Greensleeves Homes Trust

Gloucester House

Inspection report

Lansdowne Road
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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?	Good

Summary of findings

Overall summary

Gloucester House is a nursing home that was purpose built in 1990, situated in Sevenoaks, providing en-suite accommodation for up to 54 people some of whom live with dementia.

The service is split in to four units known as villages over two floors connected by a lift and each village accommodates up to 12 to 14 people. The individual villages are named after villages in Kent. There were 45 people in Gloucester House at the time of our inspection.

A registered manager is in post. 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.

We carried out an unannounced comprehensive inspection at Gloucester House in March 2016. Breaches of Regulation were found and Gloucester House was rated as requires improvement overall. This was because there were not a sufficient number of suitably trained staff deployed to ensure that people's needs were consistently met to keep them safe. Appropriate assessments of people's mental capacity and best interest meetings were not carried out and documented when necessary. The quality assurance systems needed to be developed to ensure that they identified areas for improvement. We received an action plan from the provider that told us that they were taking action to ensure the health and safety of people who lived at Gloucester House.

This unannounced comprehensive inspection was carried out on the 21 and 24 February 2017 to see if the breaches of regulation had been met. This inspection found that improvements had been made and the breaches of regulation met.

People spoke positively of the home and commented they felt safe. Our own observations and the records we looked at reflected the positive comments people made.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider, registered manager and staff had an understanding of their responsibilities and processes of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff and relatives felt there were enough staff working in the home and relatives said staff were available to support people when they needed assistance. The provider was actively seeking new staff, nurses and care staff, to ensure there was a sufficient number with the right skills when people moved into the home. The provider had made training and updates mandatory for all staff, including safeguarding people, moving and handling, management of challenging behaviour, pressure area care, falls prevention and dementia care. Staff said the training was very good and helped them to understand people's needs.

All staff had attended safeguarding training. They demonstrated a clear understanding of abuse; they said they would talk to the management or external bodies immediately if they had any concerns, and they had a clear understanding of making referrals to the local authority and CQC. Pre-employment checks for staff were completed, which meant only suitable staff were working in the home. People said they felt comfortable and at ease with staff and relatives felt people were safe.

Care plans reflected people's assessed level of care needs and care delivery was based on people's preferences. Risk assessments included falls, skin damage, behaviours that distress, nutritional risks including swallowing problems and risk of choking and moving and handling. For example, cushions were in place for those that were susceptible to skin damage and pressure ulcers. The care plans also highlighted health risks such as diabetes and Parkinson's. Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. Staff had received training in end of life care supported by the organisations pastoral team. There were systems in place for the management of medicines and people received their medicines in a safe way.

Registered nurses were involved in writing the care plans and all staff were expected to record the care and support provided and any changes in people's needs. The manager said care staff were being supported to do this and additional training was on -going. Food and fluid charts were completed when required and showed people were supported to have a nutritious and varied diet.

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff interactions demonstrated staff had built rapport with people and they responded to staff with smiles. People were seen in communal areas for activities, meetings and meal times and were seen to enjoy the atmosphere and stimulation.

A range of activities were available for people to participate in if they wished and people enjoyed spending time with staff. Activities were provided throughout the whole day, six days a week and were in line with people's preferences and interests.

The provider had progressed quality assurance systems to review the support and care provided. A number of audits had been developed including those for accidents and incidents, care plans, medicines and health and safety. Maintenance records for equipment and the environment were up to date, such as fire safety equipment and hoists. Policies and procedures had been reviewed and updated and were available for staff to refer to as required. Staff said they were encouraged to suggest improvements to the service and relatives told us they could visit at any time and, they were always made to feel welcome and involved in the care provided.

Staff said the management was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff were able to contribute to the meetings and make suggestions. Relatives said the management was very good; the registered manager was always available and, they would be happy to talk to them if they had any concerns

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

Gloucestor House was safe and was meeting the legal requirements that were previously in breach.

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

There were systems in place to make sure risks were assessed and measures put in place where possible to reduce or eliminate risks. Medicines were stored and administered safely.

Comprehensive staff recruitment procedures were followed.

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

Is the service effective?

Good

Gloucestor House was effective and was meeting the legal requirements that were previously in breach.

