Gracewell Healthcare Limited

Gracewell of Bath

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?	Good

Summary of findings

Overall summary

This inspection took place on 10 May 2018 and was unannounced. This was the first inspection of the service since it was registered in 2017. Gracewell of Bath is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Gracewell of Bath is a purpose built establishment; it provides care and support for up to 62 people. The service provides care over three separate floors depending on their level of need; Poolside (residential), Sulis Way (dementia care) and Globetrotter (nursing). Each floor has its own lounge, dining room and utility kitchen. All bedrooms are single with en-suite toilet facilities. At the time of our inspection, there were 43 people living in the home.

Staff supported people living with dementia; however there was limited evidence of the development of the environment for people with specific needs affected by their condition. We have made a recommendation about the development of the environment to meet the specialised needs of people living with dementia.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Medication Administration Records were completed accurately and guidance was in place for people who were prescribed 'as required' medication. People told us they were happy with how their medicines were managed and received this when they needed it.

Risk assessments were detailed and contained sufficient information to guide staff on how to minimise the risk of harm for people who lived at the home.

Fire procedures in the event of an evacuation were clear and regular mock fire drills were completed.

Checks were completed to ensure the environment was free from hazards.

The training records showed staff had received relevant training to ensure they had the skills to support people effectively. Our discussions with staff showed that they had a good knowledge about the people they supported and understood people's individual needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The service operated within the principles of the Mental Capacity Act 2005 (MCA). Our review of records showed that processes were in place to assess people's capacity and make decisions in their best interests.

People were supported to maintain good health and well-being. The home had a good relationship with a local GP and had regular dialogue with the local community mental health team. Referrals were made promptly to health professionals such as speech and language team, the dietician and tissue viability nurses.

People told us they enjoyed the food served at the home. Staff knew, and catered to, people's individual dietary needs and preferences. Nutritional risk assessments were completed and diet and fluid charts were in place for those who required them.

We observed kind and compassionate interactions between staff and the people they supported. Staff offered reassurance to people in distress. People told us they liked the staff that supported them. Care plans were personalised and evaluated monthly. We noted that any changes in people's needs were documented and actioned appropriately.

A complaints policy was on display in the home, which contained details for the local authority and Local Government Ombudsman if complainants were not happy to go to the provider. People told us they would not hesitate to raise concerns with the registered manager if they felt they needed to. Complaints were documented and managed in accordance with the registered provider's complaints policy.

Quality assurance systems were effective and measured service provision. Regular audits were completed for different aspects of the service such as medication, care plans and accidents and incidents. Opportunities were provided for people and their relatives to provide feedback on their experience of the care provided and contribute to improving the service delivery. This included quality assurance surveys, a suggestion box, residents, and relatives meetings.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with statutory requirements.

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's medicines were stored appropriately and administered safely.

People were kept safe by clear systems to identify and report abuse.

People's risks were assessed and managed safely.

There were sufficient staff to meet people's needs who were safely recruited.

People were protected by staff using safe infection control practices

Is the service effective?

Good

The service was effective.

Staff were well trained and knowledgeable in their understanding of supporting people when they lacked capacity to make informed decisions, including the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff were up to date in all aspects of training needed for their role.

Staff received regular formal supervision to assist them in their job roles and in their personal development.

People's nutritional needs were met.

People's health needs were managed well by staff who co-ordinated appointments and visits across a range of visits from healthcare professionals, such as GPs, hospital visits and care managers.

There was limited evidence regarding the development of the environment for people with specific needs of people living with

dementia.

Is the service caring?

Good

The service was caring.

Staff were kind and caring. They respected people and upheld their privacy and dignity.

Staff knew people well and they had built up positive relationships with people and their relatives.

People were involved in planning their care.

Is the service responsive?

Good

The service was responsive.

People told us staff were responsive to their needs.

Care plans were person-centred and detailed and were reviewed and updated on a regular basis.

There was a range of activities, outings and events on offer at the home. Activity records were held to evidence what people had enjoyed and participated in.

People's wishes for their care when nearing the end of their lives was clearly documented and some staff had undertaken training in this area.

Complaints were responded to appropriately and the service had received a number of compliments.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post at the time of the inspection.

Quality assurance systems were in place and were effectively monitoring the quality and standard of care being provided.

Policies and procedures were in place and were accessible to staff.

Gracewell of Bath

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 May 2018 and was unannounced. The inspection was carried out by two adult social care inspectors 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 had experience in dementia care.

