Lilian Faithfull Homes

Faithfull House

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 5 and 6 January 2017 and was unannounced. Faithfull House provides accommodation for 72 people who require personal care. 62 people were living in the home at the time of our inspection.

Faithfull House is a large Grade II Listed building. People's bedrooms are set over several floors, most of which are accessible by stairs, lifts or stair lifts. The home has two large lounges and a dining area on the ground floor plus two other smaller lounges, a conservatory, library and a secure garden.

The director of care held the shared position as 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 told us they enjoyed living at the home and they felt safe. We observed that staff were courteous and polite towards people. Staff understood the importance of respecting people's dignity and privacy. Staff supported and encouraged people to make their own decisions and choices. They understood the importance of acting in people's best interests however there was limited records that people's mental capacity had been assessed prior to significant others making decisions on their behalf.

People's support needs and risks had been assessed and were mainly managed well. Their care records were being reviewed nod updated to ensure they reflected people's needs and provided staff with adequate guidance. People received their medicines in a safe and timely manner and were referred to health care services when their needs had changed.

Staff had been trained to carry out their role and were knowledgeable about good care practices and their responsibilities to protect people from harm and abuse. Staff felt supported by their seniors and manager. Plans were in place to ensure staff received one to one support meetings to discuss their role and self-development. Systems were in place to ensure people were regularly checked and monitored. Adequate recruitment processes were in place to ensure people were cared for by suitable staff.

People enjoyed a variety of activities in the home and community. Concerns from people and their relatives were addressed immediately. People told us they enjoyed the meals and snacks provided. People with special diets or preferences were catered for. A chef who had recently been appointed planned to consult with people about the food being provided.

A temporary management structure was in place to ensure the home ran smoothly. Some governance and quality issues had been highlighted by the new management structure although actions were being taken to address the shortfalls. Staff felt supported by the management and were confident in the provider.

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

This service was safe.

Staff were knowledgeable about their role and responsibilities to protect people from harm and abuse. People's risks had been identified and were being managed well. People had individual evacuation plans in place.

There were sufficient numbers of staff to meet the needs of the people. Adequate recruitment processes were in place to ensure people were cared for by suitable staff. People received their medicines in a safe and timely manner.

Is the service effective?

Good

This service was effective.

Staff understood the importance in providing choices to people and acting in people's best interests, however there was limited records that people's mental capacity had been assessed prior to significant others making decisions on their behalf.

Staff felt supported and trained to carry out their role. Plans were in place to enhance the systems to support staff.

People were supported to maintain a healthy diet. Their dietary needs and preferences were monitored and catered.

People had access to health care professionals and other specialists when required.

Is the service caring?

Good

The service was caring.

People and their relatives told us the staff were caring and kind. Staff spoke to people respectfully and politely. Staff understood the importance of respecting people's dignity. People were encouraged to become more independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Work was in progress to update and review people's care records to reflect their physical, social and emotional support needs. People enjoyed a variety of activities in the home and community.

People's concerns and problems were addressed and acted on.

Is the service well-led?

Good

This service was well- led.

Regular monitoring checks were carried out by staff to ensure people's needs were being met and to improve the quality of the service being provided. Actions were being taken were shortfalls had been found.

Staff felt supported by the management. The provider had acted to put systems into place to communicate and consult with staff and people's relatives and to ensure there was a temporary management structure in place.

Faithfull House

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 5 and 6 January 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. The expert by experience's area of expertise was in caring for older people.

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 the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

We spent time walking around the home and observing how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 11 people, five relatives and several members of staff including seven care staff, three laundry staff, two activity coordinators, the maintenance manager and the head chef. We also spoke to the deputy manager and director of care. We looked at the care records of seven people and staff files including recruitment procedures, as well as the training and development of all staff. We checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Good

Is the service safe?

Our findings

People were protected from abuse because all care and non-care staff at Faithfull House had been provided with training on how to recognise and report allegations and incidents of abuse. Staff were aware of their responsibilities to report accidents, incidents or concerns and of the provider's whistleblowing process. (A whistle blower is when a staff member passes on information of concern or wrongdoing.) One staff member said, "I would report any concerns direct to the senior or team leader on duty or the manager. I'm very clear about that." Information about safeguarding people and reporting concerns were displayed throughout the home for staff, people and relatives to read. People confirmed they felt safe living at Faithfull House. They told us they felt safe amongst staff and were protected against the risks of potential abuse and harm. People made comments such as, "I'm happy here. I feel quite content" and "The staff are kind and they look after me well."

