The Council of St Monica Trust

John Wills House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this inspection on 7 February 2017. It was an unannounced inspection. When John Wills House was previously inspected in July 2014, no breaches of the legal requirements were identified.

John Wills House is registered to provide nursing and personal care for a maximum of 80 people. At the time of the inspection there were 72 people living at the service.

The service comprised of two floors. The Willows accommodation on the ground floor provides general nursing care to people. The Orchards unit, which is also on the ground floor, provides care for people living with dementia. The Beeches accommodation on the first floor primarily provides shorter term care. This includes to people receiving end of life care or to people recently discharged from hospital who are receiving care and support for reablement and rehabilitation.

A registered manager was in post at the time of our inspection. 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 and associated Regulations about how the service is run.

People at the service told us they felt safe and spoke positively about the staff that provided their care and treatment. People received their medicines as prescribed. Risks associated with people's care and treatment were assessed and managed. There were sufficient staff on duty to meet people's needs and safe recruitment processes were completed. There were systems that monitored accidents and incidents to reduce the risk of reoccurrence and further harm. The service was cleaned to a high standard. There were effective systems that monitored the safety of the environment of the service and the equipment within it.

People said they were supported by effective staff that met their needs. The service had nominated 'Champions' in different specialisms to support staff in delivering care that provided a positive outcome for people. Staff understood the principles of the Mental Capacity Act 2005 and gave examples of how this legislation impacted in their work. The service understood their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). Staff knowledge in DoLS was good and conditions attached to people's DoLS authorisations were understood where applicable. DoLS is a framework to assess the requirement to lawfully deprive a person of their liberty when they lack the mental capacity to consent to treatment or care and need protecting from avoidable harm.

Staff received appropriate training, supervision and appraisal to ensure that effective care was delivered to people. Where an opportunity had arisen, the provider had registered with a national pilot for staff to receive training in a new role being formally introduced into health and social care. The service could evidence outstanding practice through accredited schemes and there were systems in place to proactively motivate staff to provide a high standard of service. The environment had been adapted to meet the needs of people at the service in consultation with people and their families. The service was able to demonstrate they

understood the importance of eating and drinking well and excellent relationships had been built with other health and social care professionals.

People commented very positively about staff and told us they were well cared for at John Wills House. The ethos of the service was, 'Residents are not living in our workplace, we are working in their home' and this writing was displayed at the entrance of the building. The service had received numerous compliments about the care provided. Observations made by all of our inspection team supported the compliments we read. Staff understood the people they cared for well and were able to tell us about people's needs during conversations. People's visitors were welcomed to the service.

People said that staff at the service responded to their needs. People's relatives spoke positively about their involvement in care planning and care records were current, personalised and further demonstrated how the service had responded to people's needs. We observed that staff were responsive to people's needs when required. When needed, modifications within the service in response to people's needs had impacted positively on their lives.

The systems to communicate people's changing needs were robust and monitored. There were activities for people to partake in and there were systems to communicate with people and their relatives. The registered manager said that their aim of the service was for John Wills House to be seen as a support hub for the entire community of those people living on the Westbury Fields site, which is also run by the provider. This was evident by the current community links the service had established and positive steps had been taken to build further links.

People said the service was well led and commented positively on the management team. Staff we spoke with felt well supported by the registered manager and the rest of the management team. The registered manager had received written recognition of their leadership and the positive impact this had on people from a GP who attended the service. The service was involved in an innovative new multi-agency discharge scheme aimed at expediting hospital discharges. The registered manager had been asked to sit on the project board of this scheme and the project board had taken positive steps to improve communication with care homes as a result.

There were systems that captured the views of staff and meetings were held to communicate key messages. Where urgent messages needed to be communicated to staff there were methods in operation. There were effective governance systems in operation to monitor the health safety and welfare of people at John Wills House. A variety of quality assurance systems monitored the quality of service provided. The provider was a member of a local care and support network and participation in the local Care Home Provider Forum and Care Homes with Nursing Clinical Forum allowed the service to learn and contribute to the sharing of best practice The registered manager felt supported by the provider through supervision and appraisal.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe in the service and with the staff supporting them.

People received their medicines as prescribed.

Risks to people were assessed and managed safely.

Staffing levels were appropriate and recruitment processes were safe.

The service was clean and equipment was maintained.

Is the service effective?

Good

The service was very effective.

People said that staff were competent and met their needs.

There were staff champions who led and guided staff in best Practice.

People's rights were protected by staff who understood their legal obligations including how to support people who could not consent to their own care and treatment.

Staff received effective training, supervision and appraisal.

People's nutrition and hydration needs were met.

Is the service caring?

Good

The service was caring.

People spoke positively about the caring nature of staff.

The service had received many compliments from people and relatives.

We observed warm and caring interactions.

Staff understood the people they cared for well.

People's visitors were welcomed by management and staff.

Is the service responsive?

Good

The service was responsive.

People and their relatives said the service was responsive.

Care records were current and personalised.

The service responded positively to people's changing needs.

There were systems to communicate and complaints were managed.

Staff provided individualised care to people which clearly had improved their quality of life and wellbeing.

Is the service well-led?

Outstanding

The service was very well-led.

People were positive when asked about the leadership at the service.

The registered manager had received recognition of good practice.

Staff spoke of excellent leadership and management.

The registered manager was actively involved in local schemes.

There were effective and robust governance systems in use.

John Wills House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out by three inspectors, a specialist nurse advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. When John Wills House was previously inspected in July 2014, no breaches of the legal requirements were identified.

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 the improvements they plan to make. We also reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the service were living with dementia and were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us. We also reviewed seven people's care and support records.

We spoke with 15 people who used the service, two people's relatives and four people who were visiting people in the service. We also spoke with 10 members of staff. This included the provider's head of care homes, the registered manager, deputy manager, nursing staff and care staff who were providing care to people on the day of our inspection.

