Care Quality Commission

Hampshire County Council

Emsworth House Care Home with Nursing

Inspection report

Emsworth House Close
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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

About the service
Emsworth House Care Home with Nursing is a care home. The home is registered to provide accommodation and nursing care for up to 79 people. At the time of the inspection, seven rooms were closed for refurbishment and 69 people were living at the home. The home comprises single room accommodation arranged in two separate sections; the residential unit provides accommodation with personal care and the nursing unit provides accommodation with nursing care. Each unit is based over two floors with inter-connecting passenger lifts. Each unit also has a wide range of communal areas where people can spend time and socialise.

People's experience of using this service and what we found
People told us they felt safe and happy living at Emsworth House. However, we found some improvements were required to ensure people consistently received effective, high quality care.
Staff did not always follow best practice guidance in relation to legislation designed to protect people's rights.
The provider's quality assurance systems were not always effective in identifying and bringing about improvement.
There were usually enough staff deployed to meet people's needs and safe recruitment procedures were followed.
People felt safe and were protected from the risk of abuse.
The home was clean and staff used appropriate techniques to prevent the spread of infection.
Staff were suitably trained and supported in their roles.
People's dietary needs were met and people were encouraged to drink well.
People were supported to access other healthcare services in a timely way.
Adaptations had been made to the home to meet the needs of the people living there.
People and family members spoke positively about staff and we observed positive interactions between people and staff.
People's privacy and dignity were protected and people were encouraged to be as independent as possible.
People were empowered to make decisions and were involved in creating their care plans.
A range of activities and events were arranged to help people lead active, fulfilled lives.
People felt listened to and knew how to raise concerns.
Staff were highly experienced in supporting people at the end of their lives to have a comfortable, dignified and pain-free death.
Managers had developed a positive culture that was person-centred, open and inclusive.
Staff had developed links with community groups for the benefit of people.

The service has been rated Requires improvement as it met the characteristics for this rating in three of the five key questions. More information is in the full report, which is on the CQC website at: www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published 14 July 2018). The service remains rated requires improvement.

Why we inspected
This was a planned inspection based on the previous inspection rating.

Follow up
We will continue to monitor the service. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our Safe findings below.	**Good**
Is the service effective? The service was not always effective. Details are in our Effective findings below.	**Requires Improvement**
Is the service caring? The service was caring. Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our Well-led findings below.	**Requires Improvement**

Care Quality Commission

Emsworth House Care Home with Nursing

Detailed findings

Background to this inspection

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

Inspection team
The inspection was conducted by two inspectors, a specialist advisor in nursing care and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Emsworth House Care Home with Nursing is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We did not give notice of our inspection.

What we did before the inspection
Before the inspection, we reviewed information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some

key information about the service, what the service does well and improvements they plan to make.

During the inspection
We gathered information from: 20 people who used the service and six relatives of people who used the service, 11 people's care records, records of accidents, incidents and complaints, audits and quality assurance reports. We also spoke with 19 staff members including the provider's service manager, the registered manager, deputy managers, unit managers, nurses, care staff, housekeepers, the chef, activities coordinator and the maintenance person.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We received additional information from the registered manager that we reviewed.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has improved to Good. This meant people were safe and protected from avoidable harm.

