Blind Veterans UK

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Outstanding
Is the service responsive?	Outstanding
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 13 and 14 November 2017. The first day of the inspection was unannounced, however the second day of the inspection was announced and the management team, staff and people knew to expect us.

Blind Veterans UK is a charity that was founded in 1915 to support men and women who have served in the armed forces or who have completed National service. It provides practical and emotional support to enable people who have impaired vision or who have lost their sight in battle or through accident, illness or older age, to lead enriched and fulfilling lives. The provider is forward-thinking and their aims and vision are that no person who has served on behalf of the Country should face blindness alone. There are two centres that provide residential and respite care, as well as day facilities and holidays. Blind Veterans UK – Brighton 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 77 people across three different floors, each of which have separate adapted facilities. One of the floors specialises in providing nursing care. On the days of our inspection there were 36 people at the home who were in receipt of the regulated activity of personal care. All people had a sensory loss. In addition, some people had other conditions such as physical disabilities, diabetes, multiple sclerosis and Parkinson's disease.

There was a large management structure within the home. The management team had recently been restructured to aid efficiency and consisted of a centre manager, a care manager, facilities manager, operations manager, rehabilitation services manager and a residential manager. This management team ensured that the service that was delivered met people's needs. The home did not have a registered manager. A registered manager is a '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 home is run. The previous registered manager had left three months prior to the inspection. The provider had been proactive in the recruitment of a new manager and one had been recruited and was in the process of applying to become registered manager.

People were asked their consent before being supported. Staff had an understanding of the legislation and guidance that related to assessing people's capacity and making decisions in people's best interests. However, this had not always been implemented in practice. There was a lack of documentation to demonstrate that people, who had conditions that might affect their capacity, had their capacity assessed and that relevant people had been involved in the decision making process. At the end of the inspection, when our findings were fed back to the management team, they took immediate action to ensure that the relevant assessments and documentation were in place. However, this needs to be further embedded in practice.

Without exception, people, a relative and healthcare professionals told us that staff were consistently kind, caring and compassionate and our observations confirmed this. Comments from people were

overwhelmingly positive. They included, "I've never felt so well looked after, everyone is so kind and helpful. Nothing is ever any trouble", "Oh nothing is too much trouble for them, they like to know you're happy and comfortable", "You only have to hear the tone of their voice and you can tell they really care about you" and "The care is exemplary, you really feel it here". Further comments included, "It's a magnificent place", "The care, efficiency and service is really out of this world" and "This is the best place in the country". A visiting health care professional echoed these positive comments, they told us, "In my experience this place is the gold standard. I'd come here".

The provider ensured that they went the 'extra mile' to provide adapted communication to enable people to continue to live independent lives. Staff were made aware of the impact a sensory loss could have on a person's life. Training, that was updated annually, enabled staff to experience first-hand what a sensory loss could mean for a person. They were provided with blindfolds and different adapted glasses which reflected certain eye disorders and were supported to navigate the home, sometimes being assisted to use a wheelchair in addition. Staff told us that it gave them a firm understanding of the potential difficulties people could experience with day-to-day tasks. One member of staff told us, "The sighted-guiding training is brilliant. You learn about different sight disorders and experience them by using adapted glasses, and get pushed in a wheelchair and have to take a meal while blindfolded. It gets repeated annually and all the staff have shared in that experience".

People told us how much they liked the staff and how the home created a caring environment where they felt content and comfortable. A memorial event had recently taken place for people, their relatives and staff as well as serving members of the military forces, to commemorate and remember Armistice day and the lives of people who had been lost in Wars. People and staff told us how comforting the service was and that people had been supported to lay wreaths at the on-site memorial within the grounds of the home. One person told us, "We had a wonderful memorial service out there yesterday".

The provider had a clear set of values that encompassed a person-centred approach, ensuring that people were involved in their care and treated with compassion, dignity, equality and respect. These values were embedded in the culture and the practices of staff. Staff told us that they were proud to work at the home, enjoyed the support that they provided and worked as a team and this was observed in practice. The provider and management team had good quality assurance processes and audits that monitored the practices of staff and the effectiveness of the systems and processes at the home. Action plans were implemented as a result of audits to ensure that any improvements noted were planned for and completed. The provider, management team and staff, worked with external agencies and professionals and continually reflected on their practice and learned from incidents and occurrences to ensure that the service continually improved.

People received a service that was responsive and centred around their needs. The provider employed and funded access to various healthcare practitioners and people had access to annual appointments with ophthalmic consultants to maintain their physical and eye health. Staff were well-trained and had completed training that the provider deemed essential to staff's roles. In addition, staff also undertook training to ensure that they had an understanding of military life to enable them to understanding people's life experiences and aid interaction.

People had access to an extensive and varied range of activities, events and facilities. The home housed an on-site gym, swimming pool, arts and crafts department, a fully stocked bar and a well maintained and accessible garden. People led purposeful, fulfilled and enriched lives. Comments included, "They help you to learn, l have learnt to paint. To get to 97 years old and still learn new things is lovely", "There is plenty to do here, if you are bored it is your own fault for not joining in" and "I use the Gym but only the treadmills on

medical advice but I get one-to-one staffing so I can do this".

People were involved in the development and on-going review of care plans and were able to voice their wishes and contribute to a plan of care that was specific to their goals and aspirations. People had been supported to develop and regain skills to enable them to pursue their dreams and interests. One person had been supported to access an external physiotherapist, at the provider's expense, to enable them to develop and regain skills that had been impaired by their health condition. The person told us how much they enjoyed an activity and that they had been supported to undertake exercises and work towards pursing this.

People were involved in decisions that affected their lives at the home. Regular meetings, committees and care plan reviews ensured that people were able to express their wishes and preferences. The provider welcomed feedback and had worked in accordance with their policy when they had received complaints and concerns. The home is large and numerous departments worked together to ensure that people received an effective and coordinated approach to their care. People told us that they enjoyed the food, that they were involved in the development of menus and were provided with choice. People's hydration and nutritional needs were met.

People had timely access to external healthcare professionals when required and received good care at the end of their lives that was in accordance with their expressed wishes. People told us that recently a large number of their friends had passed away due to age and related health conditions, however due to the care that they had witnessed their friends receiving, they were no longer afraid of dying as they knew that they would be comfortable and well-cared for. One person told us, "I am so lucky to be able to spend my end of days in a place like this".