Records showed that all accident and incidents were logged and analysed for trends and patterns. There was evidence that staff had learnt and reflected on incidents and accidents that had occurred. For example, we found additional systems and checks had been implemented as a result of a recent incident. The incident and actions taken were discussed with staff to ensure the risk of similar incidents were minimalised.

People's risks had been assessed and managed. The home used nationally recognised assessment tools to assess people's health risks such as the risk of malnutrition and pressure ulcers. Care plans associated with the risk assessments provided staff with information on how to support people and assist them to mitigate their risks. For example, people who had been assessed as being at risk of developing pressure ulcers had been provided with pressure relieving equipment and were assisted to reposition frequently with the support of staff. Records stated the actions staff should take and confirmed that staff had regularly assisted people and ensured they were comfortable. Their skin was regularly checked for red areas which may indicate a risk of a pressure ulcer developing.

Some people had specific risk assessments in place which was pertinent to their needs. The nature of the risks, control measures and the assessment of residual risks had been clearly identified and recorded. For example, one person had been risk assessed to judge if they were able to self-administer and manage their own medicines. Each person had a personal emergency evacuation plan in place which indicated the assistance they required to reach a safe zone in the home. Generic risks to people, visitors and staff such as dealing with waste products and emergency incidents had been assessed and recorded.

People could be assured the home and grounds were safe, clean and well maintained by the housekeeping and maintenance team. Regular checks were carried out to ensure the building and equipment associated with people's care was cleaned, maintained and serviced. One person said about the home, "It's very clean. It's well presented."

Peoples benefitted from an established staff team, many who had worked at the home for several years and knew people well. Faithfull House is a large building with several stair cases and various floor and mezzanine

floors, most of which were served by lifts or stair lifts. During our inspection we observed the staffing arrangements and discussed the distribution of staff with the director of care. We were assured that systems were in place to monitor the well-being of people, in particular those people who mainly stayed in their bedroom. Staff were allocated a specific floor at the start of their shift and were responsible for the checking the people who chose to stay in their bedroom. We also found that housekeeping and domestic staff also visited people throughout the day which acted as secondary checks. People had been left with call bells within reach to alert staff. Staff carried out regular checks on those people who were not able to operate their call bell. Records showed the checks were regular carried out. The director of care regularly audited the staff response times to people's requests for assistance using the call bell system. The monitoring identified if there were any patterns or trends emerging which required investigating or actions. The call bell audits showed the majority of times, staff had responded to people requesting assistance within the timeframes the provider expected.

Some staff had been allocated specific duties such as the administration of medicines or organising the hot drinks and tea trolley. Additional staff had been made available to assist with jobs such as laying the dining room tables and speaking to people about their choice of food. The deputy manager was super-nummery during most shifts and was available to provide staff with extra support and advice where needed.

The staff rotas of November and December 2016 showed there was mostly sufficient staff on duty to meet people's needs. We were told that the staff rotas were planned a month in advance to ensure people were supported by consistent and regular staff team. Where there had not been enough staff to meet the desired staffing levels of the home, staff had picked up extra duties or the home had used bank staff or occasionally agency staff. The provider also had a group of eight flexible staff members who were contracted to work across the provider's homes as required. They were trained in all areas and could be requested to work in different roles depending on the home's requirements. The home had recently recruited new staff to ensure people were cared for by familiar staff who had been trained by the provider.

Most people and relatives were happy with the staffing levels in the home. However one relative shared with us that they felt the staffing levels were reduced at the weekends and stated "The home has a different atmosphere about it at the weekends." Our review of the staff rotas indicated that the numbers of care staff remained constant during the weekends however the number of domestic and maintenance decreased at the weekends. An on call system was in place to support staff out of hours and was responsive to any type of concerns. We were also told that an activity coordinator worked for a few hours during the weekends. A key worker system was about to be implemented to address this concern. We concluded that generally there was enough staff on duty and deployed to check and meet people's needs.

