The Chaseley Trust

Chaseley

Inspection report

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Ratings

Overall rating for this service	Outstanding ☆

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

Summary of findings

Overall summary

We inspected Chaseley on 17 and 22 May 2018. The first day was unannounced. At the last inspection on 22 January 2016 the home was rated as Good. Chaseley is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home accommodates 55 people. It specialises in the care of people with highly complex needs, including diseases or injuries that affect the brain and nervous system. When inspected, people were living with a variety of conditions, including acquired brain injuries, spinal injuries, strokes and multiple sclerosis. There is a rehabilitation gym, with designated therapy staff, which was available to some people living within the home. There were multiple communal areas, including a large dining hall, a bar and a quiet lounge, along with large accessible gardens. The facilities were adapted to suit the needs of the different people and there was an extensive range of individual aids and resources available. Technology was used throughout the home to enhance people's lives and to improve the care provided.

At the time of the inspection there was a registered manager in place. 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.

The staff were proud of the positive, inclusive culture within the home and we observed caring, empathic interactions between the staff and different people throughout the day. There were numerous activities available which were seen to enhance the quality of people's lives and promote independence. The activities included art, gardening and exercise clubs. There were activities involving the wider community, for example, a regular disco and garden parties. People were helped to access activities within the community, such as the theatre and enjoying local nightlife. Families and friends were made to feel very welcome and were actively involved, according to the needs and preferences of the different people. The home provided end of life care, as necessary, seeking support from other organisations, including the hospice, as required.

There were good staffing levels and people and relatives felt very supported throughout the day and night. There was a robust system of staff recruitment, which ensured that those employed had appropriate references and the necessary background checks were made, to ensure they could work in the care industry. People felt safe and the staff were knowledgeable about safeguarding and worked within the framework of the Mental Capacity Act. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the home supported this practice. Staff also had an excellent understanding of equality, diversity and human rights and this was seen in practice, with people being respected and enabled to lead the life the way they chose. There was an extensive training schedule in place, with staff receiving both standard training and attending courses which were specific to the people they cared for. Staff had established their own innovative system of peer support

and assessment to both maintain and improve standards. There was a robust system of supervision and appraisals to maintain high standards.

Medicines were managed safely and according to good practice and there were systems in place to ensure good infection control. There was an extensive range of audits which maintained standards, ensured the environment was safe and were used to inform practice and continually improve the care given. Any accidents and incidents were thoroughly investigated and there was a comprehensive system in place to analyse trends. This led to a proactive approach with potential trends being identified and any issues addressed.

All the people were treated as individuals and their care plans reflected this. The whole person was central to planning care with the psychological, social, sexual and spiritual needs being reviewed alongside the physical needs. All care reflected this holistic approach. There was extensive evidence of multi-disciplinary working with an in-house GP, physiotherapy staff and occupational therapist. The team also worked closely with other health care professionals, with the aim of achieving the best outcomes, for the people they cared for. There were comprehensive individual risk assessments in place and people were encouraged to take positive risks to enhance the quality of their lives.

Staff considered accessible information for all the different people within the home, although they did not have a formal Accessible Information Standard strategy. Many people had highly complex communication needs and specialist aids were used extensively. Staff were aware of how different people expressed themselves and were skilled in interpreting their needs. There were systems of obtaining feedback and information from the different people and their relatives and this information was used to make changes. One example was a survey which resulted in the gym opening hours being extended.

There was a social dining area and people had access to a healthy and varied diet. People were supported to lead a healthy life and opportunities were taken to improve people's diets and their levels of physical activity. People were asked to give feedback about the food and could influence what was on the menu.

The management team were very industrious and actively sought ways to improve the service. There was an extensive system of audit and quality assurance in place and the management constantly strove to improve the standards within the home through feedback and networking. The staff worked well as a team and the vision of the home was embedded in their practice. They had productive relationships with other organisations and were actively engaged with the wider community.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were trained in safeguarding adults and were aware of how to report signs of abuse and neglect.

There were comprehensive personal and environmental risk assessments. Appropriate Infection control policies were followed.

There were very good staffing levels. There was a robust recruitment system in place.

Medicines were well managed and were delivered safely.

Is the service effective?

Good

The service was effective.

People's needs were fully assessed. People were given choice and the staff worked within the principles of the Mental Capacity Act 2005.

There was an extensive training programme for staff and they received regular supervision and appraisals.

People received good nutrition and hydration and were helped to maintain a healthy lifestyle.

The staff team included a GP, physiotherapists and an occupational therapist and there was ready access to other health care professionals as necessary.

Is the service caring?

Outstanding

The service was very caring.

There was a person-centred culture within the home and staff were very caring.

People were treated with compassion and kindness in all things.

The home excelled in helping people maintain or gain further independence.

Privacy and dignity was at the heart of the service. People were enabled to lead life the way they chose.

Is the service responsive?

Outstanding ☆

The service was very responsive.

Staff completed comprehensive, holistic assessments and person-centred care was central to all they did.

There was an extensive range of activities available which enhanced people's independence and wellbeing.

There was a robust complaints procedure for concerns

Is the service well-led?

Outstanding ☆

The service was very well-led.

There was a positive culture which was embedded in the home and the staff and management team were proud of the care they provided.

There was a robust system of audits and governance in place, enabling constant monitoring of the service and the maintenance of high standards.