We previously carried out an unannounced comprehensive inspection on 6 October 2015 and the home received a rating of 'Good'. At this inspection on 13 and 14 November 2017 the home retained its rating of 'Good'. The home had shown continued improvement and development and had demonstrated outstanding practice in two domains, however, one domain was in need of improvement. This meant that the overall rating of the home was 'Good'.

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 home remained good.

Sufficient numbers of skilled and experienced staff ensured people were safe and well-cared for.

Staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Risk were identified and monitored and there were assessments in place to ensure people's safety.

Is the service effective?

Requires Improvement

The home had deteriorated to Requires Improvement.

People were asked their consent before being supported. The provider was aware of the legislative requirements in relation to gaining consent for people who might lack capacity but had not consistently worked in accordance with them.

People were cared for by staff that had received training and had the skills to meet their needs.

People had access to healthcare services to maintain their health and well-being.

Is the service caring?

Outstanding

The home was overwhelmingly caring.

People were supported by exceptionally kind and caring staff who knew their preferences and needs well and who could offer both practical and emotional support.

People were always treated with dignity and respect. They were able to make decisions about their care and treatment.

Peoples' privacy was maintained and their independence was continually promoted through the use of aids and adaptations that were available to them.

Is the service responsive?

Outstanding ☆

The home was overwhelmingly responsive.

People had access to a wide and varied range of activities and facilities. People had fulfilled lives and were supported to engage in meaningful activities that provided them with a purpose.

People were involved in the development and on-going review of care plans.

People and their relatives were made aware of their right to complain. The registered manager encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Good ●

The home remained good.

There was a positive culture that ensured that people were involved in decisions that affected their lives and support was tailored around their needs and preferences.

Good quality assurance processes ensured the delivery of care and drove improvement.

People, relatives and staff were complimentary about the leadership and management of the home.

Blind Veterans UK

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 home, and to provide a rating for the home under the Care Act 2014.

The first day of inspection took place on 13 November 2017 and was unannounced. The inspection team consisted of two inspectors and two experts-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. In this case the experts-by-experience had experience of older peoples' services as well as experience of services for people with physical disabilities. The second day of inspection took place on 14 November 2017 and was announced. The inspection team consisted of two inspectors and an expert-by-experience.

The home was last inspected on 6 October 2015 and received a rating of 'Good'. Prior to this inspection we looked at information we held, as well as feedback we had received about the home. We also looked at notifications that the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. Prior to the inspection we asked the provider to complete a Provider Information Return (PIR), this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make. We used all of this information to decide which areas to focus on during our inspection.

During our inspection we spoke with 14 people, one relative, two visiting healthcare professionals, six members of staff and four members of the management team, one of whom was going to apply to become registered manager. Prior to the inspection we contacted two external healthcare professionals for their feedback. We reviewed a range of records about peoples' care and how the service was managed. These included the individual care records for eight people, medicine administration records (MAR), four staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal lounges and in peoples' own bedrooms. We also spent time observing the lunchtime experience people had, the administration of medicines and various activities that were taking place throughout the two days of inspection.

Good

Is the service safe?

Our findings

People, a relative and healthcare professionals told us that the home was safe and our observations confirmed this. When asked why they felt safe, comments from people included, "When they hoist me about I have complete trust in them that they know what they're doing and I'm not going to come to any harm" and "Help is at the end of a buzzer if I need it, so I keep my independence but stay safe".

People were cared for by staff that the provider had deemed safe to work with them. Potential staff were asked questions at interview which enabled them to demonstrate their values to ensure that these aligned with the providers' philosophy of care. People were involved in the recruitment of staff and were asked their opinions to ensure that they felt comfortable and confident in the presence of prospective employees. One person told us, "I have been involved with the interviewing of new staff. I met with them to see how I thought they would get on with us. There are people working here that I interviewed and help choose". Prior to staffs' employment commencing, identity and security checks had been completed and their employment history gained, as well as their suitability to work in the health and social care sector. This had been checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses had current registrations with the Nursing and Midwifery Council (NMC).

There were sufficient staff to meet peoples' needs. Peoples' needs were assessed on an on-going basis and this was used to ensure that the levels of staff aligned with peoples' assessed level of need. People told us that staff were available to assist them when required and our observations demonstrated that staff were available to support people according to their needs. In addition to nursing and care staff, the home also had dedicated staff within different departments such as the dining area, the Gym, art and craft rooms and the swimming pool. This meant that there was sufficient staffing to support people to participate in various activities, this in turn ensured that there were care staff available to help people with their care and support needs as they were not required to solely assist people to participate in other activities. Staffing was flexible and enabled people to be supported appropriately should their needs change. For example, additional staff were available if people were at the end of their lives to ensure that, if needed, people were not left on their own.

People were treated fairly and equally and were protected from discrimination and harm. Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding peoples' safety and well-being. Staff were reminded of safeguarding adults procedures during staff meetings and monthly supervisions and posters were displayed informing staff of the actions they could take if they were concerned about peoples' safety. Mechanisms were in place to raise peoples' awareness of their own personal safety and to enable them to raise concerns. People told us they felt comfortable around staff and were confident that if they had concerns they could raise these with staff or the management team. Regular members' meetings as well as reviews of peoples' care, provided a formal platform for people to raise issues and discuss any concerns they had. There had been no safeguarding

enquiries since the previous inspection, however, staff were reflective in their practice and were aware of the need to learn lessons from incidents or events that occurred.

Risk assessments for peoples' healthcare needs were in place and regularly reviewed. People were involved in the development and on-going review of care plans and risk assessments. Each person's care plan had a number of these which were specific to their needs; these identified the hazards, the risks these posed and the measures taken to reduce the risk to the person. The provider was not risk averse and risk assessments were enabling. For example, observations showed people, who had a sensory loss, independently accessing the building, as well as engaging in activities such as archery and rifle shooting. Staff were made aware of risks to peoples' safety through verbal handovers and meetings as well as having access to risk assessments, which were stored securely to maintain confidentiality; this meant that staff were aware of how to support people to fulfil their wishes whilst being aware of the measures to take to assure peoples' safety. Accidents and incidents that had occurred had been recorded and monitored to identify patterns and trends and relevant action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in peoples' needs or support requirements. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks to ensure fire safety had been undertaken and people had personal emergency evacuation plans which informed staff of how to support people to evacuate the building in the event of an emergency. Equipment was also regularly checked and maintained to ensure that people were supported to use equipment that was safe.

