NABS

Peterhouse

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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Peterhouse provides nursing and personal care for up to 39 people who were living with a range of health care needs. This included people who live with a stroke, diabetes and Parkinson's disease. Some people had a degree of memory loss associated with their age and physical health conditions. Most people required help and support from two members of staff in relation to their mobility and personal care needs.

Accommodation is provided over two floors with a lift that provided level access to all parts of the home. People spoke well of the home and relatives confirmed they felt confident leaving their loved ones in the care of staff at Peterhouse.

There is a registered manager at the home. 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.

We inspected Peterhouse on 6, 7 and 11 October 2016. This was an unannounced inspection which meant the provider and staff did not know we were coming. There were 34 people living at Peterhouse during the inspection process.

Quality assurance systems were in place but had not identified the shortfalls found in care documentation and record keeping. Whilst people's medicines were stored safely and in line with legal regulations, people did not always receive their medicines as prescribed. There were also missing signatures for medicines. These had not been followed up to ensure that people had received their prescribed medicines. We also found poor recording and lack of directives of topical creams and 'as required' medication for pain relief. There were some inconsistencies in the completion of fluid charts and in diabetic guidance for staff to follow. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff but we asked that advice was sought from the fire service in respect of night evacuation plans.

Staff knew people well, they were kind and caring and treated people with respect. They had a good understanding of their care needs and individual choices.

Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the manager understood when an application should be made and how to submit one.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests.

Accidents and incidents were recorded appropriately and steps taken by the home to minimise the risk of similar events happening in the future. Risks associated with the environment and equipment had been

identified and managed.

Staff had received essential training and there were opportunities for additional training specific to the needs of the service, such as diabetes, catheter care and dementia. Staff had received both one to one and group supervision meetings with their manager, and formal personal development plans, such as annual appraisals were in place.

Staff knew how to safeguard people from the risk of abuse. Risk assessments were in place and staff had a good understanding of the risks associated with the people they cared for. There were enough staff in place, who had been appropriately recruited, to meet the needs of people.

People were encouraged and supported to eat and drink well. One person said, "The food is good, always tasty and looks nice." There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. People's special dietary requirements were met. People's weight was monitored, with their permission and advice sought as required. Health care was accessible for people and appointments were made for regular check-ups as needed.

People could choose how to spend their day and they took part in activities in the home when they wanted to. People themselves told us they enjoyed the activities, which included singing, puzzles and films. People were encouraged to stay in touch with their families and receive visitors.

People felt well looked after and supported, and were encouraged to be as independent as possible. We observed friendly and genuine relationships had developed between people and staff. One person told us, "They treat you well here." One person told us the staff supported them with their hair and make-up and it made them feel 'good'.

People were encouraged to express their views and completed surveys, and feedback received showed people were satisfied overall, and felt staff were friendly and helpful. People also said they felt listened to and any concerns or issues they raised were addressed. One person said, "If there is anything wrong, I tell the staff."

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Peterhouse was safe.
There were systems in place for the management of medicines.

Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it. Visitors were confident that their loved ones were safe and supported by the staff.

There were systems in place to make sure risks were assessed and measures put in place where possible to reduce or eliminate risks.
Comprehensive staff recruitment procedures were followed.

There were enough staff to meet people's individual needs. Staffing arrangements were flexible to provide additional cover when needed, for example during staff sickness or when people's needs increased.

Is the service effective?

Good

Peterhouse was effective.

Mental Capacity Act 2005 (MCA) assessments were completed routinely as required and in line with legal requirements.

People were given choice about what they wanted to eat and drink and were supported to stay healthy.

People had access to health care professionals for regular check-ups as needed.

Staff had undertaken essential training and had formal personal development plans, such as one to one supervision.

Is the service caring?

Good

Peterhouse was caring.

The ethos of the home was to enable people to live their life to the maximum every day and this is what we observed.

Staff knew people well. They had developed open and caring relationships with them.

