Trustees of Petworth Cottage

Petworth Cottage Nursing Home

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?	Outstanding ☆
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 21 and 23 June 2016 and was an unannounced inspection.

Petworth Cottage Nursing Home provides accommodation and nursing care for up to 32 older people. At the time of our visit there were 28 people living at the home.

The service has 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.

People, relatives, staff and healthcare professionals spoke very highly of the home. They told us that it had a strong reputation locally. We found that people received a high standard of care and that staff were continually striving to further improve the care and the service that people received.

People were actively involved in planning their care. Thorough pre-admissions assessments involving people, their families and community professionals ensured that effective care could be provided from the outset. Staff had taken time to get to know people and valued them as individuals. People were encouraged to pursue their independence and to participate in activities that interested them. We observed that people received sensitive, caring and prompt support from staff. On a monthly basis, each person met with their keyworker to discuss their care and make future plans. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff were proactive in monitoring people's health and worked effectively with other services to ensure that people's needs were met. Nurses met regularly with community professionals to ensure a coordinated approach in people's care, to share best practice and to anticipate changes in people's needs. A community matron told us, "They have good, knowledgeable nurses and they are very caring".

Staff had expertise in palliative and end of life care. Relatives spoke highly of the care their loved ones had received and of the support staff offered to them. One relative wrote to the provider saying, 'I would like to thank you all for the care, compassion and sensitivity you showed to my Father'. The service was working towards accreditation under the Gold Standards Framework (GSF) which aims to improve practice and reduce hospital admissions.

People had developed good relationships with staff and had confidence in their skills and abilities. They told us that staff were kind and that they treated them respectfully. Senior staff kept a focus on dignity through monitoring the delivery of care, trialling new initiatives and having regular discussions with staff. There was an established team of staff at the home, which offered continuity of care for people. Staff had received training and were supported by the management through supervision and appraisal. Staff were able to

pursue additional training which helped them to improve the care they provided to people.

People felt safe at the home. Risks to people's safety were assessed and reviewed. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. People received their medicines safely.

People enjoyed home-cooked food and were able to make suggestions for dishes they would enjoy. A team of volunteers worked on a rota to provide morning and afternoon drinks to people. Many people knew the volunteers from the local community and enjoyed their company. Staff were attentive to people's needs and supported those who required assistance to eat or drink. People's weight was monitored and prompt action taken if any concerns were identified.

There was strong leadership within the home. The registered manager and deputy monitored the delivery of care and had a system to monitor and review the quality of the service. Suggestions on improvements to the service were welcomed and people's feedback encouraged.

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 said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place and reviewed to help protect people from harm.

There were enough staff to meet people's needs and keep them safe.

People received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff had received training and support to carry out their roles.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good

The service was caring.

People received individualised care from staff who cared, who knew them well and who went the extra mile for them.

People were actively involved in making decisions relating to their care.

People were treated with dignity and respect.

People were supported at the end of their lives to have a comfortable and dignified death. Staff worked effectively with other healthcare professionals to anticipate changes and improve their practice.

Is the service responsive?

Outstanding ☆

The service was very responsive.

People received personalised care that met their needs. Staff were proactive in monitoring people's health and anticipating changes in their support needs.

Staff collaborated effectively with other services to ensure that people received consistent coordinated care.

People were involved in planning their activities and enjoyed regular contact with others in the local community.

People were asked for their views and were assured of a swift response to any concerns.

Is the service well-led?

Good ●

The service was well-led.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

People and staff spoke highly of the registered manager and leadership team. Staff were clear on their responsibilities and told us they were listened to and valued.

The registered manager used a series of audits to monitor the delivery of care that people received and ensure that it was consistently of a good standard.

Petworth Cottage Nursing 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 21 and 23 June 2016 and was unannounced.

One inspector and a nurse specialist undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed one previous inspection report and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during 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 care records for nine people, medication administration records (MAR), monitoring records, accident and activity records. We also looked at six staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with 13 people using the service, six relatives, the registered manager, the deputy manager, two nurses, four care assistants, the chef, the maintenance person, three volunteers and the Chairman of the Trustees. Following the inspection, we contacted the Macmillan nurses, a community matron, two GPs, a chiropodist and a local priest to ask for their views and experiences. They consented to share their views in this report.

