Jubilee Care Ltd

Churchill House Nursing and Residential Home

Inspection report

Keepside Close
Bromfield Road
Ludlow
Shropshire
SY8 1EL

Tel: 01584877500

Date of inspection visit:
26 January 2017

Date of publication:
30 May 2017

Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	**Good** ●
Is the service effective?	**Outstanding** ☆
Is the service caring?	**Outstanding** ☆
Is the service responsive?	**Good** ●
Is the service well-led?	**Good** ●

Summary of findings

Overall summary

This inspection took place on 26 January 2017 and was unannounced. The previous inspection of Churchill House was in December 2014. At that time there were no breaches of the Regulations.

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.

Churchill House is a care home with nursing care for up to 62 older people. People have general nursing care needs or are living with dementia.

The registered manager provided good leadership and management for the staff team. The service and staff demonstrated their commitment to care for people with dignity. They followed best practice for the care of people living at the home. They linked with care provider forums and ensured people had access to the local community. The service had a good reputation within the local community and also with health and social care professionals.

The service had a robust programme of audits in place to monitor the quality and safety of the service. Action plans were developed where shortfalls were identified so that improvements could be made. The provider reviewed the care provided so that people benefitted from a continually improving service. Any planned improvement actions were followed up to ensure they were implemented.

People were looked after with a person centred approach to care and where possible had been involved in developing their care plans. Knowledge of the person's history and personality assisted the staff team to provide the right support and maintain the person's dignity and choices. Care plans were well written. They provided detailed information about how the person wanted to be looked after and how their care was to be delivered.

People were encouraged to have a say about things that mattered to them and to raise any concerns they may have. People were looked after by staff who were kind and caring. Staff went the extra mile to ensure that people who had reached the last phase of their life could do so with dignity and comfort. The staff met not only their specific care and support needs but also their emotional, spiritual and social needs.

The staff formed good working relationships with the people they looked after but also genuinely cared about them. People felt they were well looked after. People were able to participate in a range of different meaningful activities, both in Churchill House and outside of the service.

People were provided with an exceptional and distinctive service that met their individual needs. They were encouraged where possible to make their own choices and decisions about aspects of their daily life. Staff

knew what to do to ensure that any decision made on behalf of people were made in their best interests. We found the service met the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were provided with the food and drink they liked to eat. They were provided with choice and given sensitive assistance if they needed help to eat their meal. Where people were at risk of malnutrition or dehydration there were plans in place to reduce that risk. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

People were kept safe. This was because any risks to their health and welfare was well managed. The premises were well maintained and staff were trained in how to move people requiring assistance from one place to another safely. Staff received safeguarding adults training and were knowledgeable about safeguarding issues. They knew what to do if concerns were raised and who to report the concerns to.

Pre-employment checks were robust and ensured that, as far as possible, unsuitable workers could not be employed to work in the service. People were involved in this process.

The management of medicines was in line with good and safe practice.

Staffing levels were adjusted regularly and took account of the number of people being looked after and their care, support and social needs. The staff were well trained which meant they were able to carry out their roles and responsibilities effectively. Staff were supervised and supported by their colleagues and line manager. New staff had a robust induction training programme to complete which met the standards of the Care Certificate. The Care Certificate is a nationally recognised training programme for care staff.

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 were safe and any risk to their health and welfare was well managed. Staff knew what to do if concerns regarding a person's safety were raised. Robust recruitment procedures ensured that only suitable staff were employed. There were sufficient numbers of staff on duty at all times. People's medicines were managed safely.

Is the service effective?

Outstanding

The service was effective.

Staff were very well supported and trained to provide effective care. People's rights were protected and staff acted in accordance with the Mental Capacity Act 2005. The principles of the Deprivation of Liberty Safeguards were understood and applied correctly. People were provided with sufficient food and drink. People were supported to see other health and social care professionals as needed.

Is the service caring?

Outstanding

The service was very caring.

People were looked after by staff who were caring and kind. They were treated with dignity, respect and compassion. People were supported in ways that promoted their well-being. Staff recognised people's individual care and support needs and knew the value of positive working relationships. The service was committed to providing person centred end of life care.

