Lilian Faithfull Homes

Faithfull House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 8 and 9 May 2018 and was unannounced.

Faithfull House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Faithfull House does not provide nursing care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The care home can accommodate 72 people in one adapted building. At the time of this inspection 68 people lived there. Eleven of these people lived in a separate dementia care unit called Bluebell.

People's private accommodation varied. People had varying size bedrooms of which some had a sitting room area. All had private washing facilities. People had access to additional communal lounges, dining areas, adapted toilets and bathrooms. Bluebell unit had its own lounge and dining space. At the time of the inspection the communal space for people on Bluebell unit was being increased to better accommodate people's needs. People had access to a large conservatory and well-tended garden with summer house. People who lived on Bluebell unit were supported to use other areas of the home, if doing so, supported their wellbeing.

The service was rated 'Good' overall following our first comprehensive inspection on 5 and 6 January 2017. We then carried out a focused inspection on 20 and 21 July 2017 in response to concerns shared with us about people's care. This focussed inspection looked at the key questions Is the service safe and Is the service well-led? We identified three breaches of regulation and the rating for the service was changed from 'Good' to 'Requires Improvement' following this inspection. This was the first time that the service had been rated 'Requires Improvement'.

At the July 2017 focused inspection we found risks to people had not been sufficiently identified and action had not always been taken to reduce or mitigate risk in order to keep people safe from harm. Incidents which had an impact on people's safety had not always been appropriately reported to the CQC or to other agencies as is required. Systems and processes used to monitor the service had not identified these shortfalls and had not led to improved outcomes for people

We asked the provider to complete an action plan to show what they would do and by when, to meet the necessary regulations and to keep people safe from potential harm. Also, how they were going to improve the key questions Is the service safe and Is the service well-led? to Good. The provider informed us on 22 September 2017 that they had completed their action plan.

During this full comprehensive inspection on 8 and 9 May 2018 we found all necessary regulations had been met. We also found all key questions Is the service safe, effective, caring, responsive and well-led? could be rated as Good. Following this inspection the overall rating for the service was 'Good'.

Faithfull House is required to have a registered manager of which one was in post. A registered manager is a person who has registered with the CQC 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.

During this inspection we found the home to be operating in a safe way. Risks to people's health were identified and managed and either reduced or mitigated. The same had been done with environmental risks. The safety and care of people who lived with dementia had improved through the formation of a separate dementia care unit called Bluebell. People who were at particular risk of harm, due to behaviours sometimes associated with living with dementia, were protected from harm and distress. Staff who supported people on Bluebell unit were skilled and knowledgeable in identifying situations and behaviours which could lead to upset or harm. They took action to avoid these situations or to diffuse them before they fully developed. People in the main home also lived safely and staff supported their wellbeing.

People, both in the main home and on Bluebell, 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, and protected people from potential abuse and discrimination.

There were arrangements in place for people, their relatives and other visitors to the home to raise a complaint or area of dissatisfaction. All complaints had been taken seriously, investigated and responded to according to the provider's complaints policy and procedures. In managing complaints and relatives expectations staff had remained aware of other legislation which they had to adhere to.

People were cared for by staff who were caring and compassionate. At the end of people's lives this ensured that people had as dignified and comfortable death as possible. People's privacy and dignity was maintained.

People and relatives were provided with support to help them understand information which was important to them. Information could be provided in different formats to support this. Relatives were welcomed at any time, and where appropriate, supported to be involved with their relatives' care planning and review. Information about people was kept confidential and secure.

People's needs were assessed prior to admission to the home and care plans devised to meet these needs. These were well maintained, reviewed and updated when needed. They included information which enabled people's care to be personalised. People were supported to take part in activities of their choice and which they enjoyed. Several people in the home led independent lives and chose to arrange their own activities which staff supported and respected.

The registered manager provided strong leadership and had developed a strong senior management team. Improvements had been made to how the senior management team in Faithfull House monitored the quality of care and services provided. Robust quality assurance systems had resulted in improvements having been made to the service since our last inspection. This was reflected in full compliance with necessary regulations. The service's compliance improvement plans were monitored and were effective in driving and sustaining improvement and development of the service.

Staff felt more involved and better communicated with and were actively involved in finding solutions to problems. The registered manager had promoted a working environment where staff were confident to challenge poor practice. The views of people and their representatives were valued and acted on, where it was practicable to do so, to improve the lives of people who lived at Faithfull House.

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 received support to take their medicines. Medicines were managed safely. When medicine related concerns were identified these were rectified promptly and lessons learned to improve practice.

Risks to people's health or the environment around them, were identified, assessed and either reduced or mitigated. Risks associated with behaviours, sometimes exhibited by people who lived with dementia, were managed to ensure people remained safe and protected from harm.

People were protected from potential abuse and discrimination because staff knew how to report concerns and managers ensured people were safeguarded.

There were enough staff in number to meet people's needs. Robust staff recruitment processes protected people from those who may be unsuitable.

People lived in a clean home where there were measures in place to reduce the risk of infection.

Is the service effective?

Good

The service was effective.

People were cared for by staff who had received training and support to be able to meet their needs. Staff who cared for those who lived with dementia had the right skills and knowledge to be able to do this.

People were supported to make independent decisions. People, who lacked mental capacity to make decisions, were protected from decisions which were not in their best interests, because staff adhered to the principles of the Mental Capacity Act 2005 and other legislation which protected people.

People were given support to maintain their nutritional wellbeing. Risks associated with eating and drinking were

identified, assessed and managed. People had a choice of food and a choice of where they ate their food.

Adaptions had been made to the home to meet people's needs and to make it easier for people to live in. In particular part of the first floor had been adapted to form a separate unit to meet the needs of those who lived with dementia.

Is the service caring?

Good

The service was caring.

People were treated with respect and received kind and compassionate care.

People's privacy and dignity was maintained. People's diverse needs and cultural and religious preferences were respected and supported.

People and relatives were supported to understand information which was important to them. Relatives and friends who mattered to people were welcomed and, where appropriate, they were supported to be involved in people's care and daily activities.