Prior to the inspection, we reviewed information we held on the service such as notifications. Notifications are specific events that registered people have to tell us about. We also contacted the local authority commissioning team and requested feedback from four healthcare professionals involved in people's care. We received feedback from one healthcare professional.

We also reviewed the Provider Information Return (PIR). The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We observed care and spoke with people, relatives and staff. We did not use 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 speak with us as most people could talk to us. We spoke with 12 people who used the service and four relatives. We also spoke with the registered manager, the deputy manager, two registered nurses, four care staff, the maintenance person, an activities coordinator and one visiting health professional.

We reviewed four people's care records including daily records, medicines records and seven staff files including recruitment, supervision and training information. We looked at records relating to the management of the service. We looked around the building and spent time in the communal areas. We reviewed additional information the provider sent us after our inspection visit.

Good

Is the service safe?

Our findings

People felt safe at the home and with the staff who supported them. One person told us; "I feel very safe, I have a call bell which makes me feel very safe" (this was a mobile bell, which they had beside them in the dining room.) Another said, "I feel very safe and secure here, I have visited lots of people in homes – I am pleasantly surprised (by this one)." Relatives told us, "I feel he is safe, staff do not take risks, they use sensor mats on the chair" and "It is such a relief (he is safe) I can go away on holiday as I had had a very poor experience at another home where [loved one] had fallen and been badly injured. "

There were systems in place to safeguard people from the risk of abuse. This included having both a safeguarding and whistleblowing policy and procedure in place, informing both staff and people who used the service on how they could both report and escalate concerns. The staff we spoke with were clear about what abuse was, the signs and symptoms they would look for and whom they would speak with about concerns. They stated "Report to manager, or deputy, also the nurse and if necessary CQC" and "I've done e-learning in SG and have never seen anything concerning. I would report to [registered manager] or higher in the organisation or if necessary the local authority." The deputy manager said, "All safeguarding is taken to the local authority. I think they are getting fed up with me but they said they would rather I over reported than under reported."

We looked at how the service managed individual's assessed risks. We saw each care plan we looked at contained risk assessments for areas such as fire safety, choking, falls, moving and handling and skin integrity. Clear guidance was in place for staff on how to manage identified risks.

The registered manager told that because the home was not full, they were over staffed at present. We reviewed four weeks of rotas, which confirmed these numbers were maintained by the provider. All of the people we spoke with told us there were enough staff. Staff told us there were enough of them to meet people's needs safely. Throughout the inspection, we saw requests for assistance were responded to promptly. People who were cared for in their rooms had access to call bells to enable them to summon help when they required it. During the inspection, we did not hear call bells ringing for extended periods of time, which showed people's requests for support were answered promptly. One person told us, "They come fairly speedily [to the call bell]." The registered manager monitored the call bell response times and their audits showed all bells were answered within the providers' acceptable time limits.

People received their medicines safely from registered nurses or senior care staff who all received specific training and had their competency assessed to make sure their practice was safe. On person said, "Staff do it – that is fine." Nurses confirmed they received this training, which they said was very thorough. In the medicine rooms, we found the providers medicine policy and procedures, such as homely remedies. One nurse said how the training included quizzes, a test and was "very good". Staff had gone to another of the providers homes for this.

One person was administering their own medicines, which were kept in a locked cupboard in their room, with the exception of a drug, which needed extra security, which they were very happy to have kept in a

more secure place. Where people were, using oxygen signage was clearly displayed on the door of the person's room.

The home used pre-printed medicine administrations records (MARs), but there were some hand written entries. These entries were signed by two staff, as per the providers' policy. However, one entry was signed by only one staff member and one person's hand written entries were not signed at all and did not include the amount being checked in. We brought this to the attention of the registered manager, who immediately asked the deputy manager to investigate this and ensure this would not happen again.

MARs were well organised and contained necessary information, such as any allergies, GP and each had a photograph of the person, for identification. For patches, an administered and removal date was used, to prevent mistakes and potential overdose. For external medicines, (lotions and creams) body maps were in place. Creams and other external medicines had opening dates recorded. Codes were used for when medicines had not been administered and we saw, where a person had refused their pain relief, how the nurse recorded this on a returns book.

For medicines that were taken 'as required' (PRN), there were protocol forms which were completed for each medicine. These made it clear how many of the medicines could be taken in a set time but mostly not the circumstance under which the medicine could be administered. For example, for morphine sulphate the instruction was "take one or two 5ml every 4 hours when required'. Another person's Lorazepam prn was said to be used 'for agitation' but not a description of what the agitation looked like. We spoke with the registered manager who confirmed they would ensure that this specific information would be added to all the PRN paperwork that needed it. Following the inspection, we were sent this paperwork.