Is the service responsive?

Good

The service was responsive.

People received the care and support they needed and were looked after in the way they liked. They were able to participate in a range of meaningful social activities. People were listened to and staff supported them if they had any concerns or complaints. They were involved in activities outside of the home

and enabled to live as full a life as possible.

Is the service well-led?

Good

The service was well-led.

The registered manager was a good leader and provided clear leadership and management for the staff team. People were looked after by staff who all shared the provider's commitment to running a well-led service. The staff shared the provider's vision and values to ensure people benefitted from the best possible care. Feedback from people who used the service and their relatives was used to make changes to the service and to drive any improvements required to make the service better.

Churchill House Nursing and Residential Home

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 26 January 2017. The inspection was undertaken by two adult social care inspectors 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 service.

Prior to the inspection we looked at information about the service including notifications and any other information received by other agencies. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make. We also received feedback from the local authority and Healthwatch prior to the inspection.

During our inspection we spoke with seven people living in the service and three people's relatives. We spoke with nine members of staff (qualified nurses, care staff and ancillary staff) plus the registered manager and the assistant manager. We looked at four people's care documentation, together with other records relating to their care and the running of the service. This included two staff employment records, policies and procedures, audits, quality assurance reports, satisfaction survey reports and minutes of various meetings.

We also 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.

Good

Is the service safe?

Our findings

People who were able to talk to us said they felt very safe at Churchill House. They said, "I am very happy and I feel safe, why shouldn't I?" Relatives all said they were happy their loved ones were at Churchill House and were not concerned about their safety when they were not there. One relative said," I have complete confidence in my relative's safety here. I visit every day so I know".

Staff had an extensive programme of training to complete and this included safeguarding training. Staff we spoke with knew what was meant by safeguarding people, what constituted abuse and what their responsibilities were to keep people safe. Staff said they would report any concerns they had regarding a person's safety or welfare to the registered or assistant manager. They also knew they could report directly to the local authority. The registered manager was fully aware of their responsibility to keep people safe. They showed how they had worked with the local authority on past safeguarding issues.

The provider's recruitment procedures for new employees ensured that as far as possible only suitable staff were employed. Recruitment records we viewed contained three written references and a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions. The registered manager checked qualified nurses live registration with the Nursing and Midwifery Council. Where relevant, checks were made of a prospective employee's right to work before any offer of employment was made. These measures meant people using the service were not put at unnecessary risk.

Risks to people's health and welfare were well managed. Risk assessments were undertaken for each person in respect of moving and handling, falls, the likelihood of pressure damage, nutrition and the use of bed rails. Where people were supported with moving and transferring, a profile was recorded, setting out the equipment to be used and the number of care staff required to carry out the task. Staff had a positive approach to risk and looked for solutions to reduce or eliminate the risk in order not to prevent people from taking part in activities. Staff completed person-specific risk assessments, for example, using an electric wheelchair in and outside. These measures ensured people received safe care and support.

One person had suffered frequent falls. As a result of this, the registered manager implemented the guidance from a reputable source, that had developed an exercise programme to help reduce falls. These included strength and balance exercises for healthy ageing. Staff supported different sessions according to people's ability. One member of staff told us, "Falls management presents the biggest risk for us, we have individual risk assessments in place. I encourage staff to observe and monitor people when mobilising and to be aware of people most at risk of falls." We saw that people had access to two leaflets about falls that had been developed by the registered manager. 'Are you at risk of falling?' and 'The prevention and management of slips, trips and falls.' Both gave useful information to people and their relatives to help minimise the risk of falling and injury. The provider had a 'falls champion' who was a member of staff with interest in this area. Information was recorded about any individuals who had fallen and this information was shared with their GP. We saw a falls risk assessment and management plan in the mobility section of people's care plans. This stated what action had been taken, for example, provision of pressure mats to alert staff to movement or personal alarms for people.

People were cared for in a safe environment. The premises were well maintained throughout. There was a programme of daily, weekly and monthly checks in place in order to keep the premises, people and staff safe. Records showed all checks had been completed. Contracts for servicing and maintenance were in place for all equipment. Catering staff had daily, weekly and monthly cleaning schedules to complete.