Petworth Cottage Nursing Home was last inspected in January 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I'm very happy. I like it here". A relative had written to the provider saying, 'I can honestly say that I haven't seen my Dad so happy and content since being in your care. I can finally sleep at night knowing that he is being taken care of'. Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. The registered manager had attended a training update in safeguarding procedures run by the local authority. Staff knew where to access up-to-date contact information for the local authority safeguarding team but told us they would always approach the registered manager if they had concerns. One care assistant said, "I raise any issues without hesitation. It is very open".

People's needs had been assessed before they moved to the service. The assessment looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in moving and handling, falls, pressure areas or from known conditions such as diabetes, these had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and the support that people required from staff. For example, moving and handling risk assessments considered how the person responded to instructions, their physical abilities and any environmental limitations such as restricted space or poor lighting. From this a 'safe system of work' was devised which detailed how to safely support the person in different scenarios such as moving up the bed or transferring to a chair, along with the equipment and number of staff required. Risk assessments were kept under review and any change in a person's support needs was communicated to staff and clearly documented.

Staff demonstrated a good understanding of risk and were mindful of people's safety. We observed staff assisting two people to transfer from a wheelchair to a lounge chair. This was carried out safely and one person told us, "They know what they are doing". Another person in the lounge had their feet resting on a pressure-relieving cushion. This was to reduce the risk of further damage to a sore area on their heel. Staff reminded and encouraged people to use walking aids such as frames to aid their mobility and reduce the risk of falls. A new person moved to the service during our visit. The nurse assessed the equipment the person had brought with them, including a hoist sling, to ensure that it was safe to use.

The provider carried out risk assessments of the service and had recorded actions to make improvements. For example, a near-miss reporting procedure had been introduced. This would help to identify new areas of concern so that action could be taken to minimise future risk. We found that staff were quick to record any incidents that occurred, such as if a person banged their hand. If redness or bruising was noted this was recorded on a body map and kept under review by the nurses. Each person had a personal evacuation plan in place which described the support they would require from staff in an emergency to leave the premises. The service was also equipped with a defibrillator.

There were enough staff on duty to keep people safe and to meet their emotional and social needs. One person told us, "I find they're often around and I don't need the bell". Another said, "Staff do stop and chat". A relative said, "There are always staff to talk to, they are wonderful". There was a minimum of one nurse on

duty at all times, supported by care assistants and support staff. There was a stable group of staff, many of whom had worked at the service for a number of years. On occasion, agency staff were employed to ensure that there were enough staff on duty. Staff told us that they usually had the same agency staff members and that this helped provide continuity of care. Staff told us that they were not rushed and that they had time to give people the care and support they needed. The staffing level was adjusted to meet people's changing needs, for example if a person was nearing the end of their life, additional nurses were on duty to ensure that they received appropriate support.

We looked at staff recruitment practices and found that one staff member who joined in 2014 appeared to start work before their criminal records check was returned. The registered manager was unable to confirm whether they had been on training or shadowing during this period. As a result we checked the records for seven staff who had been recruited in 2015. We found them to be in order. The records confirmed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

People received their medicines safely. Staff who administered medication had received training and their competency had been assessed. There were recorded details of how each person liked to receive their medicines. Medication Administration Records (MAR) demonstrated that people had received their medicines as prescribed. Where medicines were prescribed on an 'as needed' (PRN) basis, there was clear guidance to describe the dose and the expected effect. This helped to ensure that PRN medication was administered consistently and not used as a long term treatment. Topical creams were administered consistently and recorded.

Medication was stored in locked cabinets that were clean and well organised. The cabinet was attached to the wall by a chain or stored in a locked room. Medicines that needed to be kept cool were stored in a fridge and the temperature was recorded daily. At the time of our inspection a new fridge was on order as staff had noted fluctuations in the fridge temperature. People who had been assessed as able to self-medicate were provided with lockable storage in their rooms. Medicines for disposal were recorded and returned to the pharmacy. Medicines were checked monthly by nominated staff which helped to identify any anomalies. The nurse told us, "It is very, very rare that we have a problem". In addition, the pharmacy carried out audits of medicines within the home. The most recent audit from May 2016 had not identified any concerns. The one suggestion to buy a thermometer to monitor the ambient temperature where medicines are stored had been acted on by the registered manager.

Good

Is the service effective?

Our findings

People had confidence in the staff who supported them. One person told us, "They are very kind. They know what they are doing". Another said, "They seem very qualified". A third told us, "I'm very impressed with them. I'm very comfortable". Relatives were delighted with the care provided. One said, "It's absolutely super, I can't get over how good they are". Other relatives had written to the provider to express their thanks. We read, 'With many grateful thanks for all the wonderful care you took of my husband' and, 'I'm writing to thank you for looking after her so well'.