Information about people was kept confidential and secure.

Is the service responsive?

Good

The service was responsive.

People and their representatives were included in planning their care and reviewing it. Detailed information about people was sought and used to help personalise their care.

People were supported to take part in social and daily activities which were meaningful to them and which they enjoyed. The wishes of those who chose not to do this were respected. People's independence was supported.

There were arrangements in place for people, relatives and other visitors to the home to raise a complaint or express their dissatisfaction. All feedback was taken seriously and complaints investigated and responded to.

People at the end of their life were supported to have as dignified and comfortable death as possible.

Is the service well-led?

Good

The service was well led.

People had benefited from improved leadership and improved quality monitoring of the service. This had led to improvements having been made to the quality of care and services provided to people.

People, relatives and staff were included in decisions made about the running of the home. Their suggestions, views and feedback were valued.

Systems and processes in place ensured the home remained compliant with necessary regulations and all other legislation.

Faithfull House

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 9 May 2018 and was unannounced. Two inspectors and one expert by experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case someone used to caring and working with older people who live with dementia.

Prior to the inspection site visit we gathered and reviewed information we held about the home. This included information shared with us by the general public and commissioners of the service. We reviewed statutory notifications received from the provider since the last inspection in July 2017. Statutory notifications are information about events which the provider by law must inform us about. As part of the Provider Information Collection a Provider Information Return (PIR) was not requested prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we made the judgements in this report.

During the inspection we spoke with four sets of relatives and one lone relative and we spoke with four people who lived at Faithfull House. We spoke with 15 staff which included two staff from the catering team, two team leaders, two care staff, the clinical lead and the care planning lead. We spoke with one of the provider's physiotherapists, the facilities manager, deputy manager, provider's training manager, the registered manager, Director of Care and one other representative of the provider.

We reviewed the care records of five people which included risks assessments and care plans. We reviewed three staff recruitment files and a selection of training certificates. We reviewed the one authorised Deprivation of Liberty Safeguards document. We reviewed a selection of audits which included accidents and incidents, infection control, health and safety, medicines and call bell audit. We reviewed records pertaining to complaints and compliments received by the home.

We observed the care and support people received and two activity sessions. We attended one staff handover meeting and one staff reflective meeting.

We requested to be sent to us and received a copy of the home's Statement of Purpose, staff training record, current electrical installation certificate, 'resident' and staff survey results, copy of medication audit and the medication audit action plan and the updated Guidance for the control and administration of medicines. We also sought and received more detail on staffs; training and qualifications in dementia care.

Good

Is the service safe?

Our findings

At our previous inspection on 20 and 21 July 2017 the provider had not fully met Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At times some people had exhibited anxiety and other behaviours associated with dementia, which had put some people at risk of harm. These risks had not been sufficiently managed to prevent recurrences. People's risk assessments, care plans, staff practices and the management of the home, at this time, did not always support best practice in this area of care. By 22 September 2017 the provider told us this had been met. During this inspection we found necessary regulations had been met. Improvements had been made to how risks to people were identified and managed in order to effectively ensure people remained safe.

Following the above inspection the provider had reviewed their dementia care provision and had created the new dementia care unit called Bluebell. This provided dedicated space and specialist care to people living with dementia.

During this inspection we found the home to be operating differently from our previous inspection. The main part of the home was calm with people going about their day in a relaxed and safe way. Bluebell was also a calm place to be and people were having their needs met in a safe and stimulating way. The staff on Bluebell showed very good knowledge about the people they looked after. Several members of staff made up one consistent team which worked on Bluebell. This limited the changes of staff who looked after those who lived with dementia. This was less distressing for people and meant the staff on Bluebell knew people's needs and behaviours really well.

Staff on this unit all enjoyed working with people who lived with dementia and had the skills and knowledge to be able to meet their needs appropriately. They were aware of risks which could put people at harm, for example, they knew what may trigger people to become anxious and exhibit distress or challenging behaviours. Staff knew how to effectively avoid or manage situations that could potentially cause this. For example, we observed staff being vigilant and aware of how people interacted with each other and with their environment. They were able to help people understand what was happening around them and reduce the risk of confrontations.

There were enough staff available to meet people's needs both in the main home and on Bluebell. A senior member of Bluebell's care team told us there were always sufficient staff to be able to comfortably meet people's needs. They said, "We are absolutely fine." Relatives of people on Bluebell told us it was a safe place for their relative to live. They told us they mainly put this down to the high number of skilled staff working there and the fact the staff knew their relatives well. Staff told us they were able to spend quality time with people and have meaningful interactions with them because there were enough of them to do this. We observed this taking place during the inspection.

Risks to people were identified, assessed and managed effectively. We reviewed people's care records and spoke with staff to specifically see how risks were assessed and what information was available to staff to help them manage these. These included risks associated with people's behaviour, falls, moving and

handling, developing pressure ulcers, dietary and food related risks (such as diabetes and choking) and the risk of not being able to call for help when needed. We also reviewed how environmental risks were managed and looked at what information was available to support staff and the emergency services in the event of an emergency. We found actions were taken to reduce and mitigate risks.

When people first moved into the home any risks associated with how they moved or mobilised were assessed. Where needed, equipment and support was provided to help people walk and to move safely. For example, we observed people using walking aids and there were hoists for staff to use to be able to move people safely. We saw many people wearing a pendent call bell. This made it easier for those who could not easily reach a fixed call bell, to call for help. People who wanted to walk independently around the home and in the garden, but were at risk of falling, wore a pendent alarm. This meant if they experienced a fall they could call for help immediately. Two people's records showed they were prone to frequent falls (because of health related problems). They had both sustained injuries from falls which had required hospital treatment. We reviewed their care records and tracked the support given to them following a fall and following their latest injury. Falls risk assessments had been reviewed and updated appropriately. The support decided on had been reviewed and where needed, it had been altered. Each person's relevant care plan had been updated to ensure staff were aware of what support they now required.