People were supported by staff who were deemed to be suitable to carry out their roles and of good character. All applications and associated recruitment documents were reviewed and checked. Background and criminal checks were completed via the Disclose and Barring Service before new staff worked with people. Any queries regarding their previous employment or irregularities were discussed during their interview and documented. Some staff had received basic references from previous employers. We asked the director of care how they ensured new staff were of good character and suitable to carry out their role. They were confident that the interview process was thorough and that a statement about the new staff's conduct and attitude was provided to the manager after their induction courses. Any concerns were addressed before they took on the responsibility to care for people.

Peoples' medicines were generally managed and administered safely. There were sound arrangements in place for ordering, storing, administering and disposing of people's medicines which was supported by the home's medicines management policy. Medicines were ordered on a 28 day cycle and most were delivered

in multiple dosage system (MDS) packs with people's medicines organised according to the time of day to be administered. People were administered their medicines from locked medicines trolleys or from the person's locked medicines cabinet in their bedroom. There were daily recorded checks of the clinical room and the medicines fridge. Senior staff had received management of medicines training and had been assessed as competent to manage and administer people's medicines.

We observed the lunchtime medicines round which was carried out safely and proficiently by two senior members of staff. Staff knew people well and observed for signs of pain or anxiety. Where appropriate, they offered people medicines which had been prescribed to be used 'as required' such as pain relief or to assist people with anxiety. Protocols were in place for the safe administration of these medicines. People's medicine administration records were completed correctly. Codes had been used to indicate whether people had taken or refused their prescribed medicines.

We discussed with the deputy manager and senior staff about the potential benefits of using body maps for recording the site of analgesic patches. These were not in use at the time of our inspection but would be considered to be implemented. The deputy manager carried out a monthly medicines audit. Any discrepancies were investigated and acted on to prevent any recurrence. The home had recently received a positive audit check by the pharmacist linked to the home.

Good

Is the service effective?

Our findings

People were supported to make decision about their care and support. We observed staff encouraging and supporting people to make choices about their day such as what they wanted to drink or eat. Staff were aware of people's preferences and assisted them to make day to day decisions based from their knowledge about people. People's ability to consent to the care and support was mainly embedded within their care plans in line with the Mental Capacity Act 2005 (MCA). 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. The provider required that all people had a lasting power of attorney in place to ensure there was a lawful process to the agreement of people's care if they were unable to make decisions themselves.

The previous registered manager had identified people who were being deprived of their liberties. We observed staff supporting people who could become anxious and require continued support in the least restrictive way. People can only be deprived of their liberty to receive care and treatment when this 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). Applications to the supervisory body (local authority) to deprive two people of their liberty were in place.

People were cared for by staff who had been trained to meet their needs. Staff told us they had received the training they needed when they started working at the home and were supported to refresh and update their skills. New staff received a two week induction programme by accredited in-house trainers which included training such as moving and handling and fire safety as well as dignity, dementia awareness and safeguarding. Their induction training was cross referenced with the standards of the care certificate. New staff also had the opportunity to shadow more experienced staff before becoming part of the shift team. Senior staff met with new staff and observed their skills and knowledge during their probation period. Staff from different departments told us they had received sufficient training to carry out their role. Care staff were also encouraged to undertake a national qualifications in health and social care. One staff member told us "There are lots of opportunities to do the things you want to do." The managers and some staff had completed a locally accredited course on supporting people with dementia. They attended frequent forums and workshops to ensure their skills were in line with current practices and cascaded their knowledge to their colleagues.

A system was in place to monitor the on-going mandatory training needs of staff to ensure their knowledge was current. Records showed additional training had been planned including the five step approach to dementia and first aid. Staff also had to complete a yearly 'back to basics' training to ensure their personal care skills were in line with the provider's standards. We were told each year the course concentrated on a specific topic such as end of life care. All care staff had recently completed end of life training as part of the manager's aim to be awarded the Gold Standard Framework in end of life care. In addition staff also completed distance learning courses in subjects associated with health and social care or had received

training from heath care specialists.

Staff told us they were supported in their role and felt their colleagues; senior staff and their managers were approachable. One staff member said, "We've got good team work here. We work well together and there is a lot of support." The provider's staff supervision policy stated that staff were able to receive support in a variety of ways such as group or team supervisions, one to one meetings and individual performance meetings. Staff also had access to the provider's human resources manager who visited the home regularly. We found the notes and minutes of all staff meetings were generally captured on the provider's electronic human resources system. The system indicated when staff had attended meetings or had private meetings in relation to specific issues such as issues around poor practice, working hours or observations of work. Meeting notes also showed that managers had addressed issues where poor conduct of care had occurred and put performance plans in place.