We looked at records relating to the management of the service such as the staffing rota, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

Good

Is the service safe?

Our findings

People told us they felt safe. We received positive feedback from people, their relatives and visitors we spoke with. One person we spoke with commented, "I am safe here now, and I know I will be in the future because I see the way staff look after the people who cannot do anything for themselves - they are spoken to and treated with such kindness and patience." Another person told us, "There are plenty of people around to help me if I need it - it gives me peace of mind." A further comment we received was, "Our doors are kept slightly open unless we would prefer them to be closed so staff can see, at a glance as they pass, if we are alright."

Safe recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service [DBS] check to be completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. In addition, the service had ensured that where necessary a staff member's registration with the relevant body was current. This included nursing staff being correctly registered with the Nursing and Midwifery Council.

People received their medicines as required. All of the people we spoke with told us they were happy with the way their medication was delivered. A local pharmacy provided the majority of medicines in a Monitored Dosage System (MDS). This is a storage system designed to simplify the administration of solid, oral dose medicines. Medicines are dispensed into the MDS by a pharmacist, which reduces the risk of errors. Staff removed the medicines from the dosage system and gave them to the person at the required time.

Medicines were seen to be stored safely and appropriately. Medicine fridges were available to store those medicines that required it and the temperature was checked and recorded daily. The temperature of the medicine storage room, in which the medicine trolley was kept, was being checked to ensure that medicines were being kept at the correct temperature. Controlled Drugs (CDs - medicines which are at higher risk of misuse and therefore need closer monitoring) were stored correctly and stock levels were checked daily. Disposal of CDs was recorded and signed and witnessed by two staff members. A medicine disposal kit was available. Stock levels of three CDs were checked and found to be correct. It was noted that a pharmacist visited the home twice a week along with a GP, which is good practice in the overall management of medicines.

In the nursing areas, Willow and Beeches, registered nurses were responsible for the administration of medicines. In the residential area, Orchards, senior support workers who had undertaken a medicine management course were responsible the administration of medicines. We observed two nurses and a senior support worker on part of their medication administration rounds and saw that they were well organised and safe practice was observed. The staff demonstrated an awareness of the needs and preferences of the people they administered the medicines to.

The senior support worker confirmed that they had undertaken a medicine management course and that

their competency to administer medicines had checked following their initial training. We looked at their training record, which confirmed this .We reviewed a copy of the Trust's Medication Training Booklet. This indicated that support workers undertook four medicine rounds whilst being observed before having a final assessment of their competency. Records indicated that 12 support workers had undertaken medicine management training since 2015.

The registered manager told us that registered nurses competency to administer medicines was assessed during their induction when they were observed over three shifts, but that there was no regular assessment of competency in place for them. The introduction of regular competency checks for all staff administering medicines may enhance current practice. Medicine errors were being recorded along with details of any action taken.

A sample of Medicine Administration Records (MAR) were reviewed. People's photographs were attached to their MAR sheets to aid identification and the date the photo was taken was recorded. People's room numbers were recorded along with their date of birth. Any medicine allergies were recorded. MAR sheets were signed following administration and there were no gaps on the sheets reviewed. Appropriate codes had been entered when medicines had not been administered and the reason for non-administration had been recorded on the reverse of the MAR sheet.

Records relating to the application of prescribed topical medicines were seen in separate files that were kept in people's rooms. In four cases seen, records were incomplete. This meant that there was no recorded evidence to indicate that the prescribed topical medicine had been administered. Written details of how and where to administer the medicines were recorded, however 'body maps' to specifically indicate which area of the body the topical medicine should be applied to were not in use. These would enhance current practice.

Individual protocols for the use of 'when required' (PRN) medicines were available. This is seen as good practice as it directs staff as to when, how often and for how long the medicine can be used and improves the monitoring of effects and reduces the risk of misuse.

Staff were clear on their responsibilities for reporting and recording any accident, incidents or near misses. We reviewed incident and accident records and saw a description of what had occurred, any injuries and the immediate action taken. Each accident and incident had a completed investigation and the care plan and associated risk assessments showed any changes made to prevent future reoccurrence. We saw that when patterns or trends had been identified, action was taken to reduce risks. For example, for one person the service had sought assistance from other health professionals on how to support the person in managing behaviour that could lead to falls.

Sufficient staff were supporting people. This was confirmed in the staff rotas, observations we made and feedback we received. People told us they were supported by familiar staff and agency staff were not frequently used. There was very little staff turnover and there was a stable team. This was confirmed when talking with staff and people at John Wills House. Staff were observed responding quickly to call bells and spent time talking with people in communal areas and on a one to one level in their rooms. One person said, "I am safer here than when I was living in a flat on site, because there are staff around 24 hours a day who would know if I had another fall."

People received safe care because risks to their health and safety were being well managed. Care records included risk assessments about keeping people safe. These covered all aspects of daily living. Risk assessments included the action staff must take to keep people safe. For example, within one person's care

records it showed the person was at high risk of falls. Robust risk assessments and risk management guidance was in place. This included information about the use of hip protectors, the use of sliding sheets to support the person when moving, automatic bed controls, the use of the shower chair and wheelchair. Other individual risk assessments we reviewed identified potential risks to people and gave guidance to staff on how to support people safely. For example, these assessments included risks such as falls, skin integrity, nutrition and hydration. One risk assessment guided staff to reduce the risk of falls by, 'Reviewing the environment at night - for example the lighting. Ensure glasses are worn and are cleaned as necessary.'

Staff had been provided with training on how to recognise abuse and how to report allegations and incidents of alleged abuse. Policies and procedures were available to everyone who used the service. Staff confirmed they attended safeguarding training annually as part of their training schedule. The registered manager and staff understood their duty of care to raise safeguarding concerns with agencies including the local safeguarding team, the Care Quality Commission and if needed, the police. The registered manager also kept a log of current safeguarding concerns to ensure they were concluded as required and information was shared as needed.