People's privacy and dignity were respected.

People were supported to make day to day decisions about how to spend their time.

Is the service responsive?

Good

Peterhouse was responsive.

People had access to the complaints procedure. They were able to tell us who they would talk to if they had any worries or concerns.

People were involved in making decisions with support from their relatives or best interest meetings were organised for people who were not able to make informed choices.

People received care which was personalised to reflect their needs, wishes and aspirations. Care records showed that a detailed assessment had taken place and that people were involved in the initial drawing up of their care plan.

The opportunity for social activity and outings was available should people wish to participate.

Is the service well-led?

Requires Improvement

Peterhouse was not consistently well-led.

There were systems in place for monitoring the management and quality of the home but these did not identify some of the shortfalls we found in relation to record keeping.

The registered manager and director of operations took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure.

There were systems in place to capture the views of people and staff and it was evident that care was based on people's individual needs and wishes.

Peterhouse

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 was an unannounced inspection on 6, 7 and 11October 2016. It was undertaken by one inspector.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included eight staff files including staff recruitment. Training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises. 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 looked at four care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with eleven people who lived at the home, two relatives, and twelve staff members including the owner and directors. We spoke with a visiting healthcare professional during the inspection and a further three healthcare professionals following the inspection.

We met with people who lived at Peterhouse; we observed the care which was delivered in communal areas

to get a view of care and support provided across all areas. This included the lunchtime and evening meals. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us they felt safe living at Peterhouse. One person told us "I lived in a flat but came here because I wasn't safe to live on my own. I feel very safe here." Another person told us how staff looked after them safely, "I became unable to walk on my own, staff move me safely." People told us they received their medicines when they needed them and there were enough staff to keep them safe. One person said, "Plenty of staff, when you need them they are there." A visitor said, "I fully trust the staff to keep my mother safe. They are marvellous."

Whilst the provider had arrangements in place for the management of medicines, we found the administration and recording of medicines were potentially unsafe. This placed people at risk of not receiving their prescribed medicines. For example, one person's pain medication had not been given as prescribed and was two days late. This had not ensured that the person's pain and discomfort was managed in a safe way. There was no explanation documented as to why this had not been given and no alternative pain relief offered.

We found a number of staff signature omissions (identified as gaps) in medication administration records (MAR). For example on three different days on the ground floor there were in excess of 12 signature gaps. These gaps had not been identified by the nurse administering medicine on the next shift, and had not been followed up to determine whether it was a missed signature or a missed dose. There was no explanation recorded on the MAR as to why the medicines had not been administered. Staff had not followed the home's medicine policy with regard to medicines given 'as required' (PRN), such as paracetamol. Records had not always been completed with details of why they had been given or how many had been given. We also noted that there was a lack of directives as to when PRN medicines should be administered. For example pain charts used to assess pain and to monitor the effectiveness of the medicines. It was also a concern that when asked staff were not always aware of the origin of the persons' pain and therefore had no insight in how to use pain relief medicines effectively, for example given before movement or before dressing wounds.

Topical creams were not consistently signed as being administered as prescribed. On discussion we were told that the care staff member who delivers personal care should sign that the cream had been applied. This had not always happened which meant that we could not be assured that people received their prescribed medicines. Immediate action was taken by the management team to investigate why the weekly and monthly audits had not identified the errors. We received an action plan to address medicine practices within 24 hours. The action plan included further training from the pharmacy provider, spot competency checks on staff administrating medicines and daily audits on MAR sheets.

The organisation had emergency evacuation plans in place which included individual personal emergency evacuation plans (PEEP's) for each person. However the plans reflected only the daytime staffing numbers and did not reflect the reduced staffing levels at night. The PEEPs also identified that certain people would need to staff to move them with a hoist (a hoist is a machine that is used to people who are unable to move independently). This would not be achievable with the number of staff on duty. The staff on duty also had a responsibility to ensure the people in the adjoining supported living flats were moved to a place of safety as

they share the communal areas. This was fully discussed and plans were made to review the night evacuation plans immediately.