We spoke with the provider's physiotherapist who explained that after these people's falls, and the hospital treatment, they had reviewed them. We saw notes in both people's records of frequent visits and reviews by this professional. This professional also visited and assessed people who were generally assessed as being at risk of falling. People had the opportunity to take part in regular 'keep fit' classes and some attended the Tai-Chi sessions which we were told helped to reduce stress and improve flexibility and balance. The physiotherapist told us they also worked with people on a one to one basis. This was to either provide specific physiotherapy treatment or to improve and maintain general mobility.

People's risk of developing pressure ulcers was monitored. One person's risk of developing these had increased as their physical health had declined. This person's relevant care records showed staff had regularly reviewed this person's skin for any changes and their level of risk had been closely monitored. Staff liaised with community nursing staff when they identified a risk and they visited to carry out a more in-depth assessment. Community staff provided pressure reducing equipment to those who required it. We reviewed repositioning records which showed staff were regularly changing people's positions in order to alleviate pressure from areas of the body that were particularly susceptible to pressure damage. Risks associated with developing pressure ulcers were reviewed on a regular basis for most people in the home. This was because most people had associated health factors which put them at risk of developing these. For example, poor circulation, older skin, reduced mobility and poor posture.

We spoke with the facilities manager who told us they took a lead on all aspects of health and safety in the home. They worked alongside other staff who worked in the home, the provider's health and safety committee and the home's insurers to make sure that all practicable and reasonable steps were taken to keep people safe. They told us health and safety was everyone's responsibility and staff were made aware of this during their induction training. We reviewed fire safety records which included the home's fire risk assessment. Along with the Legionella risk assessment these documents were reviewed and updated as required. Records showed that Legionella was "not detected" during the last water tests carried out by a specialist company. They also confirmed that water storage tanks had been disinfected as part of the actions taken to mitigate the risk of Legionella growth.

The support people would require in the event of an emergency had been recorded on 'personal emergency evacuation plans' (PEEPS). These records were kept in people's care records and in a designated 'grab-bag'

for the emergency services. Fire safety records also included information on fire drills which were carried out on a regular basis. In house maintenance records showed that fire fighting and evacuation equipment and all escape routes, were routinely checked. We also reviewed contractors' records which showed that routine system checks and equipment servicing took place. A fire warden scheme operated which meant there were staff on duty who had been specifically trained to co-ordinate staff in the event of a fire. The same type of maintenance and servicing records were seen for the water and heating systems, gas boilers and other gas equipment, electrical equipment and mains wiring and all lifting equipment, which included hoists and passenger lifts.

People's medicines were ordered, stored and administered safely. For example, there were arrangements in place with a community pharmacy for the ordering and delivery of people's medicines. Staff confirmed that medicines prescribed in-between the main order dates were delivered by the pharmacy immediately. People's daily medicines were stored in medicine cupboards in their bedrooms. If people ordered their own medicines and self-administered these, this was a convenient way for them to store their medicines safely. Risk assessments were carried out to ensure people remained able and safe to manage their own medicines. Other storage areas for medicines were all kept secure. Daily temperature checks showed that medicines were stored according to the manufacturers recommended temperature. Keeping medicines within their recommended temperature ensured they remained as effective as possible. We observed staff following best practice when administering people's medicines.

We reviewed a selection of audits from across the home on people's medicine administration records (MARs). These recorded that staff maintained people's MARs accurately following the administration of medicines. Some medicines required additional checks and were managed differently. For example, medicines which needed to be checked by two staff before administration and which required more secure storage. We checked the balance of these medicines with a medicines trained member of staff. Following administration of these medicines people's MARs had been accurately recorded. A separate record showed that the stock balance of these medicines was checked on a weekly basis. We checked the stock balance against the last weekly stock balance record and they tallied. Another record was required to be completed after the use of these medicines and for two medicines administered this had not been completed. The omission in this record keeping did not appear to be normal practice as previous entries had been made consistently. This was investigated immediately during the inspection by senior managers. Additional checks on this particular record were instigated immediately to avoid future omissions.

People were safeguarded from potential abuse and discrimination. Staff knew how to recognise this and what to report to senior staff. Senior staff followed the provider's policy and procedures on safeguarding adults. This meant they reported relevant information to other agencies who also had responsibilities for safeguarding people. The provider's policies and procedures and how staff were expected to behave supported the principles of the Equality Act 2010. Since the last inspection all grades of staff had received further training in safeguarding procedures. All senior managers had completed advanced safeguarding training which enabled them to manage safeguarding issues effectively.

We spoke with the relatives of one person who had been the victim of financial abuse before they lived in the home. The relative's told us they were grateful for the staffs' vigilance at Faithfull House to ensure this was not repeated. Staff were aware of the provider's whistle blowing policy and knew how to report concerns, for example, about another staff member's practice or approach towards people. Managers took all whistle blowing reports seriously and acted on these. Staff confirmed they could speak with the managers about any concerns they may have. One member of staff said, "There was something that was worrying me and I took it to the manager [registered] and I must say I was impressed with how it was dealt with."

People were protected from those who may not be suitable through the provider's robust staff recruitment processes. Staff recruitment records showed that an up to date clearance from the Disclosure Barring Service (DBS) was sought and received before new staff started work. The DBS checks that potential staff have not been previously banned from working with vulnerable adults and it reviews all police records for convictions and spent charges. The provider made additional checks which included requesting references and checking employment histories. Any gaps in employment were explored. This process helped the provider to make safer recruitment decisions.

People lived in a clean home where infection control measures were in place and adhered to. Training records showed that staff had received infection control training. In practice we observed staff taking precautions to reduce the risk of cross contamination. For example, they wore protective gloves and aprons when delivering people's personal care and when serving food. All catering staff wore protective clothing and headwear. On Bluebell there were no offensive odours considering several people required support to use the toilet appropriately. Relatives told us they considered the home to always be clean and that the housekeeping staff "took great pride in their work." There were arrangements in place to segregate all soiled laundry and to handle it safely. Soiled laundry was washed on specific washing cycles which killed bacteria. Staff were vigilant and identified illnesses which carried infection and sought medical advice and treatment quickly for people.