Staff had a good understanding of people's care and mental health needs. Staff had received essential training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and demonstrated a sound understanding of the legal requirements.

Staff received training which was appropriate to their job role. This was continually updated so staff had the knowledge to effectively meet people's needs. They had regular supervisions with their manager, and formal personal development plans, such as annual appraisals.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals for regular check-ups as needed.

Is the service caring?

Good

Gloucestor House was caring. Staff communicated clearly with people in a caring and supportive manner. Staff knew people well and had good relationships with them. People were treated with respect and dignity.

Each person's care plan was individualised. They included information about what was important to the individual and their preferences for staff support.

Staff interacted positively with people. Staff had built a good rapport with people and they responded well to this.

Is the service responsive?

Good

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

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

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

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

Is the service well-led?

Good

Gloucestor House was well-led. Management was visible within the home and staff felt supported within their roles. Systems were in place to obtain the views of people, visitors and healthcare professionals. The manager was committed to making on-going improvements in care delivery within the home, striving for excellence.

There was an open culture, and people and quality care were at the heart of the service.

Staff were well motivated, worked as a team and wanted to make sure they supported people in a caring and person centred way.

There were systems in place to monitor the quality of the service

and any areas for improvement identified were dealt with quickly.

Gloucester 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 carried out 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 on the 21 and 24 February 2017 and was unannounced. The inspection team consisted of an inspector 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. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people who live with dementia.

The provider had completed a Provider Information Return (PIR) in 2016. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We considered the PIR and looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events.

We looked at 8 sets of records which included those related to people's care and medicines. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We consulted documentation that related to staff management and six staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with 17 people who lived in the service and 6 of their relatives to gather their feedback. Although most people were able to converse with us, others were unable to, or did not wish to communicate. Therefore we also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the operations manager, the registered manager, the deputy manager, the activities person, two nurses, six members of care staff, and two ancillary workers. We also contacted four health professionals who oversaw people's care in the home. We obtained feedback about their experience of the service.

Good

Is the service safe?

Our findings

At our inspection in March 2016, we had found there were not sufficient, experienced staff deployed to keep people safe or assist them to receive appropriate care and support. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was submitted by the provider which detailed how they would meet the legal requirements by March 2017. We found that improvements had been made, the provider was meeting the requirements of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they felt safe living at Gloucester House. One person told us, "I am safe and content." Another said, "It's a good place to live, lots of good staff and it's safe." A relative told us, "Excellent place, I totally trust them to keep my relative safe." Another relative told us, "There has been a real improvement over the past year, much happier home now."

This inspection found that there were sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. Gloucester House was divided into four villages over two floors. There were two staff teams, one for each floor. One registered nurse and three care staff provided care and support for 23 people on Penshurst and Ightham village, eight of whom lived with dementia. One registered nurse and three care staff provided care and support for 22 people on Hever and Chevening village, seven of whom lived with dementia. The organisation had introduced a staffing dependency tool that assisted in ensuring the number of staff was sufficient to individual needs. For example, the number of staff needed to provide personal care and moving. At night the staffing levels had increased to three care staff on each floor and one registered nurse.

People told us there were enough staff to respond to their needs. Comments included, "I ring for help and I get it straight away," and "A great bunch of staff, helpful, cheerful and kind." We were also told, "I feel staffing levels are sufficient." We were told that random checks/audits on call bell responses were undertaken and staff deployment rearranged as necessary. Staff told us that the staffing levels were enough to give a good level of care. One visitor told us that "Always staff visible, I have no concerns about the staffing levels, they are good." Another visitor said, "The staffing levels are much better, no complaints."

There was additional staff in the home to respond to domestic, catering, entertainment, administration and receptionist duties. The manager confirmed staffing arrangements were flexible and extra staffing was available to respond to any changes in people's needs, such as end of life. The laundry team now worked seven days a week and this has assisted in care staff having more time for care duties. We found the staffing arrangements ensured people had their individual needs attended to.