We found the service was clean. Communal areas and people's rooms seen were cleaned to a high standard and odour free. Domestic staff were employed daily to maintain cleanliness standards. There was liquid anti-bacterial gel available at designated points around the building to promote good hand hygiene practice. Staff were observed wearing protective equipment when required which also reduced the risk of cross infection. People and the relatives we spoke with did not raise any concerns about the cleanliness of the service. Staff we spoke with told us the service was well maintained and cleaned. There were also governance systems that monitored the cleanliness of the service.

The environment and equipment used within the service was maintained to ensure it was safe. The provider had dedicated staff that monitored all aspects of the environment and the equipment within the service. We received information from the provider's Facilities Operations and Health & Safety Manager that detailed the regular maintenance and servicing of mobility equipment undertaken within the service. Environmental aspects such as legionella risks and lighting were frequently audited. Mobility equipment such as wheelchairs, hoists and slings were also subject to regular checks and servicing. Passenger lifts were subject to regular servicing and the testing of the fire alarm and associated fire fighting equipment was undertaken.

Good

Is the service effective?

Our findings

People spoke positively about staff and told us they were sufficiently skilled to meet their needs. We received feedback that indicated people were very happy with the staff that provided their care and people felt that staff were competent. One person told us, "Staff respond to my requests and respect my need for independence - because of my visual impairment they are aware of the need to put things back in the same order so that I can locate them." Another said, "I have no problems with the staff's competency, they are excellent." Other positive comments we received included, "I would say without a doubt that staff are competent in all they do" and, "Staff are proficient and efficient, even the young ones, I feel very at ease with them."

The service had 'Champions' in different specialisms to support staff in delivering care that provided a positive outcome for people. Within the current staff team, there were champions in areas such as nutrition and hydration, activities and infection control leads. There was also an advanced nurse practitioner who was essentially the 'Clinical Champion' at the service. This role involved working in a supernumerary capacity to both deliver training and complete audits and observations of nursing practice to ensure effective care was delivered. Champions received training in their key area, for example the nutrition and hydration champions had attended training with the National Association of Care Catering. The champions within the service acted as a resource and guide for other staff. We saw how these roles had impacted positively for people. For example, the nutrition and hydration champions supported people with menu planning and were about to be involved in trialling new equipment with people to enhance their dining experience.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Care records showed that people's capacity had been considered. For example, we saw an assessment had been made of whether a person had the capacity to decide whether a sensor mat was used in their room. The assessment demonstrated that the person had the capacity to make this decision. When a best interest decision was needed, records showed who had been involved in making the decision, the options considered and why a particular decision had been reached. We saw an example of good practice for one person who was receiving their medicines covertly. They received their medicines this way as they lacked the capacity to consent to receiving them in this manner. We saw evidence that a best interest decision had been recorded. The relevant covert medication order and records had been signed by the person's GP, a relative and a registered nurse.

Staff we spoke with understood their obligations under the MCA and how this legislation could impact on their work when seeking consent from people. We heard staff seeking consent before any intervention and waiting for a response before proceeding. People we spoke with confirmed this was always the case. Staff

confirmed they received training in the MCA and in addition to the observations we made, staff gave examples of how they empowered people through choice. They gave examples such as supporting to people to choose their meals, their clothing for the day or what activities they wished to partake in.

The registered manager had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The register manager had made appropriate applications for people living at the service and these were currently being processed by the local authority. A senior staff member kept an up to date overview of DoLS applications and their current status. One person had an authorised DoLS. We found the conditions specified within the authorisation were being met. Care records documented how the conditions were being met. For example, a log of activities the person had been offered and what they had participated in.

Staff received effective training to carry out their roles. All of the staff we spoke with said they were given sufficient training to effectively support people and meet their needs. Staff had received appropriate training in a variety of relevant topics to meet the needs of the people who used the service that included moving and handling, health and safety, fire and safeguarding. The provider had a scheduled, 'Mandatory Update Day' to allow staff to complete a full day of update training in specific subjects. These annual training days included subjects such as health and safety, first aid, moving and handling, safeguarding, the Mental Capacity Act 2005 and equality and diversity.

Staff received regular performance supervision and appraisal. The 'Advancing Colleagues Contribution' process ensured staff received regular supervision and an annual review. Staff we spoke with said they felt supported through this process and said it gave them the opportunity to discuss their development with senior staff, together with any concerns they may have. The 'Advancing Colleagues Contribution' process also ensured staff annually completed a document that incorporated a personal training and development plan for the following year.

The provider had ensured staff had the opportunity to develop in their roles. Unique, additional training opportunities had recently been provided for staff. The provider had secured a number of places on a national project that was being piloted. The project was to identify and train care staff into the role of 'Nurse Associates.' This role was a bridge between care staff and registered nurse. A letter had been sent to all care staff inviting them to apply for the role or to discuss the role with the registered manager. An explanation of the course, including the time length and expected commitment from staff was contained in the letter. This showed the provider was proactive in supporting staff to develop.

The provider supported new staff through a formal induction. Staff also completed the Care Certificate. The Care Certificate was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. There is an expectation that all new staff working in the care industry should complete this induction during their first three months. One staff member told us, "I have finished my care certificate, which is an achievement. Now I have signed up to other training. One is working with families and the other is MCA and DoLS. There is lots of training on offer here."

The corporate induction given to new staff by the provider was a comprehensive four day induction. The provider had also increased the induction period of staff to five days if they were working with people living with dementia. New staff completed the four day induction followed by a period of shadowing senior staff. They would then be monitored by senior staff to ensure they were competent at their role. The induction included training in subjects such as moving and handling, safeguarding, equality and diversity and infection control. We spoke with a member of staff that had recently completed the induction who spoke positively about it. They told us, "[The induction] Was really good. I looked forward to starting after the induction." Dementia training was included. I did three days shadowing after the induction."