Systems were in place to monitor the health and safety of people, visitors and staff. The home was clean and tidy throughout and was well maintained. Regular environmental and health and safety risk assessments and checks had been completed for example a fire safety checks and call bell tests. There were regular servicing contracts in place for example electricity, gas, stair lifts and hoists. Where maintenance issues were identified actions were taken promptly, smaller maintenance issues were recorded in the maintenance book and dated when done.

We observed medicines being given before lunch and again before supper; these were given safely and correctly as prescribed. Medicines were stored and disposed of safely.

Risk assessments were in place specific to people's individual needs and included guidance to ensure staff provided appropriate care and support. These included pressure areas, nutrition, falls and mobility plus those related to people's individual assessed needs. Where appropriate equipment such as pressure relieving air mattresses, hoists and mobility aids were used to support people. These were identified in the risk assessments and care plans. For example the care plans and risk assessments for people identified at risk of developing pressure sores informed staff what they should do to prevent pressure sores developing. This included the use of a pressure relieving air mattresses, what the correct setting was for this and regular position changes. A number of people were unable to mobilise independently and required support from staff. Risk assessments included information about how to provide appropriate support and if any equipment was required. Where people required the use of a hoist there was information about the correct size of sling and many staff were required to ensure people were looked after safely.

Staff had a good understanding of their responsibilities in relation to safeguarding people from abuse. They were able to tell us about different types of abuse and what actions they would take if they believed someone was at risk. Staff told us in the first instance they would report to the most senior person on duty. One staff member said, "You can go to anybody here, they will always sort things." Another staff member said, "I report straight away, we don't stand for that sort of thing around here." Staff were aware that safeguarding concerns should be reported to the local authority safeguarding team. One staff member told us, "I have had to do that in a previous job, I would always make sure people were protected." Staff told us they were able to share any concerns they may have in confidence and know the appropriate action would be taken.

Staff recruitment records showed appropriate checks were undertaken before staff began work. This ensured as far as possible only suitable people worked at the home. Files showed there was appropriate recruitment and appointment information. This included a full employment history, interview notes, references and police checks. Nursing and Midwifery Council PIN checks for registered nurses had been recorded and demonstrated they had the appropriate qualifications for their job.

There were enough skilled, experienced and suitably qualified staff working at the home. We observed staff providing care in a calm unhurried manner. Staff were seen sitting and talking to people and had time to spend with people whilst doing their day to day work. Call bells were answered in a timely manner, one person said "I seldom have to use the call button; because staff are always around." In addition to the nurses and care staff there were housekeeping, administrators, kitchen staff and maintenance staff on each weekday. The rotas confirmed staffing levels were consistent with two nurses each shift, eight care staff in the morning and six in the afternoon. Staff we spoke with told us there were enough staff to meet people's needs and allow staff to spend time with people. There was no formal dependency tool in place to assess

staffing levels based on people's needs. However, staff told us staffing levels were constantly discussed and as a result care staffing levels had been increased with an extra care worker working each afternoon. Minutes from a recent staff meeting showed this had been discussed with staff and was seen to be an improvement.

Good

Is the service effective?

Our findings

Staff had the knowledge and skills to look after people and people told us they were well looked after. A visitor told us staff were good at their job. People said they were supported to attend health care appointments and were able to see the doctor when they needed to. Everybody we spoke with told us the food was good. One person said it was, "A bit too nice," as they had put on weight. Someone else told us, "We can have a drink whenever we want."