There were systems in place to ensure the proper and safe management of medicines. Medicines were stored, administered, recorded and disposed of safely. Storage facilities throughout the service were appropriate and well managed. Medicine rooms were locked and the drug trolley was secured to the wall when not in use. The temperature of areas where medicines were stored were monitored to ensure

medicines were not harmed before use. Staff were vigilant in locking the trolley when they were talking or giving medicines to people. We observed medicines being given at lunchtime and staff followed best practice guidelines. Medicines were administered individually using pots to dispense, waiting for the medicine to be taken and then recording on the Medicine Administration Record (MAR) chart. All medicines were administered by staff who had completed additional training and had undergone regular competency assessments.

Some people had been were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. PRN guidelines were in place, but lacked a pain risk assessment or evaluation of effectiveness of medicine. This was introduced immediately and was in place by the second day of the inspection.
Variable dose medicines were administered appropriately. Some people had health needs which required varying doses of medicine related to specific blood test results. We found medicines were given in accordance with any changing requirements. No one at this time was receiving medicines covertly, but there was an organisational policy should this become a need.

Risks to people's health, safety and well-being had been identified, and a management plan put into place. People had a care plan with accompanying health and environmental risk assessments completed. We saw that risk assessments included the risk of falls, skin damage, nutritional risks and moving and handling had been completed. The care plans also highlighted people's health risks such as diabetes, dementia, memory loss and Parkinson's disease.

People at risk from developing pressure damage were monitored and repositioned regularly to reduce pressure and risk of skin damage. Pressure relieving mattresses were in place to help reduce the risk of developing a pressure ulcer. Mattress settings were checked daily by staff to ensure that they were on the correct setting and adjusted accordingly. Wound records and risk assessments were up to date and demonstrated clear management strategies. One person told us, "I have a special mattress and staff ensure I move regularly." There was no one with pressure damage at this time.

Risk assessments included sufficient guidance for care staff to provide safe care and care plans were being followed. For example, good skin care involves good management of continence and regular change of position. There was guidance for people who stayed in bed to receive two or four hourly position changes and the use of a pressure mattress. People sitting in chairs or wheelchairs in communal areas had regular changes of position and were offered toilet breaks.

People were protected by safe moving and handling procedures. We observed a person being lifted and moved by an electrical hoist. An electrical hoist moves people who are unable to move themselves. The manoeuvre was safe, the person was supported by staff who were efficient and spoke with the person reassuring them constantly.

Accidents and incidents had been documented. There was a clear follow up and actions taken as a result of accidents and incidents. For people who had unwitnessed falls a record of an investigation or a plan to prevent further falls had been completed. This meant that the provider had put preventative measures in place to prevent a re-occurrence and protect the person from harm. The provider therefore was able to show there was learning from accidents and incidents.

The provider had taken steps to ensure the safety of people from unsafe premises and in response to any emergency situation. Contingency and emergency procedures were available to staff and a member of the management team were available at any time for advice. First aid equipment was available and staff had

undertaken appropriate training. Staff knew what to do in the event of a fire and appropriate checks and maintenance had been completed. Emergency information was readily available, for example a 'grab bag' was visible near the front entrance and contained information on the location of people along with individual evacuation plans.

People were cared for in an environment that was safe. There were procedures in place for regular maintenance checks of equipment such as the lift, firefighting equipment, lifting and moving and handling equipment (hoists). Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Health and safety checks had been undertaken to ensure safe management of food hygiene, hazardous substances, staff safety and welfare. People had personal emergency evacuation plans (PEEPs) which detailed their needs should there be a need to evacuate in an emergency. Staff had received regular fire training and evacuation training. Staff told us they felt confident they would be able to manage an emergency situation and talked of the organisational on call systems in place.
The environment was clean and hygienic. One person talked about the cleanliness of the home and said, "Spic and span." Other comments included, "There are never any nasty smells, it smells fresh and clean."

There was some major refurbishment being undertaken at this time and the organisation had ensured that the service to people was not affected or impacted on peoples' safety. The building work was managed well and people and visitors were kept informed of progression.

Staff received training on safeguarding adults and understood clearly their individual responsibilities. Staff and records confirmed that staff received regular training and recent safeguarding activity in the home had led to greater staff awareness. Staff had recently had a group supervision session on safeguarding people. Staff were able to give us examples of poor or potentially abusive care they may come across working with people. They talked about the steps they would take to respond to allegations or suspicions of abuse. Staff were confident any abuse or poor care practice would be quickly identified and addressed immediately by the senior staff in the home. They knew where the home's policies and procedures were and the contact number for the local authority to report abuse or to gain any advice.