The service had thoughtfully considered the needs of the people living there and this was reflected in the way the service was decorated and the items around for people to engage with. Within the Orchards accommodation for people living with dementia, people's doors had been painted in bright colours and in the style of a front door. This had been done in consultation with people and their relatives. There were black and white photographs that could be removed from the walls and carried around of significant people in history and well known geographical places. There were tactile items and sensory aids for people to enjoy. Within the Orchards accommodation the dining room had been recently been relocated to make it more accessible to people.

People were supported with meals and keeping hydrated. Relevant information was communicated to the kitchen staff on any specialist diets. People who required supplementary drinks to support them in weight gain or maintenance received their prescribed supplements. We received very positive feedback on the food at the service and staff who supported people at meal times knew people's likes and dislikes. Although people selected their meal the previous day, people were shown two meal options and could select either at time of serving. An alternative could be prepared if a person did not like either choice. Where needed, people received support. One member of staff was observed assisting a person to eat whilst they were in their bed. The staff member was sat at the same level of the person and they took their time which allowed the person to be able to swallow their food. The person was sat up and appeared comfortable. They were also offered a drink during their meal.

Comments we received about the food quality was positive. One person said, "Food excellent, nice variety, choice of two dishes, two cooked meals a day, they make sure you drink plenty too." Another commented, "We get very good meals, I prefer vegetarian food and there is a good choice." Another person told us, "Food is excellent - I have a gluten free diet, they manage this well. They know what I like and I always have a choice."

We spoke with staff about nutrition and hydration. Through speaking with staff and reviewing governance systems it was clear the service worked closely where required with a person's GP on monitoring weight gain and loss. Where people were at risk, staff were recording what meals people had eaten and any refusals. People were weighed monthly, however the service used a nationally recognised malnutrition tool that indicated if a person's weight monitoring frequency should be increased. Where this was the case, records showed the weight monitoring frequency had been increased as needed. We reviewed a sample of food and fluid charts and saw these had been completed accurately.

The service was able to demonstrate they understood the importance of eating and drinking well. In addition to the links with dietary professionals, John Wills House had been part of a pilot with a national drinks supplier and had introduced hydration stations within the service. These hydration stations had a daily choice of flavoured drinks to promote good hydration. The flavoured drinks were sugar free to ensure that they were consumable to all of the people in the service. In addition to the drinks at the hydration stations, snacks were readily available for people to help themselves.

People had access to health and social care professionals. People living at John Wills House had the benefit of the services nominated GP attending twice a week to see people in relation to any health concerns they may have. Within people's care records there was clear evidence of external professional involvement. This included community psychiatric nurses, district nurses, physiotherapists, social workers and tissue viability nurses. On the day of our inspection we observed a nurse speaking with a person about their health condition and asked the person if they wanted to see the GP. We also spoke with a senior support worker who advised us they had contacted the GP that day as they had noted that a person was not eating or drinking well.

It was evident the service had excellent links with other health and social care services. There were quarterly meetings with the local GP to review and discuss events within the service. This included deaths and end of life care plans. The local GP provided a letter describing the service as 'outstanding.' The GP had attended the service over an approximate two year period. They describe the service at all times as being calm and commented how people's needs were addressed promptly. They described staff as courteous and detail their kindness. The letter described how other healthcare professionals, for example out of hours GPs, district nurses and the local hospice team [who worked proactively with the service] had told them of the high standard of care they witnessed.

The service and staff employed within it were able to demonstrate outstanding practice by working towards achievements with accredited schemes. For example, John Wills House was a finalist in the 'Care Establishment of the Year' category judged by the National Association of Care Catering in October 2016. The service was also awarded a bronze award from the Food for Life Organisation which related to good menu planning. The service's Advanced Nurse Practitioner was nominated for a leadership award given by Care and Support West in 2016. The nomination was as a result of work undertaken in the short term care accommodation of John Wills House.

Good

Is the service caring?

Our findings

There were positive comments received about the staff. We received a very positive selection of comments from people, their relatives and visitors to the service when we asked if they felt cared for by staff. At the entrance to John Wills House, the words, 'Residents are not living in our workplace, we are working in their home' were clearly displayed. The registered manager explained this was the ethos of the service and this was why it was displayed at the entrance for all people entering the building to see.

One person commented, "I have been happy since the day I moved in here, there is nothing that has not been enjoyable, I can entertain my friends and family and offer them a tipple as I can keep a bottle of whiskey and sherry in my room." Another comment we received was, "Lovely staff, could not wish for better people to look after me, I am happy with all they do, and would not want to be anywhere else." A further person we spoke with said, "I could not have better treatment, the staff have such patience, I feel they really care about me." A visitor we spoke with said, "I have never seen my friend so happy and so well before they have moved in, this is a wonderful place, everything about it is good."

We reviewed a selection of compliment cards and letters recently sent to the service. These cards and letters contained very positive feedback and were consistent with people's views about the staff employed at the service that we obtained during the inspection. For example, within one card a person's relative wrote, 'I would like to thank you all for the care and kindness my Mum received.' A person that previously stayed at the service wrote, 'Thank you for everything you did for me during my stay. Xmas was wonderful.' Another relative had written to the service to say, 'My family and I will always be grateful for the wonderful care you gave to [person's name] during her 4 week stay with you. [Person's name] was treated all the time with dignity.'

The provider encouraged people or their relatives to use a national website to give feedback on the service. There was information about the website displayed in the main entrance to the service. The service had received one review since our previous inspection. The review was very positive. An extract from the review read, 'My Mother has lived at the Orchards for just over two years, during which time her care needs have changed considerably. I have been extremely pleased with the care that she has received. The staff are wonderful - caring, kind, patient and responsive to her needs. They make great effort to get to know and understand my Mother, in order to treat her as an individual. The staff are also alert to the needs of the family members who visit my Mother.'