Good

Is the service effective?

Our findings

People were cared for by staff who had completed training in subjects which were relevant to their needs, including their safety and general welfare. Staff, irrespective of previous experience and qualifications, completed a two week induction training. All staff completed training in subjects which the provider considered necessary. For example, safe moving and handling, fire safety, food hygiene, infection control, dementia awareness, safeguarding adults and the Mental Capacity Act (MCA) and Deprivation of liberty Safeguards (DoLS). Staff were supported to complete additional training in subjects relevant to their role and responsibilities. For example, medication training, dementia link worker and supervisory and leadership training. The provider also supported staff to complete nationally recognised courses in care as well as further training and mentorship for staff who wished to pursue a career in adult social care management. Staff new to care were supported to complete modules from the nationally recognised Care Certificate. The Care Certificate provides staff with skills and knowledge so they can deliver basic care to a recognised standard.

Since our last inspection people who lived with dementia were cared for on a specific unit called Bluebell. This unit was led by a member of staff who had completed a specialised training course in dementia leadership. Along with care staff who were dementia link workers and dementia trainers it was their role to challenge negative attitudes towards dementia care and promote best practice in dementia care within the home. They also helped staff develop care plans which supported personalised care delivery. The registered manager, also a dementia lead, was able to ensure the overall governance of the home supported this work. Other staff who worked on the unit had completed dementia training and training in personalised care planning for behaviours which challenge in dementia. All of the above enabled these staff to follow Gloucestershire's dementia pathway of care and showed the managers of the home supported Gloucestershire's Dementia Training & Education Strategy.

Staff had regular one to one meetings called "supervisions" with senior managers. These were an opportunity for staff to discuss their personal learning and development needs, as well as any other issues or concerns they may have. Managers were able to reflect with the staff member on their progress and areas of practice which required support. One member of staff told us they had wanted to do the dementia link worker course and they were due to start this soon. This aspiration had been supported through the staff member's supervision sessions.

Staff competencies in a number of care and non-care based tasks were assessed on a regular basis. This included competencies in medication administration, safe moving and handling for care staff and non-care staff and care competencies at night. Learning was also supported through 'bite-size' learning sessions, for example, in nutrition and independence and wellbeing. The provider's training co-ordinator and manager told us all training was linked to the National Institute of Clinical Excellence [Nice] Guidance, for example, in dementia care. The training manager was also a dementia link worker and had completed specific training so that they could assess staff competencies and support the dementia link workers role.

People were supported to eat and drink and to maintain their nutritional wellbeing. Systems were in place

so that information about people's dietary needs were communicated to the catering staff. For example, the catering staff knew exactly who required a particular diet, what texture of food was required, who required assistance to eat and who required a fortified diet. We observed mealtimes in the main home and on Bluebell. In the main home some people enjoyed a favourite pre-meal drink and if they needed help to get to their dining table, they were provided with this. This was a very social time with people enjoying the company of others on their table. Food here was served by the hospitality staff. Care staff were present and provided some people with additional support. They monitored what people ate and reported any concerns to senior staff. We observed one person who did not eat much of their main course. Staff picked up on this and took time to offer alternative options. We observed trays of food being taken to people who preferred to eat in their bedroom. During warm weather meals could also be served in the garden. Three people who lived on Bluebell preferred to eat in the main home's dining area so they were supported to do this. People's weight was monitored on a regular basis to ensure they were maintaining a healthy and stable weight. Weights were discussed with the person's GP if there was a pattern of concern in relation to weight loss or gain.

On Bluebell people required more support at mealtimes so the care staff provided this. We were informed that everyone required and received a fortified diet. The need for this was determined through the use of a nutritional assessment tool and monitoring people's weight. People who lived with dementia were particularly at risk of losing weight and not maintaining their nutritional wellbeing and this was the case on Bluebell. People who live with dementia can become less efficient at absorbing nutrients, they can struggle, for various reasons, to eat their meals and to know when they need to eat or drink. Some people burned additional calories through walking or during periods of being unsettled. A fortified diet therefore provided them with additional calories. This was done by the catering staff adding extra butter, cream and powdered milk to food. In-between meals care staff also provided additional snacks and fortified drinks. Staff also supported periods of rest for those who found this difficult by reminding people to sit or by using methods of distraction which involved being seated.

On Bluebell we observed one person who had taken a long time to eat their food. They struggled to remain focussed on the physical task of eating. This person could eat independently, so rather than stop them from doing this; a member of staff sat patiently alongside them and reminded them to eat their food. They said "It is very important for [name] to retain [his/her] own self-care skills." This member of staff demonstrated good care practice and a desire to help this person retain the skills they had whilst living with dementia. Another person required encouragement to eat their food so a member of staff sat opposite them and modelled eating a pudding. The person was able to follow this and they ate their own food independently. Mealtimes in general were relaxed affairs with no sense of rushing and many people took their time to eat and enjoy their food.

Some people had needed to have their swallowing assessed by speech and language therapists (SLTs) to ensure they could eat and drink safely. These people were at potential risk of choking. To ensure this risk was reduced and to make eating and drinking easier for them changes to the texture of their food and drinks had been recommended. This was the case for one person where the SLT had assessed the need for a thickening agent to be added to the person's drinks. This had been prescribed by the GP. When we spoke with the staff about this they were aware of the amount of thickener they needed to add to get the recommended consistency. Thickening agents were stored securely. Another person required their food to be pureed. To help this person still enjoy their food, to support their dignity and to help them to be included, for mid-afternoon tea, the catering staff had soaked a slice of light sponge cake in apple juice. This gave the person the right texture to eat safely but still retained the shape of the slice and gave them the ability to be included.