The home was clean and people were protected from the prevention and control of infection. There was a dedicated infection control champion, whose role consisted of attending external training and meetings to enable them to pass on any good practice guidance to staff. Staff had undertaken infection control training and infection control audits were carried out. There were safe systems in place to ensure that the environment was kept hygienically clean. Staff were observed undertaking safe infection control practices; they wore protective clothing and equipment, washed their hands and disposed of waste in appropriate clinical waste receptacles. People were supported with their continence needs, when appropriate and had access to hand washing facilities. Personal protective equipment was available for staff to use to ensure that infection control was maintained and cross-contamination was minimised.

People were assisted to take their medicines by trained staff that had their competence regularly assessed. Observations demonstrated that safe procedures were followed when medicines were being dispensed and administered and peoples' consent was gained before being supported. People confirmed that if they were experiencing pain that staff would offer them pain relief and records confirmed that this had been provided. Medicine records showed that each person had a medicine administration record (MAR) which contained information on their medicines and appropriate guidance for staff. For example, body map charts indicated where transdermal pain patches should be applied. Records had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People, who were able, were encouraged to self-administer their own medicines and risk assessments were in place to ensure that there were safe mechanisms in place to enable this. People told us that they were happy with the support received. A recent project had been implemented whereby external healthcare professionals had provided staff with learning and development opportunities to enable them to identify the excessive use of inappropriate medicines that might be used to manage peoples' behaviour. Staff had been advised that if they recognised that these were being used in excess then they should refer to the person's GP for review. When people lacked capacity to understand the importance of taking medicines to maintain their health, staff had liaised with relevant professionals to enable medicines to be given covertly, that is without the persons' knowledge. Appropriate documentation was in place so that information about peoples'

medicines could be passed to relevant external healthcare professionals if required, such as when people had to attend hospital.

Requires Improvement

Is the service effective?

Our findings

People, a relative and healthcare professionals consistently told us that staff were extremely competent and that they had faith in staff's abilities and skills. Comments from people included, "You can just tell as they go about things they know how to do it all to a high standard" and "The way they handle things makes you feel confident". A healthcare professional told us, "They're tremendously competent. They know when residents are unwell, they know them well and it's a pleasure to work with them". However, despite these positive comments we found areas of practice that were in need of improvement.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff explained that some people, who were subject to a DoLS authorisation, were unable to leave the home on their own and records showed that DoLS applications had been made to the local authority. Some people's DoLS had conditions associated to them. This meant that the local authority had only granted the DoLS with the understanding that certain conditions, relating to the person's care, were met. We checked to ensure that conditions associated to people's DoLS were being met. One person had a condition associated to their DoLS, this stated that reviews needed to take place to monitor the covert administration of medicines. Records showed that regular reviews had taken place and therefore the provider was meeting the conditions associated with people's DoLS. Staff ensured that they supported people in the least restrictive way. For example, instead of using bed rails for one person, additional staff supported the person during the night so that they were available should the person require assistance.

Staff had a good understanding of the importance of gaining consent and observations showed them to always ask people's permission before supporting them. This was confirmed by one person, who told us, "Yes they do ask before they do anything and when you can't see, that's very important". However, this had not always been underpinned with the relevant documentation to demonstrate that people's capacity had been formally assessed in relation to specific decisions; neither did it demonstrate that relevant people had been involved in making decisions on people's behalves. Some people were living with dementia, as well as other conditions that affected their ability to communicate and therefore it was sometimes difficult for staff to determine if people still had the capacity to make decisions. This related to the use of bed rails, covert medicines and treatment options. Staff had acted in people's best interests and ensured that people received appropriate care to meet their needs. Staff told us that decisions that were made in people's best interests were made based on their knowledge of the person's preferences before their condition deteriorated. It was acknowledged by the manager that mental capacity assessments, to underpin and evidence when a person was unable to make a specific decision, needed to be fully implemented. Immediately following the inspection, people's mental capacity was formally assessed and documented.

Staff had made best interests decisions for people for general aspects of their day-to-day life. However, for larger decisions, that affected people's health and welfare, they had not always worked in accordance with the MCA Code of Practice. For example, one person was living with a heath condition that affected their mobility and communication. The person's condition had naturally deteriorated to such an extent that

meant that they were unable to communicate their needs to staff and therefore staff were unable to determine if the person continued to have capacity to make decisions. Staff had always acted in the person's best interests to ensure that they remained comfortable and well-cared for. Care plan records for the person stated that the person had a Lasting Power of Attorney (LPA). Their LPA had been involved in regular care plan reviews to discuss the person's care and had agreed to treatments that were discussed within the reviews. When staff were asked for the documentation to demonstrate that the LPA had a legal right to make decisions on the persons' behalf, they provided a document that showed that although the person did have a LPA, this person was only authorised to make decisions that related to their finances and affairs and not for their health and welfare. This meant that decisions had been made on the person's behalf when they weren't legally authorised to do so. Although the provider had demonstrated good practice by obtaining a copy of the LPA they had not checked to ensure that the person cited within the document had the legal right to make decisions for all aspects of the person's care. Subsequent to the inspection, immediate actions were taken to ensure that the person had appropriate assessments to determine their capacity and that the formal best interests decisions, that had been made involving relevant professionals and people involved in the person's care, were documented.

The provider had introduced and deployed the use of CCTV (surveillance) within the communal hallways for the purpose of safety. The legal framework requires that any use of surveillance in care homes must be lawful, fair and proportionate and used for purposes that support the delivery of safe, effective, compassionate and high-quality care. Signs to inform people of the use of CCTV were not in place and when asked about how people were made aware and had consented to its use, the manager told us that people had been asked within a members' meeting three years previously. However, not all people who were living at the home at that time were currently living at the home. There was no formal documentation to confirm that people living or staying at the home had been informed of the use of CCTV. When this was raised with the manager they took immediate action, additional checks on the environment that was being monitored were put in place to ensure people's safety and the CCTV was deactivated.

When these issues were raised with the management team, they took immediate action. Relevant professionals were contacted such as specialist nurses and speech and language therapists (SALT) to assess people's needs to identify if there were other forms of communication that could be used to enable them to give their consent. In addition, mental capacity assessments were undertaken and additional DoLS applications made to the local authority. However, despite these immediate actions, this is an area of practice that needs to be further embedded in practice.