Assessing risk, safety monitoring and management
• Fire safety risks had been assessed and staff we spoke with knew what to do in the event of a fire. However, we identified that staff training in fire safety was not up to date. We raised this with the registered manager who told us they were trying to resource appropriate fire safety training for staff. Following the inspection, they confirmed this had been provided for all staff.
• In addition, whilst personal emergency evacuation plans (PEEP) in people's care plans were accurate and up to date, a summary of people's evacuation needs, kept in a 'grab bag' in the reception area, was not accurate. After investigation, the registered manager identified that the established process used to update the PEEPs in the grab bag had stopped without their knowledge. They took immediate steps to reinstate this process to help ensure that all versions of people's PEEPs remained up to date.
• Some people had catheters. These are tubes used to drain a person's urine into an external bag. They are prone to blockages, so the output needs monitoring to help identify when a blockage occurs. In the nursing unit, there was a clear process to monitor and record the output from people's catheters. In the residential unit, although staff monitored people's catheters, this was not done as consistently. We discussed this with the registered manager, who immediately introduced a system to improve the recording of catheter monitoring for people in the residential unit.
• Other risks to people had been assessed and staff had clear guidance to follow. For example, some people were taking blood thinning medicines and staff were aware of the risks these would present if the person experienced an injury.
• The risk of people falling was managed effectively. Staff followed the Hampshire falls protocol and sought medical advice when needed. Following a fall, the person's falls risk assessment was reviewed and extra measures considered to reduce the risk of further falls.
• People were protected from the risk of developing pressure injuries. Clear information for staff about how to support people, for example with regular changes in body positioning was recorded. Additionally, where pressure-relief equipment, such as specialist mattresses were in place, there was a system to help ensure the equipment remained at the correct setting.
• Other risk assessments in place included areas such as mobility, nutrition, choking and the use of bed rails.

• Checks of the water quality and temperature were conducted regularly and records confirmed they were within acceptable safety limits. Lifting equipment, such as hoists, were maintained according to a strict schedule. In addition, gas and electrical appliances were checked and serviced regularly.

Using medicines safely
• Arrangements were in place for the safe management of medicines. Oral medicines were administered by nurses and senior care staff who had been trained and assessed as competent to do so. Topical creams

were usually applied by trained care staff.
• Some medicines are subject to additional controls by law. These require two trained staff to check them before they are administered. However, we found in the residential unit, the second staff member who performed this role had not been trained to do this. We raised this with the registered manager and by the end of the inspection they had introduced a new training and assessment process for staff who performed this role. Once embedded in practice, this would help ensure people received their medicines in accordance with best practice guidance.
• Some people were prescribed a heart medicine that should not be given if the person's pulse rate is too low. In the nursing unit, arrangements were in place to check the person's pulse before giving the medicine. However, similar arrangements were not in place in the residential unit. We discussed this with the registered manager, who took action to address the concern.
• Clear protocols were in place to guide staff about when and how to administer 'as required' (PRN) medicines. A recognised tool was used to assess people's pain levels and arrangements were in place to help ensure time specific medicines were given at the right time.
• Medication administration records (MARs) confirmed that people had received their medicines at the right times. Suitable arrangements were in place for ordering repeat medicines and disposing of unused medicines.

Staffing and recruitment
• People and relatives had mixed views about whether there were enough staff to support people in a timely way. Comments included: "Quite a lot of time there aren't enough staff [which means] I can't do what I want to do", "They [staff] are really pressurised at times. They are rushing here and there." Two people told us they sometimes had to wait to be supported to use the toilet which could make them "upset".
• Other people felt there were enough staff and their comments included: "[The staffing levels] are quite good", "You don't have to wait" and "Nothing happens immediately [but] they help when you need it".
• Staff also had differing views. While some told us there were enough of them to support people appropriately, others described being "overwhelmed" at times by the work load. During the inspection, we found call bells were answered promptly and staff did not appear rushed.
• The registered manager told us staff shortages were usually covered by agency staff and said the provider was in the process of introducing a bank of staff who would be trained to work at any of the provider's homes. They had also introduced an electronic rostering system to help ensure enough staff were deployed at all times. The registered manager acknowledged that "teething problems" with the systems had led to occasional gaps in the roster not being filled. However, they expressed confidence that the initial problems had been overcome and felt the systems would be beneficial in the long-term to help ensure sufficient staff were deployed consistently.
• The registered manager told us staffing levels were based on people's needs, which they assessed using a dependency tool and by seeking feedback from people and staff. The provider had recently introduced a new call bell system that could be interrogated to analyse response times. The registered manager undertook dip-sampling of this system which showed most calls were answered within three minutes.
• There were clear recruitment procedures in place. These included reference checks and checks with the Disclosure and Barring Service (DBS). DBS checks help employers make safe recruitment decisions. For registered nurses, checks were also made with their governing body to ensure they were registered to practice.