The chef told us people's specific dietary needs and preferences were met. They added that they also catered for needs related to culture or ethnicity. They were currently catering for two people who did not eat pork or shellfish. On one day of the inspection instead of a prawn, salmon and broccoli pasta bake, these two people were provided with a pasta bake which met their particular religious preference. The catering staff also catered for any allergies such as shellfish or gluten. They told us the provider had a nutritional adviser and this person ensured that all menus were nutritionally balanced and that the nutritional value was recorded. Everyone in the home made food choices which then went to the kitchen. On Bluebell people made food choices on the day and where this was difficult for them, staff supported choice ay each meal by plating up two meal options up and helping people make a visual choice. Menus were on each dining table in the main home to help remind people of the day's menu. We spoke with one person who enjoyed the food provided but who asked us to read the menu as they could not read the print due to their diminished eyesight.

People were presumed to have mental capacity to make decisions unless for some reason it was suspected they could not. When this was the case people's mental capacity, in relation to the decision needing to be made, was assessed. Therefore, irrespective of if a person lived with dementia or not they were supported to make as many independent decisions as possible. Staff also recognised that people had the right to make decisions which they [the staff] or others may consider to be poor decisions. The staff had received training in how to support relatives to understand people's rights. Information on people's rights was available and the topic of consent and the right to make poor decisions was discussed during care planning and care reviews with relatives.

Staff were aware of who held power of attorney for people and therefore who could legally be involved in decision making on behalf of people. We spoke with two relatives who were one person's legal representatives for finances and health and welfare. They however, with the help of the staff, supported their relative to still make independent decisions. Prior to this inspection we had received concerns about one person's care and treatment and the decisions being made about this. Although all visitors who mattered to people were supported to be included in people's lives, staff adhered to the wishes and decisions made by people's legal representatives. Equally so, if staff were concerned about how a legal representative was carrying out their responsibility to act in the best interests of a person, they reported their concerns to the office of the public guardian.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff in the home were meeting the principles of the Act. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are the DoLS.

Managers had submitted 32 DoLS applications and many of these still needed to be processed by the local authority (the supervisory body). The managers were also due to apply for new DoLS as some people's original authorisations were due to expire. Nine DoLS authorisations were in place. We checked for conditions to these and one person had conditions in place which were met. Where DoLS had been applied for, but not yet processed by the supervisory body, best interests decisions, had been made and recorded in relation to people's need to live in Faithfull House to receive the care and treatment they required.

Appropriate people, such as involved professionals and people's representatives had been involved in this process.

People's consent was sought for the care delivered to them. In the case of personal care (for example - washing, dressing and help with toilet needs and eating and drinking) this had been recorded on a mental capacity assessment document. We asked managers to review the use of this document as it suggested that a mental capacity assessment, in relation to personal care, had been carried out on everyone. There was no problem with staffs' understanding of the principles of the Act, for example, that capacity is assumed. There had been some confusion over which document to use to record people's consent. Managers were keen to ensure they were able to demonstrate that they adhered to the principles of the Act so they told us they would review the use of this document for this purpose immediately.

In people's care records, under a section called "Patient treatment options". We saw "Do not attempt cardiopulmonary resuscitation" orders (DNRs) in place. For a person who had been assessed as lacking mental capacity to make this decision, the GP had discussed this decision with the person's family and other involved professionals and staff.

People had access to social care and health care professionals as needed or, in the case of a person's GP, on request if they wanted to see their GP. GP's visited the home on a planned weekly basis and in-between if required. Staff also used the out of hours GP service (111) when needed. One member of staff explained why staff had requested a GP visit for one person on the first day of the inspection. They said, "[Name] is usually very active and staff were worried because [name] was a bit listless – not [his/her] usual self.….so we asked the GP to look in on them." Staff had already carried out a test, which they could do, to see if there was an infection and this had indicated there might be. The GP visited and prescribed antibiotics. The member of staff said, "[Name] should be back on form in a couple of days." This showed that staff acted quickly when they suspected people were unwell.

Faithfull House did not employ nurses so community nurses visited and provided, for example, pressure ulcer assessment and wound care. Care records showed that referrals to other professionals were made. For example, to the local care home support team (Health care professionals with specialist knowledge and experience in various areas of care and health) who can help staff meet people's specific needs. Adult social care professionals also carried out assessments with regard to future care accommodation and care funding. Access to NHS dental and optical services could be arranged, although many people attended private practices, either independently or with family support. A regular chiropodist attended to people's feet.

People lived in a building which had been adapted to accommodate their needs. Entrances had been adapted at the front of the building and to the garden at the rear for easy wheelchair access. Communal and private bathrooms, shower rooms and toilets had been adapted. These provided walk in showers, fixed bath hoists, bath seats and grab rails to help people access these facilities more easily. Part of the first floor had been adapted to form Bluebell. This floor had been chosen because it provided a contained unit, with a passenger and large windows for light. The communal rooms and some bedrooms had floor to ceiling sash windows which provided a view of a bowling green in a square, opposite the home. One relative told us their relative really enjoyed "watching all the comings and goings in the square." We observed people doing this when we visited this unit.

We had received the views of three visitors to Faithfull House, who had been unhappy with Bluebell's environment when the unit opened. One relative had remained unhappy with this but confirmed they had no concerns regarding their relative's care. Managers were aware that some areas of the environment were

not totally ideal and told us they had adapted the unit around these issues as best as they could. For example, there was a short flight of stairs half-way along the corridor where the floor level changed. They had looked to see if altering the floor level was an option but structurally this could not be done so a gate had been placed at the top and bottom of the stairs to prevent falls. As there were plenty of staff on duty we did not observe people needing to wait to get through these gates. When people walked up to the gate they did not show any evidence of being agitated or frustrated with them, they simply turned around. We had observed that the dining space was cramped. It could not accommodate people who wanted to use it, as well as staff, easily at the same time. Managers had already been aware of a need to improve space and had decided to address this by losing one bedroom and adapting this into a second lounge with additional dining space. On the second day of the inspection furnishings for this room arrived and managers began to convert this room.

Good

Is the service caring?

Our findings

We observed people being treated in a caring and compassionate way. Staff took their time to talk with people, listen to what they had to say and responded in an interested and polite way back. Staff received training in how to communicate with older people in a positive and supportive way. We observed staff speaking to people in a way which complimented them and made them feel noticed and valued. For example, one member of staff went up to one person and said, "[Name], you look delightful today." For this person this was important as the staff later told us the person always took great care over their appearance.