People were protected, as far as possible, by a safe recruitment practice. Records included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring checks (DBS) these checks identify if prospective staff had a criminal record or were barred from working with children or adults, completed by the provider. Interviews were undertaken and two staff completed these using an interview proforma. There were systems in place to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse.

Disciplinary procedures were followed and action was taken appropriately by the manager when any staff behaved outside their code of conduct. The disciplinary procedure had been followed in relation to concerns about the practice of a particular staff member. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Good

Is the service effective?

Our findings

At our inspection in March 2016, we found that the failure to consider and act in accordance with the MCA was a breach of Regulations 11(1) (3) of the Health and Social care Act 2008 (regulated Activities) 2014.

An action plan was submitted by the provider which detailed how they would meet the legal requirements by May 2016. We found that improvements had been made, the provider was meeting the requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection found that staff understood the principles of consent and therefore respected people's right to refuse care or treatment. Staff were understanding and patient of people who initially refused assistance by allowing them time to settle and approaching them again to gain their participation or consent. For example, one person initially refused their meal. Staff removed the food and just sat and chatted before asking, "Would you like your meal now." The person was happy this time to accept their meal. All staff working had received training on the Mental Capacity Act 2005 (MCA) and mental capacity assessments were consistently recorded in line with legal requirements. The care plans contained reference to mental capacity assessments and gave guidance to staff on how to continually assess people. We saw some very good examples of how staff had individualised care plans to ensure people were supported in making decisions. However there was no clear rationale documented for those people who remained on continuous bed rest or of who had been involved in the decision making. We received confirmation following the inspection that this had been taken forward and was now in place.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. We saw staff had received training in this area and were confident of the processes in place to support people. There were people who had bed rails in place to prevent harm by falling out of bed. Appropriate risk assessments had been undertaken and DoLS referrals submitted when required.
One relative said "The staff were extremely competent, they knew exactly what they were doing when (name) came here for palliative care." Another said "They appear to be well trained and knowledgeable there are no concerns. I am extremely pleased with the care, they are efficient, personable and kind." People felt that the care and support provided was focussed on them and provided an individual approach. Visiting professionals told us staff had relevant skills and listened and responded to advice given. People were complimentary about the food and how they were provided with choice and variety.

People were supported to have enough to eat and drink to maintain their health and well-being. People had access to fluids and drinks throughout the day. One person said, "They're good about making sure you have drinks, I've always got a drink here on my table." Another person said, "Good tasty food."

People could choose where they had their meals and the dining room was attractively presented. One person said "I usually go down to the dining room, it's nice to eat properly at a table and enjoy other

people's company." Meals were served politely and there was plenty of chatter and laughing with jokes being shared in the dining room. People were supported according to their need and equipment to maintain independence was provided, for example plate guards and adapted cutlery. People were given choices and these were responded to, people were offered a choice of juice with their meal and afterwards offered tea/coffee and people were asked if they wanted sugar and how much. Some people were offered a clothing protector and napkins. The offer of assistance in cutting up food was provided to people who needed it. The mealtime was a calm experience with people chatting together at tables. People were asked by the chef if they were enjoying their meals and asked if they wanted anymore. This was then provided.

People's nutritional needs had been assessed and regularly reviewed. Risk assessments were used to identify people who needed close monitoring or additional support to maintain nutritional intake. For example a nutritional risk assessment was used routinely for people and staff monitored people's weights regularly to inform this risk assessment. Staff asked for professional advice if people lost weight or showed signs of difficulty with eating. Drink supplements were used when specialist advice indicated this. For people who had difficulty in eating and swallowing suitable meals were provided that included soft and pureed meals. Where a need had been identified staff monitored how much people ate and drank each day for a three day period to ensure they received appropriate nutrition and fluids. Associated records were completed and included fluid charts that recorded fluid offered and taken.