Feedback was actively sought from people and relatives and they were actively involved in decisions about of the home.

There was an innovative approach with the management constantly striving to improve the service. There were close links with other organisations and within the community.

Chaseley

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 17 and 22 May 2018 and was unannounced. The inspection team consisted of three inspectors and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, including what they do well and improvements they plan to make. We also looked at other information we held about the service. This included previous notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we observed care and interactions between staff and people. We spoke with the chief executive, the registered manager, the HR Business Partner and six of the care staff. We also spoke with a physiotherapist, an activity co-ordinator and the chef. We spent time talking to nine people who lived at the home along with five relatives. Not everybody within the home was able to communicate with us. We therefore used the short observational framework for inspection (SOFI), which is a way of observing care. This helps us understand the experiences of people who are not able to talk to us. We reviewed their audit folders and read comments from their suggestion and comments books. We observed the lunchtime experience and witnessed the administration of medicines. We also reviewed a variety of records including four people's care records, four staff files and other records including audit documentation, accident and incident records and action plans.

Good

Is the service safe?

Our findings

People told us that they felt safe. One person stated, "It is the staff, they are always running around and this makes you feel safe." This feeling was echoed by other relatives and by the people within the home. One relative told us they had, "never had any worries, whatsoever" and that, "you can walk away and feel easy." Staff received safeguarding training. One staff member told us, "I would report any abuse, I know how to raise alerts." When any safe-guarding concerns were raised they were investigated thoroughly. The management told us that they sought advice and support from the safeguarding team regarding any potential issues and actively sought to reduce any risks. They discussed one example of how this communication had helped them manage a challenging situation and enabled a person to engage in positive risk taking.

Risk assessments were completed and regularly reviewed. Each person had individual risk assessments, which were relevant and specific to their needs. These assessments covered all areas, including moving and handling, falls, eating and drinking and bowel management. Appropriate tools were used as part of the assessments including the Waterlow score, which assesses the risk of developing pressure sores and the ETON score which assesses the risk of constipation. Where people had risks associated with their complex health needs, appropriate assessments were in place, for example, tracheostomy and seizure care. Some people chose to take risks and this was documented and the risk assessed. One person declined their lap belt in his wheelchair and although they had fallen from the chair previously, their decision was respected, and the risk assessed appropriately. Another person had wanted alcohol through their feeding tube. Once more this had been risk assessed, involving the appropriate health care professionals and the person's choice had been respected. Risks associated with different lifestyles were also explored, to enable people to form relationships and engage in activities, according to their personal preferences.

Personal emergency evacuation plans (PEEPs) had been completed and these gave details about how each person should be assisted in case of an emergency. There was a comprehensive method of ensuring all environmental risk assessments were completed. Emergency equipment was checked weekly and there were monthly fire drills. These were completed at different times of the day to ensure all staff were aware of what action to take during an emergency.

During our inspection call bells were answered promptly and there were sufficient members of staff to care for people. A relative commented that "All (the staff) have time for him", and told us that the proportion of staff to residents was good. They also stated that there are "always two people on the floor, which I think is amazing." Staff also felt they had enough time to care for people. The clinical nurse manager was not counted in the staff numbers and trained nurses were offered quality assurance days, enabling them to have time for reviewing care plans and for things like supervision. One staff member told us, "I have time for everyone." There were physiotherapists and an occupational therapist employed at the home and they also had an in-house GP. They worked closely with the care staff, attending handovers and contributing to the care planning. The management team were constantly reviewing staffing levels. They had invested in a system that helped identify how much time the staff spent with each person. This information was used to calculate dependency scores. This system had identified that one person required more support at night.

Using the data collected, the manager had applied for additional funding, and the person now received one to one care overnight. The response times to call bells were also analysed. This had led to staff being placed in specific areas during the night, to ensure that people were seen quickly, if they called out.

There was a thorough recruitment process for new staff. This involved a comprehensive interview. All potential staff, from kitchen staff to carers, were initially taken to the communal areas and shown around by some of the people, to assess how they interacted with the people within the home. The formal interview then included scenarios, which involved realistic but challenging situations, new staff may come across during their daily work, for example how they would communicate with people who are unable to talk or express themselves. The home also ensured their references were checked and ensured there were no restrictions to their being able to work in the country or within the care setting. Nurses also had their details checked to ensure they were registered with the Nursing and Midwifery Council (NMC). These checks were ongoing. When staff had supervision, they were asked if anything had changed which may affect their suitability to work within the care setting. The home also had a formal system to recheck every member of staff every three years. There were many volunteers working within the home. They went through a similar, thorough, vetting program.

People received their medicines at the correct time. There was an electronic recording system and medicines were delivered by the nurses. The electronic medication charts had been developed to send an alert to the staff if drugs were not given, so they could check if the medicine had been forgotten. It also identified if people were requiring more "as required" medicines than normal, so that the nurses could review the charts and decide if this was significant and warranted a medication review by the GP. The medicines were stored appropriately and there was a robust system in place for ordering and disposing of drugs. A medicine audit was completed daily and there was an external company reviewed the medicine management twice a year. We observed people being given their medicines, as prescribed, in an appropriate and sensitive manner. Individual choices were maintained. One person told us, "I have no issues with medication. I go home Tuesdays and staff give me my meds to take with me."