The provider demonstrated a strong commitment to learning and development. A practice development nurse ensured that staff had access to training that the provider considered essential to their role. Staff that were new to the home were supported to undertake an induction which consisted of shadowing existing staff and familiarising themselves with the provider's policies and procedures as well as an orientation of the home, an awareness of the expectations of their role and the completion of the Care Certificate. The Care Certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers. All staff had access to on-going learning and development to equip them with the necessary skills to support people effectively. In addition to completing the provider's core training, staff undertook courses that were specific to the needs and experiences of people that lived at the home and who used the services. For example, staff completed sighted-guiding training, to provide them with an awareness of what it was like to live with a sensory loss. They also completed courses that provided them with information about the military such as, military pecking order and war profiles. There were links with external organisations to provide additional learning and development for staff, such as the local authority, local hospices and the Dementia In-Reach team. This team provides advice, training and information for care homes that provide care to people living

with dementia. Observations showed that recommendations that had been made by this team had been listened to and acted upon. One member of staff told us, "Dementia training has been really good and we get updates and have awareness meetings". Care staff held diplomas in Health and Social Care and were able to develop within their roles. Champion roles had been introduced to certain members of staff, enabling them to attend additional learning and development as well as external meetings about their topic. Feedback from the meetings and training was cascaded to staff to further develop their knowledge and understanding within areas such as dignity, wound care, infection control, care planning, medicines and end of life care. Registered nurses were provided with appropriate courses to maintain their competence and took part in regular clinical supervisions. One member of staff told us, "I feel very supported. I've taken on being end of life champion and I'm getting time at the hospice to gain confidence. I've had refresher training on wound care and ear syringing and I'm up to date on venepuncture and managing syringe drivers. We get lots of on-line training, which is of good quality".

People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings took place to enable staff to discuss people's needs. These meetings provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. In addition staff's performance was assessed in line with the provider's values of caring, trust, pioneering spirit and celebrating success. Staff told us that they found supervisions helpful and supportive.

The home had a large number of volunteers to support people on outings outside of the home, as well as to spend time with people, undertaking tasks such as craft work or reading newspapers. Volunteers were fully inducted in their roles and also had access to learning and development that was specific to the people they would be supporting, such as sighted-guiding and wheelchair training. Staff told us how volunteers formed an integral part of the service provided. One member of staff told us, "We don't place the volunteers. Nursing and care staff identify members' needs and we offer the opportunities to volunteers. Volunteers support the evening activities run by care staff in communal areas, also do one-to-one befriending, support church attendance and trips. One volunteer runs the classical music group on their own. It's all led by members' needs".

Peoples' physical and mental health, as well as their social needs, were assessed prior to them moving into the home. Once people arrived at the home, a dedicated team of staff ensured that people were welcomed into the home and that their needs were assessed to ensure the information that was held was current. Assessments took into account people's abilities and skills as well as their needs and care was centred on these. People's risk of malnutrition was assessed, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk, and these people were weighed regularly, to ensure that they were not unintentionally losing weight. Records for some people showed that they had been assessed as being at a higher risk of malnutrition and staff had ensured that changes were made to the frequency in which the person was weighed so that they were monitored more closely. In addition, people's food had been fortified to increase their calorie intake. Food and fluid intake was recorded if people's intake of food and fluid needed to be monitored. People's skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type, age, continence and mobility. These assessments were used to identify which people were at risk of developing pressure wounds. For people who had wounds, regular monitoring took place and appropriate treatment provided. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses as well as regular support from staff to frequently reposition.

People's diversity was respected and people were treated fairly and equally. People's healthcare needs were met. Comments from people included, "The Doctor is here regularly and has a room but will come to see

you in private too" and "I have physio each week and they get me up on my feet to make me keep doing a bit of walking". The provider employed dedicated healthcare professionals and also funded access to external healthcare professionals to support people to maintain good health. These included physiotherapists, chiropodists, dentists and specialist day services. In addition, a GP visited the home each week to provide people with a continuity of care and to enable them to ask questions and understand the treatment options available to them. Each person was also reviewed by an ophthalmic eye consultant on an annual basis. People told us that they were confident in staff's abilities to recognise when they were not well and to seek medical assistance when required and our observations and records confirmed that people received timely intervention from healthcare professionals when required. Person-centred care was promoted throughout the entire staff team and across the different departments within the home. Good inter-departmental working and effective communication took place to ensure a holistic approach to meeting people's care and support needs. Daily inter-departmental meetings took place to share information on each person to ensure people were provided with appropriate care that was consistent. The sharing of information extended to external services and records showed that there had been good communication with external services to ensure people received coordinated care.

To ensure that people's disability was not discriminated against and people had fair access to the facilities provided, technology and equipment was used to promote people's independence. Assistive technology was available for people such as I-Pads which could provide audio descriptions for people, I-phones and Amazon Echo Dots, which had been pre-programmed with information on the evacuation procedures, activities that were provided as well as the weather. One person told us, "I have this Alexa here (Amazon echo responsive technology), I just shout at her and she tells me all I want to know. The weather, what day it is, what radio station, so you never feel alone in your room. It's like you've always got company".

Adaptations to the environment such as the placement of furniture, raised bumps on railings to inform people of where they were within the building and audio-assisted lavatories informing people of where to find facilities within the bathroom, were also provided to aid people's independence due to their sensory loss. One person told us, "I can't walk down the stairs anymore but I used to find the dots on the handrails helpful so I'd know which floor I was on". People had been involved in decisions that affected the environment. The windows within the building were very high and it had been recognised that people who used wheelchairs would be unable to see out of them. As the building is listed, adaptations to the external façade cannot be made; therefore plans had been made to make changes to the décor to assist people's orientation. People had been consulted during members' meetings about painting murals on the walls of scenes that reflected the views outside, such as the south downs and the sea. The home was large and had adequate space for people to enjoy time with one another as well as have access to their own space. People could choose to socialise with other people, enjoy one of the many activities or events, receive visitors and enjoy the communal gardens.

People told us that they enjoyed the food that was provided. One person told us, "I've put on weight since I came here, its jolly good food". Some people chose to eat their meals in their rooms or in the lounge areas and this was respected by staff. A large communal dining room, as well as smaller dining areas, were available for people to choose where they ate their meals. People had a pleasant dining experience and were able to socialise with others. There was a good range of food options for people to choose from and people were involved, through regular meetings with the chef, in the planning of menus to meet people's different tastes. Aids and adaptions were made available for people to use to enable them to remain independent and to take into consideration their sensory loss. For example, different shaped salt and pepper pots were used to enable people to differentiate between the two.