The provider had a business contingency plan in place. The plan set out the arrangements to be followed if the service had to be evacuated for any reason. The plan included what would happen if any untoward events affected service delivery. Personal emergency evacuation plans (referred to as PEEPs) had been prepared for each person. Each room had a coloured sticker on the bottom of the door to inform staff of the ability of the person to be evacuated.

The registered manager provided for sufficient staff to be on duty each shift to ensure that everyone's care and support needs were met. The staffing numbers were adjusted regularly, taking in to account the number of people in residence and the complexity of their care needs. The registered manager explained that an extra member of staff was allocated to each shift so that they had time to spend with people. This staff member would also assist people with their meals. Staff told us they were able to comment to the registered manager if they felt the staffing numbers needed to be reviewed. One staff member said, "If I had any concerns about staffing I would raise it with management." People were looked after by staff that were familiar with their care and support needs. Any gaps in the staff rotas were picked up by the staff team who did extra shifts.

One person told us, "There have been a couple of time (person's) been in pain but he gets the relief he needs when asked." The systems in place for ordering, receipt, storage, administration and disposal of medicines were in accordance with the provider's medicines policy. The policy covered the administration of medicines, controlled drugs, medicine errors, homely remedies and the procedures to be followed if a person wanted to self-administer their medicines. The registered manager showed us evidence of how their medicines policy had led staff to pick up on errors in the receipt of medicines from the supplier. We looked at a sample of four medication administration records (MAR), which recorded when and by whom medicines were administered to people who used the service. The records were up to date without omissions. Medicine administration within the home was carried out by a qualified nurse. On occasion a trained senior care assistant would administer medicines on the dementia care unit. Competency checks to ensure the nurses had the relevant skills and knowledge for safe administration were in place. Medication known as PRN or 'when required' such as pain relief was supported by protocols. This provided guidance to nurses on the safe administration of such medicines. Staff told us that they accessed medicine summary sheets from the person's previous GP before they administered medicines to a new person. This ensured that medicines were given correctly and were up to date.

Controlled drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) were being stored as per legislation. Regular stock checks were made of the controlled drugs. The fridge temperature was recorded daily to ensure that medicine requiring cold storage did not spoil.

Outstanding ☆

Is the service effective?

Our findings

People we spoke with considered that staff were well trained to support them. One person said, "I am confident that they know what they are doing and look after me well." Another said, "They (staff) know what they are doing alright. They are very professional too." Staff we spoke with had a good knowledge of people's care and support needs and were skilled and confident in their care practice. For example, a clinical incident occurred with a person during the inspection and a nurse immediately dealt with the situation. This prevented a potential admission to hospital. Relatives and health care professionals said the staff understood people's needs, including those living with dementia. One relative commented, "Staff are well trained and are patient and professional with people. They know how to deal with people who become agitated," another said, "Staff are professional and well-trained."

We saw that new staff completed an induction training programme when they first started working at the service. Staff said their induction had consisted of completing mandatory training and they had worked as supernumerary with experienced staff. The induction programme was in line with the Care Certificate and had to be completed within a 12 week period. The Care Certificate was introduced for all health and social care providers in April 2015 and ensured care staff were prepared for their day to day role. This meant new staff were well supported and well trained. One staff member said, "We get a good mixture of training each year, such as moving and handling, food hygiene, first aid, fire safety and safeguarding. I've done an activity course for people with dementia." Another commented, "When I came here I had two months training, and then I worked for two months with a Team Leader. I also completed my care certificate."

Staff that had an interest in a particular area of care were given the role of 'champions'. These were staff that would advise and guide other staff on the best practice in these areas so that consistent, up to date care was given to people. For example, the provider had staff champions in; infection prevention and control, tissue viability, end of life care, falls and spirituality and dementia care. These champions worked to improve the quality of service experienced by people. For example, the implementation of the exercise programme for people who were at risk of falls.