We observed medicines being given on two of the three floors. The nurses used a trolley, which they locked when they needed to leave it. They took individual medicines to people and spent time with them, providing assistance, such as water, it was unhurried and uninterrupted.

Medicines were stored in air conditioned rooms and the daily temperature of the room was recorded. Trolleys were secured to the wall and each cupboard had its own lock and key. Keys were kept by the nurse on duty and no other keys were kept on the bunch. Stock was well organised, we were told that a stock check took place each time there was an order. We checked records against stock and found them to be correct. Where people needed more medicines, we heard a senior staff member, twice, chase up a medicine with pharmacy.

Staff followed good infection control practices. The service had an infection control champion to ensure all policies and practices were up to date and adhered to. We observed hand washing facilities were available for staff around the service. The laundry and kitchen were clean and well-ordered. Staff were trained to follow good infection control techniques and provided with gloves and aprons.

We checked to see that staff were recruited safely. Staff told us it was "Very thorough." We looked at seven staff personnel files and found there was evidence of effective recruitment procedures. The files included application forms, proof of identity and references. Registered nurses were employed at the home and employment checks included making sure they were appropriately registered with their professional body. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. These checks demonstrated that staff had been recruited safely.

The provider had ensured all equipment used in the service underwent regular safety and maintenance

checks.

Good

Is the service effective?

Our findings

People told us they were happy with the care they received and they felt staff had the knowledge and skills to meet their needs. Comments included, ""They are well trained, come and ask the right questions","– they are sympathetic "and "Good professionals ". One relative told us, "[Name] changes a lot sometimes needing to use wheelchair, sometimes sleeping a lot, sometimes still walking with support – staff seem to know, understand and support."

Records showed that staff completed a thorough induction when they joined the service and their training was updated regularly. Staff felt well trained and told us they could request further training if they felt they needed it. They told us they received regular supervision and this was confirmed in the records we reviewed.

An assessment of people's needs had been completed before the service began supporting them. Assessment documents included information about people's needs, risks and personal preferences. This helped to ensure that the service was able to meet people's needs. We reviewed four people's care files. We found they included detailed information about people's needs and how they should be met, as well as their likes and dislikes. Each care file was personalised and contained information about what people were able to do for themselves, what support was needed and how this should be provided by staff.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

Where people lacked the capacity to make decisions about their care, mental capacity assessments had been completed and their relatives had been involved in best interests decisions in line with the MCA. Where people needed to be deprived of their liberty to keep them safe, appropriate applications had been submitted to the local authority. Staff told us they had completed MCA training. They sought people's consent before providing care, for example when supporting people with personal care or administering their medicines. Staff provided additional information when necessary to help people make decisions. The people we spoke with told us staff asked for their consent before providing support. One person commented, "They always knock on the door ". People told us their liberty was not restricted unnecessarily. One person commented, "I'm never stopped from doing anything". Another person said, "I do what I want, when I want".

The legal arrangements around relatives with lasting power of attorney were recorded in people's care records to ensure staff knew who had the legal right to make decisions on their behalf. A lasting power of attorney (LPA) is a legally appointed person, such as a relative or friend chosen by the individual to help them make decisions or make decisions on their behalf. There are two types of LPA; one for health and

welfare and one for property and financial affairs.

Care plans and risk assessments included information about people's nutrition and hydration needs. Where there were concerns about people's diet or nutrition, monitoring was in place and appropriate referrals had been made to community healthcare professionals. Care files included information about people's dietary likes and dislikes and intolerances. The staff we spoke with were aware of people's preferences and special dietary requirements. People living at the home told us, " I can't speak too highly of the food – there is a choice – if I can remember it – staff help and there is a menu" and "Good choice, they are helpful and you can get different things (i.e. not on the menu) and you can make suggestions." We observed staff talking to people about lunch choices. They were very polite and courteous and clearly knew people well and able to steer people towards safe choices (for example people who were diabetic or needed gluten free diet).

We observed staff explaining what was in dishes and therefore enabled people to make choices for both lunch and dinner. We asked them about snacks and they told us there were always sandwiches, fruit salad and yoghurt in the fridge as well as biscuits if people wanted to eat outside of the main meal times.