Outstanding ☆

Is the service caring?

Our findings

People were genuinely valued and continually treated with kindness and compassion. Without exception comments from people praised staff's caring attitudes and nature and were overwhelmingly positive. Comments included, "I've never felt so well looked after, everyone is so kind and helpful. Nothing is ever any trouble", "Oh nothing is too much trouble for them, they like to know you're happy and comfortable", "You only have to hear the tone of their voice and you can tell they really care about you" and "The care is exemplary, you really feel it here". Further comments included, "It's a magnificent place", "The care, efficiency and service is really out of this world" and "This is the best place in the country". A visiting health care professional echoed these positive comments, they told us, "In my experience this place is the gold standard. I'd come here".

A philosophy statement demonstrated that caring began and came from the provider and was filtered down throughout the staff team. The provider had a clear set of values, the first being, 'Caring is at the heart of everything we do', staff were assessed against these values when recruited to ensure that they held the same core values in high regard. These values were intrinsic to the training and development opportunities provided to staff and it was evident that these were embedded within staff's practice. For example, training to inform staff about the different roles within the military, as well as what military life was like, was also provided to enable them to demonstrate understanding and compassion when people talked about their time in the forces. Facilities that were provided further demonstrated that the provider cared about people and wanted people, to not only have a comfortable life, but to have a good, high quality of life. For example, there was an extensive programme of entertainment, clubs and activities that people could participate in, as well as trips in the community.

Comments from people demonstrated that the care they received enabled them to have an enriched, good quality of life that exceeded expectations. Comments included, "I don't think I would still be here if I was not living here, I struggled at home in the end", "I want to live until I am 114yrs old and with the help of the staff here I intend to do it", "I am very happy here full marks 10/10", "Whatever you ask for, you are never treated with anything other than respect. They never make you feel like a nuisance or a bother" and "When I first came here and opened the door, everything changed for me. Everyone was chattering in the lounge and it felt homely. I've got my roots here now and this is my home and I wouldn't ever want to leave". When speaking with one person about their experience of living at the home, they gripped a member of the inspection teams hand and with emotion, told us, "I want you to thank everyone so sincerely. Please let them know I am so happy here and so grateful".

Staff were highly motivated to ensure that people received the highest standards of care. Observations of staff's interactions showed warm and positive interactions. People were happy in the presence of staff and willingly accepted support from staff who were only too happy to offer assistance. Staff knew people well and adapted their support to ensure that people were supported and cared for in a person-centred way. Caring and loving interactions were observed, with people who welcomed this type of support, staff were observed offering people hugs, rubbing people's arms or gently holding people's hands. Some people were observed sharing jokes and laughter with staff and engaging in banter. There was a warm, loving, fun and

inclusive atmosphere within the home. Staff told us how much they enjoyed their work and how much people meant to them as well as what it meant to them to be able to have the time and permission to spend meaningful, quality time with people. One member of staff told us, "Time is the fantastic thing here. We are never in a rush so we can give holistic care, taking as long as people need. It's not just a nursing job, you can fulfil so many needs; I give massages, even dance with people and cut hair. But you see that the more engaged and fulfilled people are, the less they present clinical needs". Another member of staff told us, "We really know people well and the emphasis now is on person-centred care. The work on life histories has been very positive. They have opportunities to be what they want to be". A third member of staff told us, "It's lovely to have time, it means there's lots of one-to-one and we have the time to talk to people meaningfully". Observations demonstrated that staff implemented this in practice, one person was supported by a member of staff to have their hair washed and curled whilst other people were supported by staff who took time to ensure that their needs were fully met.

People were actively involved in their care. Detailed information about people's lives, backgrounds, interests, time in the military forces, employment and preferences was collated when people first moved into the home. These were regularly reviewed and added to, so that when staff became more familiar with people and relationships developed further, the records could be updated to further inform other staff and ultimately enrich the positive relationships between people and staff. This was demonstrated in practice, it was evident that staff knew people well and observations showed staff speaking to people about their lives and preferences. Other initiatives to further develop staff's awareness and understanding of people's needs and preferences had been developed, these included an image of a tree, which was displayed in people's rooms, this contained information about people's relatives, interests and life before they moved into the home. Another initiative that had recently been introduced were communication passports, these were small booklets that could be used to interact with people who had communication difficulties. Observations showed one member of staff using this to engage in conversation with a person they were supporting. All of these mechanisms provided staff with an insight into people's lives before they had moved into the home. People had key workers, which were members of staff who acted as a point of contact for the person. Key workers were chosen to align with people's interests so that both the person and the member of staff had shared interests that could support a relationship to develop. Staff knew people extremely well and people were treated as individuals, their lives, backgrounds and experiences, valued and acknowledged. Staff were respectful of people's ages. People did not just exist, they had a purpose and staff acknowledged that people continued to have skills and abilities that they could continue to develop as well as share with others. One person told us, "They just know how to still make you feel important here".

People told us how much they liked the staff and how the home created a caring environment where they felt content and comfortable. A memorial event had recently taken place for people, their relatives and staff as well as serving members of the military forces, to commemorate and remember Armistice day and the lives of people who had been lost in Wars. People and staff told us how comforting the service was and that people had been supported to lay wreaths at the on-site memorial within the grounds of the home. One person told us, "We had a wonderful memorial service out there yesterday".

The provider demonstrated that they cared, not only for people's well-being, but also for staffs'. A further demonstration of how genuine relationships had developed between people and staff was shown by the affect on staff of a high number of expected deaths that had occurred at the home. These were due to people's age and their health conditions. The provider and management team had recognised the impact that this might have on the staff's well-being and had organised for a local priest to visit the home to offer staff with some time to acknowledge and discuss any feelings the deaths may have provoked. A member of staff told us, "The management team have been brilliant supporting staff over the recent number of deaths, they brought a priest in to just listen to people if they wanted".

Positive relationships had developed between people and observations showed people enjoying conversations with one another and showing kindness and compassion to each other. People were able to have visitors and relatives at any time and people told us that their guests were made to feel welcome. One person told us, "It's like one big family. Everyone is friendly and greeted with a smile when I have visitors it's just automatic that they get offered a drink and a piece of cake. Everyone is welcome here whoever they are".