Staff had a good knowledge of people's dietary choices and needs. The chef and catering staff were responsive to people's needs and preferences and were proactive on promoting good food experiences for people. The chef was involved in discussions with staff, relatives and health care professionals to respond to individual needs and special diets. Specific dietary needs were recorded on diet sheets that were used by the catering staff and were updated in conjunction with the nursing staff on a regular basis. Surveys were also used to gain additional feedback on preferences and choice. We found individual needs were given a high priority.

Staff and training records confirmed that a programme of training had been established and staff had undertaken essential training throughout the year. This training included health and safety, infection control, food hygiene, safe moving and handling, and safeguarding. Staff training was closely monitored to ensure staff had completed required training and the computer system highlighted if staff had fallen behind. Staff told us the training provided them with the skills they needed and included practical sessions along with time to discuss specific areas of care. Senior staff reviewed staff training at supervision and supported them to complete the required programme.

Additional training was also provided to support staff with developing roles, specific interests and changing needs of people living in the service. For example, a dignity champion and infection control lead. A senior staff member was responsible for ensuring peoples weights were monitored, the assessment tools were up to date and accurate. They then ensured that changes to care plans were documented and liaised with the chef and catering team. The training programme was varied and reflected the needs of people living in the service. Staff received training in diabetic care, Parkinson's disease, catheter care and end of life care.

The registered nurses were supported to update their nursing skills, qualifications and competencies., One registered nurse had recently attended a skills update on wound management and urinary catheterisation. They had the opportunity to reflect on these and their own practice through a supervision process. The registered nurses were also supported in maintaining their registration with the training they are required to undertake with the Nursing and Midwifery Council (NMC). One registered nurse told us they were being supported with their re-validation process and training on this area had been provided by the organisation.

People were supported to maintain good health and received on-going healthcare support. People said that they could see the GP when they wanted which was a great reassurance and were supported in attending hospital appointments. One person told us, " I felt unwell and staff rang for a doctor immediately." Relatives confirmed health care support was sourced appropriately and they were kept informed of any health changes. Records and discussion with staff confirmed that staff liaised effectively with a wide variety of health care professionals who were accessed regularly. The staff worked hard to communicate effectively and co-ordinate a multi-disciplinary approach to care. For example, a community psychiatric nurse was involved in planning and reviewing care for a person with specific mental health needs. Specialist nurses were also used to advice staff on specific care needs such as pressure damage .Staff demonstrated professionalism and a commitment to providing the best care possible working in conjunction with all additional health care professionals available.

Good

Is the service caring?

Our findings

The home had a relaxed atmosphere and people responded positively when staff approached them in a kind and respectful way. The feedback from people included, "Really lovely staff, so kind and patient," and "I like it here, they look after me very well." Relatives felt staff offered the care and support people needed and wanted. One relative thought the staff were, "Wonderful, kind and patient" and, "Always cheerful and ready with a smile." One person told us "I feel cared for, staff are patient and sweet, I'm slow but they have never tried to rush me." One staff member said, "I feel that our staff team is really focussed on caring, we want to do our best."

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. A relative told us, "They ask us for suggestions and keep us well informed." Staff supported people and encouraged them where they were able to be as independent as possible. Another relative said, "X (name) doesn't have capacity to make decisions, but the staff encourage her to make choices." The registered manager told us, "People are supported to do what they want when they want."

Staff promoted people's independence and encouraged them to make everyday lifestyle choices. People who liked to move around independently were supported sensitively and discretely by staff. Staff talked to people and asked them if they needed assistance, they explained to people what they were going to do before they provided support and waited patiently while people responded. One staff member said, "Shall I help you to the table, its lunchtime soon." They crouched down to talk to the person face to face so they could see their expression, and waited until the person responded. Comments from staff included, "We encourage people to be independent as they can be. We give them space and respect their independence" and, "We let people to make their own decisions if they can. For example, if someone doesn't want to do something then we make sure we offer later." Some people were able to confirm that staff involved them in making decisions on a daily basis. One person said, "I can choose to have breakfast in bed or in the small dining area. Staff always ask me." Another person said, "Due to my health I spend a lot of time in bed, but staff do what they can to relieve my frustration, they pop in all the time and ask me if there is anything I need."