We observed that many people required staff to be patient with them, either because they moved slowly or it took time for them to understand and comprehend what was being said to them. One relative told us, "It's been especially good since [name] moved to Bluebell floor. It's been a very good time for [name] and we notice when we visit how contented [name] seems. The carers are infinitely patient and kind to [name]." One person who required the support of staff to lead as independent life as possible said, "I can't fault them [the staff], they are wonderful." Another relative said of the staff that "Nothing is too much trouble."

People and staff had good relationships with each other and communication was relaxed. Staff ensured people were supported to be able to engage in conversation and feel included. Staff were aware of the risks associated with loneliness and self-isolation. We therefore observed staff helping people to converse with each other and spend time with, for example, a person they enjoyed the company of. We observed staff asking people if they would like to sit next to a particular person or join a friend who they knew. Staff made particular note to ensure people had their hearing aids in or had their glasses on or nearby to ensure communication and inclusion was not hampered. This showed that staff cared about people's quality of life and they helped people to achieve a sense of wellbeing.

People's care and their daily activity was organised and tailored around their particular needs and choices. It was very apparent by how the staff spoke with people and what they organised for them that they knew them well. People's life histories, personal backgrounds, their likes and dislikes were all explored with them or their relatives and this helped staff to get to know people particularly well. Information about people's care was specific in terms of people's wishes and preferences and it was clear that people, or those who knew them well, had contributed to this.

Information about people was kept secure and confidential. All paper records were kept in secure areas and computer stored information was password protected. Where people did not want information shared with family members or anyone else this was respected. For example, some people chose to arrange their own health appointments and chose not to share information about their health with the care staff. Staff only shared information about people's care and treatment with appropriate person's, such as legal representatives or professionals. The provider took steps to ensure they complied with data protection requirements.

Information could be made accessible in different formats. For example, large print and braille for people with reduced or no vision. The provider was organising for some information to be available in audio form,

on a disc for example. This was to include the home's main information - The Statement of Purpose and Service User Guide. Information could also be provided in different languages for people of different ethnicity. Where people may require support from an external advocate this could be organised. Information about advocacy services could be provided.

One person had been supported to attend a health appointment. They had specifically asked a member of staff to be present in the appointment with them so this had been arranged. This had been so that notes of the discussion could be taken in order to help the person remember the detail of this once they returned home. The member of staff showed particular compassion towards this person when they both arrived back to the home later. The person was tired and did not feel able to attend the main dining room for their tea or wanted what was on the menu. The member of staff suggested something a little lighter, which the person agreed to, and they organised for this to be delivered to the person's bedroom.

People's privacy was maintained and personal care was delivered in private. People's right to private and family life, home and correspondence was upheld. People received their correspondence unopened, staff respected the fact that people's bedrooms were their private space and respected people's property. One person's feedback in the last resident survey gave an example of this. The person had commented, "Special commendation to my cleaner who rifled through the contents of his vacuum machine to retrieve a thumb sized ceramic donkey, part of a matchbox crib set- and glued together the broken halves." During the inspection the registered manager commented, "It's the little touches that can make a difference to people."

People's dignity was maintained and staff were trained to adhere to the principles of dignity in care. For example, they ensured people could choose their own clothing to wear, people were addressed in the way they preferred and personal care was managed sensitively. When staff care competencies were checked senior staff in particular looked to see how staff maintained people's dignity. The training co-ordinator gave an example of where they had observed a member of staff help a person with their personal care after a night's sleep. The member of staff had made a particular point of combing through the person's hair, which had matted at the back of their head. This had made the person feel more comfortable and had ensured their dignity had been upheld.

Good

Is the service responsive?

Our findings

Relatives told us their relative's needs were met and that support was given in a personalised way. One relative said, "Dad is quite frail now and the staff do a truly remarkable job of looking after him. We are so glad to have the chance to speak to you today because we really want to let you know how wonderful this home has been for him." Another relative said, "……..she really enjoys watching all the comings and goings in the square. I feel that mum can 'be herself' up here [in Bluebell]. She's more relaxed and there's always someone to spend time with her. I've stopped coming every day now because I know she is contented when I'm not here." Another relative said, "It's been especially good since [Name] moved to Bluebell floor. It's been a very good time for her and we notice when we visit how contented she seems."

The formation of Bluebell had concerned some visitors to Faithfull House. We had received comments about people being 'imprisoned' in a separate unit and about Bluebell's environment not being fit for purpose. We found representatives of people had been fully consulted about their relative's move to Bluebell. The principles of the Mental Capacity Act and Deprivation of Liberty Safeguards had been fully adhered to by the staff. Staff had provided support to help people, their relatives and friends adjust to the change. We discussed with staff the care of two people where there had been concerns expressed about their move to Bluebell. Both these people had required more intensive support with their dementia. One person still lived on the unit and staff confirmed that they had become more settled and their overall wellbeing had improved.

People's formal and recognised representatives were involved in planning their care and were kept fully up to date with any changes to this. One relative said, "They [staff] know I like to be kept informed so I get regular updates over the phone." Another relative said, "[Name] is excellent, she is often on the phone keeping us updated." We reviewed the care records of seven people across the home. The risk assessments, care plans and professionals' records showed that people needs had been identified, assessed and responded to. Care plans were devised around all aspects of a person's care, for example, communication, nutrition, mobility and mental wellbeing. Those that we reviewed had been reviewed and updated regularly. The Alzheimer Society's' document called 'This is me' had been completed by relatives of people who lived with dementia and who knew the person well. This gave information about the person which staff used to help inform their care planning. A senior member of the care staff told us "We go through everything [care records] every month."

People who lived on Bluebell had 'RAG' (Red, Amber, Green) charts. These provided directions for staff to help a person become calmer and to bring them back to a state of wellbeing. These directions were tried, before staff resorted to using medicines, which had sometimes been prescribed to be used 'when required' for anxiety and altering people's behaviour. Simple actions were recorded and had often been successful in improving a person's wellbeing. For example, taking a person to a quieter area, going for a walk or going downstairs. In the case of one person who sometimes raised their voice when they were anxious, the RAG said, 'If you talk with (name) in a quieter voice, [he/she] will quieten their voice."