Preventing and controlling infection
• Staff had been trained in infection control techniques and followed safe operating procedures to reduce the risk of infection; for example, they used personal protective equipment, including disposable gloves and aprons, when delivering personal care to people.
• The home was clean and staff completed regular cleaning, in accordance with set schedules. One person

told us, "It's spotlessly clean, they are always washing the floors. The bed is nice and clean too."
• The laundry was organised and there was a clear system to prevent cross contamination between dirty linen and clean linen. In addition, people who used hoists had individual slings allocated to reduce the risk of cross infection.

Systems and processes to safeguard people from the risk of abuse
• People said they felt safe at the home. For example, one person told us, "I am 100% safe here. I would give the staff 10/10 for keeping you safe."
• Staff had received safeguarding training and knew how to prevent, identify and report allegations of abuse. One staff member told us, "My first concern is the person and I would report any concern straight away. I would whistle blow if I needed to."

Learning lessons when things go wrong
• The registered manager described how they constantly monitored incidents, accidents and events to identify any learning which may help keep people safe. For example, they had re-assessed the safety of a flight of stairs following a fall and had made changes to reduce the risk of further falls.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. There was a lack of consistency in the way consent to care and treatment was recorded in line with legislation and guidance.

Ensuring consent to care and treatment in line with law and guidance
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.

• Where people did not have capacity to make decisions, staff had consulted with those close to the person and had made decisions in the best interests of the person. However, we found staff lacked an understanding of how to record MCA assessments and best interests decisions in line with the MCA Code of practice. We had identified this as a concern at our last inspection and there had been no improvement.
• The provider had template forms to support staff to record capacity assessments and best interests decisions, but we found these were not used consistently by staff at Emsworth House.
• Where an MCA assessment had been completed and had concluded that the person lacked capacity, a best interests decision was not always recorded, together with the views of the people consulted. This meant staff were not able to demonstrate that they had acted on the result of the assessment and were taking the least restrictive approach to supporting the person.
• On other occasions, a best interests decision had been recorded before an MCA assessment had been completed. This meant staff could not demonstrate that the person lacked capacity to make the decision for themselves.
• Decisions that had not been properly documented included those in relation to the delivery of care, the use of equipment to monitor people's movements and the administration of covert medicines. (This is when medicines are hidden in a small amount of food without the person's knowledge).
• We discussed the issues with the registered manager who assured us they would review people's care needs and complete assessments as necessary. Following the inspection, they provided evidence to show this had been done. However, these processes need further time to become fully embedded in practice.
• Throughout the inspection, we heard staff seeking verbal consent from people, in an appropriate way, before providing support and records showed staff had received training in the MCA.
• Where people were able to, they had signed consent forms to show their agreement with the care and support planned.
• Records showed that people's right to decline care was respected. One person confirmed this and said, "If you don't want to [do something], they [staff] leave you. They don't make you."

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and found that they were.

• Applications for DoLS had been submitted to the appropriate authorities by the management team, as required.
• The registered manager and staff understood their role and responsibilities in relation to the MCA and DoLS.
• There was a system in place to ensure that DoLS authorisations did not exceed their expiry date.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Comprehensive assessments of people's needs were completed before people moved to the home. These identified people's needs and the choices they had made about the care and support they received.
• Staff followed best practice guidance. For example, they used nationally recognised tools for assessing pain, the risk of skin breakdown and the risk of malnutrition. They then acted to achieve positive outcomes for people identified as at risk.
• Nurses took an evidence-based approach to their practice and followed guidance produced by national bodies, for example in relation to end of life care and diabetes. Care staff supported people appropriately to mobilise, for example by giving clear instruction and reassurance to people using walking frames.
• Staff made appropriate use of technology to support people. An electronic call bell system allowed people to call for assistance when needed and movement-activated alarms, linked to the call bell system, were used to alert staff when people moved to unsafe positions.
• Part of the home was taking part in a pilot to computerise people's care plans. A comprehensive project plan was in place to support this, together with a programme of staff training. Staff taking part in the pilot were using hand-held devices to record the care provided to people immediately after it had been delivered, which helped ensure care records were completed in a timely way.