People were well cared for. People looked well kempt, their hair was neatly groomed and fingernails were clean. Staff were seen to interact with people in a kind and compassionate manner and were heard to refer to people by their preferred name, using appropriate volume and tone of voice. Where people were being cared for in bed, those seen appeared to be comfortable and were well positioned. We saw that staff regularly visited people in bed. People appeared to have a good relationship with staff. People looked comfortable when approached by staff and there was friendly banter between them. All of the people we spoke with agreed that they were treated with respect and dignity, and said that their privacy was maintained. People confirmed that staff knocked and waited for a response before entering their rooms,

and bedroom doors were closed and curtains drawn before any personal care was carried out. This was confirmed from our observations, and an 'Engaged' sign was also shown on the door during periods of personal care.

Staff we spoke with were knowledgeable about people's care and treatment needs. Staff understood personalised care and demonstrated this when they told us how different people liked to be cared for. This showed they understood the people they cared for. During our conversations with both nursing and care staff, it was clear that people's care and treatment needs were known. It was evident through our observations between people and staff that there were good, caring relationships and people always appeared relaxed and happy during interactions with staff. One nurse we spoke with said, "It's very homely here, not regimented; very person centred." Staff were also knowledgeable about maintaining confidentiality within their role. One member of staff described this as, "Care plans and computer files. Being careful about the information we share."

We made observations of staff supporting people in a kind, caring and sensitive manner. For example, with a person's consent, we observed two staff members using a hoist to transfer the person from their wheelchair into an armchair. This procedure was completed with competence by staff, who ensured they communicated with the person throughout the process and offered instructions and reassurance when needed. Another observation was of two members of staff supporting someone to move around the home safely. Staff were kind and encouraging throughout the time they supported the person. One staff member said, "You go slowly, take your time."

We made observation during the lunch periods in the Orchards and Willows areas of the service. We observed positive interactions during both of these dining experiences. On Orchards, there were seven people dining. All were comfortably seated at tables, those people who required support with their meal had a member of staff sitting next to them. Staff supported and helped these people in a sensitive unhurried manner, taking their cues from the person and offering a drink as needed. People were asked if they wished to have their meal cut up once it had been placed in front of them. Staff were very vigilant, allowing people to be independent but offered support where needed. People's portion sizes were judged by the staff who evidently knew people's eating habits well. All of the people we observed were wearing clothes protectors, and staff had gained the appropriate verbal consent before they put them on the person.

On Willows we observed staff sat alongside people at mealtimes and gave individual support and encouragement when needed. All staff we observed described what was on offer to people and asked what they would like to try. One staff member said, "Would you like to try the chicken or the potato first?" The table was nicely laid with different cutlery options, condiments and flowers. People had space to eat their meals whilst retaining a social environment. One staff member said to a person, "Would you like to try the soup?" and supported them to do this. Staff gave encouraging comments such as, "You're doing really well."

We saw that when a person did not appear to want what was on offer, the staff member offered alternatives, inviting the person to look at the other options as well as describing them. One person could not recall what they had chosen for dessert a staff member prompted them. This led the person to engage in a conversation about different variations of this dessert. Staff spoke with people about forthcoming activities and the music people were listening to during their lunch. The atmosphere was welcoming, positive and friendly.

People could be visited by their friends and relatives at any time of day. There were no restrictions on people's relatives or friends visiting the service and relatives were welcomed. This meant that people living in the service were not isolated from those closest to them. During our inspection several visitors came to the service to see people. It was clear that staff knew the visitors well when we heard them speaking with

them. A member of staff said, "Families can visit any time they like." During our inspection we saw several people receiving visitors. We saw that family and friends were invited and encouraged to join in activities and outings that were provided by the service.

Good

Is the service responsive?

Our findings

People and their relatives were positive when they spoke of the responsiveness of staff at the service. People said they felt involved in decisions about their care and treatment. One person we spoke with said, "I am involved in all decisions regarding my care, staff understand my views, at my age I will take it as it comes, and have made plans for my end of life care. This was done in agreement with my family and has been noted carefully. It was done with respect and sensitivity by staff." Another person commented, "Both myself and my family member are involved in my care, I am well looked after in all ways, but would tell my family member if I had any worries or concerns." A further comment received was, "Staff seem to understand me and my funny ways, I am very happy with my care, I tell my family member everything and would leave it for [family member's name] to sort out if I was worried."

People's relatives also expressed satisfaction at their level of involvement in care planning and the communication they received from the service. A relative told us they were very involved in the care of their relative living at John Wills House. They felt staff keep them informed at all times of any changes in their relatives condition. This was evident as during our conversation with the relative, staff who had been giving care approached the relative said they were going to call the GP because of their concerns for the person. The relative went on to tell us they were very happy with the level of care provided, and said it was delivered in the way their loved one would want, and said all their needs were being met. They said they were certain their loved one was well cared for and was treated with dignity and respect.

Care records contained an up to date photograph, any known allergies and contact information for family members and health professionals. People's life history was described giving an insight into people's interests, past employment, family members and areas of significance. For example, one care record described how a person's experience during the war affected their present sleeping patterns. This demonstrated the service had ensured they understood the people they cared for and had used key information about the person during the planning of care.

Care plans were person centred. They described people's personal preferences' and gave guidance to staff about how people wished to be supported. This included people's usual routines. For example, some comments within people's records were, 'At night likes the room light off but the bathroom light left on. Likes an early morning cup of tea.' Care records gave details on the level of support people required for different tasks. If people could undertake the task independently or the number of staff to support them safely. For example, 'Is independent with hot drinks,' or 'Requires supervision for dressing and undressing.' Care records gave many individual details to ensure that people received care and support how they wished. People's religious, cultural and social needs were identified within people's care records and gave guidance to staff on how people wished for these to be met. For example, '[Name of person] is a private person. Likes the comfort of their own room. Not keen on participating in activities but likes to be kept informed of them.'