Staff gave us three examples of how, being able to work in a consistent and personalised way with people,

had improved the outcomes for people who lived on this unit. For example, for one person's wellbeing it was important they were kept busy and included in meaningful activities. Staff recognised the value of meaningful activities and the use of distraction to diffuse potential conflict and improve people's wellbeing. Another person was very particular about how they were spoken to. Staff knew what type of interaction would trigger distress and frustration in this person. They tailored their communication to ensure this did not happen. They were vigilant about how other people interacted with this person in order to avoid situations where communication or intentions were misinterpreted. Another person liked to exercise regularly and they preferred the company of male staff. The staff team worked in such a way to ensure, as much as possible, that a male member of staff supported this person. Improved staff knowledge and skills, a designated environment and team and the ability to work flexibly around people's needs had reduced risks to people. It had helped people to live well with their dementia.

Updates on people's care and progress were recorded in the 'holistic monthly record'. The Director of Care for the Lilian Faithfull group received an updated 'holistic' report on each person on a regular basis. This enabled them to be aware of each person's care and progress and it helped them to have meaningful interactions with the person when they visited the home on behalf of the provider.

People had access to, and were supported to take part in, social activities and other daily activities which were meaningful to them and which they enjoyed. Four staff were employed to specifically support people's activities. Relatives were supported to be involved in these if the person wished them to be and if it helped to support a more successful and meaningful visit. During the inspection we observed a singing session and a gardening group facilitated by an activity worker. People were engaged in these and enjoying themselves. At other times people were supported to meet and take part in poetry groups, quizzes, art groups and discussion groups.

We observed activity workers supporting people to meet with them for afternoon tea and a chat in the garden. At one point we observed a member of staff go outside to water the vegetable patch, which people were supported to enjoy. Some people were able to tend parts of the garden independently and when they wished to. There was a full activities programme, which people could take part in if they chose to. People were also supported to go out in groups or on a one to one basis. One person said, "There's plenty to do here. There are organised activities and trips for those who want them, but I don't. I've got my books and my music and people to talk to when I want to and that's just fine. They [staff] let me do my own thing." One relative said, "Dad has a good social life here, it's better than mine. He joins in all the activities and he loves it. All the staff know him and they make me feel welcome too."

People, their relatives, representatives and others were able to raise a complaint or express an area of dissatisfaction. The complaint records showed people had done this in various ways, in writing, by email or verbally. The management staff told us they took these seriously and aimed to resolve complaints and concerns, where they could, to the satisfaction of the complainant. Records showed that complaints had been followed up and investigated. They also showed that where complaints had been upheld apologies and, in some cases, a financial reimbursement had been made. For example, for lost or damaged clothing. Where the complainant had not been satisfied with the initial complaint response, the complainant had been able to take their complaint further. Next stage complaints had included a review or further investigation by a representative of the provider and in one case, to the ombudsman. In this case the ombudsman had decided there was no need for a further review. We found in the management of complaints the registered manager and provider adhered to their complaints policy and procedures.

The registered manager, their senior management team and representatives of the provider were aware of the need to respond to and support the expectations of people, their relatives and friends. There was

evidence to show that they met with people, relatives and friends to discuss their expectations. In some cases these and other wishes of people, friends and relatives could not be satisfactorily met. This was because staff had needed to adhere to relevant legislation or consider other necessary factors. For example, in one case they had considered and adhere to the decisions made and wishes of a person's legal representative. In another case they had considered the person's best interests and ensured these and the best interests of others were met. All feedback was accepted and the registered manager's view was that from any type of feedback lessons are learnt. They said, "We constantly need to evolve and look at what lessons have been learnt."

People, at the end of their life, were supported to have as dignified and comfortable death as possible. Family and friends were supported at this time. Staff worked closely with other health care professionals and pharmacists to ensure people's health needs were met at the end of their life. We reviewed one person's end of life care during the inspection. We observed staff taking it in turns to sit with this person and provide end of life support which met their needs. The care records showed that this care had been delivered consistently. The person was kept comfortable by staff who were clearly fond of them and who had built up a meaningful relationship with them.

The second day of the inspection we were told this person had died peacefully. Staff had kept a family member updated and informed and they had been able to visit as they chose. A reflective meeting was held for staff which we attended. It was a time for those who had supported the person, to talk with colleagues about their feelings, but also for the staff team as a whole, to look at what had gone well, and where they felt things could improve further. Staff in the home felt well supported by local GPs and community nursing staff at this time. Supporting relatives and friends at the time of a person's death and afterwards could sometimes be challenging for staff and they were given opportunities for support and to reflect on this and learn from situations.

People's care records showed that people's end of life wishes had been explored with them. Where people had wanted to share these they had been had been recorded so that staff were aware of these and could meet these at an appropriate time. In one case it had been decided that the person would discuss their end of life wishes with their spouse and then they would both discuss these with the staff. People were asked if they had a living will and the details of, or a copy of this were added to the person's care records.

Good

Is the service well-led?

Our findings

At our previous inspection on 20 and 21 July 2017 the provider had not fully met Regulation 17 and of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. Quality monitoring processes had not effectively identified that risks to people were not being sufficiently managed in order to reduce or mitigate risk to people. It had failed to identify those incidents which potentially put people at risk of harm, had not been appropriately reported to relevant agencies. There had not been effective monitoring processes in place to identify these shortfalls and address them. The provider told us these regulations would be met immediately. During this inspection we found these regulations had been met and sustained. There had been improvement in how the home's compliance and the service people received were monitored. All staff were fully aware of what had to be reported to external agencies.