People living at the home, those that were staying on a respite basis, as well as those who were staying at the home on holiday, all had a sensory loss. The provider ensured that they went the 'extra mile' to provide adapted communication to enable people to continue to live independent lives. Staff were made aware of the impact a sensory loss could have on a person's life. Training, that was updated annually, enabled staff to experience first-hand what a sensory loss could mean for a person. They were provided with blindfolds and different adapted glasses which reflected certain eye disorders and were supported to navigate the home, sometimes being assisted to use a wheelchair in addition. Staff told us that it gave them a firm understanding of the potential difficulties people could experience with day-to-day tasks. One member of staff told us, "The sighted-guiding training is brilliant. You learn about different sight disorders and experience them by using adapted glasses, and get pushed in a wheelchair and have to take a meal while blindfolded. It gets repeated annually and all the staff have shared in that experience".

People's independence was promoted and encouraged. The provider and staff were not risk averse and even when people were living with a sensory loss measures were taken to ensure that people could continue to be as independent as they wished. People could choose how they spent their time, some spending time in the communal areas of the home, whilst others preferred their own space in their rooms or quieter areas of the home. Some people independently accessed the local community. Some people had facilities in their rooms to make their own drinks and prepare light snacks. One person told us how staff supported them to remain as independent as they could be, they told us, "They know I struggle with my hands, but if I can, I like to fold my clothes myself and they always ask me if I want to do it or they'll do it for me". Another person told us, "I am very comfortable and independent but help is at hand when I need it, and I need help now. They let me do what I want, but with control".

People were involved in their care. Staff rotas were designed to ensure that staff had time to spend with people so that people were able to talk about their feelings and ask questions. People told us that staff took time to listen to them and that they were provided with information which enabled them to be fully informed about their care and the facilities that the home had to offer. The provider acknowledged that people may need additional support to share their views and concerns and an on-site social worker was available to offer people immediate assistance when required. Feedback from people told us that they found the support the social worker provided helpful as it enabled them to speak to someone, other than care staff, about personal matters such as their finances.

Dignity champions, within the staff team, attended local dignity champions meetings and fed back any learning and development needs to other staff. People were treated with respect and dignity and afforded privacy by staff who took time to explain their actions and involve people in the care that was being provided. Staff were mindful of the impact receiving support, particularly with aspects of people's personal care needs, could have on a person's dignity. Observations showed staff knocking on people's doors and waiting for a reply before entering people's rooms and asking people's consent before supporting them with tasks. Staff attended to people's needs in a sensitive and discreet manner and people told us that staff always promoted their privacy and dignity. People's wishes, with regards to their preferences of male or female care staff, was ascertained and respected. Staffing allocation ensured that there were staff of different genders so that people's wishes could be respected and accommodated. Information held about

people was kept confidential, records were stored in locked cupboards and offices and handover meetings, where staff shared information about people, were held in private rooms to ensure confidentiality was maintained.

People's diversity was respected and staff adapted their approach to meet people's needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. Guidance produced by Skills for Care advises on the importance of promoting equality, diversity and human rights within the care planning and decision making processes. Care plans considered people's religious and spiritual needs and measures had been taken to ensure that, even when people's physical health deteriorated, they could still practice their religion. An on-site chapel as well as a faith room, which had been converted to enable people with mobility issues to access more freely than the chapel, was made available for people to access. People also had access to leaders of religious faiths. One person told us, "I was a practising Roman Catholic and I only have to ask and they'd take me to a local Catholic church".

Outstanding ☆

Is the service responsive?

Our findings

People, a relative and healthcare professionals consistently told us about an exceptionally personalised service that met people's individual needs. Observations showed that people mattered and staff spoke with pride about the people they cared for and celebrated their achievements. Staff continuously looked for ways to improve care so people had positive experiences and led fulfilling lives. People told us that the activities and events provided them with a purpose, occupied their time and enabled them to learn new skills. Comments from people included, "They help you to learn, I have learnt to paint. To get to 97 years old and still learn new things is lovely", "There is plenty to do here, if you are bored it is your own fault for not joining in" and "I use the Gym but only the treadmills on medical advice but I get one-to-one staffing so I can do this".

Following an assessment of people's needs, care plans had been devised that contained specific information about people's skills, abilities and needs in relation to their physical, mental, emotional and social well-being. People were involved in the development and on-going review of care plans to ensure that they were person-centred and reflected the person's wishes and aspirations. These provided staff with information to guide their practice and meant that people were supported in the way that they preferred. Additional documentation contained information on people's preferences and life histories. These provided staff with an insight into people's lives before they moved into the home. Observations showed that staff knew people extremely well and engaged in conversations with people about their interests. Care plans were reviewed on a monthly basis or when changes occurred and regular reviews, involving people, their relatives or representatives, if appropriate, as well as healthcare professionals, took place to ensure that people were content with the support that was being provided. People told us that they were able to share their views about their care during this time. Comments included, "Yes usually they get those sorted and we have a private meeting to discuss matters" and "I have this assessment meeting regularly where they ask what is personal to you".

When people first came to the home their needs were assessed and they met and had on-going contact with a Rehabilitation Officer for the Visually Impaired (ROVI). Once assessed, the person's needs were recorded in their care plan and they were provided with a plethora of aids that they could chose to use to assist them with their sensory loss. These included aids and adaptations to encourage independence as well as Braille, larger print documents, talking books, DVDs, Moon (a simplified version of the alphabet) and deaf blind sign language. Efforts were made to ensure that people received timely care and support, as part of the welcome induction to people moving into the home, they were shown how to operate and use systems that would enable them to call for staff assistance and make contact with people outside of the home. People told us that the use of this equipment and the support that was provided by the ROVI, aided their independence and provided stimulation and interest and this in turn developed their confidence and self-worth.

People received appropriate care and were enabled and encouraged to set goals and develop new skills, providing them with a purpose and a goal to aim towards. One person, who had been a keen archer, had experienced a recent decline in their health and had found that they were unable to continue to pursue their interest as they had difficulties standing and using their arms. Staff had worked hard, involving relevant

healthcare professionals, to enable the person to regain their skills. The person wanted to take part in an archery tournament at an event and wanted to improve their posture and strength to enable them to do this. The person made use of the on-site gym and referrals had been made to external physiotherapists, however, due to wait times, there was a risk that the person would not have received timely support to enable them to develop their skills in time for the event. Staff had arranged for a private physiotherapist, at the provider's expense, to work with the person, undertaking exercises to improve their core strength to enable them to stand as well as exercises that had been designed using resistance bands to improve the movement and dexterity of the person's arms and hands. Staff at the on-site gym had continued to support the person to undertake the necessary exercises to enable them to develop their strength. The person told us how much they enjoyed archery and that they were really looking forward to the event. This demonstrated that staff were aware of the impact working towards a goal could have on people and had worked creatively to enable the person to regain their skills and pursue their interests.

