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?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Emsworth House 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 home provides accommodation and nursing care for up to 79 older people some of whom live with dementia. At the time of our inspection 73 people were living at the home.

The home comprises single room accommodation arranged in two separate sections of the home; 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.

This inspection took place on 14 and 17 May 2018 and was unannounced. At our last inspection in February 2016 we did not identify any concerns and rated the service 'Good' overall.

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

The provider had clear recruitment procedures in place, although some pre-employment checks were not completed for staff appointed during a recruitment event held earlier in the year.

People and their relatives had mixed views about the staffing levels, commenting that they sometimes had to wait for support. However, the registered manager was in the process of recruiting additional staff to cover busy periods.

There were appropriate arrangements in place for obtaining and administering medicines safely. However, risk assessments for some high risk medicines were not put in place until we brought this to the attention of the registered manager and some medicines were not stored safely.

Staff sought verbal consent before providing care or support and acted in people's best interests, although they had not always recorded decisions they had taken on behalf of people.

People expressed mixed views about the quality of the meals, Some people complained that the meat was tough and we found people did not always receive they support they needed to eat.

We observed that one staff member did not always treat people with consideration and respect. However, most people told us they were supported by kind, caring and compassionate staff and we observed other staff treated people with kindness.

Staff also told us people could choose the gender of the staff member who supported them with personal care, but we found these arrangements were not robust and people's preferences were not always met.

There was a comprehensive quality assurance system in place, but this was not always effective as it had not picked up the concerns we identified.

People received personalised care from staff who understood their individual care and support needs. Care plans provided comprehensive information and were reviewed regularly, although information was not always clear and easy to find.

Effective systems and processes were in place to protect people at risk of abuse. The registered manager conducted thorough investigations in allegations of abuse when required.

All areas of the home were clean and there were systems in place to protect people from the risk of infection.

Risk assessments had been completed for all identified risks to people, together with action staff needed to take to reduce the risks. Staff knew what to do in the event of a fire and had been trained to administer first aid.

Staff were supported appropriately in their roles and completed a comprehensive training programme to help ensure they had the skills to support people. Registered nurses demonstrated an evidence based approach to their practice.

The home had been adapted to make it supportive of people's needs and staff created a relaxed environment in which people felt at ease.

People were supported to access other healthcare services when needed. Staff encouraged people to be as independent as possible and involved them in discussing the care and support they received. They respected people's beliefs and supported them to follow their faith.

Staff were responsive to changes in people's needs, including at the end of their lives, when people were supported to have a comfortable, dignified and pain free death.

People enjoyed living at Emsworth House and felt it was run well. They had access to a range of activities within the home. The provider sought and acted on feedback from people and people felt able to raise concerns.

Staff were organised and communicated effectively between themselves. The provider had clear expectations about the values staff should work to and these were clearly communicated to staff.

There was an open and transparent culture. Visitors were made welcome at any time and the provider notified CQC of all significant events. Positive links had been developed with the community, to the benefit of people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Appropriate recruitment procedures were in place, but these were not always followed.

People felt there were enough staff to meet their needs, although at times they had to wait for support. However, the provider was recruiting additional staff to support people at busy times.

Medicines were not always managed safely. Risk assessments for high risk medicines had not been completed and medicines were not always stored safely.

Appropriate systems and processes were in place to protect people at risk of abuse.

There were systems in place to protect people from the risk of infection. Individual and environmental risks to people were managed effectively.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff acted in people's best interests, but did not always record decisions they had made on behalf of people.

People expressed mixed views about the quality of the meals and did not always receive appropriate support to eat.

Staff followed a comprehensive training programme and were appropriately supported in their roles by managers.

Adaptations had been made to the home to make it supportive of the people who lived there. Staff created a relaxed environment in which people felt at ease.

Staff supported people to access other healthcare services when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed that one staff member did not always treat people with consideration or respect and one person described how staff made them feel like a nuisance.

However, other staff interacted positively with people. They were kind, patient and affectionate and sometimes supported people in their own time.

Staff respected people's privacy; however, people's preference for the gender of staff that supported them with personal care were not always met.

Staff respected people's beliefs and supported them to follow their faith.

Staff promoted independence and involved people in making decisions about the care and support they received.

Is the service responsive?

Good

The service was responsive.

People's individual needs were met in a personalised way and staff responded promptly when people's needs changed.

Staff supported people at the end of their lives to ensure their comfort and their dignity.

Care plans contained comprehensive information and were reviewed regularly.

People had access to a range of activities suited to their individual interests.

People knew how to raise a complaint and there was an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a comprehensive quality assurance process in place, but this had not identified concerns we found during the inspection.

People said they were happy living at the home and were consulted about the way the service was run.

There was a clear management structure in place. Staff were organised and communicated effectively between themselves

The service had an open and transparent culture, visitors were welcomed and the registered manager notified CQC of all significant events.