The previous registered manager stopped managing the service in February 2018. In April 2018 a new registered manager was registered with the Care Quality Commission as the registered manager of Faithfull House. This manager had previously been a registered managed of another care home in the Lilian Faithfull group; they were an experienced registered manager. The current registered manager had developed the senior management team and during this inspection we found these staff to be clear about their roles and responsibilities. When talking about the management structure in place and how important it had been to get this right, the registered manager said, "I need to be confident that my residents are getting the best care and service possible."

A member of staff responsible for ensuring all in-house provider quality monitoring audits were completed and the information was collated and recorded said, "The systems were here, but they needed to be brought under control." This member of staff, along with the registered manager had altered some of the audits to fit the needs of the home. The member of staff had improved on how the data from these audits was collated and was reported to the registered manager. From these audits action plans were developed by the registered manager and their senior management team. The member of staff said, "The overriding goal is that we do not miss anything." They also said, "I'm now feeling far more confident that these processes are working."

We saw examples of how these improved quality monitoring processes had led to improvements along with overall stronger leadership. An example of altered and improved quality monitoring was seen in the infection control audit. A new slimmed down audit had been developed, which met with the provider's requirements and those of the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections. Instead of one very in-depth audit, completed once yearly, the management team now monitored compliance and practices more frequently. Patterns in practice for example, could now be identified by comparing areas of an audit with one completed previously. The member of staff explained, for example, the audits had showed "a dip" in best practice when experienced housekeeping staff left and new staff started in post. This kind of analysis had helped the senior management team identify areas of particular practice which they needed to focus on supporting and monitoring more closely.

Another example of improved monitoring and governance was seen in health and safety audits. In 2017 a basic list of necessary improvements had been formulated and several actions had been identified for completion. Subsequent audits showed that actions had not been successfully met within the set timeframe. Through improved monitoring and better overall governance these actions had been completed both in-house and by external contractors. By April 2018 there was one outstanding action, which required contractors to be involved in and which the provider's estate management team were addressing.

The provider had also strengthened how they monitored the quality and compliance of the service. The appointment of a new and experienced quality care manager in December 2017 had helped this. This member of staff devised and monitored on-going compliance improvement plans (CIP) which were met by the senior management team. This CIP was re-visited by the quality care manager and registered manager on a monthly basis. Actions on this were signed off when fully completed by the quality care manager. Regular visits to the home by the quality care manager and Director of Care ensured all information between home and provider was up to date. Other reports, such as the manager's weekly report, which was forwarded to head office, supported this flow of information.

The Director of Care reported to the board of trustees who also visited the home on a regular basis to gather the views of people and staff. They monitored progress and compliance and held the provider's senior management team to account.

The registered manager provided supportive and strong leadership. They had developed a whole home team approach which meant staff shared their vision for the service. The registered manager told us their vision was "Outstanding care with a view to continued improvement." In order to facilitate and manage this in Faithfull House, the registered manager held a weekly 'heads of department' meeting. This gave each department a chance to come together and discuss what had gone well in the last week, what issues had arisen for each department and plans for the coming week. It ensured that all departments were aware of each other's plans and issues and a collective approach could be taken to problem solving. The registered manager told us all departments were motivated to deliver a high quality service.

Meetings and discussions were held with all staff on a regular basis and the registered manager's approach was that each member of staff had something valuable to offer. They were keen to hear staffs' suggestions and ideas for improving services to people. We found staff had a sense of ownership and were proud of working at Faithfull House. The staff survey completed in late 2017 showed an increase in this view. Staff were confident to express thoughts and ideas and managers clearly valued this input. This was seen for example, when we attended a reflective meeting during the inspection. Staff told us they were used to being part of reflective meetings and discussions and found them both supportive and useful.

One suggestion, by a member of staff, had provided the solution to how staff response times to people's call bells were improved. Call bell response times were monitored as part of the quality monitoring process by taking a random day and analysing the times it took staff to answer all call bells on that day. Call bells over a 24 hour time frame ran into the hundreds. Response times over five minutes were not considered good enough for safety reasons and it was longer than managers wanted people to wait. The suggestion had involved alterations to the call bell system and how and where the call bells sounded. The necessary work to the call bell system was completed\ and this had led to improvements in staff response times; predominantly two to three minutes improvement. The changes to the system had allowed staff to more easily hear and focus on call bells which were ringing in their immediate areas of responsibility.

Families were encouraged and supported to attend a regular 'family and resident' forum. Meetings was led by family members and provided support to relatives who needed this and gathered views and suggestions

for improvement and development of the service. The registered manager was invited to attend every couple of months. This was an opportunity for them to give relatives an update on progress and any other news. The registered manager explained that this forum was not used to discuss personal areas of complaint. Complaints were approached on an individual basis and privately.

The views of people had been gathered in a survey in December 2017 and any actions from this completed in January 2018. The mealtime experience audit had originated from feedback from this survey and from other meetings and discussions held with people. Some people had expressed disappointment with certain meals. A new chef had been employed and following this feedback one of Lilian Faithfull's chef managers, who knew Faithfull House well, provided additional support and guidance to the new chef. The "mealtime experience" had also originated from this feedback. A mealtime audit meant people's experience at mealtimes was more closely monitored and people's views more actively sought. On one day, a member of staff had considered the standard of the food provided not to be a good as it could be. They had reported this to senior managers and the reasons for this looked into and addressed. Where a small number of people had commented for example, that their bedroom was not homely enough or they experienced a draught from their window, more support had been provided to address this, for example, by adding furniture, putting up book shelves up and fitting draught excluders.

The staff survey in 2017 offered comparisons to the one completed in 2016. This showed improvements in several areas, for example, how staff felt included in decisions made, how they felt communicated with and valued. The registered manager considered this to be positive feedback and relating to areas which the senior management team had specifically focused on. To improve the staffs' communication with representatives of the provider two members of staff had also been chosen, by staff and managers, to represent the staff as a whole at the provider's staff forum meeting. This allowed staff to discuss issues which affected them directly with members of the provider's senior management team.

The registered manager ensured they met their responsibilities and ensured the home remained compliant with all necessary regulations. This also included ensuring the rating of the home was prominently displayed and ensuring all necessary notifications were made to the Care Quality Commission immediately.