The home was clean and tidy. There were cleaning rotas in place and the home was deep cleaned monthly. One relative commented, "Cleaners there every day, day and night." The laundry had a method to ensure clean and dirty clothes were kept separate to reduce the risk of contamination. There were plentiful supplies of personal protective equipment (PPE), for example, gloves and aprons. There were regular audits for infection control and East Sussex County Council also audited the service on a yearly basis. The registered manager completed a weekly audit of any infection amongst the people within the home. This was used to quickly identify trends and was also used to minimise the spread of any infection.

The management team were constantly seeking ways of improving the care provided. This included analysis of any accidents and incidents within the home. Reviews included looking at the person, the place and the type of incident to enable trends to be identified. One person was found on the bedroom floor on a few occasions. It was identified that the person preferred sleeping on the floor. The room and furniture were modified to ensure the person's continued comfort and safety. After another incident each floor and the dining hall was supplied with special kits to use if a person choked. The home also investigated any pressure area damage, again looking for any trends and aiming to learn from any issues identified. All the incidents were discussed with the Board of Trustees and any lessons learnt were raised at the regular staff meetings.

Good

Is the service effective?

Our findings

People received effective care which was focused on the individual and their particular needs. The people and relatives were all very positive about the care received. One relative told us "Shame there are not more places like it," whilst another commented that "(Chaseley) outstrips anywhere." This feeling was supported by the staff, with one telling us, "I came here to work as I realised it was the best care home around." Every person had a comprehensive assessment which looked at the whole person. This included their physical, emotional and social needs, alongside their sexual and spiritual needs.

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 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 make 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 the care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that there was a system in place for applying for these authorisations and for ensuring the conditions were followed.

MCA training was mandatory and the staff had a good understanding of the MCA. One staff member stated, "I know all about the MCA." Each decision was recorded in the care plans and the decisions were specific to each activity. One person we reviewed, was not able to make any decisions independently. There were clear directives as to what was in their best interests, including what medical interventions were appropriate. These had been written with the person's family and the specialist palliative care team and were clearly documented. We saw people's choices being respected and consent being sought by the staff, throughout the day.

Staff received training and support to help them deliver safe and effective care. There was an induction programme for new members of staff and a probationary period. Due to the complexity of the people all staff received a very thorough moving and handling training programme. New staff members were not involved in supporting people to move until this had been completed. New care staff were enrolled on the care certificate. This outlines 15 standards for health and social care workers to follow. The care certificate is aimed at people who are new to a caring role and introduces them to the required skills and knowledge with the aim of promoting care which is compassionate, safe and of a high quality.

There was a programme of essential training for all staff, from the reception to the care staff. This covered a wide range of topics, including health and safety and infection control. There was also specific training for the nurses and carers to reflect the needs of people within the home. This included the use of specialist equipment and training on the specific diseases, for example, Parkinson's Disease and Multiple Sclerosis. Staff could demonstrate their knowledge about the different conditions. One member of staff could discuss a condition called Autonomic Dysreflexia, which is associated with spinal injuries, discussing its cause,

complications and the implications for people. Staff were encouraged to suggest topics to be included in the training schedule. Recently one staff member had suggested training on sepsis and this had been incorporated in the training programme. One member of staff confirmed this stating, "If I ever want any training they will make it available to me." After the care certificate the staff were encouraged to continue to learn and develop new skills. Courses included the "Passport for Care Excellence," and the Regulated Qualifications Framework qualifications (RQFs), previously known National Vocational Qualifications (NVQs), up to level 5. We asked the staff if the training and the different courses were helpful and changed their practice. One member of staff told us, "We are tested to know the answers" and could tell us how recent training had helped them consider and manage challenging behaviour. Staff also received regular supervision and appraisals. The physiotherapists received supervision from an external supervisor who had specialist insight into their role. The staff found supervision helpful and overall felt supported in their training needs.

People enjoyed the food and their nutritional needs were met. People had nutritional assessments, which were reviewed regularly and had care plans regarding eating and drinking. Some people were not able to eat orally and their nutritional needs were met with enteral feeding, which is the delivery of a person's nutrition via a feeding tube. Most people ate in the large dining area. Some people required assistance to eat. The staff helped these people, sitting next to them and going at the person's pace. The level of support and encouragement they gave was seen to depend on the person's needs. Mealtimes were seen to be a social occasion. At one table a person introduced us to their fellow diners, telling us, "These are my friends. We meet up every day." Menus were clearly displayed and people could choose their food when they entered the dining hall. People could help themselves to hot and cold drinks, from a well-stocked selection. Food looked appetising and there was a presentation guide for laying out the trays. The room had large round tables, which were height adjustable for wheelchairs and each table had table cloths and napkins. People could make requests or suggestions about the menu. Outside the dining hall was a comments book. In this book someone had written, "Almost every meal has been very good or more," whilst another comment stated, "Todays menu was really good, I enjoyed being able to see the food and pick what I wanted." The chef knew people's needs and preferences. The staff updated the chef if anyone's nutritional status changed or if they required a different diet. The chef told us how different people liked their food, showing their knowledge about the different people and their dietary needs. They stated, "One of the residents did not like the texture of the moulded puree so we went back to the normal way," referring to how the puree was presented. They also described how they added chilli to another's dinner because they preferred things hot. Sharing meals was also central to some of the activities within the home. On the week we were there they were planning a bar-be-que in the garden to celebrate the royal wedding and there was also mention of tea parties on the lawns. Snacks and drinks were available throughout the day in the bar area and we observed people sitting and chatting together, whilst eating ice lollies.