Emsworth House Care Home with Nursing

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 14 and 17 May 2018 and was unannounced. It was completed by two inspectors, a specialist advisor in nursing care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us. In April 2017, the registered provider completed a 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. We reviewed the PIR for this home and information which had been provided by the registered manager to update this document.

We spoke with 12 people who used the service and seven family members or friends of people who used the service. We spoke with the provider's service manager, the registered manager, two deputy managers, two registered nurses, four assistant practitioners, five care staff, an activities coordinator, an administrative officer, two kitchen staff and two housekeepers. We also received feedback from a doctor and a community nurse who had contact with the service.

We looked at care plans and associated records for 16 people and records relating to the management of the service, including: duty rosters, staff training and recruitment files, records of complaints, accident and incident records, maintenance records and quality assurance records.

We observed care and support being delivered in communal areas of the home. 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.

We last inspected the service in February 2016 when no breaches of regulation were identified.

Requires Improvement

Is the service safe?

Our findings

The provider had clear recruitment procedures in place. Whilst these were usually followed, we found they had not been followed for all staff who had been recruited during a recruitment event held earlier in the year. The usual procedures required applicants to complete an application form, to provide a full employment history and to be the subject of pre-employment checks, including references, before they started work at the home. References enable an employer to take account of the applicant's past performance and behaviour when considering their suitability to work with adults at risk. We found relevant references had not been sought for a staff member who had recently worked for another care provider for a period of four weeks. The provider was unable to confirm the staff member's conduct in that post or their reason for leaving, so were not able to assess whether this might affect their suitability to work with adults at risk. For two other staff members, we found there were unexplained gaps in their employment histories; therefore, the provider was unable to consider whether the reasons for the gaps would impact on the staff member's suitability for their role. We discussed this with the registered manager and the provider's service manager who told us they would review the procedures used during recruitment days to ensure the usual practices were followed.

In all cases, we found pre-employment checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions by disclosing any previous convictions held by the applicant. In addition, checks were made with the nurses' regulatory body to ensure the nurses were registered to practice.

People expressed mixed views about the level of staffing and whether it was adequate to meet their needs. Overall, people felt there were enough staff to meet their needs, although there were times when they might have to wait for support. When asked how quickly staff responded to call bells, one person said, "Sometimes you press the buzzer and it takes such a long time. It's understandable, some [people] are pressing all the time. They fit me in when they can." Another person told us, "I was going to go into the garden with the others this afternoon, but I was waiting for someone to change my [continence] pad. They came and said, 'Sorry we're so busy, can you wait a bit?' I know they are very busy, but you do have to wait. Sometimes they are short staffed." A family member said of the staff, "They don't always come if they are seeing to others. [My relative] has to wait his turn."

Other people were more positive about the staffing levels. For example, one person told us, "Sometimes they're very busy [but] they always make time for you" and another person said, "I think [there are enough staff]. At times there's too many. The mornings, up to lunchtime, are busy [but] it eases up in the afternoon when people go to sleep." A family member commented, "You don't hear [call] bells ringing for ages. There certainly doesn't seem to be a lack of staff." On the days of our inspection, we found people were supported in a timely way and we did not observe any undue delays in staff responding to people's call bells.

The registered manager told us staffing levels were assessed on the basis of people's needs. Staff duty rotas confirmed that the assessed number of staff was consistently provided on each shift. Any gaps in the rota were filled by permanent staff working additional hours or through the use of a small number of regular

agency staff. They told us they had identified the need for additional staff to support to people in the early mornings and the evenings and were in the process of recruiting additional staff for these times.

People were supported to receive their medicines safely. One person told us they received their medicines "Every day, regularly, at the same time". When asked if they could access pain relief when needed, one person said, "Yes, all the time. It's very good. I have a lot of pain and they think of me all the time."

There were appropriate arrangements in place for obtaining and administering medicines safely. Staff were suitably trained to administer medicines and had their competence assessed annually by one of the managers. A random check of a sample of medicines showed the number in stock tallied with the number shown on the medication administration records (MARs); this indicated that people had received their medicines as prescribed.

Some people were prescribed blood thinning medicines and staff we spoke with were aware of the risks these posed, including the risk of increased bleeding in the event of an injury. Care records confirmed that when two people who were receiving these medicines had experienced falls, the attending paramedics were advised of this risk. However, risk assessments had not been completed to highlight these risks or the risks involved in eating certain foods that could interact adversely with these medicines. Therefore, we could not be assured that the risks would be managed consistently by all staff. We discussed this with the registered manager and by the end of the inspection appropriate risk assessments had been completed for all people receiving these medicines.

In the nursing unit, medicines awaiting disposal were stored securely and were properly documented. However, in the residential unit, we found medicines awaiting disposal were not stored in accordance with best practice guidance. They had been placed in a locked cupboard, but not in a tamper proof container. Staff told us the medicines should have been recorded in the 'returns book', but we saw this had not been done. This meant they were not accounted for and the provider would not have been aware if medicines had gone missing before being returned to the pharmacy for disposal. We discussed this with the registered manager who undertook to review the procedures in the residential unit.