There was a continual training programme available for all staff with 171 different topics. For example, gold standards framework training where the values included 'giving the right person the right care, in the right place at the right time, every time.' Another example of training was in respect of providing person centred care where there were challenging behaviours. One staff member explained how the dementia care training had enabled them to care for someone better and to understand their behaviours. They said they understood how the person's daily routine would vary according to their mood state and adapted their care accordingly. The courses the provider defined as mandatory were available regularly for staff to complete. The registered manager had a matrix system in place to monitor staff training that identified when staff required updates. It was evident the provider placed great emphasis upon staff training which meant people benefitted from receiving care from knowledgeable, competent staff.

Staff received support through regular one to one supervision with a line manager. Group supervisions were included in handover reports and staff meetings. Senior staff and qualified nurses worked on the floor with

care staff, monitoring their practice, giving feedback to the individual and the registered manager. Staff had an annual appraisal and regular performance review meetings. These provided an opportunity for the registered manager and the member of staff to discuss their practice and identify any further training and support needs. People who used the service were involved in this process known as '360° feedback'. People received a questionnaire to complete about an individual and this was included in the overall score rating for the staff member. Staff provided one to one assistance for people to help them complete the forms.

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. Staff said that a person's capacity was always assumed. They ensured that people's rights and freedoms were protected. Staff we spoke to had an understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. A staff member told us, "People are always given choices. With some people, if I encourage them, they will do what they can for themselves. A relative told us, "They will always offer choices, such as when to get up, what (person) wants to wear and (person) does respond. (Person) has never been forced to eat or do something (person) didn't want." One relative said, "I'm very happy, staff are very approachable. I also like the nurses telling (person) what they are going to do rather than just go ahead and do it". We saw that staff sought people's consent for all day to day support and decision making, using ways appropriate to the person's individual communication needs. Staff said they always asked people's consent before providing any care or treatment and continued to talk to people while delivering care so people understood what was happening.

People were supported to make important decisions. These decisions included Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and records showed that relevant people, such as relatives, legal representative and other professionals, had been involved. The records for these were held confidentially in the staff office. However, one person requested where the information was and had not been happy that it was kept away from them. They had felt that if an 'incident' occurred then it would take time for staff to locate the directions and wishes of that individual to DNACPR. Staff listened to this person and decided to put a discreet symbol outside the bedroom of people who had a DNACPR in place and it was also recorded on the current 'resident list'.

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). The registered manager and senior staff had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They spoke to us about their understanding of the legislation and guidance. The assistant manager was able to name the people living at the home who were having their liberty restricted. We saw relevant records that showed people's needs regarding this had been assessed. The registered manager had consulted with the local authority about these assessments. "Staff knew how to access the DoLS advocate if a person didn't have family or the family did not want to be involved in decisions. This advocate visited people and liaised with staff.

Staff explained how they balanced people's rights with the wishes of significant others in people's lives. Staff said they made professional judgements and liaised with professionals to deliver care in people's best interests. For example, they assessed that on admission a person, who lacked capacity, was being over sedated with medication. They considered it was not in this person's best interests to continue to have this medication as they could meet their needs by appropriate staff support. Staff consulted with the community

health team and GP to review and reduce the medication.

The registered manager explained about a person whose first language was not English. Their relatives did not live in the UK and so could not visit as often as they wished. The person initially could converse well with staff. But, as their condition deteriorated they began to communicate more and more in their native language. A care assistant who spoke their language volunteered to be their translator. They assisted the GP at their visits and escorted the person on hospital visits with their consent. This enabled the person to be involved in all their treatment and care decisions and to maintain vital contact with their family. As the person's capacity began to fluctuate the care assistant was an invaluable member of the team communicating wishes and desires up to the end of the person's life.

We saw that staff tried to make mealtimes a positive and sociable experience for people. They understood the importance of people's meal time experience as a way to promote their health and wellbeing. We observed the meal time which was calm and relaxed. We observed that staff sat with people to encourage them to eat their meal. Staff were available throughout the meal and assisted people to eat where needed. We noted this was done in a discreet and respectful manner. Staff were knowledgeable about the importance of good nutrition and hydration. Food was freshly cooked and looked appetising. People were aware of the meal options as menu sheets were placed around the home with the options available.