People were treated with kindness and respect as individuals, and it was clear from our observations that staff knew people very well. Staff made eye to eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. Staff knocked on people's bedroom doors before they entered, saying, "Morning (name)" and, "How are you today." We saw several lovely interactions, such as staff giving gentle physical contact as they supported people and people responded with smiles. We also saw a care staff member sit with a person during their lunch and encouraged them with eating independently with gentle prompting, "Can I help or are you managing ok ?" and, "Let me help you with that." This enabled the person to retain their dignity whilst accepting help. The SOFI told us that staff and people engaged positively using verbal and non-verbal communication. During the meal service staff sat alongside people who needed assistance and maintained eye contact whilst assisting them. The pace that staff assisted people was set by the person and not the staff member, which meant that the person was not rushed and enjoyed their meal.

Staff had the time to ensure that people received their care and support as they desired. People's dignity was promoted. People's preferences for personal care were recorded and followed. We looked at a sample of notes, which included documentation on when people received oral hygiene, bath and showers. People confirmed that they had regular baths and showers offered and received care in a way that they wanted. One person said, "They know how I want my care given." Care plans detailed how staff were to manage individual people's continence. This included providing assistance taking people to the toilet on waking or prompting to use the bathroom throughout the day. Throughout our inspection we observed that people were prompted and offered the opportunity to visit the bathroom. People who were not independently mobile were taken regularly to bathrooms.

People told us they were treated with dignity and respect, "Staff are kind and caring, "I find them all quite caring and helpful" and "Very kind. " People's need for privacy was promoted and their privacy respected. For example, staff ensured that people's dignity was protected when assisting them. We also saw that people's personal care was of a good standard and undertaken in a way that expressed their personality. People were supported to wear make-up and jewellery, and wear clothes of their choosing. When prompting people to eat or drink, staff talked in a quiet manner ensuring that other people did not hear. Relationships between staff and people receiving support consistently demonstrated dignity and respect. Staff understood the principles of privacy and dignity. Throughout the inspection, people were called by their preferred name. We observed staff knocking on people's doors and waiting before entering. We observed one person calling staff as they wanted to go to their room. This was attended to immediately, with appropriate support used by staff and good interactions between the person and staff. Staff were patient and responsive to people's mood changes and dealt with situations well by using diversional verbal tactics and a kind word.

A key worker system was in place. A key worker is a named member of staff with special responsibilities for making sure that a person has what they need. The key workers sat with people and went through their plans of care with them and invited relatives and/or people's legal representatives to participate in annual reviews.

Information about the service and its facilities was provided to people and their relatives. There was a residents' handbook that had been updated and included information about the provider, their values and their philosophy of care. It was printed in large print to help people with visual impairment and included information about the facilities, the fees, the staff team, the planned key workers scheme, social activities and how to make a complaint. The complaint procedure was also displayed in the reception area. All staff wore name badges so people knew their names. The weekly programme of activities was displayed on an information board, in a pictorial format in each village so people knew what was on offer. There were photographs and names of the staff who were on duty that day. Menus were also in pictorial form and displayed in communal areas.

Relatives told us that they felt welcome at the home at any time. They said: "Fantastic, always welcomed, has changed a lot in recent months and all for the better, staff seem happy and so we are happy," and "They make us feel welcome, warm smile and a chat" and "We can come at any time, which is a relief because we work so it could be difficult." Relatives described the care as positive and felt staff genuinely cared about the people they supported. A relative told us they thought their family member looked "Content and settled."

People told us they were well cared for. One person told us, "Excellent." Another person told us, "I'm happy and I would say if I wasn't." People were supported to maintain their personal and physical appearance and to make choices about how they spent their time. A hairdresser visited on a regular basis and people enjoyed this visit. People were able to spend their day as they chose. People spent time in the communal

areas or in their bedrooms we saw staff checked on them regularly ensuring they had everything they required or wanted.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information.

Good

Is the service responsive?

Our findings

People commented they were well looked after by care staff and that the service listened to them. One person said, "They listen, we have home meetings and they listen and try to get it right for all of us." A relative said "Very responsive to suggestions."