The staff we spoke with understood the principles of the Mental Capacity Act (MCA) and gave us examples of how they would follow appropriate procedures in practice. There were also procedures in place to access professional assistance, should an assessment of capacity be required. Staff undertook a basic mental capacity assessment on people admitted to the home and this was then regularly reviewed. Staff were aware any decisions made for people who lacked capacity had to be in their best interests. We saw evidence in individual files that best interest meetings had been held. During the inspection we heard staff ask people for their consent and agreement to care. For example we heard the staff say, "Shall I help you

The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. There were DoLS checklists in place for each resident so that applications could be made as necessary. At the time of the inspection, there were no active DoLS applications. Assessments were in place, for example for people who required bed rails but these did not always include the reason these were needed. Although decisions had been discussed with people's relatives there was no evidence of any best interest meetings having taken place to determine whether other less restrictive options had been considered. We raised these as areas for improvement.

We observed staff asking people's consent prior to offering any support throughout the inspection.

People received care from staff who had knowledge and skills to look after them. Staff told us they received regular training and updates and we saw certificates were in place in staff files. These included moving and handling, dementia awareness, infection control and safeguarding. These were updated annually and there was a training plan in place to show when staff had received training. We saw further training was booked throughout the year and this included mental capacity and DoLS. The nurses told us about training they received to support and update their clinical skills, for example one nurse said they were to receive further training in relation to end of life care. They also received training specific to people's individual needs from other professionals who visited the home for example the tissue viability team. Care staff told us they were supported by the nurses to provide care for people with more complex health needs.

The nurses had a good understanding of what was current best practice for example in relation to wound care. Where appropriate best practice information was stored in people's individual care plans to provide guidance for all staff.

There was an induction programme in place for staff who started work at the home which included information about the home, policies which were signed when read and the day to day running of the home. Staff then spent some time shadowing other staff until they were confident and moving and handling competencies had been completed. Staff told us there was always other staff available to support them when they needed it. The Training Manager was currently developing an induction programme for new care staff based on the care certificate, in conjunction with senior managers. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff received regular supervision and appraisal. This included one to one and group supervision. Staff were able to identify areas where they required more support or any discuss concerns. Group supervisions included elements of training and updates for example a recent group supervision had discussed social activities for people who lived at the home. Staff told us although they received regular supervision they could approach and senior staff to discuss concerns or training needs at any time. Comments included, "We don't have to wait until supervision, we can discuss things at any time."

People were supported to maintain a balanced and nutritious diet. Records confirmed that people had their nutritional needs assessed and when risks were identified these were reflected within care documentation. There was information about the type of diet people needed, how this was presented for example one person liked to have finger foods and others required support to eat their meals. People were weighed monthly so staff could identify anybody who was at risk of weight loss or malnutrition. All staff had a good understanding of people's dietary needs and choices. Information was recorded in care plans and in the kitchen and was accessible to all staff for reference.

There was a choice of two dining room's at the home. People chose where they wanted to eat their meals and we saw some people remained within their friendship groups. Some people chose to eat in the dining areas and others remained in their bedrooms. People told us, "Lunch is a social occasion, I meet my friends." People were provided with a choice of freshly cooked meals each day, this included a cooked breakfast if people wished. There was a set meal at lunch time or people could choose alternatives if they preferred. We saw people eating a variety of meals of their choice each day. One person said, "There's always something to tempt you." Where people needed support this was provided appropriately. We observed staff sitting on chairs and maintaining eye contact with people. They spoke softly and asked if they would like more food or offered alternative choices. People told us they enjoyed the food one person said, "It's lovely, I don't think you will get any criticism from anyone."

Hot and cold drinks were served regularly throughout the day however people could have a drink whenever they chose. There were tea and coffee making facilities in the reception area where people and visitors were able to help themselves. Staff were regularly heard asking people if they, "wanted a cup of tea or coffee." One person said, "My friends comes in and visits and can eat with me."