Where people were at increased risk of malnutrition or dehydration staff increased the nutritional and calorie contents of their meals, by fortifying foods. The provider was to start a programme of providing people with higher nutritional food rather than relying on prescribed supplements. Staff had ascertained that people hadn't liked having supplements. The local Clinical Commissioning Group also wanted to reduce supplement reliance through the 'Food First for Care Homes' initiative. We saw that kitchen staff interacted with people during the mealtime. One person had a discussion with staff about the option for the supper menu and whether it was suitable for their dietary needs. If it wasn't suitable then other options were available.

We looked at records that showed people's nutritional needs were assessed and kept under review. People's care records contained information about people's nutritional intake and the support they needed to maintain optimum health. Records confirmed people's weight gain or loss was monitored so any health problems were identified and people's nutritional needs met. We saw staff wrote in people's personal care files after the mealtime. This showed they monitored what people ate.

One person told us, "I can see the GP by appointment, just as I did when I lived at home. I like that." The provider had commissioned fortnightly GP visits for services extra to routine GP medical cover. People told us they could request a visit in private and any information was kept confidential. People were told of the dates the GP was to visit so they could plan if they needed to see them. This improved people's access to healthcare and enhanced their quality of life. People had access to other professionals such as optician, chiropodist and the tissue viability nurse.

We saw that on the dementia care unit there were limited visual displays on the walls. The rear corridor was quite sparse with limited dementia friendly signage. We spoke to the registered manager about this who explained they were looking into this. They had already identified some areas for improvement for the decoration in this area.

The registered manager described how a member of staff had identified an issue in the service. They had noticed that some people who used wheelchairs within the home had problems when navigating through the front door. People could open it but then struggled to pass through and close it behind them. This staff

member had attended equality and diversity training. This had resulted in them noticing that people were reliant upon other people or staff to assist them each time. This reduced their independence, caused frustration and was possible discrimination. The registered manager investigated possible solutions to this and adapted the premises by fitting an electric door. This resulted in those people who used wheelchairs being able to maintain their independence.

Outstanding ☆

Is the service caring?

Our findings

People we spoke with complimented the service for its friendly atmosphere and genuine care from the staff team. Comments included, "The staff are very kind and caring, they have made a very difficult time easier to deal with for me," and "It's nice here, if you want anything, they will always get it for you. If I need anything you don't have to wait too long." One staff member said, "We support people to make decisions, we offer choices of clothing, ask them what colour they want to wear. At meal times we have options and I explain and show them what is available." Staff showed concern for people's well-being with a caring and meaningful approach and responded to people's needs. When speaking with people they used physical touch to reassure them which made them feel valued. We saw people were spoken with by staff in a caring, respectful and dignified way because staff used people's preferred names to address them, or used words of encouragement to which people responded. We saw staff smile at and hold hands with people providing contact and affection. There was genuine affection in the way staff spoke with people and gave them reassurance. A relative said, "They do encourage (person) to be independent like dressing and she does her own hair."

One relative said, "Staff treat people with dignity and respect. Even people shouting at staff are shown compassion. They try very hard to give people love." Another said, "(Person) is not excluded from activities and is encouraged to get involved." A third said, "Staff are very caring. I come in four times a week and I have never encountered any concerns with staff, even with the nature of issues in this (dementia) unit." All staff were seen to interact with people in a kind and compassionate manner and it was evident they knew people well. The ethos and culture developed by the registered manager and staff was one of valuing people and treating people as individuals. Care people received was very kind, caring and compassionate.

Staff spoke about the people they were looking after respectfully. They said they wanted to and were expected to treat people with dignity and respect at all times. They said they used their time to encourage conversation with individuals apart from delivering personal care. Staff clearly knew the people they were caring for and were able to describe their likes, dislikes and preferences. One staff member talked of the importance of having good working relationships with people and their families. The registered manager told us it was important for the staff team to care for each other too in order to deliver a caring culture.