Staff felt confident in their skills and abilities. New staff completed a period of induction which included training courses and time shadowing experienced staff. Staff told us that the length of the shadowing period depended on the skills of the new staff member, for someone new to care it could be a month or more. New staff were also able to work towards the Care Certificate which is a nationally recognised qualification. New staff told us that they had felt ready to start working independently. One said, "I was put with a lady who showed me round and gave me lots of information. I'm really pleased with it".

Ongoing training was organised through an external training company. Staff completed workbooks and were required to sit a knowledge check which was sent off to be marked. Courses included safeguarding, basic first aid, infection control, health and safety and the Mental Capacity Act 2005. Some staff had completed courses in dementia care and pressure sores. The provider had a room dedicated to training and staff told us that they had allocated time to complete the courses. Support was available to staff who had any difficulty with this style of learning. We noted gaps in the workbook training for some staff. These were being addressed with individual staff members.

Moving and handling training was delivered annually by an in-house trainer who was qualified for the role. Fire safety training was delivered face to face by an external trainer. Staff were happy with the training offered by the provider. They told us that they were able to attend additional courses that were of interest and relevant to their roles and to undertake diplomas in health and social care. One care assistant said, "A few external trainings have come up and they asked if I had an interest to go".

Nurses attended an annual training course which covered key areas of training including infection control, moving and handing and safeguarding. They also attended annual medication training which included a knowledge and competency test. Nurses told us that they were supported to further their professional knowledge. One nurse told us they had completed training in wound care and the verification of death. They also told us that there was lots of training offered as part of the Gold Standards Framework (GSF), an accreditation programme relating to end of life care that the service was working towards.

Staff felt supported. The Chairman of the Trustees told us, "The care of our residents is paramount, but the care of our staff comes a close second!" One care assistant told us, "Any problems, I just go and ask. The door is always open". The chef said, "You're appreciated for what you do". A nurse described one of the best things about the home as, "The caring nature of everybody. If you're feeling a bit down about something, they're there for you. Never is anything too much trouble". Nurses told us that they worked closely with care

staff. One nurse said, "We work hands-on. We observe them on the floor. We are here and they will come and talk to us". At the beginning of 2016 the registered manager had revised the system for supervision. Each nurse had a team of care staff to supervise who were designated as keyworkers to people. Each month, this team met to review people's care. One care assistant told us, "Each month we get together. We get feedback from that".

While staff had received supervision, formal supervision had not taken place at the three-monthly frequency intended by the provider. Records of supervision demonstrated that observation was a key part of assessing the staff member's competency. In one we read, 'I have monitored (Name of staff member) giving personal care, she is always polite, gaining consent, explains procedures and maintains their dignity'. A new 'supervision and performance' form was about to be introduced. This detailed specific tasks such as use of equipment, monitoring of diet and nutrition and support with personal care. The deputy manager told us that they hoped this would help to formalise the system and provide a detailed record of ongoing staff supervision.

Staff performance was reviewed annually during an appraisal meeting. Staff were asked to assess their performance and to state any training wishes. They were also asked whether there was anything the provider could do to help with their performance at work. We noted that two staff had said they lacked confidence in communication with relatives. The registered manager had arranged for them to attend a 'Sage and thyme' course at a local hospice. The course information describes the objective of the course as, 'To teach the core skills of dealing with people in distress'. At the time of our inspection the 2016 appraisals were underway and all staff had completed their self-assessment ready for the appraisal meeting, which were due to be concluded by August 2016.

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.

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). At the time of our inspection, one application had been made to deprive a person of their liberty, which had been approved by the local team.

We checked whether the service was working within the principles of the MCA. People were able to move freely within the home and grounds and were not prevented from leaving the service by a locked front door. The home's welcome pack stated, 'We recognise that we provide a home for you, therefore we ensure that wherever possible and for as long as possible you continue to make your own decisions'. People were involved in decisions relating to their care and their preferences were respected. One care assistant told us, "We talk about everything when they arrive so you're not doing stuff they don't want". Another said, "We start from the point that they have capacity". We saw that people had made decisions such as to decline wearing their dentures, or to drink more alcohol than might be advised. A staff member told us, "One lady refused personal care all day. Until she agreed you can't, you have to step away. She was OK the next day".