However, there were limited notes of when staff had been given the opportunity to discuss and reflect on their own personal development. Regular private support meetings would enhance the systems in place to support staff and give them the opportunity to discuss any issues or training requests. This had been identified by the director of care and they had plans in place for all staff to receive one to one support meetings within the next month.

People were positive about the meals and food they received. We received comments such as "The meals are very good standard as far as I'm concerned" and "I've got nothing to complain about, the meals are consistently good." People could choose to eat their meals in their bedrooms or in the home's main dining room. We observed people being assisted to eat at their own pace and being intermittently offered a drink of their choice. New colourful crockery had been introduced to assist people with dementia or sight impairments to distinguish between the items of food on their plate.

A new chef was in post and had plans to review the meals being offered. They told us they wanted to have more of a presence in the dining room to gain a better understanding of people's preferences and food suggestions. At present, the kitchen staff prepared meals from a four week seasonal menu and were aware of people who required a special diet, allergies and food preferences. The chef told us the menus were nutritionally balanced and communication from the care staff about people's dietary needs was generally good. One staff member had been given the responsibility to monitor and audit people's nutritional consumption and monitor the systems to manage people's diet and fluid intake. They produced a monthly report which was reviewed by the director of care. The quantity of the food people ate during mealtimes was also monitored and recorded. Throughout the day people were offered hot and cold drinks, homemade cakes, biscuits and fresh jugs of water were replenished daily in people's bedrooms. People told us they enjoyed afternoon tea on traditional china crockery.

People were supported to maintain good health and had access to health care services such as an optician. They also benefited from two weekly physiotherapy sessions and enjoyed exercise classes. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. The home had good connections with two local GP practices. Records showed that staff had sought additional guidance from health care professionals when people's needs had changed and had implemented recommendations from community mental health teams and speech and language teams. One health care professional told us that the working relationship with the home was good and said "We try and communicate as much as possible. If the service needs assistance then they come to us, they inform us."

Good

Is the service caring?

Our findings

People told us they enjoyed living at the home. One person said, "If you've got to go and live somewhere, you couldn't get a better place. There just wouldn't be anything better." The person added that staff helped them said "They certainly do, day and night. This place is like the Rolls Royce (of homes)."

People were positive about the care and support they received from staff. We received comments such as: "The staff don't intrude"; "Everything is tailored to your needs" and "It's a lovely place to live. It's glorious." Relatives also praised the caring nature of staff such as "The home has a very caring ethos"; "The physical care provided was very good" and "On a whole the care is very good." Relatives also complimented the communication from staff and told us they were always contacted if there were any problems. They told us they were always welcomed into the home and could join their family member for lunch or other events in the home.

Whilst Faithfull House is a large residential home, it had a warm friendly feel about it. Staff knew people well and were chatty and attentive to their needs. The director of care explained where possible Faithfull House was 'a home for life'. They described how they have supported people to remain in the home even when they were in their final days of living. To do this, all staff had received end of life training and the home had formed good links with the local community medical teams. A person was receiving end of life care at the time of our inspection. We saw the person was comfortable and well cared for. Records showed the person's health and well-being were being monitored and their immediate needs were being met. Senior staff were working towards being accredited for the Gold standard framework when supporting people at the end of their life. Records showed a clear plan was in place on how the staff were going to work towards the individual standards within the framework. The senior staff had introduced systems to assist staff to detect early changes in people's well-being and a system to improve the communication about people's medical needs when being transferred between the home and medical services.

We noted a calm, pleasant atmosphere in the home and people and staff had a good relationship. We saw that staff were friendly and respectful in their approach to people. Care staff did not wear uniforms which assisted to break down any barriers and helped build a rapport with people. Staff were respectful towards people. For example, we observed staff being courteous and polite during the lunchtime period. They addressed people with their preferred name or title and informed them of the meal they were serving. Later in the afternoon we observed some people playing bingo in the dining room. We noticed that two people had fallen asleep; however a staff member who was walking by stopped and gently asked the people individually if they would like to be helped to their bedrooms or rest in a more comfortable chair. We also saw staff assisting people to adjust their clothing and ensuring doors were closed when assisting them with their personal hygiene to ensure their dignity remained intact. Most staff had signed up to be a 'dignity champion' and recognised the importance of respecting people's dignity. Staff were able to confidently describe what dignity means when caring for people. We observed good care practices and found that all staff were knowledgeable in their role.