There was ready access to health care professionals. The home had a GP who they employed on a retainer basis. This meant that the GP, or their partners visited Chaseley from Monday to Friday and were also on call if the nurses wanted emergency guidance out of hours. This promoted continuity of care. However, people could keep their own GP, if they preferred. The regular staff also included physiotherapists and occupational therapists. The staff worked closely with other health care professionals, including the speech and language team, clinical nurse specialists and the palliative care team. One relative told us that "any physical needs immediately dealt with." We were also told that even if the person's condition changed, they felt reassured that the staff would respond quickly and would know what to do. One person told us, "If there is a crisis, they are magnificent" and another commented, "When (name) has a seizure in the home they are there immediately."

The staff were also seeking strategies to help people maintain their health and wellbeing. After recognising

that not everyone had access to the gym an exercise class was introduced. Similarly, relaxation classes were created. The role of diet in healthy living was also recognised and one relative commented favourably on a recent decision to offer calorie controlled snacks at the bar.

The home was adapted to suit the large number of people in wheelchairs. The corridors were wide and communal areas were designed to enable free movement of people, whilst retaining a comfortable feel. The flooring had been chosen to reduce noise. The garden was accessible to everybody and there were various rooms and areas for social activities including the bar, the conservatory and the arts room. An area of the bar had been made into an IT café so that people could use computers in a social environment, reducing isolation. There were simple strategies to help people orientate themselves around the home, including different colours on the different floors. People had been involved in choosing the décor. Bedrooms were selected with the individual in mind and each room had the specific hoist and equipment the person required.

Technology was used throughout the home to enhance the care. The call bell system incorporated lights outside the room. The light came on when someone was receiving personal care. This was colour coded for who the carer was, so others could find nurses if required. It also indicated people should not be disturbed. The system also enabled the analysis of interventions each person required. The prescription charts and care plans were electronic and sent reminders when activities were due, for example when a person's catheter was due to be changed. Electronic tablets were used to update when care was given whilst still at the bedside. People were also seen to be using computers and keeping in touch with emails. There was also specialist equipment throughout the home, including equipment in the gym, communication devices and specialist moving aids. If a new piece of equipment was introduced the staff received training on how it worked.

Outstanding ☆

Is the service caring?

Our findings

Throughout our visit people made extremely favourable comments about the home. One relative stated, "I don't think I can fault it," whilst another stated, "there is no other place like it." One person when asked about the home stated, "love it, I give them 10 out of 10," and another told us, unprompted, "This is the best home I've been in – and I've been in six." These comments were echoed by the staff who took pride in the care they provided. One staff member stated, "The care here is fantastic, it's a higher quality care." Another told us, "We're here for the residents and we're here to give them the best care. That's all that matters." The manager also reiterated these feelings, talking about the passion within the staff and their desire to "be the best."

All the people within the home were treated as individuals. The staff knew all the different people and adapted their approach to suit the person. One member of staff told us, "I know specifics about everybody, how they want to dress, what they want to do. Whether they want to be pampered or encouraged." Another mentioned, "Some people have specific routines…and that's fine, the same as they only want male staff, that's fine too." This attitude was observed throughout the inspection and we were told how certain staff were involved in different people's care, to reflect choice and lifestyle. This acknowledgement of differences was also seen in small gestures. One example was how staff greeted people differently. With some people it was a courteous greeting, whilst with others the same staff used a fist bump to say 'hello' as they walked past.

People were treated with high levels of kindness and compassion. One relative told us "It's all about the residents not about the staff…the residents come first." Another relative described the staff as "loving, in the right kind of way," whilst another described how they shared a joke with the people. They commented, "She's always smiling…they tease her. It's fun." They went on to describe the staff as "caring and humorous." We witnessed this caring attitude throughout the day. We observed one person being escorted in a lift. The carer carefully ensured the person's arms were secure and whilst the lift was moving, reassured them with a gentle, "Relax, relax." Another person had been identified as feeling lonely at night. We were told how they were helped out of their room so they could sit with the staff for company. This was one example of how the emotional and psychological wellbeing of people was central to the care provided.

Staff treated everyone with high levels of respect and dignity. The principles of equality and diversity were embedded in the service. One member of staff stated, "We have strong minded characters here, we would all challenge any type of discrimination." Another member of staff added, "People are entitled to live a private life." A relative agreed with these comments, telling us people had "complete freedom. All respected." We were told that those within the home who identified as lesbian, gay, bisexual or transgender (LGBT), were actively supported to live their lives according to their wishes, with sensitive and respectful support from members of staff. One person told us, "They are very cool about it." Posters about events aimed at different sections of society were clearly displayed on the notice boards. People were helped to attend these events, if they wanted. The accompanying staff were also selected to reflect the needs and preferences of the people. Similarly, people could follow their desired spiritual beliefs. The home had established links with a local church and those who wanted were helped to attend the weekly services. The home also had monthly

church services within the quiet lounge. The sense that all people were respected was seen in practice during our inspection and freedom of expression was central to the ethos of the home.