Staff support: induction, training, skills and experience
• People and family members told us staff were highly competent. One said, "I think [the care] is quite good. We're well looked after." A family member told us, "There is excellent, good quality care here, and it's constant."
• Staff completed a comprehensive range of training to meet people's needs, which was refreshed and updated regularly. In addition, they were encouraged to gain vocational qualifications relevant to their role.
• New staff completed a comprehensive eight-day induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff. Staff who were new to care were supported to complete training that followed the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.
• The registered manager explained how one staff member's training had been specifically designed to meet their individual learning needs, together with "reasonable adjustments" to enable them to perform their role effectively.
• Nurses were supported to undertake continued professional development to meet the needs of their registration; for example, they had completed specialist courses in certification of death and end of life care.
• Staff told us they felt supported in their roles. Comments included: "If there is a problem I am listened to, yes I do feel supported", "The training is really good. The trainers are lovely, you feel you can ask them anything" and "I feel very supported; when I've had personal problems, [managers] have always supported me".
• Staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Yearly appraisals were

also completed, to assess the performance of staff. In addition, the registered manager had introduced 'care practice monitoring'. This involved a senior member of staff observing the practice of care staff (including agency staff), to enable them to assess their level of competence and offer support if needed.

Supporting people to eat and drink enough to maintain a balanced diet
• People and their relatives expressed mixed views about the quality of about the meals. Positive comments included: "The food is good, there's always a choice", "There are several choices for each meal. There's usually something you like out of what they've got" and "It's excellent, it can't be faulted". Less positive comments included: "Occasionally the meat's a bit chewy, I can't eat the blooming stuff", "The vegetables are not cooked enough for me" and "You get chewy meat."
• We discussed the comments with the registered manager who told us they had adjusted the menu in response to feedback from people and assured us they would continue to monitor the quality of the food provided.
• People's dietary needs were assessed and met. They were offered regular meals and snacks and could ask for alternatives if they did not want any of the menu options for the day. Where people needed a special diet, such as a low sugar diet or required soft or pureed food, this was provided consistently.
• Staff encouraged people to drink well and ensured people always had access to water and drinks. When there was doubt about a person's fluid intake, staff monitored the person closely for three days to gain a better understanding of how much they were consuming.
• Staff monitored the amount people ate and acted if people started to lose weight. For example, they referred people to GPs or specialists for advice and offered meals fortified with extra calories.
• The lunchtime meal was a sociable occasion with positive interactions between people and staff. People sat in small groups, with people they knew. Tables were decorated with fresh flowers which one person described as "lovely". Staff were attentive to people and where
people needed one-to-one support to eat, this was provided in a dignified way.

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care
• People told us they received all the support they needed at the time they needed it. We observed staff communicating effectively with people. For example, when talking to people living with dementia, staff faced people, used short simple questions and gave them time to respond.
• People were supported to access other healthcare services when needed. Care records confirmed people were regularly seen by doctors, specialists and chiropodists. A family member told us, "When [my relative] wasn't well, they brought the doctor in straight away." A healthcare professional who visited the home often told us, "[Staff] are sharp about calling us if they have any concerns. When we give advice, they always follow it."
• When people were admitted to hospital, staff provided essential information about the person to the medical team, to help ensure the person's needs were known and understood.

Adapting service, design, decoration to meet people's needs
• Adaptations had been made to the home to meet the needs of older people with reduced mobility. For example, a passenger lift gave access to the upper floors, corridors were wide and well-lit with hand rails in a contrasting colour to the walls to make them easier for people to spot. Toilets and bathrooms had non-slip flooring and were well-signed to help people find them.
• Should they wish to, people could have personal fixtures and fittings in their bedrooms to make their rooms feel more homely.
• People had access to a level garden area which we saw being used to good effect during the inspection. A paved area had been extended since the last inspection to provide improved wheelchair access.
• There was a clear system to help ensure any maintenance issues were resolved promptly. People were

