asked them, "What would you like on" and the person said, "Come on you know me". The staff member then replied, "Classical it is then". Before moving on to their next task the staff member checked with the person to make sure the music was at the correct volume. This demonstrated that staff knew and respected the people they were supporting.

People were treated with kindness and respect by staff, who understood their individual needs. For example, one person had difficulties communicating. The person did not use conventional methods, such as sign language and Makaton. However, the person used a board and marker pen to spell out words to support them in their communication. During our inspection, we observed this person communicating effectively with staff, who gave the person the time they needed to write down what they were asking or discussing. This person's care records gave guidance for staff to recognise and respond to the person's needs.

Staff showed concern for people's wellbeing in a caring and meaningful way. For example, one person refused their medicine. Staff spoke with this person and explained what the medicine was for and why it was important to take it. As a result, the person took their medicine. We observed staff speaking with this person in a warm and gentle manner whilst maintaining a clear focus on the person finishing their medicine.

Staff told us they respected people's privacy and dignity. One staff member said, "We always make sure doors and windows are closed and when we have discussions with people about their care, then we ensure that it is done privately. This also helps to build trust and rapport". Another staff member told us, "We speak to people in a way that makes them feel that they are involved in their care. If we don't do this then there is also a risk that people could become afraid or feel unsafe. By involving people in everything we do promotes respect and dignity". One person told us, "There is nothing lacking in the respect and dignity department in this place".

We saw staff spoke with people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they demonstrated compassion and respect. During our inspection we noted that staff were always respectful in the way they addressed people. We observed staff knocking on people's doors and where people had their doors open staff still knocked and waited to be invited in. One person told us, "The staff always knock and wait before they come in". Another person said, "The staff are terribly polite and kind and they always knock on the door before they come in".

Care records highlighted what people could do for themselves in order to remain independent. This included aspects of personal care, mobility and getting dressed. Were the need to promote independence had been highlighted, there was guidance for staff on how to prompt and support people effectively. We observed staff following this guidance. One person told us, "No one ever try's stopping you doing anything you can already do".

Staff told us how they supported people to do as much as they could for themselves and recognised the importance of promoting peoples independence. One staff member we spoke with highlighted how promoting independence would prevent a rapid decline in people's health and wellbeing. They told us, "If we start just doing everything for someone then there is a good chance they will just give up".

Staff understood and respected confidentiality. Records were kept in locked cabinets and only accessible to staff.

Good

# Is the service responsive?

## Our findings

Relatives told us that the service was responsive to people's needs. Comments included; "They have this knack of picking up on things before you do", "The home make the necessary arrangements if [person] needs to see anyone and they let us know what's happened" and "They respond well to mums needs. In fact they respond to everyone's individual needs".

People received personalised care. People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person was referred to their optician following a change in relation to their eye sight. This persons care records had been updated to include recommendations made by the optician. Staff we spoke with were aware of the recommendation and told us they followed it.

The assessment process included information to ensure that people understood that Framland was a care home for elderly Christians. During the inspection we observed the registered manager speaking to people who wanted to go on the waiting list for Framland. During our observations, we noted that the registered manager was clear that Framland was a Christian based home. The registered manager described to us how people who were waiting for admission to the home were prioritised by their level of need. They told us, "We need to make sure people know we are a Christian based home, we don't want to force people, it must be their choice". "People are assessed on their level of needs, we need to ensure people are safe in their own homes. If not then we need to get them in here".

People's diverse needs were respected. Discussion with the registered manager and staff showed that they respected people's individual needs. They told us, "We must respect people's beliefs and needs because it makes them who they are; an individual", "Everyone is different but we don't treat people differently, what we do is ensure everything is delivered in a person centred way that matches their individual needs and wants"

Care plans contained person specific information that captured people's preferences, hobbies and interest, favourite radio stations, daily routines and likes and dislikes. Staff we spoke with were knowledgeable about the person centred information within people's care records. For example, one person's care records contained details of the person's daily routine and why this was important to them. A staff member we spoke with was able to describe this routine to us as it was written within the persons care record. We spoke with this person and they told us, "They know my routine and they always stick to it". Person specific information about the staff team was also captured and visible throughout the home. For example, within communal areas of the home there were staff profiles attached to the walls, which included, a photo of the staff member, information about where they were born and what they liked doing in their spare time.