People were actively involved in all decision making. This ranged from small choices, which encouraged a sense of independence, to large choices about lifestyle. One member of staff told us "They (people) have choices for everything they do. Whatever they want we just follow." Another commented on specifics, telling us, "We style people's hair and help them choose their clothes, they've got free choice." Everyone was seen to be dressed in individual styles. One relative commented, "She's up and dressed, earrings in and hair done." Similarly, the bedrooms reflected the individual and people were seen to be helped to live unconventional lifestyles.

The home excelled in encouraging people to maintain and build their independence. One member of staff told us, "We are encouraging people all the time to do things for themselves." One example of this was an innovative approach to building independence at meal times. It was acknowledged that, on occasions, people may feel inhibited about feeding themselves, which could impact negatively on their developing independence. This was explored with people and following feedback and suggestions larger napkins were being used in the dining area, and staff wore larger aprons to protect their clothes. One staff member told us, "If they spill food, then so what? It's better they continue to feed themselves." There was also a specially adapted kitchen for those whose aim was to move away from the home. With support, one person was now able to write a shopping list, do the shopping and prepare and cook their own meal. It was felt their aim of leading an independent life was within reach. Similarly, another person's goal was to leave the home and lead an independent life. To help them achieve this goal they now had their own kitchen area within their room, including a toaster, kettle and microwave. The physiotherapy department and gym was also central to this. One physiotherapist told us, "We meet the rehabilitation needs of the residents. We support them to achieve their goals and increase their independence." We heard of one person who used the gym daily. When they had first arrived at the home they had been very reliant on the staff for all care. The person was now able to stand without assistance and the staff were helping the person take steps toward their goal, which was to live independently. One physiotherapist also commented on how the gym was also used as a way of releasing negative emotions. They told us, "People progress with us, not just physically but behaviourally as well." This impact on behaviour was noted by one of the relatives, "(person's name) is so much calmer now." This once more demonstrates how staff recognised the psychological and emotional needs of the person and the impact this can have on a person's recovery and wellbeing.

The care of the individual extended to their families and friends. Relatives and visitors were made to feel welcome. One relative commented, "I'm always welcomed." Another told us of the private dinners they shared with their spouse and how they continued to entertain their family by inviting them into the home. This was echoed by another relative who told us, "My husband and daughter come for lunch, staff set up a table in the conservatory so we can have a lovely family dinner." Another person had a young family. They had one of the larger rooms with a play area full of toys and activities so the child felt welcomed when they visited. Personal relationships were also enabled with examples being given of how intimate relationships were developed and maintained. One person liked an active night life. Their friends could stay over at the home so they could go to a nightclub together. This person also liked to travel by train when visiting relatives, to preserve a sense of independence. This was supported and enabled by the staff. We were also told of another person who was accompanied regularly by a member of staff when they went out in the evening, to ensure continued safety whilst respecting the person's right to lead the life they wanted. This again demonstrates that the staff recognised people as individuals and acknowledged the need for an intimate and social life. Some of these people had extensive physical needs but the staff proactively sought ways of providing individualised and holistic care.

People's privacy was respected. The call bell system indicated when people were receiving personal care and helped maintain privacy and dignity. One carer told us, "I always make sure that the curtains are closed, doors are shut and people covered when doing personal care. You would always knock, never just walk in." This was seen in practice, with bedroom doors being shut and all personal care being given in private. One room had a "do not disturb" sign on the door, as the person did not like his personal things touched or disturbed. This need for private space was acknowledged by the staff and their wishes were respected.

Outstanding ☆

Is the service responsive?

Our findings

The care people received was highly individual. There was a thorough assessment of people's needs prior to admission. Staff described how they familiarised themselves with the needs of the different people prior to their arrival. One told us, "We provide the care people need, we learn so much about them." There were comprehensive care plans in place, covering all aspects of care each person required, including their physical, psychological, social and spiritual needs. These were reviewed and updated regularly. One member of staff stated, "I've read the care plan and anything out of the ordinary gets updated and we discuss it." Many people had highly complex care needs and care plans about a person's physical needs were very detailed. One example of clear documentation was the mobility care plans for those who needed all care. These included careful descriptions of how each person should be aided, with photos to illustrate how people should be supported in different positions. Similarly, there were photos demonstrating how each person should be helped with their regular exercises. The number of repetitions and frequency of these exercises were clearly documented. The photos were taken by the physiotherapists and were an example of multi-disciplinary working. Another care plan for a person, with highly complex needs, guided staff on the care and equipment required to enable the person to access the community safely. These listed steps to be taken if there is an emergency whilst outside and a list of the equipment they needed to have with them. This person had one to one care, throughout the day and night. Taking them outside required planning and time, but was seen as crucial to their continued wellbeing and, as such, was an integral part of their care plan.

The care plans also included detailed information about people's personal preferences and these were clearly recorded and acted upon. One person had seven preferred activities ranging from going out in nice weather to doing crosswords. People's preferred routines included the time they liked to get up, their preferred time for personal care and bedtime and what activities they liked to do and when. These preferences were respected. If a visiting health care professional arrived before the time the person liked to be up and ready in the morning, they were asked to either reschedule or to wait, as the needs of the person was given priority.

