Highcliffe Nursing Services Limited

Newtown House

Inspection report

Waterford Road
Highcliffe
Christchurch
Dorset
BH23 5JW

Date of inspection visit:
29 February 2016
01 March 2016

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09 May 2016

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?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

This inspection took place on the 29 February 2016 and was unannounced. The inspection continued on the 1 March 2016 and was announced. The inspection was carried out by a single inspector.

Newtown House is a residential nursing home that provides care for up to 23 older people. At the time of our inspection there were 19 people living at the service. The home has a registered manager but they were not at the service during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their families told us they felt safe. Staff had up to date safeguarding training and knew how they would recognise signs of abuse. Staff told us they felt able to report poor practice without fear of any discrimination.

Personal and environmental risks to people had been assessed and where a risk had been identified actions had been put into place to minimise the risk. Risks had been reviewed regularly. Information about people's changing risks where shared with staff. Staff demonstrated a good understanding of people's risk whilst understanding the need to respect a person's freedom and choices.

The building, service and fire equipment had been well maintained. Fire drills had been carried out with staff. Drills had all been carried out in the morning. We discussed this with the deputy manager who agreed to look at including other times of day so that the night staff were able to be included.

There were enough staff with the right skills to provide the care that people needed. Staff had been recruited safely. Staff files contained references from previous employers, criminal records checks and evidence of the persons' eligibility to work in the UK. Profiles for agency staff were in place prior to them beginning their first shift at the service. The deputy manager agreed to speak to nursing staff to ensure that they have sight of a person's profile and are satisfied the person is suitable before they commenced a shift. The service had disciplinary processes in place to manage poor or unsafe practice.

Medicines were ordered, stored and administered safely. Staff had a good understanding of actions they would need to take if an error was identified.

Staff received training to give them the skills to carry out their roles. New care staff completed the Care Certificate induction course. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Three senior staff had been trained as assessors for the Care Certificate. Agency care workers received an induction on their first shift which familiarised them with the building, health and safety and people they would be supporting. Nurses received clinical updates and opportunities to continue with their professional development.

Individual supervision and appraisals were not consistently happening. However staff were being supported by nurses and managers. In the interim staff meetings had been used to provide group supervision and staff were receiving additional training and development opportunities.

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

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had been working within the principles of the MCA. Assessments had been carried out to determine whether a person had the ability to consent to key elements of their care. DoLs applications had been sent to the local authority for authorisation where people had been unable to consent to care and treatment. When a person had in place legal arrangements for somebody else to make decisions on their behalf staff were aware of this and had the correct paperwork on file. Staff asked people for their consent before administering medicines or offering support with personal care.

People had their eating and drinking needs met One person had been assessed by a swallowing specialist and they had written a safe swallowing plan. Staff were aware of what the plan said and supported the person safely. People had their weight monitored and actions had been taken when risks had been identified.

People had access to their GP and a range of health professionals including opticians, audiologists, physiotherapists and specialist health professionals.

Staff were caring. We observed positive interactions between staff and people. Staff had a good understanding of people's interests, likes and dislikes and people's communication skills. People felt involved in decisions and had been given information about advocacy services that would be able to speak up on their behalf.

People were supported to maintain their independence. .We observed staff treating people with respect and dignity. We saw staff caring for people in a relaxed way, laughing and sharing a joke.

People or their representatives were not always involved in planning their care. We were told that there were four people who chose to spend their time in bed. We spoke to two people and they had not been involved in decisions or given choices about how they wanted to spend their day. We discussed our findings with the deputy manager who told us that they would review both people's care plans with them.

Assessments had been completed prior to a person moving into the service. Information had been obtained from the person, family and other professionals and formed the basis for people's care plans. Involvement of people and their families in ongoing reviews did not continue. Reviews had regularly taken place. Staff had a good knowledge of people's identified care needs.

Activities were available to people every day. Care records included information about people's interests and hobbies. We spoke with staff who demonstrated a good knowledge of what people enjoyed. People were able to access the local community. Links had been made with a local church and local schools.

People and their families were encouraged to provide feedback. Resident meetings were held and chaired by one of the people living at the service. People were listened too and actions taken if concerns were raised. People and their families had been given information about the carehome.co.uk website and had used it to review the service.