Staff understood the requirements of the Mental Capacity Act (2005) and put this into practice. In one supervision record we read, '(Name of staff member) always assumes all residents have capacity and gains consent before giving/offering care' and 'She maintains a calm approach, gives time for the resident to express their wishes/likes/dislikes'. In one person's notes we read that staff had shared the results of a scan

with a relative, 'with (name of person's) permission'. Where people lacked capacity, staff had worked in line with the MCA to ensure that their rights were protected. If people had appointed a Lasting Power of Attorney (LPA) to be their representative this was clearly recorded, along with a copy of the decision. Best interest meetings involving representatives, relatives, staff and professionals had been held to make decisions on behalf of people who lacked capacity. These included decisions regarding tests and further treatment. When one person appeared to be in pain but was unable to verbalise this, staff met with the GP and relatives and a pain relieving patch was prescribed. A nurse told us that this appeared to have made the person more comfortable.

People enjoyed the food served at the home. One person told us, "The food is very good. It's varied". The chef explained that meals were made from scratch and that the menu was adapted based on people's preferences and according to locally available produce. There was a choice of breakfast, including cooked breakfast, and supper daily. At lunch there was one main dish, though individual likes and dislikes were catered for. One person told us, "At lunchtime it just comes, but they will change it if it isn't liked". Another said, "I don't like curry. They know that". A third told us,
"You can have an omelette or something. There is always plenty". The chef told us that some dishes had been made following particular requests, such as one for Cottage pie. Every couple of months there was a fish and chip night where a take away was ordered, and often enjoyed with a film.

The chef had a record of people's dietary preferences and needs. A board in the kitchen detailed those who required soft meals or thickened fluids to aid with swallowing, those who liked a small portion and those who needed support from staff to eat their meals. We observed the mealtime in the main lounge. Staff were attentive to people's needs. As meals were served they explained what the dish was and asked if the person would like assistance in cutting up the food. People who required assistance were supported and ate at a pace that suited them. People's weight was recorded on a monthly basis. Unintended weight loss was followed up with people being offered additional snacks or high-calorie supplements. Where appropriate, staff had made referrals to the dietician for further guidance.

Throughout our visit we observed that drinks were in reach and that staff supported people to drink. In the minutes of a staff meeting we read, 'Staff were also reminded about the importance of sufficient fluids for residents and the avoidable problems dehydration causes. All were encouraged to check drinks are being offered to residents throughout the day'. Volunteers served tea and coffee to people each morning and afternoon. The volunteers had a record of people's drink preference and whether they used a cup, beaker or straw.

People had access to healthcare professionals and the service worked in collaboration to ensure that people's needs were met. One person told us, "I am able to see the GP if I want to. I've been to the surgery and had my hearing tested". Another said, "They got me to the dentist. I've been fine ever since". Visits from professionals were recorded in people's care notes, along with any advice or guidance given. Professionals told us that staff contacted them promptly if they had concerns and that staff followed their advice. A GP told us, 'I have no safety concerns around the care that is provided at the nursing home. They discuss appropriate issues with us in a timely manner and always respond to the advice that is given'.

Good

Is the service caring?

Our findings

People spoke very highly of the staff, who we observed to be exceptionally warm and friendly. One person told us, "All of the staff are lovely, couldn't be nicer". Another said, "I get on well with everyone. It is very nice". Relatives were equally enthusiastic. One had written to the provider saying, 'Thank you so much for all you are doing for Dad. He is very lucky to stay there with such lovely staff'. Another wrote, 'We could not have chosen a better nursing home for Mum. You showed true kindness and empathy and responded with empathy when Mum was distressed and in pain'. A third simply said, 'We are singing your praises to all who will listen!'

There was a consistent team of staff and people had developed good relationships with them. One staff member told us that the registered manager was excellent at interviewing for staff to recruit for caring qualities. They told us, "She looks at how caring they'd be". People told us that the staff knew them well and valued them as individuals. One person told us, "I get on very well with them. I smile now more than I did". Staff described how they took time to get to know people. One nurse told us, "We try to make sure we know what a person was like before they were sick". A relative said, "They get to know your family and your background".

Staff supported people to maintain contact with friends and relatives that were important to them. Each person had the option of a private phone line to be installed in their bedroom, which many people told us they valued greatly. One person visited a relative for lunch on a regular basis and was taken and collected by staff using the home's minibus. There was a separate lounge area adjacent to a kitchenette where people could entertain visitors. Relatives told us that they were also offered the option of staying at the service, either with the person in their room or in a vacant bedroom. This was especially appreciated when people were unwell or at the end of their lives as it meant that family members could be together.