People were supported to have access to healthcare services and maintain good health. People's physical and mental health and wellbeing was monitored on a daily and staff were pro-active in identifying when people were unwell or required medical attention. Information in the care files demonstrated other external healthcare professionals were involved in supporting people to maintain their health. This included GP's, dieticians, physiotherapists and tissue viability nurses.
This meant people received healthcare from the appropriate professionals. Staff told us how they supported people who were able to attend their healthcare appointments. Regular health professionals visited the home including the chiropodist, dentist, and optician. People were able to use these services if they chose

to. Visiting healthcare professionals we spoke with told us staff referred people to them appropriately.

Good

Is the service caring?

Our findings

People told us that staff were kind and compassionate and gave examples including how they helped them, spoke to them kindly and took time to support them. We saw staff were kind, caring and respectful. One person said about staff, "The staff are excellent, nothing is too much trouble." Visitors told us staff supported them, as well as their relative who lived at the home. One relative said, "I cannot speak more highly of the staff here, they listen and they genuinely care." Another relative said, "They're friendly, accommodating and very approachable." Staff repeatedly told us, "We treat people how we would like to be treated ourselves or our family."

Staff told us the ethos of the home was that this was people's home where they could live their life to the maximum every day. The director and registered manager told us it was important that people were able to live as 'normal' life as possible at the home. We observed these maxims were embedded into the day to day life, care and support at the home and upheld by all the staff.

There was a homely and relaxed atmosphere where people chose how they would like to spend their day, what time they would like to get up and what they would like to eat. Throughout our inspection we observed staff supporting people, as far as possible, to do this. One person told us they liked to have lunch in the dining room return and then return to their own room on and staff supported them to do this. This person told us, "This is my home now, my room is full of my memories and little bits and bobs." Other people also liked to spend time in their rooms and staff supported them to do this. We were told, "Staff pop in and make sure I have everything I need. They offer me drinks and snacks." One family member said, "Unfortunately my relative is unsafe to sit out in a chair for long periods so spends most of the time in bed, but staff ensure that they check him regularly."

All staff had a good knowledge and understanding of the people they cared for. They were able to tell us about people's choices, personal histories and interests and the care they needed. In all conversations and communications staff used people's preferred names and kind words and it was clear that they knew the residents and their particular ways. One person, who was unable to communicate verbally, did not have family or friends who could tell staff about their life prior to living at the home. Staff told us how they spent time with this person observing what they enjoyed doing and building on that knowledge. We saw how they had identified this person enjoyed music and had ensured this person was provided with music and television programmes they may enjoy.

Staff had time for people. When undertaking their daily tasks staff were constantly stopping and talking with people. People appeared happy to ask any staff member for assistance. We observed one person asking the maintenance staff for assistance. The person said, "Would you be able to do the honours." This person received the assistance they needed without hesitation. Staff frequently told us, "We're a team, we all look after people and want them to have a good life." We saw that staff sat with people and engaged in conversation with them when they had time.

It was clear staff had genuine empathy for residents' feelings, they were caring and compassionate towards

people. Visitors to the home told us how they and their family members were supported by the staff. One visitor told us about the support they had received from staff during a particularly difficult time. They said, "They (staff) were so kind and caring I can't praise them enough; they are wonderful." One person told us, "I have found it difficult to settle after leaving my flat, but the staff are wonderful, they spend time with me and ensure I am okay."

People were treated respectfully, with dignity and offered privacy. One person said, "They (staff) are always respectful and compassionate." People were dressed in clean clothes of their choice and were well presented. We observed staff speaking to people with kindness and patience, having "banter" with them and getting them to smile and laugh. They were able to engage people in conversations which interested them or encouraged them to reminisce.

All of the bedrooms were single occupancy and where people chose to, they had been personalised with their own belongings such as photographs and ornaments. People were able to spend time in private in their rooms as they chose. Bedroom doors were kept closed when people received support from staff and we observed staff knocked at doors prior to entering. Staff understood how to maintain people's dignity. One staff member said, "We empower people as much as possible, we help them to try for themselves and build up their confidence."