A complaints procedure was in place and included contact information for the local authority, the NHS clinical commissioning group and an advocacy service. People and their families were aware of the complaints procedure and felt able to raise concerns with staff. The complaints book contained a record of written formal complaints. It included details of how the complaint had been investigated and the outcome and response to the complainant. It did not include records of verbal complaints received. This meant the records did not fully capture people's feedback and the actions taken by the service in response. We discussed this with the deputy manager who told us they would introduce this to the complaints process.

The registered manager had been awarded by the Hampshire Care Association the 'Manager of the year Award 2015' and the certificate was displayed in the foyer.

The service had an open, positive and transparent culture. A monthly newsletter was produced and had been put on the noticeboard in the foyer. It included information about redecorations being carried out, entertainment and news about staff leaving or joining the service.

Staff had a good understanding of their roles and responsibilities. Information was shared with staff so that they had a good understanding of what was expected from them and were involved in improving the service and keeping people safe.

Auditing processes were in place. They included care plans, health and safety, catering, recruitment, medicine administration and housekeeping. They identified actions required, the person responsible and a completion date. Audits were also completed as part of the operational directors' weekly visit to the service.

A quality assurance survey was completed annually. In January 2016 the survey had been sent to people, their families, other professionals and staff. The results had not been analysed at the time of our inspection. We were told by the deputy manager that findings would be shared at a resident and staff meeting, in the monthly newsletter and on the noticeboard.

The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way.

The service had achieved the 'Gold Standard Framework' accreditation (GSF). The (GSF) is a national award. It is a model of care that enables good practice to be available to people nearing the end of their lives. It provides a framework for a planned system of care in consultation with the person and their family. The framework promotes forward planning with the GP to ensure medication is available when needed.

Links had been made with Bournemouth University and student nurses had begun carrying out some of their practical training at the service.

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.

Staff had up to date safeguarding training and knew how they would recognise signs of abuse. Staff told us they felt able to report poor practice without fear of any discrimination.

Personal and environmental risks to people had been assessed and where a risk had been identified actions had been put into place to minimise the risk. Staff demonstrated a good understanding of people's risk whilst understanding the need to respect a person's freedom and choices.

The building, service and fire equipment had been well maintained. Fire drills had been carried out with staff.

There were enough staff with the right skills to provide the care that people needed. Staff had been recruited safely. The service had disciplinary processes in place to manage poor or unsafe practice.

Medicines were ordered, stored and administered safely. .

Is the service effective?

Good

The service was effective.

Staff received training to give them the skills to carry out their roles.

Staff were supported and given opportunities for additional training and personal development.

The service was working within the principles of the MCA.

People had their eating and drinking needs met

People had access to their GP and a range of health professionals.

Is the service caring?

Good

The service was caring.

Staff had a good understanding of people's interests, likes and dislikes

Staff had a good understanding of how to communicate with people with poor verbal skills.

People felt involved in decisions and had been given information about advocacy services that would be able to speak up on their behalf.

People were supported to maintain their independence. .

Staff treated people with respect and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People or their representatives were not always involved in planning their care.

Activities were available to people every day. Staff had a good knowledge of people and what they enjoyed. People had access the local community.

People and their families were encouraged to provide feedback.

A complaints procedure was in place. People and their families were aware of the complaints procedure and felt able to raise concerns with staff.

Is the service well-led?

Good

The service was well led.

The service had an open, positive and transparent culture.

Staff had a good understanding of their roles and responsibilities.

Auditing processes were in place which enabled the service to effectively monitor quality standards and safety

A quality assurance survey was carried out annually to gather feedback from people, families, staff and other professionals.

The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way.

The service had achieved the 'Gold Standard Framework' accreditation (GSF). It is a model of care that enables good practice to be available to people nearing the end of their lives.

Links had been made with Bournemouth University and student nurses had begun carrying out some of their practical training at the service.

Newtown 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.

The inspection took place on the 29 February 2016 and was unannounced. It continued on the 1 March 2016 and was announced. The inspection was carried out by a single inspector.