People were involved in planning their care. There was an information pack about the home which was given to people prior to admission. This explained the ethos of the home, how it was run and provided useful information on the services available. People were also encouraged to visit the home prior to admission. The registered manager said, "Many come to view beforehand, some come on recommendation alone". Once at the home, each person had a keyworker who took the lead in ensuring that they were happy with their care. People told us that they met regularly with their keyworkers. One person said, "One of the staff comes in and asks for my opinions". Another told us, "Once a month they come round and see if we want anything. They do listen". These meetings were documented and formed part of the monthly review of people's care completed by staff. As part of the individual reviews, relatives were invited to participate or were contacted by the keyworker for their feedback. We observed that people were free to make choices about how they spent their time. One person told us, "I feel fortunate to have such a lovely room with a beautiful view. I always have my big windows open. I love the fresh air". Another said, "I do join in occasionally but I'd rather stay here (in their room)". A third person had been offered a trip out to a local pub but had declined.

We observed staff as they supported people. They were gentle and kind in their approach. One person was

sleeping at lunchtime. The staff member softly woke the person and asked if they would like to eat their lunch. We saw another staff member waiting patiently for a person to respond to their question. The staff member later told us that this person was able to express their views but that they needed time to do so, demonstrating an understanding of how to effectively communicate with the person. People were encouraged to be as independent as they were able. Staff offered to assist people with tasks such as cutting up their meals. When one person felt they'd be able to manage the vegetables, staff just cut the meat to assist them. Another person told us that they always had their wash things and clean clothes ready in the morning before they asked staff to assist them. They told us that maintaining their independence was very important to them. Staff spoke about how they assisted people. One said, "If I know they can wash their own hands and face, or walk even just a little distance, I encourage it". Another told us, "If you take time with him, he can do it (stand). All the time he wants to do it we encourage him"

People told us that staff treated them respectfully. One person said, "They're all very nice at everything they do". Another told us, "There are a couple of young men (staff) I'm very attached to. They do what's needed and don't embarrass me". We observed that staff always knocked on people's doors before entering and that they spoke with people warmly and politely. During the shift handover staff spoke respectfully about each person. When we were speaking with one person in their bedroom a staff member stopped to ask the person if they could shut the door for a moment as they were assisting someone from the bathroom back to their bedroom. This showed respect for the privacy and dignity of both people. One staff member described their approach as, "It's how you would want to be treated".

The management kept a focus on dignity by discussing it with staff and monitoring staff as they worked. We read in the minutes of a staff meeting in January 2016 that staff were reminded about maintaining dignity when hoisting and making sure no more than two staff were present if personal care was being given. Staff had also trialled assisting people who were doubly incontinent and used pads to sit on the toilet at different times. The registered manager told us that this had been very successful. In the minutes of the June 2016 staff meeting we read, 'Residents are responding well to being offered the commode at different times of day. Improvement has been seen in bowel habits and thus less intervention has been needed'. This had not stopped incontinence but it had improved people's wellbeing and on many occasions meant the person was able to use the toilet rather than their pad. This encouraged people's dignity in relation to their continence needs. There were numerous comments and letters of thanks from relatives which spoke of how people's dignity had been upheld. One read, 'Just a little card to say thank you so very much on behalf of our Dad for giving him care, dignity and respect on a daily basis. Words could not explain just how much it is appreciated'. Another, 'Thank you for caring and for your gentle approach to (name of person). You afforded her dignity during her final month with your patient approach'.

People received high quality care at the end of their lives. The home had expertise in palliative and end of life care. Relatives of people who had passed away at the home spoke highly of the support they received. One relative had written, 'To say a huge thank you for your endless care and support of our father and of us'. Another, 'All at PCNH (Petworth Cottage Nursing Home) did a great deal to ease his passing – not just for (name of person) but for his mother and me too. We all had precious time together, gently supported by the kind staff at the house. Please thank all those who helped (name of person) and tell them that their care shone a light in our dark grief'.

The home was working towards accreditation under the Gold Standards Framework (GSF). The GSF is, 'A framework to help deliver a 'gold standard of care' for all people as they near the end of their lives'. It aims to improve quality of care, improve collaboration with other professionals and to reduce hospital admissions in the final stage of life. As part of this programme, staff had been asked how confident they felt in planning care for dying residents and in caring for them. Additional training and support for staff had been identified

through this. Furthermore, the deputy manager had a degree in palliative care and worked closely with the staff team to improve their understanding. Staff told us they felt confident in how to support people at the end of their lives. They told us how they took time to get to know the person and their family and to understand their wishes. One care assistant summed it up as, "We take time with them". A relative told us, "We've talked it through with them and the GP and produced an end of life care plan. I can't fault them, they've done extremely well". Staff told us that there were always enough staff to provide careful support to people. One said, "Those last few moments will be the lasting memory". Another told us, "If Matron knows someone is frightened or near the end she'll always get someone else in so that we can be with them".