Care records showed that the service was responsive to people's choices. For example, one care record described a person's night routine which often involved disturbed sleep. It documented how the service supported the person in the way they preferred for example, by providing a hot drink and snack in the early

hours of the morning. Another care record described how a person liked their food served very hot and how the service supported them to do this safely. People had individual messages on their door to notify staff of their preferences. For example, 'Please don't wake [Name of person] in the morning. [Name of person] will ring their bell when they are ready,' and 'I would like my door to remain open.' This demonstrated that people's chosen likes and preferences were actioned in accordance with their wishes.

We observed staff being responsive to people's needs throughout the inspection. Call bells were answered quickly when they rang and people were observed to have the correct mobility equipment to hand. Where people had limited mobility, or were nursed in their bed due to poor health, we observe they had call bells to hand. Staff carried pagers which rang and notified them which resident was calling.

We saw the service had been responsive to people's needs and this had resulted in a positive impact on their lives. For example, following consultation with a commissioned social care professional modifications were made to the dining experience in the Orchards accommodation for people living with dementia. This included the entire relocation of the dining area and adjustments in staff practice. This was noted in a follow up report as having a positive impact on people and stated, 'The patience and positive persistence of staff paid off and clearly had a significantly positive impact on the resident's nutrition and hydration.'

Dining tables were also adjusted to different heights to accommodate people with mobility needs to allow them to enjoy their dining experience. Additional alterations were made to accommodate wheelchair users to enhance their dining experience. In addition to this, a pilot on one area of accommodation in John Wills House was due to commence in trialling adapted equipment to promote people's independence with eating and drinking. This trial was with a national catering equipment company. Following this, for the people who wished to participate their opinions would be sought to establish suitability of the equipment. A nutrition and hydration champion would be appointed to undertake this trial together with the deputy manager, chef and a representative of the equipment supplier.

There were systems to communicate key messages to staff to ensure people's changing needs were met. There were daily handovers completed in the service between shifts. A member of our inspection team attended a handover between the nurses who had completed the morning shift to the nurses undertaking the evening shift. We found that during the handover, the information communicated between staff was informative and the handover was robust. Information such as new or current risks to people, medication changes of significance, vital signs and observations together with any relevant information relating to dietary and fluid intake was discussed. During the handover, people to whom the information related to were discussed in a dignified and respectful manner.

The service had a complaints procedure and this information was available to people and their relatives. The complaints procedure gave guidance on how to make a complaint and the timelines and manner in which the service would respond. There was information on how to escalate a complaint to the government ombudsman should people wish to contact this department. Complaints were subject to a monthly review and the complaints we reviewed had been responded to in line with the provider's policy. People said they would feel comfortable in raising a concern if they needed to and would tell a family member or staff.

A range of daily activities were available for people to participate in. There were designated activities co-ordinators in the service known as Activities Champions.' In addition to this, an activity co-ordinator employed at the provider's head office liaised with the 'Activity Champions' on site at John Wills House. There was a detailed timetable in foyer and in each separate area of the service about the activities available. We saw a Valentine celebration was planned with a quiz and reminiscence about how people had met their loved ones. There was a well-attended afternoon pampering session within the Beeches lounge on

the day of our inspection. The environment was calm and interaction was natural.

Other activities available included worship, poetry reading, tai chi, singing for the brain, alive, harp concert, a local pat-dog and singing songs from musicals. There were also trips arranged on the mini-bus to the local area, the venue of which was chosen by people at the service. We spoke with the registered manager about the activities. They explained how they had the view that, 'If we can't take them there we will bring it here' when it came to activities. They gave examples of how this was achieved, for example by having a 'Wimbledon' theme during the annual tennis competition and a big screen had been obtained for the service to do a 'Fireworks Night' and the kitchen prepared food similar to that experienced at such an outdoor event. This showed that innovative methods were used to increase people's social experiences.

The service had made clear efforts to support staff in communicating with someone. Within the service, a person currently accommodated in the shorter term care area of the Beeches did not speak English as their first language. We noted simple questions had been translated into the person's first language and affixed to a unit in their room, for staff to use. During the inspection, it was evident that staff were attempting to engage with this person in their language. We observed a nurse, who was not a fluent speaker of the language, greet the person in their first language and the nurse also attempted to use different words during their conversation with them. A member of the inspection team, who was fluent in this language, was able to engage with the person, who although not responding verbally, smiled and was visibly pleased.

The registered manager sought the views of people and their relatives through communication at meetings and had responded to observations made by people and their families. A bi-monthly meeting was held. We reviewed previous meeting minutes that the registered manager and people's families had discussed matters such as management team changes, activities, menu planning and any upcoming themed evenings. This ensured that the views and opinions of people were sought to ensure they had input on matters important in their daily living. We also saw further responsiveness, as people had requested the times of the meetings be altered and this had been facilitated by the registered manager. People also told us the service were responsive, for example one person said, "They listen to us, and act on what we say, for example I said the pork chops were too hard to cut, also that the porridge was cold by the time I got it, they have changed things, so everything is fine now."

The registered manager said that their aim of the service is that John Wills House to be seen as a support hub for the entire community of those people living on the Westbury Fields site and the wider local community. People from the local community were invited to John Wills House every week to enjoy events and socialise with people at the service. The registered manager stated that some family members of people that used to live at the service visited the service regularly and that this was actively encouraged. Some family members of people that used to live at the service had become a volunteer which was also actively encouraged. An example of this given to the inspection team was a family member that now volunteers to run a poetry group within the service that now meets every two weeks.