The home had a huge number of organised activities. People engaged in activities that were appropriate to their needs and based on their preferences and abilities. One member of staff stated, "People are never bored here, there is always something going on for everyone." There was a dedicated group of activity co-coordinators who actively sought ways of engaging with all the people within the home. One member of staff had a degree in glass and ceramics and used their experience in innovative ways to engage and assist different people in producing pieces of art or ceramics, according to their individual abilities. There was an art room with extensive equipment available. We saw examples of the art work the people were working on. These were often given as personalised gifts to family members. There was a corridor displaying people's paintings and we were told how they had recently displayed their work at a local exhibition on the pier. Some of the paintings had been sold following this exhibition. We were similarly told about a choir made up of people within the home. This was led by a voice coach, with the aim of strengthening people's voices and confidence.

The activity lead gave us specific examples of how activities were used to improve people's wellbeing and enhance their quality of life. One of them told us how they overcame one person's increasing reluctance to join in group activities. The person's dexterity had deteriorated, affecting their ability to do the things they had previously enjoyed. It was identified that this was affecting the person's emotional well-being with them becoming more withdrawn and spending more time alone. The activity team had sought ways to address this, involving the person in identifying ways to overcome the new challenges. They bought special equipment and adapted the activity so that it involved things the person was familiar with. With patience and perseverance, the person had regained their confidence, initially just watching the activity, then feeling able to re-join the group. The activity lead also gave another example. Once more a person had initially been reluctant to participate in group activities. At that time there had been a group making wheelbarrows. When the person's family asked to buy a wheelbarrow, they had joined in with enthusiasm. It was felt that the family purchasing the wheel barrow had added meaning to the activity.

People were encouraged in activities which gave them a sense of self-worth and responsibility. Different people had different jobs within the home. One person delivered the post, whilst another had become the librarian. We were told how one was helped to make cakes for when their family visited. This was felt to be important as it helped establish and maintain roles within the family. This was described as a way of linking with their past but also promoting a sense of self-worth and independence. Another person had previously worked within a garden centre. They were now involved in the gardening club and the sights and smells of the garden were described as helping them recall memories from their past. As this person had difficulty remembering things there was a memory wall in their room, with photos of them enjoying themselves whilst gardening, to act as a visual reminder. Another person had similarly loved the garden. The gardening tools were now left out for them to use at any time. It was noted that when their visitors arrived, they had all gone into the garden and spent time gardening together. The herbs grown in the garden were used in the food, again promoting a sense that people were contributing to the home and giving meaning to the activities.

The kitchen garden was in the process of being redesigned. A professional garden designer had been employed with the brief to involve the people and to make the garden accessible to all. Local community volunteers had cleared the flower beds of weeds and the home had tapped into charitable donations by becoming one of the nominated charities for the local Tesco. The plan included the formation of a sensory garden, with an emphasis on touch and smell. This acknowledged that for some people within the home touch and smell were their primary senses.

The activity co-ordinators organised regular trips in and around Eastbourne, including to the bandstand on the sea front and to the theatre. They also arranged for different organisations to visit, for example, the mobile library, a clothes shop and Pet Pals where different animals were brought in. They also hosted different events when family and friends were made welcome. They had an events calendar which included tea parties, creating and performing a pantomime, hosting other local care homes during the annual Eastbourne Airbourne event, and participating in the local carnival. After the carnival one visitor commented on the effort involved in their entry. They stated, "A lot of time had been invested by both residents and staff," and referred to the props on the wheelchairs and large displays which were carried. The home won the award for the best walking entry and the observer reflected how the home was "dedicated to helping and supporting their residents to live life to the full." The home held a monthly disco for people with physical disabilities, which was open to anyone from the local area. This was originally held in another location within the town. However, one of the people who lived in the home had reported a difficult evening, as the location did not have a bathroom to suit their needs. As a consequence, the home had offered to host the disco and it had now become a regular feature in the social calendar.

Some of the people were less able to participate in planned activities. The activity co-ordinators actively

sought ways of involving them with activities suited to different abilities. Some examples were seat based yoga and the relaxation class. The people with the most profound needs were also brought into activities, as once more it was felt to be beneficial to their wellbeing. Some of the facilities were dependent on funding, for example, access to the physiotherapists and gym. Following interest from other people an exercise class had been established to give them access to a regular exercise regime. The activity lead also explained how they tried to involve everyone in different celebrations. They described how they were arranging a choir for Christmas, describing how they would go to every floor so those with more complex needs "can experience Christmas."

People had regular meetings with the multi-disciplinary team. These meeting were attended by the person, relevant health care professionals and the person's family, according to the person's wishes or needs. These meetings had a dedicated time to discuss progress and to set goals for the future. Action plans were made after each meeting and options explored. Some of the goals were ambitious and called for the staff to think about alternative strategies to help the person. One person wanted to lead an independent life. The home was proactively seeking extra funding with the aim to access hydrotherapy as it was thought this would help them achieve their goal. Another person was keen to access physiotherapy, which was not included in their funding arrangements with the local authority. Due to the person's history the home had applied to an alternative source for this funding, demonstrating that they considered all options. After a meeting to discuss the needs of a person, one health care professional documented, "In this case (the home) is going above and beyond what would normally be expected."