The registered manager and deputy worked closely with other professionals to ensure that people received effective and compassionate care. In the past four months the home had been involved in fortnightly meetings involving Macmillan (Macmillan nurses provide specialist cancer support), the GP surgery and community nurses. The purpose of the meetings was to discuss changes in people's condition and to anticipate changes to their support needs. The meetings also served to discuss people living in the community who had expressed a wish to move to the home for end of life care. The meetings improved collaboration, helped staff to improve their clinical skills and knowledge and to share expertise. A nurse from Macmillan that we spoke with told us, "We have great confidence in the quality of care in the home. They admit patients from our caseload with complex needs at end of life and with our support provide excellent care. The staff have developed skills over the years and manage quite complex situations very well". A community matron said, "They recognise it (end of life). They don't send people to hospital inappropriately. There's no flapping around. They know exactly what they're doing. They're very organised. They do that really, really well. They're very experienced; they see the patient and they embrace the family".

The registered manager and deputy were looking to further develop and improve their practice. As part of the GSF programme, reviews had been conducted after a person's death. These considered what worked, what didn't work and what could be improved. One idea for development was to create a pack for relatives giving support and guidance on practical arrangements in relation to bereavement. Staff told us that they currently discussed this with relatives but said that written information might help some families. This would help to improve the experiences of bereaved relatives by providing them with essential information and support.

Outstanding ☆

Is the service responsive?

Our findings

There were clear aims and goals for each person's support and their care was reviewed monthly as a minimum. This review involved the person and often their relatives and was completed by the person's appointed keyworker. One keyworker explained, "We go in and chat with them to see if they are happy and to check if there are any worries or concerns". A relative told us, "The staff have looked after her very well. They're very considerate and friendly. I'm able to talk to them about (name of person)". Each group of keyworkers would then meet with their appointed nurse to review people's care. In one person's review we read, '(Name of person) still finds it hard with walking and likes to have someone with him'. Others had been updated with new support tasks to address concerns such as an area of redness on a person's skin. There were also notes on appointments and new information that had been noted, such as that one person preferred fresh fish to fish in breadcrumbs. Each change was noted and actions were assigned to named staff to be followed up. On a day to day basis, care staff used an electronic records system to record the support they had provided to each person. Nurses used this to monitor the delivery of care and were able to check people had received appropriate support and that this was recorded. One care assistant told us, "It does get checked, for example if you've forgotten to record drinks they (nurses) will ask you". At the shift handover any queries were addressed and information was relayed to the staff taking over. The team worked effectively together and care assistants contributed confidently to the meeting by making suggestions and observations regarding the people they supported.

Staff were extremely proactive in monitoring people's health and anticipating changes in their support needs. Monitoring was in place to manage known concerns, for example bowel monitoring to reduce the risk of constipation. In the care plans there was a section detailing 'anticipated problems' which helped staff to plan ahead and ensure that the necessary support was in place. For example, it was noted that one person's mobility was declining and that they might need to be assessed to use a stand-aid. Another person had struggled on occasion to swallow one of their tablets and the nurse was due to liaise with the GP for a soluble equivalent. Staff actively monitored the use of pain relieving medicines and those used to treat anxiety. One person's mood was being monitored with a view to reducing their medication; another was already on a reducing dose. Staff told us that this had improved the person's mood and that they appeared to be more settled. A third person was on a reducing dose of a pain relieving medicine, which was due to be discontinued later in the week. This demonstrated that staff monitored people's use of medication to ensure that it was necessary and supported their wellbeing. A relative told us, "(Name of person) is well looked after and the staff are very good and responding to changes in her needs". Another relative said, "The nurses are on the ball". The community matron told us, "It's a very good home, I'd highly recommend it. They nursing care is very good".