On a wall in the reception area was a display of cards and thank-you letters from families. In one card the family had applauded the home for the care and support they and their relative had received at the end of their loved one's life. Comments and compliments that had been received from families of people that had passed away showed that the care provided had been extremely caring and compassionate for both the individual and the family members. We were told that relatives were encouraged to visit the home for a remembrance coffee morning. Relatives of deceased people returned to continue the friendships with people they had come to consider as friends and were able to share memories of their loved ones. This meant that people met and had conversations with a variety of people helping them to interact with different people and prevent social isolation. This helped to make life more interesting and created a sense of community between the people using the service and their relatives.

The home provided an exceptional standard of care to people with palliative and end of life care needs. They supported families through difficult conversations and offered support to bereaved families. The home had signed up to the nationally recognised Gold Standard Framework for end of life care (GSF). The GSF is a model of good practice which enabled a 'gold standard' of service to be provided for people who were nearing the end of their lives. It aimed to ensure people lived well until they died. This meant the staff followed best practice guidance and people received care tailored to their specific needs. The provider was one of only seven in the country to achieve double beacon status for their outstanding end of life care. This recognised that staff maintained a very high level of service and continued to deliver innovative, personalised end of life care.

A person who used the service had made a comment to staff about knowing someone in the home. They hadn't been aware that the person may be dying and had wished they had known about this so they could have been able to say goodbye. We were told that staff discussed how they could recognise this and also discussed it at a 'resident meeting'. It was agreed that staff would place a symbol, with the person's permission, on the person's bedroom door. This made staff and visitors aware the person was near the end of their life. This also meant that people were not disturbed unnecessarily by staff and those that visited them.

Staff considered that people embraced end of life issues better and were more at peace with their circumstances because of their approach. This was demonstrated by completed surveys from relatives several months after their loved one's death. A staff member explained, "We have good relationships with family, often with us taking the lead as many find this a difficult subject, but this is always the family and resident's decision, we are facilitating and supporting them." The registered manager had prepared 'end of life information leaflets' for people and their families including information about grief and bereavement services and the practicalities of organising a funeral. They said, "We aim to involve people right from the start of their care with us and to present our philosophy." We were shown a board with comments written by people about what end of life care meant for them. Staff then responded with comments about what they would do to facilitate this. We were shown the specific care record developed by the NHS and hospice providers with invited input from the provider. From this the registered manager had developed an advanced care plan leaflet given to people when they were admitted to Churchill House. All this had been discussed with people at a 'resident meeting' so they were involved with it all. We were told of one person who had taken their plan to complete themselves when they were ready to. It was all done at the person's pace.

A relative made a comment, "All of my family has been impressed with the entire staff with whom we've come into contact. Whether it was cleaners and maintenance, carers, nurses or management, everyone showed a real sense of personal care about their role and, importantly, my (person) who was treated with real dignity. (Person) could not have been made more comfortable. This relative went on to share a comment on a review website about the home. This was regarding the collection of personal belongings after a person's death. Staff responded to this by developing small personal boxes for people's personal effects. This was a more respectful way of handing back people's personal belongings to their relatives after death instead of in a bag.

The registered manager and staff showed a passion for constant reviewing of the end of life care they provided. They had introduced 'spiritual' training for staff and held one to one sessions with people in the home. A member of staff was an end of life 'champion' who reviewed the care pans and was the 'go to' person for advice. We were told that they discussed difficult deaths at staff meetings and why, if at times, things hadn't gone according to plan. For example, when unexpected deaths occurred in the home. In order to remember each person who had passed away, a memory tree in the reception area was used to display

names of each person that had died. Staff told us this helped them also to grieve.

People had access to information within the service about independent advocacy services. Information was displayed in the entrance hall along with lots of other leaflets. An advocate is a person who represents and works with a person or group of people who may need support and encouragement to exercise their rights. We were told of how the staff had assisted a person to visit their home for the last time before it was sold. An advocate lawyer had been arranged to help this person through the practicalities of the sale.