The home housed an on-site gym, swimming pool, arts and crafts centre and a fully stocked bar, as well as attractive and accessible gardens. A dedicated activities team ensured that people were able to take part in an extensive range of meaningful occupations that met their interests and were specific to them. Several sessions were held each day and evening that people could choose to participate in, such as IT and gardening club, yoga, quizzes, comedy club, external entertainers, dominoes, PAT dogs (Pets as Therapy), baking and organised talks on areas of interest such as the Civil War and The Royal British Legion. People's skills were recognised and they were encouraged to share their knowledge and skills with others, for example, one person had taught people how to read Braille. Regular trips out to the surrounding local areas were organised for people to participate in and links had been built with the local community such as schools and Beaver groups so that people continued to have a link to the community outside of the home. Comments about the responsiveness of staff and of the facilities provided were overwhelmingly positive. People told us how the facilities at the home, as well as the activities that were provided, enabled them to lead enriched and fulfilling lives. One person told us, "I've always loved doing crafty things with my hands and I used to come to the art classes here before I came to live here. It helped as I knew the place well and knew I'd have nothing to worry about as my sight deteriorated I'd be well looked after by people who would understand. Everything is up to me but they always ask you and let you know what is going on".

People were not at risk of social isolation. Although there were a wide range of activities for people to participate in and volunteers that spent time with people, the provider had recognised that some people would benefit from more one-to-one style activities or interaction. Two new roles had been developed that enabled care staff who had a keen interest and who had the relevant skills, to dedicate some of their time to supporting people on a one-to-one basis. Although this was in its early stages staff told us that this had proved successful and was something that they wanted to develop further.
A member of staff told us, "We are alert to people who spend a lot of time in their rooms. We wouldn't undermine their choice and preferences, some people just don't like mixing and a lot are old and like to take it easy in the afternoon. Staff look in on people at least every hour. We offer trips out. There's a person who has always said they wouldn't go outside, but we identified it was organised group trips they didn't like. We found out they like to go out one-to-one shopping for a couple of hours and so we make sure they can. We can also try to match people with a suitable volunteer." The home was used by people who visited during the day to use the facilities as well as people who were staying at the home on respite or holiday. People living at the home told us that they liked it when people came to stay at the home on respite or on holiday, as it meant that there was always someone new to talk to. One person told us, "It's very good as you always have different members to speak to. It's not always the same so you get them asking all about you and they tell you what they do away from here".

People were encouraged to maintain contact with those that were important to them. Comments from

people included, "On my 90th birthday I had a big family meal held here in the trophy room, everyone made it a very special day. It is like one big family living here", "My daughter visits regularly and she is always made to feel welcome and has got to know a lot of the staff", "The IT staff have lent me an I-pad so that when my young Grandson comes to visit he can use it to keep him entertained", "My family can visit when they like and for how long they want" and "I am encouraged to meet up with others and staff will take me to where my friends are". One person was supported to shop for clothing to enable them to attend an external military event, they told us, "I need a new jacket for my regiment meeting, staff are going to assist me to go into town to do this. I have a regiment meeting in Bexhill this month one member of staff has arranged everything so that I can attend". People's positive comments and our observations showed that staff went the extra mile to ensure that people led their lives to the full.

People had access to technology to enable them to call for staff's assistance. Call bell points were located in people's rooms as well as in communal areas. In addition, pendants that could be worn were provided so that people could continue to independently access areas of the home and grounds and would still be able to call for assistance if needed. People had timely access to assistance and told us that when they used their call bells staff responded promptly. Comments from people included, "I got nervous living alone and feel so safe living here and now have no worries. I have a bell so that I can call whenever I want", "There are always plenty of them around, wherever you are and you only have to ring. They'll be with you in no time at all" and "It was 4.00am and I just couldn't get my head comfortable in bed but I rang and they came straight away, no trouble at all, even for that. No, you never worry about calling them for any help at all". For people who were unable to use a call bell, due to their capacity and understanding, pressure mats were used so that when people mobilised staff were altered and could go to the person to offer assistance.

People were informed of their right to make a complaint when they first moved into the home. Larger print posters were displayed that informed people of the complaints procedure and comments boxes were available for people, relatives and visitors to use to make their comments and concerns known. People told us that they knew how to make a complaint and that staff would assist them to complete complaints forms and comment cards. People told us that they would feel comfortable making a complaint, without the worry of any repercussions to their care. Comments included, "You can complain as you know that there will be no comeback", "Staff are fairly easy to approach, but I have never complained" and "(Staff's name) is a great chap, always happy to listen if you're ever worried about anything". Regular meetings, such as members' meeting and care plan review meetings, provided additional forums for people to make their feelings known. People told us and records confirmed, that people were able to speak freely and air their views and concerns. These were listened to and changes made as a result. Comments within a recent survey completed by people, included, 'I could voice concerns and request meetings when I want. If something is wrong it is sorted straight away' and 'Nobody would hold anything against you. People's opinions are respected; they act on comments straight away'. Complaints that had been made had been dealt with in accordance with the provider's policy and demonstrated that the provider was transparent and open with people who used the service. The management team and staff demonstrated a reflective approach to their practice and were constantly reviewing how they worked and learned from instances. For example, when people died, staff would discuss the person's death to identify if anything could have been dealt with differently to improve the person's experience.

People received good end of life care and were supported throughout their death by caring staff that respected people's wishes and maintained their comfort and dignity. Staff were competent and had received training and advice from an external end of life care facilitator as well as local hospices to ensure their knowledge and skills were current. People's end of life care was discussed, planned and documented in their care plans. Records for one person showed that their expressed wishes had been respected and honoured, their relatives had been involved and they had received the end of life care they had chosen, they

had spent time with their family and had received visits from a priest. Records documented people's wishes with regards to where they wanted to spend their last days and who they wanted with them, as well as if they had any religious or cultural requirements. People were reassured by the experiences of others that had passed away. Comments from one person summed up how people felt about the care they received at the home. One person told us that many of their friends had recently passed away and although they were obviously sad, they said they felt comforted and were not afraid to die as they had seen that people had received such wonderful end of life care that it was nothing to be afraid of. Another person told us, "I am so lucky to be able to spend my end of days in a place like this". The provider took precautions to ensure that they were prepared for people's conditions deteriorating. Advice had been sought from external healthcare professionals, equipment hired or purchased if needed and anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life. In addition, the provider had purchased syringe drivers so that these were available for use if people required them. A syringe driver helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin. Relatives were welcome to spend time with people and could stay at the home or at a nearby facility that the provider owned. Staff also told us that if a member of the charity had passed away, then their spouse would continue to be supported by the charity to ensure that their on-going needs were met.