Staff collaborated effectively with other services to ensure that people received consistent, coordinated care. A relative told us, "They seem very professional in the way they handle transition". The community nurse we spoke with said that the home worked to make admissions as easy as possible. She told us, "They do particularly well. They make it an easy process. It is much more about the patient and the family". She explained that the home did what was best for the person even if that meant some administrative or financial issues had to be resolved after admission. Where people had long term conditions, staff met with

the nurse practitioner from the local GP surgery to do a joint assessment and to agree on how to best manage their symptoms. Staff told us that as a result of this joint-working, they felt that the number of GP and out of hours' calls had been reduced. The GP told us, "Calls to us are appropriate (clear internal effective triage) and there is consistent evidence of discussions with patients and family about their care. They are aware of and utilise other services available to them".

Staff were forward-looking and were willing to participate in local initiatives and contribute to developing understanding and making improvements in health and social care. The home had been involved in a pilot project run by a local NHS Trust, which used software to track specific patients with the aim of preventing unnecessary hospital admissions. Following the pilot, this software was now being rolled out by the NHS Trust. The community matron who had worked with staff during this pilot told us, "They were willing and able to take part, they were very engaged. We couldn't fault them". The pilot required staff to carry out regular observations, including blood pressure, blood sugar and pulse rate, and send this data to the project team over a six month period. Following their participation the registered manager explained that they had continued to document these observations. She told us, "It was helpful. We are more alert to small changes. It highlights that something is going on and we can get the doctor involved sooner. It has made the nurses more aware". By closely monitoring small changes in people's health, staff were able to take timely action to offer appropriate support. This helped to avoid unnecessary hospital admissions, which can be unsettling and stressful for people. The registered manager was also due to participate in a new working group set up by a local hospital to look at discharge planning. The first meeting was scheduled in July 2016.

People received person-centred care that met with their individual needs and preferences. Before a person moved to the home they were asked how they liked things to be done, what was important to them and for preferences including daily routine and diet. Staff also liaised with healthcare professionals who had been supporting them in the community and, where desired, made contact with local churches to offer pastoral support to people. The thorough admissions process meant that people's needs could be met from the outset. One relative told us, "My wife is appointed to a carer (keyworker). She produced a statement of what she likes and how to deal with (name of person). They do it (provide the care in this way). I can't think of anything to improve". Another relative said, "They were so caring and really, really lovely. They asked us everything and we talked about how it would be done. They were super. They spent time with us. It made me feel quiet and more peaceful to know I've got professionals in charge".

Throughout our visit we observed prompt, caring and sensitive interactions between people and staff. People told us that staff responded quickly. One person told us, "If you want someone to come you push the bell and they will come". Another said, "They're very sweet. They can't do more than they are doing". As we were being shown around the home the registered manager stopped to respond to one person who was calling for assistance. At lunchtime we saw another person say to staff that they needed the toilet. This was just as their lunch was served but staff took the lunch back to the kitchen and immediately supported the person to the bathroom. A third person said that they were feeling hot and staff assisted them to roll up their sleeves and opened a nearby window. A relative told us, "She's happy. They take their time with her".

Each person had a care plan which detailed the support they needed and how it was to be provided. There were details on eating and drinking, medicines, mobility, communication, cognition, skin integrity, pain management and social interaction. Most people had also completed advanced care plans to explain how they would like to be supported at the end of their life, such as where they'd prefer to be cared for and who they'd like to be with them. The care plans included details on the person's past medical history and how to manage risks to their health. Care plans provided personal details about the person's family, current and past interest, jobs and places they had lived. This helped staff to better understand the person and served as a starting point to get to know them. There were also details on things that worried the person and a section

entitled, 'What makes me feel better if I am anxious or upset'. For temporary staff, the nurses maintained an overview of people's care as a quick reference. This explained the person's medical history, any allergies they had and specific needs such as if they had a poor swallow or needed to use a hoist to stand. This ensured that essential information about a person and their care were readily available for agency staff or new staff who may not be as familiar with people's needs.

People were able to participate in a variety of activities and to meet with others from the local community. People received copies of the activity programme for the month, which was also displayed in the communal areas. The programme of activities was coordinated by a member of staff who had responsibility for activities. In June activities included bingo, keep fit, afternoon tea, a film afternoon, a trip to a local garden centre, morning coffee and a Wimbledon afternoon with strawberries, cream and Pimms. There were two church services monthly for those who wished to participate, one led by an Anglican vicar and one by a Roman Catholic priest. There was also a visiting speaker due to deliver a 'creative talk' entitled 'The great British summer'. People told us that they enjoyed the activities. One person said, "I've been ever so happy here. I go outside when it is nice and fine". Another told us that they had plenty of company and said, "I'd give it 100%".