Some people within the home had very limited communication. The staff were aware of how each person communicated and used different strategies and aids to help people communicate their needs and preferences. The home referred people to a specialist communication service. This enabled them to access specialist support and equipment. We observed people talking with the aid of iPads and voice activated alphabet devices and another using an alphabet coloured pad. We observed a person and carer exchanging a joke with these devices and choosing their own music with just a pressure pad. One person could manage their own emails using a system controlled with a sensor and eye movements. Some people were not able to use these devices but the staff were still aware of how they expressed their needs. One carer told us, "One person communicates with blinks and nods of the head. It takes time to understand them, but now it's second nature." Assessing the small changes also helped staff maintain people's comfort. Another member of staff explained, "When one lady is poorly, she keeps her eyes closed. I notice her expressions and can see if she is unhappy."

Concerns and complaints were dealt with quickly and effectively. One person had complained about a specific item on the menu. The Chef Manager went to the person's room to talk this through with the person. Another concern about the food had been reviewed and resolved with the help of the chef, the dining room host and the care staff. There was open communication between the staff and the people within the home. One relative told us, "I can see anyone at any time." Most concerns were addressed without it becoming a formal complaint. We were told by one relative how they felt the person was overwhelmed if asked too many questions at once. They had raised this with the staff and their concerns had been acted upon. Another told us they had asked the staff to increase their relative's involvement in activities. This had again been acted upon.

All staff were trained on end of life care and the home had close links with the local hospice. We read cards from bereaved relatives thanking the staff for all they had done as their loved ones approached the end of their life. People's wishes were explored when they first came to the home and it was noted if they wanted any particularly social, cultural or religious practices to be observed. One person had very complex needs. There was clear and specific guidance about the medical care they should receive. These advance decisions

had been written with the relatives and the hospice team and were based on best interest decisions.

Outstanding ☆

Is the service well-led?

Our findings

The people and relatives we spoke to all told us that the home was very well led. One person told us it was, "The best home I've lived in – the best by far." This was echoed by visiting health care professionals, with one documenting, "Chaseley is a very well-run establishment, which provides excellent care."

There was an exceptionally strong management team in place. This included the Registered Manager and Chief Executive. They referred to the inspection in 2014, which had happened before their time. This had identified significant concerns around the care being delivered. The Chief Executive told us how they had reviewed the whole service, when they had first joined the home and decided, "everything needed to change." They told us how they had prioritised their list, starting with the things that had the biggest impact on people. This resulted in the home achieving an overall rating of good in 2016. Since that time they had continued to review and develop the service, with the aim of both sustaining and building upon their achievement, with people at the heart of everything they did. This drive and commitment to continued improvement was recognised by the people and the visitors to the home. One relative told us, "(The Chief Executive) is like a new broom. I applaud her." They had also been shortlisted for the "Management Team of the Year Award" in the 2017 Caring UK Awards. This is a national event recognising excellence throughout the care industry. The website states the awards were "created to highlight and pay tribute to the care home teams making an outstanding contribution to caring."

We asked people and the relatives about the management style within the home. One relative told us, "I can see anyone at any time," going on to say they were "always approachable." Another relative told us that the management team were also both accessible and responsive telling us they "do listen." These comments were supported by staff with one stating, "The management are very caring, very open, there is an open-door policy here." This availability was very important to the management team. They had relocated their offices to be near the entrance and designed them to fit wheelchairs. They discussed their open-door policy. We were given an example of how one person woke up early. They regularly came down to see the Chief Executive, who made coffee for them to share in their office. This regular time together helped them develop a close relationship. It also gave the manager valuable insight into what was working well, as well as any potential issues or concerns affecting the people within the home.

The vision statement was clearly displayed throughout the home and was seen to be embedded in the culture. The managers explained how new staff were carefully selected with the aim of employing staff who shared this vision. This had led to the people within the home taking an active part in the selection process, with their feedback being sought after they had shown the new recruits round. When new members of staff were employed their photographs were taken and were displayed on notice boards and shown to the people at the residents meeting. We were told that people liked spotting the new staff members playing "new staff bingo." Another way the managers established a shared vision within the home was by ensuring all new staff spent an induction day with the management team. During this day they aimed to develop an open relationship with the new member of staff and they spent time discussing the values of the home. All new staff were assessed throughout their probationary period and we saw evidence that anyone who was not performing well, or who did not share their values or work well within the team, did not have their

contracts extended. Once more the views of people in the home were central to this process. One person told us, "Say a new starter (staff) supports me and they are good, I go to the office and tell them how good they were." The management team developed relationships with their staff and actively sought to allocate staff according to the needs and preferences of people within the home. Their recruitment document states, "We… place staff to work on a floor which is the best suited to their personality, experiences and team fit, as our staffing floors vary in line with the Residents."

The management team were aware of the benefits of a stable and happy workforce and were actively seeking ways to improve staff retention. They listed some initiatives including fixed rotas and flexible hours, Christmas bonuses and Easter eggs. On the recent "Nurse's Day" they had arranged for all the trained nurses to receive a thank you card, from the people within the home, along with a badge, in recognition of all they did. These strategies were having a positive effect on staff morale and retention and the staff we spoke to told us they were very happy in their work. If staff did leave, they had an exit interview. The results were audited to see if there were things that could be done differently to encourage future staff to stay.

The staff told us they felt able to discuss any concerns with the management. They told us the managers listened and took their concerns seriously. One staff member told us, "If I've ever had a problem they are all ears." Another told us, "They always help us, I can't say anything bad about them," with a third commenting, "The Managers are great, they always support us."