People had access to activities, which included faith based activities and non-faith activities, such as board games, visits out within the community and quizzes. People who decided that they did not wish to participate in activities were protected from the risk of social isolation. For example, we observed staff

sitting and speaking with a person who did not wish to participate in a quiz. We spoke with this person and they told us "Me and [staff] just had a chat about things. I didn't feel up to it [doing the quiz], they don't force anything on you here".

We saw evidence that people had access to information about their care. For example, menus were available in large print and picture format enabling them to read the information. One person had information about their care available in large print and picture format.

The provider had a policy and arrangements in place to deal with complaints. Records showed there had been four complaints since our last inspection. These had been dealt with in line with the provider's complaints policy. The complaints policy was available throughout the home and contained details for The Local Government Ombudsman (LGO). The LGO is a service that investigates complaints from the public about councils and about registered adult social care providers.

At the time of our inspection there was no one receiving 'end of life' care. However, the registered manager was able to evidence how the service had previously recorded and respected people's preferences and wishes. Records confirmed that people's funeral wishes in relation to burials, cremations and family arrangements had been discussed with people.

Good

# Is the service well-led?

## Our findings

People knew the registered manager who demonstrated an in-depth knowledge of the staff they employed and people who used the service. They were familiar with people's needs, personal circumstances, goals and family relationships. We saw them interact with people who used the service, relatives and staff in a positive, warm and respectful manner. One person told us, "[Registered manager] is wonderful". Another person said, "I can see [Registered manager] whenever I want".

Staff told us the home was well-led, open and honest. Comments included; "[Provider] is honest and fair", [Provider] pops in now and again to make sure we are alright, "[Registered manager] mucks in with everything", "[Registered manager] is very good, she always listens to what we have to say" and "[Registered manager] acknowledges our hard work and commitment". A relative told us, "[Registered manager] is always involved in helping out".

We saw evidence that arrangements were in place to formally assess, review and monitor the quality of care provided at the home. This included regular audits of the environment, health and safety, medicines management and care records. Results of audits were used by the registered manager to develop and enhance the performance of staff and systems, to help drive improvements in the home. For example, following a recent audit of medication administration records (MAR) the management team identified inconsistencies in peoples MAR charts. We saw evidence that initially the information from the audit was cross referenced with people's care records to ascertain that people had received their medicines as prescribed. Once the registered manager was confident that people had received their medicines, they then communicated their findings and concerns with staff. As a result, the standard of records improved. Findings from audits carried out by the provider were corroborated and put into a 'Care Quality management Report'; this was then shared with people and made available within communal areas of the home.

Since our last inspection, the provider had introduced a new mode of working practices to support staff in working with people who had different levels of cognitive abilities. This was called GEMS, the aim of the model was to support staff in understanding peoples individual abilities and to support them in identifying the level of support that would be appropriate to match their needs. This demonstrated that the provider was continually looking to improve the quality of care they provided.

The service encouraged open communication between the staff team. A staff member told us, "We meet regularly, we consider how we can make improvements and how well as a team we are doing our jobs. We can also bring things up outside of meetings". We viewed the team meeting minutes, which showed that staff had regularly met to discuss people's individual needs and to share their experiences.
The home sought people's views and opinions through satisfaction surveys . We noted that the results of the satisfaction surveys were positive. The results were analysed by the provider and then made available in communal areas under the heading of 'You said we did'. We saw one example were people had requested that a microphone was used during faith based activities so people could hear what was being said more clearly. We noted that this had been put in place by the provider. People we spoke with told us they felt confident in giving feedback on the service and that they would feel listened to. One person told us, "We just

tell them, and they listen".

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. One staff member told us, "I would alert someone straight away if I had any concerns. I have done it in a previous job and would not have a problem doing it again".

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of reportable events.

The service worked in partnership with visiting agencies and had links with GPs, the pharmacist, and Care Home Support Service.