The service employed specific staff to organise and facilitate activities and entertainment and they worked as part of the care team. They knew people well and were attentive to people's individuality and differing needs and abilities. The activity person was enthusiastic and dedicated to their role in the home. She told us of how they had taken part in the Guardian Public service awards with a virtual John O'Groats to Lands End challenge. Out of 400 entrants Gloucester House was in the final five. People in Gloucester House cycled using a specialist cycling machine suitable for people with very limited mobility. To ensure that everyone was involved the activity person added a mile for those that attended the arm chair exercise group and some of the more independent people had their daily walks measure so that they could add to the miles. Staff wrote to homes across the country asking them to send a postcard of their location and received post cards as people virtually travelled up the country. Themed days took place along the route which were enjoyed by people. In the first three months exercise at the home tripled and this had improved their health and well-being.

There was a full activity programme that reflected people's interests. This included quiz times, exercise sessions, visits out and external entertainers and pet visits. Gloucester House had their own petting rabbits which were thoroughly enjoyed by all, including those who remained in bed or in their room. The staff had developed good relationships with local primary and secondary schools and there were regular choir and musical sessions held. There were plans to further develop activities specifically for those who lived with dementia. Following feedback last year from people, gardening was an area that had proved successful and they were planning this years' planting sessions with the people who were interested. People liked to colour books and the activities person had obtained colouring books and pencils, and we saw that this was enjoyed by people in the reception area. Certain people were supported to deliver newspapers and run a trolley shop for those less able.

The activity person had introduced many good ideas to deliver meaningful activities. They felt that things were progressing well but acknowledged that there was still a lot to do to ensure that everybody had the social interaction and lifestyle to enhance their life. A second activity person had been employed and was due to start work in March 2017.

There were celebrations and events held in the home which were enjoyed by the people living in Gloucester House. People's birthdays were remembered and celebrated.

There was a commitment shown by the organisation on the promotion of good health and independence. Gloucester House employed two physiotherapist and one physiotherapist assistant who all worked part-time. The Physiotherapy team assessed each of the people who lived in the service and had developed a physiotherapy programme to get people out of bed, up in personalised wheelchairs and had obtained

equipment that enabled people to exercise whatever their physical frailty.

Before people moved into the service a senior staff member carried out an assessment to make sure staff could provide them with the care and support they needed. Following this assessment the possible admission was discussed by the senior staff in the service to ensure a suitable placement and that the admission process was managed appropriately. For example ensuring all appropriate equipment and training is in place before admission. Where people were less able to express themselves verbally or they wanted less involvement people's next of kin or representative were involved in the assessment process. This meant people's views and choices were taken into account when care was planned. One visitor told us "My (relative) can't make decisions now, so the home consult and inform myself and family about things that happen."

The assessment took account of people's beliefs and cultural choices this included wishes surrounding people's death. Care plans were written following admission and updated as people's needs changed and on a monthly basis. One day a month was allocated to one person for a full review which was completed in consultation with all staff. Relatives all told us they were kept fully informed of any changes in care and felt they were included and involved as their relatives would want. Care plans gave guidelines to staff on how to meet people's needs while promoting an individual approach. The care documentation was mostly detailed and supported staff to view people as individuals. Senior staff were aware that some care plans needed further attention and were progressing this. The staff were receiving training to enable them to We found staff had a good understanding of people's specific care needs and responded to them appropriately. For example, one staff member told us "A person had diabetes and staff were in contact with the GP to ensure the care plan reflected clearly what action to take in response to regular blood test monitoring.

Care plans also had specific guidelines to care for people who were at risk from falling or were unable to use their call bells with records confirming hourly checks to be undertaken. Staff were regularly updated about changes in people's needs at handover and throughout the day. The deputy manager had introduced catch up session which occurred most mornings with staff which meant staff had an opportunity to discuss people. During the inspection we saw staff communicating regularly with each other. Staff listened to each other and shared information provided by visiting professionals with care plans updated accordingly.

People told us, preferences and choices were respected. Comments included, "I have a shower whenever I like, usually every couple of days," "I have my routine of when I like to go downstairs so I please myself what I do" and "Sometimes I have my breakfast in bed and sometimes I might go down to the dining room" This told us the staff team were responsive to peoples individual preferences on a day to day basis.