People were involved in planning their activities. One person laughed as they told us about the live reindeer that was booked to come at Christmas time and said they wondered what would happened if they made a mess on Matron's new carpet! Others told us that they enjoyed visits home, trips to the pub, and drives out in the home's minibus. On the day of our inspection, one person was taken to the local polling station to cast their vote in the Referendum; others had been supported to complete postal votes. Another person told us that they enjoyed gardening and had been involved in planting some seeds. The home had a team of volunteers from the local community who served hot drinks in the morning and afternoons. There were also volunteer flower arrangers. People told us that they enjoyed their company. The local priest told us that the home had, "A real community feel". The registered manager said, "It's somebody else coming in, lots of them have known the volunteers in the past".

People felt confident to raise any concerns or complaints with staff. One person said, "They're quite happy if you complain". Comment forms were available in reception and were provided in the welcome packs that people received. On the form we read, 'We try to promote an open and listening policy involving all staff, residents and visitors… We take these comments seriously and use them to maintain the standard of care offered'. Where people had made suggestions, these had been addressed. One person told us that they had requested more vegetables. In the kitchen this had been added to the board detailing people's needs and preferences, saying 'lots of veg'. The time of evening drinks had been made later following feedback. In order to gather feedback from relatives, the registered manager had started to run cheese and wine evenings, afternoon tea parties and morning coffee, each on a monthly basis. This was to offer a variety of times and days to accommodate relatives. One relative told us, "If there is anything you are not happy with she'll (the registered manager) be on it at once". The chiropodist said, "If I've shown any concerns, I've always been listened to".

The provider had a complaints policy and the complaints procedure was displayed within the home. There had not been any complaints since our last inspection. Everyone we spoke with was delighted with the service. One person said, "It's very good. I have no complaints".

Good

Is the service well-led?

Our findings

The home had an open and positive culture. People were respected as individuals and staff felt supported in their work. In the home's welcome pack we read, 'Our culture is based on independence, choice, dignity and privacy, which is what you will see and experience throughout our care home'. We found that the home was living up to this aim. Relatives had written to the provider to express their thanks. One wrote, 'I have never been in a place as relaxed and happy as yours with the attention to detail, cleanliness and kind, friendly staff'. Another, 'What a lovely welcome we had and the fact we could bring the dog was an added bonus. You really make the place feel very homely which is down to much planning and organisation'. A staff member told us,
"I'm proud of the care and the welcome".

People spoke highly of the registered manager and said that they saw her often. One relative told us, "(Name of registered manager) has her finger on the pulse". The registered manager was open and continually seeking ways to improve the service. Staff felt able to raise any concerns or suggestions and told us there were regular staff meetings. One staff member said, "You can say what you need to say". The registered manager was supported by a deputy. The registered manager and deputy arranged the rotas so that one of them was always on shift during the day and on call at night. This helped to provide continuity and effective leadership. The registered manager reported to the Board of Trustees who were actively involved in the service and visited regularly. A GP told us, "Leadership there ensures the staff know their patients very well and they manage to retain staff providing good continuity for patients".

The registered manager had a visible presence within the service and actively monitored the delivery of care. By working late or arriving early, the registered manager and deputy were able to meet with night staff and to monitor how the night shift was running. People and their relatives had been asked for their feedback in satisfaction surveys during November 2015. The questions covered the environment, care and activities and asked if they would recommend the home. The results showed a high level of satisfaction. One person wrote, 'My family have heard nothing but praises outside in the community'.

A variety of audits were in place to monitor the quality of the service. Fire safety and water checks were carried out by the maintenance person and external companies were contracted to monitor water, gas and electrical safety and to service equipment including hoists and the passenger lift. Medication audits had been carried out by the local pharmacy and monthly provider visits were completed by the Trustees. Any actions identified were reviewed the following month, or addressed with the registered manager during the six-monthly board meetings. At the time of our inspection an infection control audit was in progress and the registered manager was in the process of gathering staff feedback to complete a dignity audit.

Audits were used effectively to drive improvement in the service. In response to a visit from the Fire and Rescue Service in December 2015, the registered manager had commissioned a fire risk assessment via an external company. They had also installed fast release doors and improved emergency evacuation signage around the home. Following the 2015 infection control audit, new commodes had been purchased and some carpets replaced. As recommended by the pharmacist, new thermometers had been purchased to

monitor the ambient temperature of areas where medication was stored. The provider had an improvement plan for 2016. This set out works to be completed and equipment to be purchased each month. Completed tasks included landscaping of the gardens and purchasing profiling beds. One relative told us, "It's plus, plus, plus. There is nothing I could fault".