Before the inspection we looked at notifications we had received about the service and we spoke with social care and health commissioners to get information on their experience of the service. We looked at information on the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with six people who used the service and five people who were visiting. We spoke with a Registered Manager who was providing support to the home, the deputy manager, one nurse, three care staff, an agency care worker, student nurse and the chef. After our inspection we spoke with a GP who had experience of the service.
We reviewed four peoples care files and discussed them with care staff to check for accuracy. We checked three staff files, health and safety records, maintenance records, medication records, management audits, staff meeting records and the results of quality assurance surveys.
We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

Is the service safe?

Our findings

People and their families told us they felt safe. One person said "I do feel safe. Staff come quickly if I need help". A relative told us, "Feel mum is very safe. Much safer than when living at home on her own". Another said "I feel he is safe from any harm". We spoke with staff who told us they had up to date safeguarding training. Training records and certificates were evidenced on staff files. Staff were able to tell us how they would recognise signs of abuse. They knew who to report any concerns to which included the manager, CQC and local authority. Staff told us they felt able to report poor practice without fear of any discrimination.

Personal and environmental risks to people had been assessed and where a risk had been identified actions had been put into place to minimise the risk. Peoples risk assessments included skin care, diet, hydration and falling. Risks had been reviewed regularly. Accidents or any incidents were recorded and reviewed. Actions were taken to prevent a recurrence occurring. These had included changing the use of equipment and referrals sent to specialists. Information about people's changing risks where shared with staff at shift handovers.

Some people had a risk of developing skin damage. They had air mattresses on their beds to help support their skin from developing pressure damage. Mattress settings were checked and recorded daily. Some people needed to have their fluid and diet intake monitored as they were at risk of dehydration or malnutrition. Charts detailed the amount of fluid and diet the person needed and staff had recorded what the person had actually had during the day. Charts were reviewed each day to monitor and review the risk.

Staff demonstrated a good understanding of people's risk and the need to respect a person's freedom and choices. We spoke with a nurse who told us about a person who was at risk of falls. "At night time we go into people's rooms to check they are OK. This person has chosen not to have this as it wakes them up. In their care plan it states they can use their call bell and we can just stand at the bedroom door but not go in or use our torch. Staff do look into the room but they don't hear them".

The building, service and fire equipment had been well maintained and records included service checks. An external health and safety company had completed an audit in April 2015. Actions had been prioritised dependent on risk to people. A record had been kept of when actions had been completed and signed off by the manager. Some medium and low risk actions remained outstanding. An external company carried out weekly checks on fire equipment. In November 2015 three fire drills had been carried out with staff. Drills had all been carried out in the morning. We discussed this with the deputy manager who agreed to look at including other times of day so that the night staff were able to be included. A personal emergency evacuation plan had been put in place for each person which clearly identified each persons' individual risk.

We found that there were enough staff with the right skills to provide the care that people needed. One person told us, "My call bell is always in reach and the staff comes quickly". We spoke with a relative who told us, "There are enough staff but at times they have had to rely on agency staff and then feel not so good. Albeit my relative is happy".

Two staff members told us about concerns they had about staffing levels. One said, "Feel there's not enough staff when the home is full. It's OK at the minute". Another told us, "Could do with more staff downstairs in the afternoon. Staffing reduces by one person to three carers and one nurse, so busy. Not always time to spend with people in their rooms". We spoke with a nurse who said "I allocate staff considering their strengths. This morning there are enough staff to meet people's needs. In the afternoon staff reduces by one member of staff but that is OK". Another carer said, "Normally there is enough staff. When there are agency staff it is more difficult as they don't know people". We discussed with the deputy manager the mixed views we had from staff. They told us they could understand this as there had been a period of high agency usage which had put added pressure on staff but that recruitment had been successful and agency usage had reduced.

Staff had been recruited safely. We looked at three staff files. They contained references from previous employers, criminal records checks and evidence of the persons' eligibility to work in the UK. We saw profiles for agency staff that had worked at the service. The profile included a photograph, confirmation of mandatory recruitment checks, qualifications and training. An agency care worker was working on the day of our inspection. Their profile was not in the file. We discussed this with the deputy manager. During our inspection they contacted the agency and had a profile e-mailed immediately across to them. The profile had been previously e-mailed to the manager who was not available to access it. The deputy manager agreed to speak to nursing staff to ensure that they have sight of a person's profile and are satisfied the person is suitable before they commenced a shift.