involved in choosing colour schemes for the home when redecoration was planned.
• Small kitchenettes had recently been enhanced in each of the units which people could use with support.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People and family members spoke positively about staff, describing them as "kind" and "caring". Comments included: "[Staff] seem to like [my relative] and he likes them", "[Staff] are careful with me when they are helping me", "All the staff are polite and friendly" and "My [relative] is really happy here and the staff are good to her. They are really friendly and helpful".
• Staff created a calm atmosphere which helped reduce the level of people's anxiety. One person told us, "There is a really good friendly atmosphere here and the carers work really hard. I like them."
• Staff also used touch, appropriately, to reassure. For example, when a person became anxious, we heard staff reassure them by saying, "Don't worry, you're absolutely safe. We are all here looking after you." They then distracted the person by talking about an event that was planned for later that day.
• When a person became upset at losing their hearing aid, a staff member knelt in front of them and said, "Oh it's alright, don't get upset. It doesn't matter, we can find it."
• During light-hearted banter with staff, a person feigned annoyance, to which the staff member said, "We love you" and kissed the top of the person's head. The person looked pleased and said she liked the staff member.
• People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments before they moved to the home. People's care plans included detailed information about their background, including their hobbies, interests, previous employment and circles of support.
• Staff recognised people's diverse needs and there were policies in place that highlighted the importance of treating people as individuals. This was confirmed by a family member who told us, "[My relative] feels they can be themselves here."
• Staff supported people to follow their faith by facilitating regular visits by religious leaders of relevant faiths, including to give Holy Communion. There was a small spiritual area in one part of the home to enable people or their relatives to take part in quiet reflection or prayer. The area was furnished with items relevant to the dominant religion of people living in the home, but staff told us it was available to people of all faiths.
• When we spoke with permanent staff, they demonstrated a sound understanding of people's individual needs, preferences, backgrounds and interests. They used this knowledge to engage with people in a meaningful way.

Supporting people to express their views and be involved in making decisions about their care
• Records confirmed that people were involved in meetings to discuss their views and make decisions about the care provided. These included their choice of activities and how they wished to be supported.
• Throughout the inspection, we heard people being consulted; for example, at lunchtime staff checked that

people were happy with the music that was playing.
• Staff ensured that family members and others who were important to people were kept updated with any changes to the person's care or health.

Respecting and promoting people's privacy, dignity and independence
Staff promoted people's independence. One person said of the staff, "They let me do as much as I can for myself, which isn't very much, and then help me with the things I can't do. It makes me feel less useless and more in control."
• A staff member told us, "If someone can wash their own face, you have to let them; otherwise you take away their independence and I wouldn't want to do that." When a person needed support to find the bathroom, the staff member checked whether they also wanted to support to use it. The person declined and staff respected their decision.
• When supporting people to mobilise, staff were patient with people and allowed them to go at their own pace.
• Staff described how they protected people's privacy during personal care. This included listening to people, respecting their choices and closing doors and curtains. We saw people were asked discreetly if they needed help with anything, including using the bathroom.
• Comments from people included: "The staff are very polite and helpful, they keep things private when helping with personal care. They are very considerate" and "The staff are always polite. If you want to know anything they will always explain." A family member echoed these comments and added, "Staff are very kind and always treat people with respect."
• Care records were kept securely in locked offices. Information on the computer was password protected and restricted to those who needed to view it.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant People's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People told us their needs were met and this was confirmed by family members. Comments included: "Yes, I think they look after me very well" and "I haven't been here long, but I'm happy and safisfied [with the care]".
• Care plans had been developed for each person and provided sufficient information to enable staff to support people in a personalised way. These were update monthly or when people's needs changed and included a discussion with the person to seek their views.
• Staff usually understood people's needs, wishes and preferences and could explain them to us. For example, a staff member told us, "Each person is an individual and has different likes and dislikes; [named person] loves a hug, but other people don't." Another staff member said, "Every person here is different, we try to understand them all as individuals."
• Staff responded promptly to changes in people's needs. For example, when care staff found a person was not as responsive as usual, they called the nurse, who conducted tests to check whether the person was well.
• People were empowered to make their own decisions and choices and people confirmed they could make choices in relation to their day to day lives. For example, what time they liked to get up or go to bed, what they ate and where they spent their time in the home. We observed choice being offered to people throughout the inspection
• Staff described how they supported people living with dementia to choose their clothes, for example by offering a limited number of options and giving people time to make a decision.
• People had access to a range of activities. These included: exercise sessions, quizzes, singing, bingo and craft work. Staff told us they particularly enjoyed organising events and trips out for people. A family member told us. "[My relative] had a trip out to a fort with a meal and a drink. It was a big treat, he really loved it."
• During the inspection, activities included a visit to a lavender farm and an 'Indian cultural day'. Staff dressed up in traditional costume, performed music and dance and served Indian food for people to try. They created a vibrant, happy atmosphere and people clearly enjoyed the event.
• The home also encouraged people to identify "wishes" which staff then worked with the person to achieve. For example, one person had been supported to go shopping and another to go for a walk. These were significant events for those involved and photos showed they had enjoyed them.
• One of the deputy managers told us about some 'dementia mapping' work they had undertaken. This is designed to achieve a more person-centred approach to supporting people living with dementia, through observations and interactions. They described how this had benefited two people, for whom individual, purposeful activities had been designed; they said this had led to reduced levels of anxiety and "enhanced