One relative said to us, "I often have seen staff trying to stimulate residents by talking to them about their childhood for example. There appears to be a lot of staff engagement with people." A member of staff said, "We have 'golden moments' with people in the afternoon to engage with them. I do think it is beneficial for people and relatives are able to read what they have done. One relative told me they were surprised what their mother could do." It was evident the staff went the extra mile in caring for people and strived to make sure people were happy and continued to have a meaningful life. 'Golden Moments' were personal one to one time spent chatting or doing some activity such as; hand massage, foot spa, manicure and painting. These were recorded and the impact on the person's wellbeing this had.

Outside the dining room was displayed the provider's 'culture of compassionate care' board. This detailed information about care, compassion, competence, communication, courage and commitment. There was also the dignity in care newsletter for people and their relatives to read. Staff and people put their views on the board about what the culture meant for them for example, one said, 'Giving people what they need,' another read, 'Remembering the small things-attention to detail.'

One person told us that staff respected their individuality. They said, "I am not treated as someone in the home, this is my home and I am a person in my own right. I find that very caring." Staff told us they always studied any aspect of a person's information they did not understand. For example, a qualified nurse had carried out a pre-admission assessment on a person who had a particular faith. The staff member had known little about this faith and its beliefs but wanted to ensure the person and the rest of the staff had some knowledge prior to the admission. They researched for information and discussed this with the person on the day they arrived at the home. Staff had learnt that people of this faith did not use any prefix before their names. A name plaque for the resident's bedroom door was ordered with the name only on it. Staff also arranged for them to have regular involvement with their faith group. They provided a quiet space for their meetings and assisted them to maintain contact with this local community group.

Good

Is the service responsive?

Our findings

People were able to tell us they received the care and support they needed and that responded to any change in their circumstances. One relative said, "My relative is now in a wheel chair. (Person) was having falls at home all the time, but (person) has only had a few minor falls since coming here. In my view she is very safe here, no concerns at all, they respond well." Another said, "I am able to choose what I do and where I go. We have no restriction here."

Pre-admission assessments were completed for people prior to moving into Churchill House. Where possible people or their relatives were invited to visit the home, have a look at the facilities on offer and to meet the staff team. The assessment gathered information about the person's care and support needs and provided a 'whole picture' of the person. Assessment of the person continued after admission. The document covered the person's abilities, their physical health and well-being, their prescribed medicines and dietary requirements. It also included the person's lifestyle choices and preferences.

A person-centred care plan was written for each person and provided clear instructions for care staff to follow. The writing of the plans had involved the person where appropriate, their family and other information provided by health and social care professionals. People's wishes and preferences were incorporated into their plans. Where people had wounds we saw records were made of when the wound was attended to, were detailed and evidenced the progress of the wound. Wounds were regularly measured and photographed. The plans were reviewed on a regular basis and where changes were noted to the person's needs, the plans were adjusted accordingly.

One relative said, "I'm really impressed by the fact they spend time with (person) such as manicures and activities. (Person) is encouraged to get dressed and is often taken down stairs to be involved in bell ringing. They actually had reindeer in during the Christmas period." Another said, "They have various activities. I've seen them doing yoga and flower arranging. My relative loves bingo and bell ringing. They try very hard to get people involved, but my relative won't go to a lot of things." Staff said that outside entertainers mainly performed in the lounge downstairs and that people were always asked whether they wanted to go. They said that each unit had an activities coordinator, with different activities each afternoon. Examples of activities organised were; arts and crafts, bell ringing, skittles, word games and regular communion. Another member of staff spent time with individuals doing massage and chatting as part of a 'Bee-Active' programme. The registered manager said they often used the internet as a source for 'special events.' For example, they had held an Oscars themed day with a special menu called 'A day at the movies.'

During the afternoon, we observed a person who became very agitated and distressed. Staff supported them by giving them a toy cat, which relaxed and calmed them down. They spoke about the cat and other cats to the person who responded to the conversation and very quickly was smiling and hugging the toy.

The service maintained links with local facilities to ensure that people remained part of the community. People's relatives were encouraged to visit as often as they were able and were provided with refreshments. Local community businesses had been visited by people, such as, The Ludlow Brewery, local shops and

various tourist spots.