The service had disciplinary processes in place to manage poor or unsafe practice. Staff and management had a good understanding of them. One nurse told us, "If I saw poor practice I would carry out an instant supervision and then discuss with the manager".

Medicines were ordered, stored and administered safely. We looked at the medicine administration records (MAR) which contained a nurse's signature against medicines they had administered to people. We checked medicine remaining and it corresponded with the records. Some people had medicine prescribed as and when it was required. Records showed when the medicine was given, why it was given and whether it had been effective. We discussed with a nurse the action they would take if a drug had been signed as given and in error it hadn't been. They told us, "I would complete a meds error form which includes all the people that would need to know. If a critical drug I would inform safeguarding".

Good

Is the service effective?

Our findings

Staff received training to give them the skills to carry out their roles. New care staff completed the Care Certificate induction course. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. We spoke with a senior carer who told us, "I'm involved in new starter's inductions. They are supernummary for two weeks and they will shadow care with me. It's nice to see staff building their confidence". Three senior staff had been trained as assessors for the Care Certificate.

We spoke with an agency worker about their induction. They told us, "The nurse in charge showed me around. Explained about fire, the laundry etc. I worked with another carer from the permanent staff. I know where the care plans are and will write daily notes with the other member of staff".

Staff told us that training they received was good. One carer told us "The moving and handling trainer is in-house. They are very good, very experienced". Staff files contained certificates for courses successfully completed. They included record keeping, dementia, mental capacity act, managing supervision, safeguarding and death, dying and bereavement. A training matrix contained an overview of all the training staff had completed and renewal dates where appropriate.

Nurses have to re-register with the Nursing & Midwifery Council every three years in order to be able to continue to practice. To support their re-registration as from April 2016 they have to be revalidated. This means that they have to demonstrate that they have continued with their professional development and kept their skills up to date. We spoke to a nurse about clinical updates and training. They said "Last year I had a two day course on end of life care and also syringe driver training. We have got a staff meeting next week to discuss revalidation".

Staff told us that they felt supported by senior staff and managers on a day to day basis. One carer said, "The shift is managed well, the nurses are supportive". Staff had opportunities for personal development. We spoke with a nurse who said, "When I had supervision I was able to discuss personal development. I wanted student mentorship". Another member of staff told us they had started their QCF diploma in health and social care. Talking to staff and checking records showed us that individual supervisions and appraisals were not consistently taking place for staff. We spoke with the deputy manager who told us this was an area they were aware needed improvement and was part of their plan for 2016. In the interim staff meetings had been used to provide group supervision and staff were being given the opportunity of taking additional training and development opportunities.

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

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had been working within the principles of the MCA. Assessments had been carried out to determine whether a person had the ability to consent to key elements of their care. People had signed to consent to having medicines administered, photographs taken and to the care they were receiving. DoLs applications had been sent to the local authority for authorisation where people had been unable to consent to care and treatment. When a person had in place legal arrangements for somebody else to make decisions on their behalf staff were aware of this and had the correct paperwork on file. We observed staff verbally asking people for their consent before administering medicines or offering support with personal care.

People had their eating and drinking needs met. One person said "Food is very good and always plenty of choice". Another person said "The chef and cook are brilliant. Plenty of choice. They come around every morning to see what you would like. They've been trying to build me up as I had lost weight. Staff have talked with me about my weight. I'm having complan. Would like to put some weight on". One person had been assessed by a swallowing specialist and they had written a safe swallowing plan. Staff were aware of what the plan said and we observed them supporting the person safely. We observed staff supporting people individually and at the persons pace. Some people had plate guards or beakers to aid their independence. People had their weight monitored. Records showed us that when a person had lost weight referrals had been made to their GP.

People told us that they had access to their GP whenever requested. Records showed us that people had good access to a range of health professionals including opticians, audiologists, physiotherapists and specialist health professionals.   We spoke with a GP who said "They are quite good. They will do observations and inform us of any changes. Requests for a GP have been appropriate".