The staff discussed working closely within a team, to get the best outcome for people. One member of staff stated," We are a very good team. We help each other and we get on well," a thought echoed by one of their colleagues, who commented, "One of the great things here is how well we all work together." The relatives expressed trust in the staff, with one telling us they "never had any worries whatsoever," and another describing the staff as "excellent." Another went on to say, the staff have a "Hugely difficult job which they are doing splendidly."

The management actively sought suggestions for how things could be improved within the home. Some people were more vocal and there were meetings and forums for them to express their views and make suggestions. One example was the food forum. At a recent food forum people had tried different sausages. Their favourite was then selected for the menu. Resident meeting were also held monthly. People had decided, as a group, that they did not want relatives to be present at these meetings. This decision was being respected. People had also formed a resident's committee, which was facilitated by the activities team. There were suggestion boxes and comment books throughout the home. People's opinions were also sought on specific issues. A recent survey had revealed the benefit that those people, who had access to the gym, gained from the facility. In the survey people had requested longer opening hours. The management had reviewed the survey results and had changed staff hours, enabling the gym to be open daily. People were actively involved in decisions throughout the home, from helping suggest new activities, to choosing the décor and planning the new garden layout.

However, there were a significant number of people who were not able to attend or contribute to meetings or write suggestions in comments books. Staff were aware of this and actively sought suggestions and views outside of the resident meetings and forums. There were regular multi-disciplinary meetings for all the people. Family members, or representatives, were invited to attend and contribute to these meetings. At the end of every multi-disciplinary meeting the staff checked if the people were happy with the food and their room and asked for suggestions on how to improve things. This ensured that even the less vocal people could express their opinions and give feedback. It also acknowledged the importance of obtaining the views of family members. Similarly, the management were devising a questionnaire to be sent to all relatives. This once more acknowledged that not all the people within the home were able to join meetings, or make their

thoughts known and their relatives were often their representatives within the home.

Staff meetings were held regularly and were inclusive. The same agenda was discussed at different times of the month, to ensure all staff could attend. Night staff were paid to attend. Staff were encouraged to contribute to the agenda and it covered different topics, including learning from incidents or complaints and the analysis of any trends identified by the ongoing audits.

The staff were actively encouraged to make suggestions and develop leadership skills. The care co-ordinator had devised a peer led training and mentoring system, which had been embraced by the management. It had initially been for new staff but had been rolled out to everyone to ensure that, "people's skills remain fresh. "We were told, "It keeps us working at a good level and improving as we don't get stuck in our ways." The new system incorporated a practical skills assessment. This was person specific, with the staff member telling us, "this makes sure that we have the right skills for people's specific and complex needs." When the changes were implemented feedback on the new system had been sought from the different people and relatives.

There was an extremely comprehensive audit process. There were quarterly meetings with the Trustees and comprehensive quality assurance tools were in place to ensure that policies were adhered to and procedures followed. The compliance monitoring tool was electronic so that it could be accessed and used by everyone. There were audits in place for all aspects of the home. This ranged from audits checking the receptionists were greeting and welcoming visitors appropriately and to large annual audits reviewing things like environmental hazards; including checking the information was current, storage was appropriate and all staff were aware of risks. There was a schedule for the audits and reviews to ensure they were all completed regularly. The data collected was also reviewed with the aim of identifying any trends and enabling continued improvements within the home. The management team also completed spot checks, including night time visits, to ensure that high standards were maintained throughout the day and night. Through these systems of checks and asking for feedback from staff, the management had identified that the care plans required some further improvements. They had arranged a meeting with the company who had created the system so they could feedback their concerns and suggestions. They were also investigating if a bespoke system would be more helpful in capturing the complex needs of the people in their care.

The home had become part of the local community. They participated in numerous community events, for example, the carnival and local art exhibitions. They also had numerous fund-raising events, which raised their profile within the local community and was helping them fund the re-design of the garden. They had a good relationship with the local authority. They described how they had been approached by the town council. The council had wanted feedback from wheelchair users. People from the home had consequently helped review the town's pavements and made comments on how accessible the town was for wheel chair users. The home had also established close links with other nursing homes within the area and visited other homes to network and share ideas. They also invited other homes to visit them, both to network and to engage in social events. One example was the annual Airbourne event, where they hosted people from other homes, enabling them to enjoy the views and atmosphere of their seafront position.

The home constantly sought to increase their knowledge and use this to drive improvements. They subscribed to care magazines and were aware of recent updates and legislative changes, for example the new data protection laws and the new guidelines for the management of dysphagia. When these legislative changes had been made they had arranged teaching sessions for all the staff affected. They were determined to remain up to date and experts in their field and gave us some examples. The Chief Executive and five nurses had recently attended a conference on acquired brain injuries. The Chief Executive had also attended a conference on the neuro-functional approach, for achieving positive outcome, in everyday life

after a brain injury. The management team had established links with Brighton University and attended updates on infection control, which focused on prevention and management within the care home setting.

The management team were aware of their responsibility to inform the Care Quality Commission (the CQC) of any important events within the service. They had informed the CQC of notifiable events in a timely and appropriate fashion. They also adhered to the principles of openness and transparency, as laid out in the Duty of Candour. This regulation provides a set of guidelines which providers must follow if things go wrong with care and treatment. The management team were very familiar with all the regulations and based the running of the home on the principles laid out by the CQC.