their self-worth and sense of purpose".

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's communication needs were identified, recorded and highlighted in their care plans. This helped ensure that staff were aware of the best way to communicate with people, including those who were non-verbal and how to present information.
• Documents could be given to people in a variety of formats; for example, easy read, large print and pictorial.

End of life care and support
• At the end of their lives, people received appropriate care to have a comfortable, dignified and pain free death. Information about people's preferences for their end of life care was discussed with people and their families and included within care files.
• Emsworth House had recently been recognised for the quality of their end of life care by achieving "platinum status" with a national end of life training scheme for "sustained, high-quality practice". Nursing staff demonstrated a sound understanding of best practice, for example in the use of symptom control medicines. In addition, they had access to advice from specialist nurses at a local hospice if needed.
• Following a death, staff sought feedback from relatives to help inform their practice. We reviewed a sample of comments from people, which included: "We could not have been kept better informed, nor treated with more kindness and dignity. We were amazed at the calm professionalism of everyone involved" and "The staff were very kind and supportive throughout and it was much appreciated by the family".
• Staff also facilitated an annual 'service of memories' for families of people who had died and staff to remember people. This gave family members an opportunity to remember their loved ones. A family member who attended the last service described it as a "lovely tribute" and a "great comfort".

Improving care quality in response to complaints or concerns
• There was an accessible complaints procedure in place and people told us they would feel happy raising concerns.
• Records of complaints showed they had been investigated and dealt with thoroughly, promptly and in accordance with the provider's policy.
• The registered manager described how they used learning from complaints to help drive improvement and gave examples of when they had done so. For example, they had changed the way they conducted checks of a person during the night to better suit their needs.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has remained the same. This meant systems and processes were inconsistent and did not always ensure that identified improvements were made in a timely way.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• There was a quality assurance process in place consisting of a range of audits by senior staff, including: medicines management, infection control, recruitment, clinical issues and care plans. In addition, a representative of the provider conducted regular overview audits.

• However, the systems had not always been effective in identifying and addressing concerns. Following our last inspection, a representative of the provider conducted a review of mental capacity assessment (MCA) records in people's care plans. The review had concluded that staff were recording MCA assessments and best interest decisions correctly, but during this inspection we found that was not the case. You can find more information about this in the Effective section of this report. The provider's MCA review had, therefore, not been effective.

• The provider's quality assurance process had not identified that the process used to update people's personal emergency evacuation plans had stopped. Although it had identified that staff training in fire safety was out of date, this had not been addressed in a timely way. You can find more information about this in the Safe section of this report.

• Other audits had been more effective and had brought about improvement; for example, the medicines audit had identified the fridge was not working correctly and this had been replaced.

• There was a clear management structure in place consisting of the provider's service manager, the home's registered manager, three deputy managers, assistant unit managers and assistant practitioners. Each had clear roles and responsibilities. One of the managers told us, "[The registered manager] gives me control to manage but is there to support."