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said "Staff help you and just let you take your time". Another said "Staff are really helpful. Don't make you feel your any trouble". We observed positive interactions between staff and people. A care worker stopped on their way through the lounge and said to a person "That's a pretty scarf it matches your jumper, you always look pretty". The comment brought an immediate smile to the ladies face. A person told us "The staff stop for a chat and ask how you are. They are friendly, kind and interested". A relative said "Staff engages with mum, they make time to speak". We looked at records of compliments sent to the service. We read one that said 'Every member of staff gave everything. What beautiful care'

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A nurse told us how they support a person who gets agitated when being assisted with personal care. They said "When you're helping her get dressed you have to explain what you're doing step by step. We have found it helps if you suggest once you're dressed you can go and join others in the lounge".

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. Staff had a good understanding of people's communication skills. One person used facial expressions to let staff know their needs. Staff told us "We have known them for a long time and through their facial expressions and body language have found a way of communicating". With another person staff told us they could understand what was being said but could only answer by saying yes or no. They told us that they needed to keep sentences simply phrased. Care files supported what we had been told.

People felt involved in decisions. One person said "I feel I have a voice, it hasn't been taken away from me". A relative told us "My relative can't speak but they understand. Staff involves her, they understand what she wants. The staff all like her and are respectful". People had been given information about advocacy services that would be able to speak up on their behalf.

People were supported to maintain their independence. One person said "Staff help me be independent. I do need assistance but they encourage me to do myself. I can make my own bed but they always ask me if I want help making it". They also said "Wi-Fi and using the IPad is highly essential to me. I use it to speak to family; have a good chat and a laugh". We observed a care worker ask a person if they could help cut up their food. This enabled the person to eat their meal independently.

We observed staff treating people with respect and dignity. Staff knew the informal names people had chosen to be addressed by and used these appropriately. One relative said "The staff are always polite". We saw staff caring for people in a relaxed way, laughing and sharing a joke. Staff knocked on people's doors and waited to be invited in. We spoke to one person who was in bed and they told us they felt warm and cosy. We read feedback from a relative that said 'Personal needs are most important and are handled with such care that there is little or no embarrassment'.

Requires Improvement

Is the service responsive?

Our findings

People or their representatives were not always involved in decisions about their care. We were told that there were four people who chose to spend their time in bed. However we asked one of these people if they liked to stay in bed and they said "No". We asked them if they would like staff to discuss with them getting up they said "Yes". The person's care records stated that they had the capacity to understand conversations but could only give yes and no answers. The person had not been involved in decisions or given choices about how they wanted to spend their day. The care assessment had highlighted a risk of social isolation. We looked at the persons' activity sheet which showed six nail care sessions since 10 December 2015. They had not been involved in any other activities at the home. We spoke with another person whose care records said they chose to stay in bed but that staff to ask each day if they would like to get up. We spoke to a care worker who said "It's her wish to stay in bed. They have a lot of family and friends that visit". When we spoke with the person they told us "Never been discussed about getting up". We discussed our findings with the deputy manager who told us that they would review both people's care plans with them.

We spoke with another person who always stayed in bed. They said "It's my choice to stay in bed. I don't go to the lounge as I don't want too. I enjoy reading and watching the TV".

Assessments had been completed prior to a person moving into the service. Information had been obtained from the person, family and other professionals and formed the basis for people's care plans. Involvement of people and their families in ongoing reviews did not continue. Reviews had regularly taken place and included assessing risks to people and changing care plans to reduce any identified risk. Staff had a good knowledge of people's identified care needs. We spoke with one care worker who said "I do read the care plans as they're interesting. Changes are told to us at handover. After a holiday you get a more detailed rundown of what has changed".

Activities were available to people every day. A programme had been given to people for the week and had been displayed on the noticeboard. There were three activity staff and between them they provided social support to people Monday to Friday and alternate weekends. A person told us "Really nice ladies. I do join in but had a bad night so didn't go down today. You do have a laugh". We observed people in the lounge enjoying word games together, sharing music and enjoying conversations. Care records included information about people's interests and hobbies. We spoke with staff who demonstrated a good knowledge of what people enjoyed. We asked them about how one person liked to spend their time. They told us "They like knitting and conversations about gardening. Also staff initiated arrangements for a resident, who had previously lived in another service they too had lived in to visit her and they have carried on with a friendship".