Complaints were responded to and used to improve the service. The home had a clear complaints procedure that was available to people within the home and from staff if requested. People spoken to said they were able to complain and were listened to. Visitors were also confident that they could make a complaint and it would be responded to. One visitor said "I have no doubts now that I will be listened too and action taken." Another said, "I would not hesitate to talk to a member of staff if I needed to." Records confirmed that complaints received were documented investigated and responded to.

Good

Is the service well-led?

Our findings

From our discussions with relatives, staff, the registered manager, the provider and our observations, we found the culture at the home was open and relaxed. Care and support focused on providing the support people living at Gloucester House needed and wanted. Relatives and staff said the registered manager was available and they could talk to them at any time. We observed the registered manager greeting and sitting with people and talking to them at various times throughout our inspection. Relatives said the management of the home was good and all staff were always very helpful. One relative said, "The home is well led, clean and calm."

Effective management and leadership was demonstrated in the home. The registered manager was keen and passionate about the home and the people who lived there. They told us that the philosophy and culture of the service was to make Gloucester House 'Their home'. He also told us, "It's important that we make it comfortable, homely and safe. We give good care because we do care." The registered manager took an active role within the running of the home and had good knowledge of the staff and the people who lived there. There were clear lines of responsibility and accountability within the management structure. The culture of the service was described as open, honest and friendly by people and staff. The registered manager said their door was always open if staff wanted to have a chat with them. One member of staff said; "You're not going to get any better bosses." Staff were happy to challenge poor practice if they saw it and would contact the registered manager or other senior staff immediately if they had any concerns.

Staff spoke of the home's vision and values which governed the ethos of the home. Displayed in areas of the home was a value statement that staff were proud of. The ethos of the home was embedded into how care was delivered and the commitment of staff to provide good quality care and person specific care. The manager and staff had a strong emphasis on recognising each person and their identity. Staff wanted to provide care that was individual to that person and it was clear staff recognised each person in their own entity. From observing staff interaction, it was clear staff had spent considerable time with each person, gaining an understanding of their life history, likes and dislikes. Care was personal to each person and staff clearly focused on the individual and their qualities.

Quality monitoring systems had been developed and sustained over the past year. There were a wide range of audits undertaken to monitor and develop the service and we looked at a selection of these. Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so that quality of care was not compromised. Areas for improvement were on-going such as care documentation. The registered manager said it was an area that they wanted to continuously improve. Where recommendations to improve practice had been suggested, from people, staff and visitors, they had been actioned. Such as laundry service and menu choices. Falls, accidents and incidents were recorded, monitored and an action plan put in place to prevent a re-occurrence. There were additional audit tools that looked at 'hot spots' of accidents/incidents in the premises. Medicine audits looked at record keeping and administration of medicines and the manager said action would be taken through the supervision process if issues were identified.

The management team had been working consistently to develop the support and care provided at the home. The manager said, "Whilst we feel we have really improved, we want to continue to improve to deliver really outstanding care." Staff were proud of the improvements they had made, the morale of staff was strong and cohesive.

Systems for communication for management purposes were established and included a daily meeting with the senior staff. These were used to update senior staff on all care issues and management messages. For example, discussion around who had fallen and what risks had been identified. Staff felt they could feed into these meetings. One staff member said, "The manager is open to suggestions, staff meetings give us the opportunity to raise issues and solve problems." Each shift change also had a handover meeting so staff changing shifts shared information on each person. A handover sheet given to staff facilitated this process with key aspects of care being recorded. Staff told us they were involved in discussions about people's needs and were encouraged to put forward suggestions and opinions during the daily meetings and the monthly staff meetings. Staff said, "We are encouraged to be involved in developing the service here." "I think the management is strong and approachable" and, "I feel sure that if I speak to the manager about anything, something will be done about it. I don't just mean complaints suggestions are encouraged as well and they listen to us."

The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them and this ensured advice and guidance was acted on by all staff. Comments received included, "The staff are knowledgeable about the people they care for, and want to get it right" and, "They listen, take advice and act on the advice."

Relatives felt they were able to talk to the manager and staff at any time and the relatives meetings provided an opportunity for them to discuss issues and concerns with other relatives, friends and management on a regular basis. One relative said, "If I have a problem I just talk to the staff or manager and they deal with it."

The service had notified us of all significant events which had occurred in line with their legal obligations.