Each person's care file contained information about their medical history and any prescribed medicines. Detailed information was also included about people's nursing care needs and how these should be met by staff, including wound care, pressure care and end of life care. We saw that people had been referred to a variety of healthcare professionals, including GPs, dentists, tissue viability nurses, dietitians, podiatrists and speech and language therapists. This helped to ensure that people's healthcare needs were met. People told us they received medical attention when needed. One person said, when asked how his general health care needs were met "OK. Good actually". They described keeping their own GP, which they liked, and how dental and ophthalmic appointments were made. They confirmed people were encouraged to drink by staff when it was hot and said staff were "On the ball".

We found that information was shared with other services when appropriate. For example, the home ensured that important information, such as people's Medication Administration Records, and a summary of their needs, accompanied them when they went into hospital. This helped to ensure that other healthcare professionals were aware of people's needs and risks. The community professionals we contacted provided positive feedback about the care provided at the home. One healthcare professional told us, "The staff are very good at recognising changes in patients if they are becoming unwell. The patients seem very happy and well cared for".

The home had been designed and purpose built to meet people's needs. Bathrooms had been designed to accommodate people who required support with moving and transferring and there were two passenger lifts and hoists available. Adapted cutlery and crockery was available to enable people to be as independent as possible at mealtimes and parts of the grounds were accessible to people with mobility needs. The garden space was commented on by a number of people very positively. One person said "Garden – love it." A relative said, "I don't get here that often, about once a month. One thing which really thrilled me was to see a picture in his room of him holding a new born lamb and his face was radiant." They explained just how lovely it was for her as a relative to actually see this, not only the event happening but also someone kindly taking a photo of their loved one enjoying the event.. However, we found that there was no handrail on the path in the garden for people to use as a support, as it sloped. We spoke with the registered manager and regional manager about this and they assured us that one would be ordered at once.

However, the physical decoration and facilities lacked evidence of development to meet the needs of

people with specific needs due to dementia. For example, there were no features to distinguish one corridor or indeed one door from another. Bedroom doors were all the same as were all other doors including staff areas. This did not consider those who were disorientated or people living with dementia who would find it difficult to orientate themselves within their home and the taps in bathrooms were not suited to people with impaired senses as they were difficult to make sense of or see which was which.

The registered manager acknowledged the need to develop the environment to meet people's needs. They acknowledged the benefits of using specific colours and picture symbols to help people be orientated to their own bedrooms and other facilities such as the bathrooms and toilets. The deputy manager told us they have a 'memory care' lead. The lead had rolled out a memory care train the trainer programme for two staff. This related to 'interaction', walking in their shoes', and 'understanding their experience' The deputy then talked about the two planned 'memory stations' of 'nursery' and 'office', and this was a "work in progress."

We recommend that the provider seeks guidance and advice about best practice in ensuring the environment supports people living with dementia and puts this into practice.

Good

Is the service caring?

Our findings

Staff displayed kind and caring behaviour. People told us, "Staff are very compassionate, caring, treat me with kindness and respect, very gentle, very kind" and "Staff are lovely, very friendly, courteous, thoughtful." Relatives confirmed this. Their comments included "Staff are kind, very patient and very kind [name] has become a messy eater but he is always clean and shaved" and "Staff are always positive and tactful even if at the end of the shift – at the last home if I said I thought he needed attention (e.g. pads changing) their faces would drop – here they move positively towards him, I have never seen anyone's face fall, they help each other – there is no back biting, I have never had to ask twice".

We observed staff interacting with people in a friendly and gentle manner. The staff appeared to have plenty time in between their task related duties to sit with people and engage in meaningful conversation and activities. We saw staff protected and promoted people's privacy and dignity and they spoke to people respectfully. All of the people we spoke with felt the staff respected them. People told us, " They always knock on the door"; "I like my door open so people can come in – they call out before they come in" and "My room is very much my own personal space." We saw staff upheld people's confidentially by speaking with them discreetly about personal issues and escorting them back to their bedrooms if they required assistance with their personal care.

Sensitive and confidential information was securely stored in areas of the home, which were locked and only accessible to staff. The registered manager continued to promote caring initiatives within the home by starting a 'key working' system. The staff had a dedicated time of the week where they stopped 'work' and sat with people who they key worked, to chat informally over a hot drink and a snack. This demonstrated that the service promoted inclusion and socialisation and that it encouraged the staff to build positive relationships with people.

The provider had invested time and training with the staff who had designated 'champion' roles. A champion's role was to promote best practice and share new initiatives with staff to increase knowledge and awareness around a specific topic such as dignity, nutrition or infection control. Information about these initiatives were also displayed around the home.