The trust had a pastoral care team who lead a weekly service of worship. Other links with the community that had recently been formed were with the local pre-school that performed Christmas carols for people during the festive period. During our conversations with people this was mentioned as being a positive experience which demonstrated this link had impacted positively on people's lives. The service currently aimed to build further links by planning to make the attendance of the local pre-school a regular occurrence and aim to invite the children to partake in 'Story Time' with people in the near future. The overall aim would be to involve people living at the service in taking part in the story telling. If this was successful the registered manager aimed to make this a monthly event for people and the children. There were also future plans to develop additional links that could include a sports day for the children on the Westbury Fields site

for the people of John Wills house and the local community to be involved in.

Events to support the local community and the wider area were also held and involved people living at John Wills House. For example, the recent annual Christmas fair included raising money for the Alzheimer's Society and St Peter's Hospice, with whom the service have a close link. In addition to this, prior to Christmas a 'Bake Off' was held at the service as a fundraising event for the McMillan Cancer Trust. People were supported by staff to bake and enter a cake into the competition, with one member of staff being recognised for giving up her own time to help people decorate their cakes by being entered in the 'Star of the Month' incentive. The competition was judged by the Chief Executive. The registered manager told us that people at the service decided where the charitable donations were sent to increase their involvement in fundraising events.

Outstanding ☆

Is the service well-led?

Our findings

When we spoke with people and their relatives we received positive feedback about the registered manager and the overall management of the service. Most people knew the registered manager by name. One person we spoke with commented, "The manager always comes in for a chat on my birthday." Another told us, "The manager is always there if you want her." A further comment we received was, "If you wish to see the manager, staff will always take a message asking her to come."

The culture and visions of the service were outstanding. This was evident through recognition of strong and positive leadership that had been received from a GP who felt the care in the service was outstanding. An extract of correspondence we reviewed from the GP read, 'This outstanding care is down to your outstanding leadership! I am in awe of your management skills and I think you have a terrific senior management team who are all good 'hands on' clinicians as well as competent team leaders. You are also good at 'growing your own' and I have witnessed some successful promotions among your staff.' This demonstrated that visiting healthcare professionals view the registered manager as a positive role model to their team.

Further evidence of the outstanding visions of the service were that the registered manager was actively involved in an innovative local scheme recently launched by the local Clinical Commissioning Group (CCG). The 'Discharge to Assess Pathway' was now used at some local hospitals. John Wills House has been involved with this project since its commenced. The schemes aim is to allow older people to leave hospital earlier and to have an assessment of their on-going social care needs within John Wills House. This scheme assists local hospitals in freeing up beds, and also offers a choice to older people to have the space and time to make their own decisions whilst having first-hand experience of a care home environment at John Wills House.

In November 2016, the registered manager was invited by the CCG to become part of a project group looking at ways to increase the understanding between the hospitals, local CCG's and social care providers. The aim of the project group was to ensure safe, effective and timely discharges and for each member of group to have a better understanding of what each other required to enable this to happen. The registered manager was currently the only person employed within a care home service on this project group. The project group meets every two weeks.

The project group had subsequently identified a need to improve the flow of information between the hospital and care home providers. As a result a new 'Discharge to Assess' single point of referral form has now been developed from this work. It will be piloted from two wards from within local hospitals and the registered manager has ensured John Wills House will be part of this pilot with the new referral form. The registered manager had been asked to attend the hospital discharge board rounds to give feedback on referral forms effectiveness following the conclusion of the pilot.

The service also worked in co-ordination with the local university. As a result of this, the service took student nurses on a nine week placement during their education and training. The registered manager stated this

was routinely successful and the students frequently joined the services bank of nurses at the end of their placement.

All of the staff we spoke with were positive when asked about the leadership and management of the service, as well as their overall employment satisfaction. All of the feedback we received was positive. When asked about their employment, one member of staff commented, "No concerns here. Worked in three other homes and left. I need to be working somewhere that is giving good care and here does. Managers have an open door policy and are open to ideas and suggestions. They listen to staff on the floor. It is a good home and the care is good." Another staff member told us, ""I am really well supported. There is always someone around to ask. Everyone works together. Staff help and guide you. I can talk to the manager at any time. I can always speak to her." One staff member when asked about the registered manager told us they were, "Approachable and easy to talk to. Really good manager."

A staff survey was distributed to staff to allow them to express their views and opinions on their employment. We spoke with the registered manager about the most recent survey completed in October 2016. They explained that despite in excess of 100 surveys being sent out, the response rate was very poor at 15. As the results were not measureable, the action arising from the survey was establishing how to obtain better staff engagement at the next survey. We did see that staff were involved in the choosing of colours and furniture of the new staff room recently provided from them following a grant from senior figures in the Trust.

Messages were communicated to staff through meetings. The registered manager told us that meetings were currently held every two months for day staff and quarterly for night staff. Staff we spoke with during the inspection told us they attended these meetings and spoke positively saying they could contribute to them. We saw that matters such as actions from the previous meeting, current policies, annual leave, supervision, staff changes and training were discussed. In addition to the structured meetings, the registered manager told us that key messages were communicated quickly through letters to staff. Each staff member had their own post drawer to receive mail. We saw a sample of letters that showed information such as new policies or procedures and any changes to processes in matters such as medicines were communicated.

We saw that additional key messages that for matters that could have an impact on the health and welfare of people were produced by the provider who distributed a 'Care Bulletin' across the provider's locations. For example, following an incident at a different location, information about undertaking safe hoisting practice was immediately communicated. Other communications included accident and incident reporting, potential prescribing errors and the safe use of sharps bins.