At the time of the inspection nobody at the home was receiving end of life care. However, there were care plans in place which provided details of people's end of life wishes. Healthcare professionals we spoke with told us staff at the home had a good understanding and knowledge of providing end of life care. One healthcare professional told us, "They give excellent palliative care here." Another said, "Staff are good at building relationships with people who have complex needs, especially those who may have difficulty communicating." They added, "Staff look after people well."

Good

Is the service responsive?

Our findings

People told us they were able to do what they liked during the day. One person said, "I don't like sitting in the lounge, so I stay in my room." Another person said, "I do what I want to, I join in with what I like to do." People were treated as individuals and care and support was personalised to meet their needs and wishes. People were aware when activities were taking place and could join in if they chose. Visitors said they were kept informed of any changes or concerns related to their relative.

Before moving into the home the registered manager or deputy manager assessed their needs to ensure Peterhouse could provide them with the care and support they required. Care plans were then developed and reviewed as people's needs changed. People were involved in deciding how their care was provided and received care that was responsive to their needs and personalised to their wishes and preferences. Where possible people had signed their care plan to show they had read and agreed with the contents. Where people were unable to we saw the care plans had been discussed with their relatives. Care plans showed people were involved and able to contribute to how their care was provided. People received care which was personalised to reflect their needs, wishes and aspirations. Care records provided detailed information for staff on how to deliver peoples' care. For example, information was found in care plans about personal care and physical well-being, communication, mobility and dexterity. The staff had recently changed care plans from a computerised system to a handwritten care plan. Work was being undertaken to improve people's care documentation as some were very basic in detail. This was on-going as more staff received training in care planning and gaining experience in writing care plans. Staff were attending in house training on person centred care and the registered manager said she was including care planning in supervision sessions.

One person's care plan was detailed in how they would like to be presented each day. This included detailed information about their personal hygiene needs and their clothing preferences. The way this person was dressed reflected their care plan. Where people were unable to communicate verbally their care plans informed staff how these people were able to communicate. For example facial expressions and hand gestures. During the inspection we observed staff responding appropriately to people's needs for example when they required support and assistance. Care plans were reviewed monthly or when people's needs had changed. In order to ensure that people's care plans always remained current, the senior staff checked them regularly alongside daily notes and handover records. Daily records provided detailed information for each person, staff could see at a glance, for example how people were feeling and what they had eaten.

There was information in the care plans about people's personal histories, likes, dislikes hobbies and interests. This information was used to support people to take part in activities or continue with their hobbies and was included in a care plan to guide and support staff.

Staff knew people really well. They told us it was important people continued with routines and interests they previously had. People who were able told us they had plenty to do. They were able to continue with their own interests and take part in new ones. One person told us about a recent shopping trip and how staff had supported them to buy new clothes. They told us they were planning another trip soon. Other people

were taken out individually for walks or to the coffee lounge. People who were able went out for walks around the gardens.

Most of the activities took place in the day centre attached to Peterhouse which also served the people who lived in supported living accommodation. There was a range of activities taking place some of which were provided by outside organisations. Also the activity organisers had put structures in place to support staff to deliver individual activities that people enjoyed should they choose to stay in their room. We saw people who chose to remain in their room were supported to take part in activities. For example pamper sessions, relaxation sessions and specific reminiscence therapy.

Staff supported people who were unable to communicate verbally or participate in group activities. Staff told us they tried to base individual activities on the person's past interests and hobbies. For example art and crafts or painting. There was a record of activities people had taken part in, we saw there had recently been a movie afternoon and there were records of one to one activities people had taken part in, for example gentle arm chair exercises. Photographs of activities and events demonstrated people had enjoyed barbeques that had taken place throughout the summer and various trips out. People's birthdays and special occasions such as Christmas were always celebrated. One staff member said, "We do a lot with people, we celebrate all their occasions."