The service had received many compliments; we saw them on display around the home. There were many comments in 'Thank you' cards to show relatives were appreciative of the care and support their family members had received.

We found that people and their relatives had been involved in the planning of their care and support and care records contained information from people and their relatives about their life histories, past occupations, family, hobbies and interests. This meant that staff would be informed about what was important to people and deliver their care and support around this. For example, one person's social care plan included information that they used to build bombers in the second world war. It meant staff had up to date information about people to enable them to engage in a meaningful way.

Staff's approach to communication with people was good. We saw multiple examples of how people's individual communication needs were met, such as bending down to people's eye level when speaking and speaking clearly. For example, we talked to staff about one person's choice of when to give them information and how much they discuss his deteriorating condition. They said, "He speaks to us on his own terms."

Up to date, relevant information, advice and guidance were displayed around the home, which would benefit people who used health and social care services. Information about what to expect from the service, such as their 'service user guide' and 'statement of purpose' were also on display in an area accessible to people and their relatives. Other material such as the provider's complaints procedure, the home's latest food hygiene rating and the CQC registration and information was also prominently on display.

Staff we spoke with were not aware of how to access an independent advocate if they felt a person needed this additional provision. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights. Most people had relatives who acted on their behalf as advocates. However, there was information displayed about advocates in the reception area. The registered manager acknowledged this as a training need for some staff.

Good

Is the service responsive?

Our findings

People and relatives told us they had been involved in the planning of their care, as well as any subsequent reviews. Relatives told us "[Name] has Parkinson's – they manage this well. He used to fall a lot but coming here they spent a lot of time at the beginning on the care plan and got [Names'] likes and dislikes" and stated "I did the care plan with them. [Name] used to stand but can't now."

People using this service and their relatives told us that the management and staff responded to any changes in their needs. A relative told us, "Staff have been proactive, they come to me and say we have found he can/can't do can we try this or that instead? They are intelligent about it" and "He is diabetic and at the previous home the diet was a problem. They have talked with the doctor and changed medication and now he can eat nearly the same as everyone, which helps. He has been able to keep the same GP."

Care plans were found to be detailed and person centred and gave information about people's likes and dislikes, choices and preferences. The care staff team knew the people they supported and demonstrated knowledge and awareness of people's likes and dislikes and how they wished to be cared for. Care plans were reviewed and updated where required on a monthly basis. However, we found that for one person, with mental health needs, the care plan lacked the detailed support the person needed. For example, where the person displayed behaviours that challenged, their care plans lacked detail around how staff should reassure and calm the person before using any medicines. One nurse we spoke with regarding this person knew their care needs and were able to give examples of how they worked with the person and reassured them but could not find the relevant written information on the care planning system. We discussed this with the registered manager who told us they were surprised that the information was not there. Following the inspection, the registered manager sent us the information, which was on the person's care plan and stated that the staff member was having more training on the on line care planning system.

People were supported to engage in activities if they chose to do so. Most people said they enjoyed activities and could pick and choose what they went to. The activities coordinator had recently left and a member of staff was acting in that role until two new activities coordinators came into post. There were mixed views about this, some people on the ground floor felt that the flower arranging was excellent, others mostly on the other floors felt that there had little for them. A person told us, "I enjoy discussions and would like some talks on things like aeroplane management." A relative told us, their loved one who also is very active and lives on the 1st floor had "Spent some time walking around with the person doing medication holding a medical dictionary." However, one person said there was "Nothing for men." We spoke with the registered manager about this and they told us that there was a dedicated "Men's' Club" which was attended by both men and on occasions, women and students from a local school who spoke with people about individual interests, including practising other languages with each other. Although activities mainly took place on one floor of the home, people from other floors were supported to attend the planned activities. Several people talked about the importance of church services which they went to regularly within the home. One person told us "My local church come in and I take communion, the clergy from there visit me, it's a different church but I had a previous link."

People and relatives told us that they felt able to complain if they needed to and were confident that their complaint would be dealt with appropriately. A person told us, "If something daily I would talk to staff", a second person told us, and "I would talk to the nurse in charge of the floor." A relative said "If I was not happy would go to [Name] the registered manager or [Name] home administrator or a nurse" and "Things will happen, incidents, but they think about it and manage things very calmly, the training is good, people know what to do. I am impressed by how cool headed they are. There is calmness, things are in hand, people think ahead so there are few crises." There was a system in place for capturing and responding to complaints, comments and suggestions. We found that all complaints received had been investigated and responded to. Complaints, comments and feedback were all used as ways of learning and to further develop and improve the service provided.