There was evidence that the service placed employee welfare as a key priority. In addition to staff telling us they felt supported and the incentive schemes available, we found additional measures were taken to support employees when needed. For example, following a review of the infection outbreak policy in 2016, a decision was taken to ensure the provision of free flu vaccinations for staff. This was aimed at giving staff protection from the virus and also to reduce the risk associated with people in the service therefore having a positive impact on their lives. In addition to this, the registered manager explained how the Chief Executive of the Trust personally took time to speak with European colleagues following the recent referendum result to discuss the possible outcomes and provide reassurances where possible.

There were proactive support systems in place to motivate staff and others to provide a quality service to people. There was a 'Star of the Month' incentive in operation. We discussed this with the registered manager who explained how anyone can nominate any one to be in receipt of this award. For example, staff could recommend a colleague, a healthcare professional, a person who lived at the service or a relative for

the award. This meant that the 'Star of the Month' scheme was not exclusive to staff but was inclusive of everyone either living in or visiting the service. Signs were displayed around the service about how people can do this. A prize was awarded to the winner and a photo of the monthly winner was displayed.

The ROSE (Recognition of Special Endeavours) Award was an annual event held by the provider. The award was primarily to celebrate staff and volunteer achievements during the year. Staff, volunteers and residents can be nominated for an award at any time during the year. Also, all the monthly winners of the 'Star of the Month' Awards at John Wills House were put forward as ROSE award nominees. A number of people would be chosen to win a ROSE award and these are given out by senior managers as a surprise. An annual awards dinner is also held at a local venue where awards were given out linked to the provider's values. These were, 'We are people people, we are caring, we are responsive, we are honest, we are inspirational and we are dedicated.'

There were systems to communicate with people's relatives. The registered manager told us that they used different methods to communicate with people's relatives. We saw that six monthly meetings were held for relatives that discussed matters such as changes to staffing and management, drawing awareness to the fact the service were now on social media, any planned works or renovations being undertaken and any future activities or events. In addition to this, where the need was identified letters were sent to both people and their relatives explaining new schemes and projects, staffing changes and redecorating. A quarterly newsletter was also produced. We also saw that people and their relatives were consulted for their views on the installation of Closed Circuit Television [CCTV] cameras. This CCTV consultation was undertaken prior to any decision being taken by the provider which showed the thoughts and opinions of people and their relatives were valued.

There were governance systems to assess, monitor and reduce the risks associated with people's care and treatment needs. For example, weekly and monthly medicine management audits were being undertaken. We saw records of these that indicated appropriate action was taken in response to audit findings. Medicine errors were being recorded along with details of any action taken. People's malnutrition risk was effectively monitored and records showed appropriate communication with relevant healthcare professionals had been completed following this audit, demonstrating its effectiveness.

People who currently had or who were at risk of developing a pressure ulcer had their care and treatment needs monitored. A governance system that monitored wound care ensured wound healing progression, together with the level of support the person required and any specialist nurse involvement was clearly documented. There were infection control systems in operation to record data throughout the year. The provider subsequently produced an annual statement that demonstrated audit results and key findings from the year.

The registered manager had innovative methods to ensure key information related to identifying risks was communicated. There were governance systems that monitored the quality of handovers completed by staff during a shift change. The handover sheet was audited to ensure it had been updated and essential information was included. A recent audit had identified the need to be more concise with written information. In addition to this, the registered manager completed a handover observation. Records showed the length of handover was monitored and if the handover stayed on topic. Other matters such as if the correct process was followed, were there any distractions and if the quality of relayed information was sufficient.

The registered manager explained how they captured information to continually improve the service. For example, we saw that a short time after commencing employment, new starters at the service had a meeting

with the registered manager or a senior member of staff. This focused on how the employee was, together with how they felt their initial time at the service had been and if the new employee had any suggestions or improvements that could be made. This had recently resulted in a new, 'I'm new here' badge being created for new staff to wear for up to month to inform their colleagues, staff and relatives they were new to the team. The registered manager also commented on how they asked potential new staff members for their 'first impressions' on entering the service during an employment interview as a form of feedback.

Quality assurance systems were in operation. A 'Daily Service Quality Audit' was completed that ensured areas such as the main reception area and other communal areas of the service were clean, presentable and at the standard required. This check also monitored cleanliness and ensured that nurse's stations were locked when not in use. The audit also monitored if drinks were readily available for people and their relatives. Previous checks had resulted in damaged chairs being identified and that mobility equipment required moving to a safer location. A further weekly quality audit monitored cleanliness around the service but also encompassed speaking with people and observing staff interactions. Recent records did not demonstrate any matters of significant concern arising.

The service had a 'Quality Dining Audit' tool to allow the registered manager and staff to understand the dining experience of people living at John Wills House. This was an observational audit tool that monitored if the dining table was well presented, if there was a pleasant atmosphere, if people were welcomed and offered choices, if dining was a nice social experience and it also monitored what people ate. We saw the audit was effective, with an action plan being produced showing that more options should be made available, that in certain places more finger food was needed, that some people weren't offered a hand wash and to ensure that comments from people were communicated to the chef.

Provider level audits were completed to ensure the service was delivering care and treatment in accordance with requirements. Service quality audits and meetings were completed by the registered manager and other members of the provider's senior management team. These service quality auditing systems ensured the service undertook a 'self-assessment' against the five key questions the Care Quality Commission ask of a service when completing our comprehensive inspections. In addition to this, trustees undertook a quality assurance visit to monitor the quality of service provided. During these visits the trustee's also engaged with people and staff to seek their views. The provider also employed the services of an external social care consultant to review the services performance against the five key questions.

The provider was a member of Care and Support West. Membership of this group helped ensure the provider's locations were aware of current guidance, legislation and best practice. In addition to this, participation in the local Care Home Provider Forum and Care Homes with Nursing Clinical Forum allowed the service to learn and contribute to the sharing of best practice The registered manager felt supported by the provider through supervision, appraisal and meetings they attended. They were aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required. The Provider Information Return (PIR) we requested was completed by the registered manager and the PIR was returned as required.