People said if they were unhappy they would ask to speak to the registered manager, the assistant manager or one of the nurses. Relatives gave the same response but added they had no reason to complain because they considered everything was alright. Relative comments were; "If I had a problem I would chat to them straight away. They are always accessible and respond positively. I'm aware of the formal complaints procedure, but have never had cause to use it," and "I have seen the comments and suggestions box, but never needed to use it." A third said, "If I had the slightest concern I would raise it, though I've never needed to make a formal complaint."

People and their relatives were provided with a copy of the complaints procedure and there were complaints leaflets displayed in the main reception area along with a suggestion box. The registered manager agreed that these required updating to give people details of other authorities people could complain to. People who lived in the home and their relatives were also able to raise any concerns or complaints they may have during care plan review meetings and 'resident meetings.'

The staff had received many written compliments via letter and thank you cards. The registered manager ensured all comments were shared with the staff team. The letters and cards were posted on the notice board in the entrance hall.

Records showed that any concerns had been handled in accordance with the complaints policy. The registered manager said that any complaints were used as an opportunity to learn, to make changes and to do things better. The registered manager talked about 'grumbles' such as missing laundry items and these were investigated as well as formal complaints.

Good

Is the service well-led?

Our findings

It was evident from the responses we received from people, relatives and staff that this was a well-led service. The staff team was led by the registered manager, a qualified nurse with many years of clinical experience. They described themselves as passionate about the care of older people and providing people with a quality life.

The provider had been considered for the placement of student nurses from a university. A member of staff explained that they had attended mentorship training for trainee nurses. They had been involved with Staffordshire University and had completed a 12 week course. From September 2017, together with Staffordshire University, trainee nurses placements were due to commence at the home.

The registered manager and the assistant manager operated an open door policy and led from the front. They were both visible throughout the day and did a daily walkabout round the home and generally spoke to every person and every member of staff on duty. The registered manager said this promoted effective working and made it clear what the priorities were for that day. There was someone on call day and night for emergency situations or to provide support and guidance for the rest of the team.

Relatives and professional visitors said they had a good relationship with the registered manager and the staff team. They all found the manager to be accessible, approachable and supportive.

The visions and values of the service were shared by the whole staff team. The aim was to provide person centred care, using knowledge of each person's history to provide the right support whilst maintaining dignity and choice. Staff told us, "The management is wonderful, they are great people who really care about people living here."

The provider had a range of different measures in place to assess and monitor the quality and safety of all aspects of service. There was a programme of audits to check they complied with regulations and the fundamental standards. We saw that audits were completed on a regular basis. Examples of audits completed were medicines, infection control, health and safety and care planning documentation. Where shortfalls were identified as a result of the audits an action plan with timescales was put in place to ensure the improvements were made.

The registered manager and nominated individual regularly reported to the provider. This ensured the provider was aware of how the service was performing. Any accidents and incidents were reported on. The events were analysed and investigated to ensure that lessons were learnt, acted upon and that risks were reduced or eliminated where possible. For example, we saw that information from the falls strategy fed into the audit of falls to monitor trends. The staff team could then act upon this to minimise the risk to people and improve their safety.

People and their relatives were asked for feedback about the service they received and the way they were looked after. This was done informally in daily discussions and social events and formally through surveys,

care plan reviews and 'resident meetings.' External professionals, such as the GP, district Nurses and Community Mental Health teams were also surveyed for their views on the service provided. Outcomes from the quality assurance surveys were collated and posted on a notice board and also put in the newsletter. People were provided with their own copy to keep.

The registered manager conducted a post admission review. This found that people were happy with the literature they received, the information they continued to get and the welcome that they had. Relatives of people who had died at the home were asked for their views some months after the event. This helped staff to understand how well they had supported people and the relatives at that distressing time. They were also invited to a coffee morning twice a year to visit the home if they wished to.

The registered manager, attended meetings with the manager from another service run by the provider. Amongst other things they shared information about events that had happened in their service, outcomes of CQC inspections, feedback following visits by health and social professionals and other regulatory bodies.

Regular staff meetings were held (qualified nurses and care assistants), team meetings were held for each of the individual areas of the home such as, catering and housekeeping staff. Staff told us they were encouraged to make suggestions and were listened to.