Care plans documented that advanced care planning and end of life care was discussed with most people and their relatives. People's choices and wishes were recorded in relation to planning the way in which they wanted to be cared for and preferred funeral arrangements. Some people preferred to let their next of kin make the decision, which was documented. Relatives told us staff had advanced care planning conversations with them. A relative told us, "They asked me how I wanted things done and they gave me time to think about things."

The registered manager told us they were working to make the home more welcoming and a livelier place, which was observed by the inspection team throughout the inspection. Both people living at the home and their relatives said that visitors were made very welcome. People said "Dogs and children can visit – the children who visit seem very at home. Family are made to feel welcome – it's very inclusive" and "Staff are very welcoming to visitors, couldn't fault them, they offer drinks. I could include them in meals."; Can have visitors how, when and where I want, I want them to see how good it is."; "They are very welcoming of people coming in staff great them like old friends and remember their names". Relatives stated, "Staff are fantastic very welcoming", and "We can use the lift and come down to the bistro for a change or in the garden, [Name] loves going in the garden and I can bring the dogs, they are welcomed and there are even treats for them by the front door."

Good

Is the service well-led?

Our findings

People and staff told us the service was well led, their comments included. "We have a lovely manager. She's a lovely person. She listens to you. She's reasonable. She's fair." "The manager is a nice person because she explains everything to me. She knocks on the door and comes and chats with me. She manages well as it must be difficult. I think staff are happy with their jobs." "[Name] is the best manager" and "I'm glad she is captain of our ship."

The provider's mission statement was prominently displayed. They aimed to provide 'a welcoming and homely atmosphere.' Staff told us they learnt about the provider's purpose during their induction. Staff told us the service was a good place to work. One staff member commented, "This is now a happy place to work." Another commented, "A really good, close knit team here." A healthcare professional said, 'Gracewell put in place everything I suggest. The staff all look to be very supported and motivated - and she knows exactly what is going on all the time.'

Staff were recognised through the introduction of a 'Heart and Soul' scheme where staff, people and relatives were asked for their views about which staff had done something extra for people to enhance their experience.

People were cared for within a positive culture where staff felt valued. Staff felt well supported and well-led by management. One said, "We have staff meetings regularly where you can put forward new ideas, I feel that I am listened to and the nurses and the manager are very supportive. I feel happy to go to them if I want to ask anything, they are all very helpful." Another commented, "We talk about any problems to either [Name] registered manager or [name] deputy manager and they do listen. I feel comfortable talking to them and I feel supported." There was a clear management structure with the registered manager, a deputy manager and registered nurses and senior carers.

The registered manager completed a monthly report for the provider, covering areas such as safeguarding and issues for people or staff. The provider had a regional manager who supported the registered manager in their role, especially in the first year of the service being opened.

We saw the registered manager was visible and accessible to people within the service. They completed a daily 'walk round' of the service and spoke with people. They also noted what was happening within the service in relation to incidents, complaints, reviews and staffing by having a 'Daily Huddle' with all the heads of department each morning.

There were regular resident/relative meetings and staff meetings during which people and staff's views were sought, and they were consulted. People told us "There are monthly residents meetings – talk about food, meals, activities programme" and "Yes I do get listened to. I am not a militant body but I could speak. I would pipe up" Following the last meeting where the chef had sought feedback about the quality of the food and people had commented that the portion sizes were too large and that there were too many dishes

containing potatoes, dishes had changed.

People, their relatives, professionals and staff had just been sent a quality assurance survey. From the feedback received already, the registered manager told us it looked very positive overall. Feedback received from a professional as part of the inspection demonstrated that there was a positive approach in ensuring the quality of peoples' care.

The registered manager told us they had spent a lot of time putting in place audits and different ways of finding out how people felt about the care in the service, to make improvements and to make sure actions had been completed. A range of aspects of the service had been audited, these included infection control, people's care plans and medicines. Where issues were identified, relevant action had been taken. A range of trackers were maintained, in relation to falls, infections, weights, pressure ulcers, hospital admissions, to enable the management team to identify what action had been taken and any trends that required action.

Staff worked in partnership with other agencies. They attended training and learning forums organised by both the local authority and the clinical commissioning group (CCG). The deputy manager led a research project in clinical governance and how to manage change in care settings. They stated, "It was really fruitful for me." They had also been support by the registered manager to complete a 'CQC preparation [for inspection]' course, which enabled them to support staff in what to expect during an inspection.