A complaints policy was in place; a copy was displayed on the notice board near the entrance to the home. When complaints had been received we saw a record had been maintained and they had been investigated following the providers policy. People and visitors we spoke with said they didn't have any need to complain but if they needed to they knew who to speak with and they felt comfortable to do so.

Requires Improvement

Is the service well-led?

Our findings

People told us the staff were all approachable, they could talk to them about anything at any time. One person said, "Staff and (owner) are, to all intents and purposes my family." People knew all the staff by name and who they would approach with a particular concern for example maintenance. For example one person said, "If I want to talk about food I speak to (name), if I want to talk about my medicines it's a nurse."

There were systems in place for monitoring the management and quality of the home. However the medicine audits had not identified that PRN protocols were not all completed properly and there was a lack of guidance for managing pain and pain relief. The audits had not identified gaps on the MAR charts for example in relation to the late administration of a weekly pain patch, and the application of skin creams. Therefore there was no evidence of what actions had been taken to address this. As discussed at the inspection there were some inconstancies found in people's care documentation, such as fluid charts and diabetic guidance. Whilst this had not impacted on care delivery at this time, there was a potential of risk if agency or new staff were not as knowledgeable of people's needs as the permanent staff. We have received action plans from the provider of actions already taken. We identified medicine administration and care documentation as an area for improvement.

The provider and staff were committed to improving the service and enhancing day to day life for people. Throughout the inspection they responded positively to ideas and suggestions. We observed actions were taken quickly during our inspection. As a result charts had been introduced which staff completed to identify the effectiveness of pain relief. The nurses told us that the auditing system had been changed to check charts had been completed correctly on a daily basis.

There were a range of policies and procedures in place to guide and support staff in safe care delivery and these were being regularly reviewed and updated. Staff told us that they were expected to read and sign that they have read and understood the policies. For example, staff told us that there was a policy in place for the new regulation 'Duty of Candour'. The Duty of Candour is a regulation that all providers must adhere to. The intention of the regulation is to ensure that providers are open and transparent and sets out specific guidelines providers must follow if things go wrong.

Peterhouse is a charity run home. There was a management structure in place and the board of directors were kept up to date on a regular basis. The director of operations worked at the home on a daily basis and worked alongside the registered manager. They were involved with overviewing the care and support people received and provided support for the staff. They knew about people, their individual needs, preferences and personal histories. When the registered manager and director of operations were not at work there was an on call system in place for staff to contact if needed, and all staff were aware of this. The provider had developed an open and inclusive culture at the home that fully embraced the ethos of the home which was embedded into everyday practice in all of the staff. The director of operations was aware of the day-to-day culture in the home as she worked directly alongside care staff and encouraged staff to talk to her openly. She spent time talking with people and visitors, providing care and engaging with staff throughout the day. We observed people and staff were comfortable approaching and talking with her. She

had a good understanding of people's individual preferences and their care and support needs.

There was a passion and commitment to make life for people at the home as happy and fulfilled as possible. It was also to ensure Peterhouse was a 'real home' for people. We observed all staff worked closely together. There was no distinction between roles and grades. Staff were aware of their individual roles and responsibilities however they all took responsibility for ensuring people were well looked after. There was a relaxed, open and happy but professional relationship between the staff and the management team.

Staff told us they were well supported they were able to discuss concerns with senior staff at any time. One said, "Any problems I can always speak with the registered manager or (director of operations), there's always someone to go to." They said concerns were listened to, taken seriously and acted upon with discretion and confidentiality. They told us they enjoyed working at the home. Comments included, "It's a lovely place to work, very much a home-from-home," and "We all work well together, everybody mucks in."

People, their relatives and the staff were involved in developing and improving the service. We saw a recent survey had been sent to relatives and the feedback was positive.

There were resident meetings which included discussions about meals and activities. This demonstrated staff and people were listened to and their ideas used to improve the service. We saw thank you cards and compliments were kept in a folder and shared with staff so they were aware of the positive feedback the home received.