Staff were aware of respecting people's needs and wishes. Staff interacted with people in a positive manner

and were sensitive to people needs and preferences. When staff spoke to people clearly and altered their approach to ensure people fully understood what they were saying. Staff were positive and compassionate about the people they cared for. One staff member said "I love caring for the residents here. They make me smile." Another staff member explained how they viewed their role and said, "I'm here for the welfare of the people I look after." We saw many warm exchanges between people and staff. Staff were considerate about people's welfare. For example they asked people about their well-being and ensured they were comfortable or warm enough. We heard staff complimenting people about the attire or their hair style and also reminding people of the time and day.

Requires Improvement

Is the service responsive?

Our findings

People were assessed before they moved in to the home to ensure the home could meet their needs. Information had been sought from the person, their relatives and healthcare professionals involved in their care. The provider was trialling out a 'respite/new resident holistic care plan' which initially captured people's health, emotional welfare needs and risks. We were told the monitoring tools within the care plan would be used to ensure people's wellbeing was effectively monitored and documented when they moved into the unfamiliar environment of the home. An informative handover system with daily handover notes occurred between shifts to ensure that all staff were fully informed of people's progress and needs. We observed staff worked well together and effectively communicated when people's needs had changed.

People's care records were personalised and centred around their care needs and preferences. Information about people's personal and family backgrounds were detailed in a document called 'This is me'. Their care plans had been reviewed and we noted updates had been recorded in the form of the 'holistic monthly record'. However a recent audit carried out by the managers had highlighted that people's care plans did not always consistently reflect their current needs. We noted that the details of some people's care documents did not consistently provide staff with adequate guidance. For example, one person had been identified as being at risk of dehydration and had a fluid chart in place to monitor their food intake. However we found there was no target amount or running total of fluid to identify how much the person was drinking. Additionally the person's fluid intake was being recorded in two separate places. This meant the records did not provide staff will adequate information about the hydration needs for this person.

Records showed that best interest decisions had been made on behalf of people who were unable to make specific decisions about their care. However, there was limited recorded evidence that people's mental capacity had been initially assessed before a specific best interest decision had been made on their behalf, although we found no impact on the well-being of people.

However as a result of the audit findings, a member of staff had been allocated the role to review and update everybody's care plans accordingly. We were told they were working through everyone's care needs and had spent time with people, their relatives and staff and had reviewed all records and monitoring charts to ensure they correctly recorded the person's current needs. Plans were also in place to give key staff members the time and responsibility to review an allocated number of people's needs and update their care plans on a monthly basis.

Staff were mindful of people's comfort and welfare. People were encouraged to decorate their own bedrooms with personal items and furniture. We were told people were encouraged to have a profile bed (adjustable bed) to enhance their safety and to help eliminate moving and handling risks to staff. Staff had responded to changes in people's needs to ensure they remained comfortable and could engage in the home's activities. For example, one person had been referred to have a specialised chair and adaptations had been made to their bedroom. Staff shared with us how this had improved this person's quality of life.

Staff were encouraged to socially engage with people while supporting them with their daily living activities

such as during their personal care. The home employed three activity coordinators who provided a range of activities including skittles, garden club poetry and coffee mornings. All the provider's activity coordinators met regularly to share ideas and were also part of a local activity network forum.

People had access to the home's library, hairdresser, a secured garden or could relax in the conservatory. People told us they enjoyed the home's activities, visiting entertainers and musicians as well as a variety of trips in the community. Weekly activities were displayed around the home and we were told that most sessions were well attended. An activities log was kept, but this only highlighted those people who were involved in the group activities. We were told that the activities coordinators spent one to one time with people who did not wish to attend the group activities. However, people's one to one social/meaningful activities or moments were not clearly recorded. This was raised with the director of care who said they would review the recording of people people's social interactions with the activities coordinators. An 'activities overview' document was shared with us after the inspection which highlighted the activities and events people's had participated in each month, but there was limited recorded evidence that people had meaningful moments or social interactions each day.