Good

Is the service well-led?

Our findings

Without exception, people, a relative and healthcare professionals told us that they thought the home was well-led. One person told us, "It's extremely well-run and organised. Everything happens when it should and they do what they say they're going to do". A healthcare professional told us, "It's beautifully run".

Blind Veterans UK is a charity that was founded in 1915 to support men and women who have served in the armed forces or who have completed National service. It provides practical and emotional support to enable people who have impaired vision or who have lost their sight in battle or through accident, illness or older age, to lead enriched and fulfilling lives. The provider has two centres that provide residential and respite care as well as day facilities and holidays. Blind Veterans UK – Brighton is one of those centres. The provider is forward-thinking and their aims and vision are that no person who has served on behalf of the Country should face blindness alone. The provider had a clear set of values that encompassed a person-centred approach, ensuring that people were treated with compassion, dignity, equality and respect. Staff also worked around one central statement 'We work together as one team'. These values and the statement were embedded in the culture and the practices of staff. Prospective staff were assessed against the provider's values and these were central to the supervision of staff and they were asked to reflect on their practice in relation to these. Staff told us that they were proud to work at the home, enjoyed the support that they provided and worked as a team. This was evident and observed in practice.

There was a large management structure within the home. The management team had recently been restructured to aid efficiency and consisted of a centre manager, a care manager, facilities manager, operations manager, rehabilitation services manager and a residential manager. This management team ensured that the service that was delivered met people's needs. The home did not have a registered manager. A registered manager is a '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 home is run. The previous registered manager had left three months prior to the inspection. The provider had been proactive in the recruitment of a new manager and one had been recruited and was in the process of applying to become registered manager. Managers held appropriate management qualifications or were supported to work towards them to ensure that they had the skills to manage the service appropriately. In turn, they ensured that staff felt supported and equipped to support people effectively. Staff told us and observations showed, that management had a visible presence in the home to ensure that both people and staff knew who to approach if they had any queries or concerns.

Staff were supported well by the provider and the provider had previously achieved the Investors in People award. This sets the standard for better people management and defines what it takes to lead, support and manage people well. In addition, they had also achieved the Investors in Volunteers award. This helps organisations assess the quality of volunteer management and prove and improve the effectiveness of their work with volunteers. Staff told us that they were involved and kept informed of any changes within the organisation and that they felt valued. Records demonstrated that the provider was open and transparent with staff, regardless of their roles, through a range of regular meetings and meetings, held by the chief executive of the charity, took place to inform staff of the vision and strategies that were in place to assist

them to implement changes. Staff had access to regular one-to-one meetings with their managers and told us that they could approach management at any time if they had any concerns or needed further support. The provider demonstrated a caring approach with regards to staff's well-being, an employee assistance programme was available for staff to access if required. Staff were provided with regular feedback on their practice to enable them to reflect on and develop their knowledge and skills to improve the support that people received and to know what was expected of them. Staff morale was good. Staff told us that they worked well as a team and were able to work together to resolve challenges that affected their work, such as the recent management restructure.

The provider demonstrated their awareness of the Duty of Candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. Although there had been no adverse incidents to share with people, records showed that people had been informed, within members' meetings or reviews, of changes that were occurring within the home and had been involved in planning and contributing to any changes that were going to occur. Other records showed that people and their relatives or representatives, if appropriate, were informed if people's health needs or condition had changed. The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of certain events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. The provider was proactive in recognising when requirements changed; new Key Lines of Enquiry (KLOE) had recently been introduced and implemented. The provider had already assessed their practice against the updated KLOEs to ensure that they were meeting the requirements.

People's right to privacy was respected and information held about people, within both manual records and electronic, were stored and passed to other professionals appropriately. A data manager also ensured that staff were working in compliance with appropriate legislation and regulations. Both manual and electronic quality management systems were in place that ensured that regular audits of the service, which included surveys that were sent to people and professionals, were conducted and monitored by the management team. Action plans as a result of the audits were implemented and monitored to ensure that any improvements that needed to be made were completed appropriately and in a timely manner. The provider, management team and staff were aware of their roles with regards to quality assurance. They were responsive and once areas in need of further development were identified and recognised they ensured that timely action was taken to improve the service people received. This was demonstrated in practice when the shortfalls with regards to the practical application of MCA and DoLS were recognised. The management team took immediate action to ensure that this was addressed.

People told us that they were asked for the feedback, one person told us, "I have been asked to feedback about the service and feel that my opinion has been noted and changes have been made". People were involved in the running of the home. Regular members' meetings took place to enable people to share their ideas and be kept informed of changes at the home. Committees, such as dining, activity and gardening committees, had been set up which were run by people who lived at the home. These enabled people to represent other people's views and make changes to aspects of the home. For example, as a result of the gardening committee a person was able to grow their own tomatoes in the garden which people then enjoyed eating. One person told us, "We have monthly members' meetings. I asked about the dining room as the walkers were going in first and then it made less space for us in wheelchairs to manoeuvre so it was suggested that the wheelchair users go in first and that's how it is now and it's much better".

Staff were encouraged to identify areas that could be improved upon and feedback forms that had been completed were reviewed and discussed at the regular management meetings. In addition to this, a whistleblowing policy informed staff of their responsibilities to raise any concerns. A whistleblowing policy

provides staff with guidance as to how to report issues of concern that are occurring within their workplace. There were good systems and processes in place to ensure that the home was able to operate effectively and to make sure that the practices of staff were meeting people's needs.

The provider had developed good links with the local community. The on-site chapel was open for people within the local community to attend, and regular fundraising events took place that further developed the link with the local community. There were also plans to develop links with the community further. Relationships with external healthcare professionals and local authorities had been developed to ensure that people who used the facilities at the home as well as those that lived at the home, received a coordinated approach and service.