People were able to access the community. Staff told us of one person who independently visited family and friends who lived close to the service. Staff took people to local cafes and shops nearby. A local church minister visited the service regularly and saw people individually. Links had been made with local schools who had visited over the Christmas holidays.

People and their families were encouraged to provide feedback. One person told us, "Management asked me, due to my past experience, to get views of other people about any concerns they have. For example, a person who has just come in. I go and see them, ask them if they want to talk".   Resident meetings are held and chaired by one of the people living at the service. People were listened too and actions taken if concerns were raised. They told me "We often have discussions about food not being hot enough. We were getting the main meal and sweet together. Now they are separated and this has improved". One relative told us "I feel able to talk with staff and they would listen. If I discuss care with the staff you feel they have responded".

A complaints procedure is in place and includes contact information for the local authority, CGC and an advocacy service. People and their families were aware of the complaints procedure and felt able to raise concerns with staff. A relative told us of an incident where a person had needed staff to come and help and had been pressing their call bell but nobody came. Eventually the person had needed to use their mobile to call family to help. The home investigated the incident and found the call bell was faulty. In response they introduced a weekly call bell check. This incident had not been recorded in the complaints book. The complaints book contained a record of only written formal complaints. It included details of how the complaint had been investigated and the outcome and response to the complainant. We discussed this with the deputy manager who told us that they would record verbal complaints in order to fully capture people's feedback and the actions taken by the service in response.

People and their families had been given information about the carehome.co.uk website. There had been six reviews of the service. Each review had received a response from the manager.

Good

Is the service well-led?

Our findings

The registered manager was not at the service during our inspection. Appropriate arrangements to manage the service had been made in her absence. A relative told us "The manager is lovely, staff are happier. Things have improved under her leadership. You can talk to her, I feel kept informed". Another relative said "The manager runs a tight ship".

The registered manager had been awarded by the Hampshire Care Association the 'Manager of the year Award 2015' and the certificate was displayed in the foyer.

A monthly newsletter is produced and had been put on the noticeboard in the foyer. It included information about redecorations being carried out, entertainment and news about staff leaving or joining the service.

The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way.

Staff had a good understanding of their roles and responsibilities. The deputy manager told us "The manager has been brilliant for the home. She has enhanced the role of the senior carers to make the role more interesting to them. Staff have been encouraged to take courses to become in-house trainers such as moving and handling and care certificate assessors". We spoke to a senior carer who told us her role included ordering personal protective equipment, supporting new starters, supporting with new admissions and had completed a supervision course so that they could begin supervising staff.

Auditing processes were in place that included care plans, health and safety, catering, recruitment, medicine administration and housekeeping. They clearly identified any actions required, the person responsible for the action and a completion date. Actions had been signed off by the registered manager. Audits were also completed as part of the operational directors' weekly visit to the service. Information was shared with staff so that they had a good understanding of what was expected from them and were involved in improving the service and keeping people safe. We saw that there had been two incidents of people tripping over wires. A staff member was aware of these incidents and demonstrated they were aware of the actions staff needed to take to avoid any further similar incidents.

A quality assurance survey was completed annually. In January 2016 the survey had been sent to people, their families, other professionals and staff. One person told us "I was given a form to fill in but I can't see very well. A member of staff sat with me and asked me the questions". The results had not been analysed at the time of our inspection. We were told by the deputy manager that findings would be shared at a resident and staff meeting, in the monthly newsletter and on the noticeboard.

The service had achieved the 'Gold Standard Framework' accreditation (GSF). The (GSF) is a national award. It is a model of care that enables good practice to be available to people nearing the end of their lives. It provides a framework for a planned system of care in consultation with the person and their family. The framework promotes forward planning with the GP to ensure medication is available when needed.

Links had been made with Bournemouth University and student nurses had begun carrying out some of their practical training at the service. The deputy manager said "We learn as much from them as they hopefully do from us".