• Staff were organised and carried out their duties in a calm, diligent manner. They communicated well between themselves to help ensure people's needs were met, including during handover meetings at the start of each shift. Staff confirmed they were invited to other regular meetings and that they were actively encouraged to provide feedback and make suggestions which would improve things for people.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; and how the provider understands and acts on their duty of candour responsibility

• People told us they felt the service was run well and said they would recommend it to others. Comments from people included: "The home is very well run and I think [staff] treat people properly. I would recommend it if someone I knew needed this kind of care for a family member" and "I do think it's a good home and that it's well run".

• The provider had clear expectations about the values staff should work to and these were set out in a 'staff

charter' that all staff had signed. These included putting people first, showing kindness and treating people with respect. These values were communicated to staff at recruitment, during one-to-one discussions with managers and during staff meetings.
• Staff expressed an understanding and commitment to the values. For example, a staff member told us, "I believe in Hampshire [County Council] and their standards. I feel very proud to work for them." Another staff member told us they had brought bubbles in for people as "I like to see people smile". They added, "We all do things like that, it's like we're all part of a big family." A further staff member said the values were about "treating people as you would want for your own loved ones".
• The registered manager was fully involved in the daily running of the home. They were visible and accessible to people. They demonstrated an open and transparent approach to their role and acted promptly to all feedback provided during this inspection. They understood the requirements of their registration and had notified CQC of all significant events.
• The home's previous rating was displayed in the entrance hall. The registered manager had also complied with the duty of candour requirements by notifying relevant people, verbally and in writing, when people living at the home had come to harm.
• Friends and family members could visit at any time and were made to feel welcome. A family member confirmed this and said, "I come [most] days and I can come at any time. They [staff] are always happy to see me. They will always tell me if there's been any issues and they always offer a cup of tea."
• On the first day of the inspection, staff created and engaged in an "Indian day of culture", including during their own time. A similar event had been held the previous year and was being repeated due to popular demand. Staff dressed in traditional costume and brought in saris for people to wear, as several people chose to. Children of staff members also attended to perform music and dance.
• From the smiles, laughter and comments we heard, it was evident that people had clearly enjoyed the event. Feedback from a relative afterwards stated: "The decorations, music, the dancing, the food, being introduced to the [staff's] delightful children all helps to make you a real team and it shows."

Continuous learning and improving care
• We identified numerous examples of where the provider was investing for continuous improvement. For example, they were piloting the use of an electronic care planning and recording system.
• The provider was also developing a bank of staff who would be recruited and trained to the provider's standards and available to cover staff shortages at Emsworth House and other homes operated by the provider.
• An on-line rostering system had been developed and was being rolled out to make staff planning more efficient. In addition, a new call bell system had been introduced that required staff to swipe their ID card on a sensor when they performed a task or answered a person's call bell. This promoted an open culture by making staff more accountable for their actions.
• The registered manager was the end of life lead for the provider and told us they were developing an end of life diploma pathway for staff to follow. This would further enhance staff member's knowledge of end of life care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider consulted people in a range of ways. These included quality assurance surveys, 'residents' meetings' and one-to-one discussions with people and their families. The registered manager had acted on people's feedback, for example by changing the menus to meet people's requests and arranging more activities in the community.
• We observed a residents' and relatives' meeting, chaired by the registered manager, on the first day of the inspection. The atmosphere was relaxed and people were encouraged to offer their views. People were quite open in voicing their opinions, indicating they felt safe and comfortable doing so. One person was

updated on plans to alter a door to give better access to part of the home, which they had previously raised as an issue.
• Staff told us they felt engaged in the way the service was run, that morale was good and that they worked well as a team. They spoke positively about the registered manager, describing them as "approachable" and "supportive" and "visible". A staff member who had been nominated to attend the Queen's garden party told us, "It most definitely made me feel valued and appreciated."

Working in partnership with others
• The service worked in collaboration with all relevant agencies, including health and social care professionals.
• Staff had developed links with resources in the community to support people's needs and preferences. These included tissue viability specialists and the Older Persons Mental Health team.
• Staff had developed links with community groups for the benefit of people living at Emsworth House. These included fund-raising for enhancements to the garden, use of a mini-bus for trips to local attractions and visits by children from a local nursery who we were told people enjoyed interacting with. In addition, a Beaver group visited several times a year; they had helped plant flowers for people to enjoy and performed an outdoor carol concert for people at Christmas.