People's day to day concerns and complaints were encouraged, explored and responded to in good time. Concerns and complaints were used as an opportunity for learning or improvement. We reviewed the home's compliments and complaints log and found that complaints had been documented and acted on within the guidelines of the provider's policy. However information of a concern which had been raised with CQC regarding a complaint that had been made in 2016 hadn't been documented or logged. We followed this up the director of care and deputy manager who explained the circumstances around the complaint. They shared with us the actions at the time of the compliant and subsequent actions to improve the service for people who stay at the home for short breaks. They acknowledged that the recording of the complaint had been an over sight. However we were reassured that complaints were generally managed well and logged in accordance to the provider's complaints policy. The home's manager had summarised the format and nature of the complaint and the action taken to assist the management in identifying any trends or patterns.

Good

Is the service well-led?

Our findings

The provider had acted promptly and implemented a temporary management structure to support the deputy manager of the home due to an extended absence of the home's registered manager. The director of care and their deputy manager now had a significant presence in the home and were now involved in the day to day management of the home. They had subsequently become aware of some shortfalls within the service being provided and had recognised that some practices and systems to monitor the governance and quality of care being provided had not consistently been adhered to.

A recent staff survey had raised some issues around the management of the home and staff morale. The director of care said, "We are very aware that the home is not running as smoothly as it could and we are working hard to get things back on track." As a result of our conversations with the director of care and other key staff members, we were assured that actions were being taken such as reviewing the deployment and staffing levels in the home and that records associated with people's care were being reviewed and updated. For example, the reinstatement of some quality assurance systems had improved the quality of service being delivered and the running of the home.

An audit team was in place to assist with the monitoring of the service and help the director of care understand the standard and quality of care being delivered. A clear plan was in place for the frequency of these audits and the staff responsible for completing audits which included audits on accidents and incidents, call bell, fire drills and medicines. For example, staff had been designated to audit and improve people's nutritional welfare, infection control procedures and the recording of people's care needs and report their findings back to the managers. Records showed that audits were consistently and effectively being carried out. A training and compliance officer also visited the home and assisted with the monitoring of the home and a maintenance team was in place to ensure people lived in safe environment.

The director of care provided the board of trustees with a quarterly report based from their findings such as information gathered from their unannounced visits to the home; team reports and findings from meetings with managers and staff. For example the home's manager provided them with an overview of each people's support need and progress; room vacancies, staff training and absences.

Talking with people and their relatives revealed that most people were happy with the quality of care and service provided. Regular 'resident's forums' were held which gave people the opportunity to make suggestions or raise any concerns about the home. Records showed the discussion topics and the actions that had been taken and followed up at the next meeting. A recent survey showed that people, their relatives and visiting health care professionals positively commented and rated the home.

People's families were supported to understand their relatives' health and medical needs. For example, the home had a Memory Awareness Support Team (MAST), who provided advice to families about understanding and supporting people with dementia. Regular meetings were held to give family members the opportunities to share their concerns and receive advice. A monthly topic such as stroke awareness was introduced to provide staff with additional awareness as well as being shared with families.

However, some relatives felt the communication about the general running and changes of the home were not effectively communicated to them. One relative shared with us they were concerned that the management of the home "had lost its grip". This was raised with the director of care and chief executive at the end of our inspection, who told us they produced a quarterly newsletter and were in frequent communication with relatives. However, they agreed that the implementation of a regular relatives meeting would be beneficial to share information and consult with relatives. Since our inspection, we have been informed that relatives have now been invited to a regular 'relative's forum'.

Staff told us they enjoyed working at Faithfull House and for the provider. They were positive about the management of the home and told us the managers were supportive. We received comment such as, "They (the managers) are brilliant. They're always there", "The home worked as a team" and "The Management is very approachable." Information was shared with staff at departmental staff meetings but some staff felt a general staff meeting would assist with the communication across the home. The provider valued staff opinions and views of the service they provided. Staff representatives from each of the provider's homes met regularly to discuss any concerns or discuss changes in the provider strategies or policies. Managers and senior staff kept their knowledge and information up dated by attending local conferences and reviewing national research.

Staff were involved in improving the quality of care being delivered. For example, the deputy manager told us they had been supported by the director of care to make changes to the management and governance of the home such as implementing a homely remedies policy. They also shared with us their previous concerns about the running of the home but confirmed that they were confident that they now had the support they needed to drive the quality of care being delivered forward. They said, "It is really important that we improve staff morale, clear the clouds and provide them with clear standards and direction."