Medicines that needed to be stored at cool temperatures were kept in secure medicine fridges. Although staff monitored the temperature of the fridges, they did not always take action when the temperature was outside of the safe range. The temperature of the fridge in the nursing unit had continually been recorded as too low during the previous two weeks, but no action had been taken. This posed a risk that the medicines may no longer have been safe for use. We discussed this with the registered manager who undertook to remind staff of the need to take action when this occurred.

People told us they felt safe living at Emsworth House. One person said, "If there's anything personal wrong, I can go to someone and talk to them and they make me feel safe." The provider had effective systems and processes in place to protect people at risk of abuse and staff understood their safeguarding responsibilities. They had received safeguarding training and knew how to report concerns. One nurse described how they had raised a concern and confirmed it had been recorded and dealt with appropriately. Records showed the registered manager had notified CQC and the local safeguarding authority of all relevant safeguarding incidents and had completed prompt and thorough investigations where required.

People felt the cleanliness of the home was satisfactory. Comments included: "It's not spotless, but they [housekeepers] work hard at it" and "I've never found anything wrong with [the cleanliness of the home]. They're always sweeping up". A family member confirmed this and said, "You feel [the home] is clean and there are no smells." We found all areas of the home were clean and cleaning records confirmed they were

cleaned regularly, in accordance with a cleaning schedule.

There were systems in place to protect people from the risk of infection. All staff had attended infection control training and had access to personal protective equipment (PPE), which we saw they wore when needed. They described how they processed soiled linen, using special red bags that could be put straight into the washing machine. Within the laundry, there was a clear system to help prevent cross contamination between dirty linen entering the laundry and clean linen leaving it. One person had an infection that was resistant to antibiotics and we saw staff used appropriate barrier nursing techniques when supporting the person.

Individual risks to people were managed effectively. Risk assessments had been completed for all identified risks, together with action staff needed to take to reduce the risks. Where people came to harm, the provider had robust procedures in place to investigate the cause, learn lessons from the incident and take remedial action to prevent a recurrence. For example, following a significant choking incident, a comprehensive investigation had been conducted by the provider's service manager and new procedures introduced. These helped ensure swallowing assessments were completed promptly, together with referrals to speech and language therapists (SALT) where needed. When we spoke with staff, we found they were alert to potential choking risks. They described how they took great care to follow any recommendations made by SALTs, for example by supporting people to eat on a one-to-one basis, ensuring people were sat upright when eating and providing modified food and drinks consistently when needed.

Some people were at risk of developing pressure injuries and we saw care plans had been developed to reduce these risks. These included the provision of pressure-relieving mattresses, the use of barrier creams and regular repositioning. There was a clear process in place to help ensure the pressure mattresses remained at the right setting according to the person's weight. In addition, 'turn charts' confirmed that, where needed, people were supported to reposition regularly.

Other people were at risk of falling and had been given walking aids; staff made sure these were accessible and prompted people to use them correctly. When people experienced falls, their risk assessments were reviewed and additional measures considered to keep them safe. When the fall involved a possible head injury, staff completed observations in accordance with best practice guidance to help identify any neurological injury. In conjunction with the provider's Care Governance Team, the registered manager reviewed all falls in the home on a monthly basis to identify any patterns or trends; none had been identified, but they described the action they would take if a common theme emerged.

Environmental risks were also managed effectively. Staff protected people from scalding by checking and recording the temperature of bath water before use. They also checked the temperature of hot water outlets on a monthly basis, including those in people's rooms. Gas and electrical appliances were serviced routinely and fire safety systems were checked weekly. Staff were clear about what to do in the event of a fire and had been trained to administer first aid. Furthermore, each person had a personal emergency evacuation plan (PEEP) detailing the support they would need if the building needed to be evacuated. All equipment used in the home was checked and maintained regularly to help ensure it was safe to use. This included bed rails, suction machines and an automatic external defibrillator.

Requires Improvement

Is the service effective?

Our findings

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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

During the care planning process, senior staff had assessed people's capacity to make specific decisions, such as to receive medicines, a modified diet and support with personal care. Where the assessment concluded that the person lacked capacity to make certain decisions, staff acted in people's best interests by making decisions on their behalf and providing appropriate care. However, they did not always document the decisions they had made to show why the decision was in the person's best interests and to confirm that relevant people, such as family members and healthcare professionals, had been consulted. Although this had been done in respect of some decisions for some people, it had not been done consistently or in accordance with the MCA Code of practice. We discussed this with the registered manager who provided an assurance that they would review the relevant care records to ensure best interests decisions were correctly documented. When we spoke with staff, they were clear that they only provided care and support with the consent of the person and we heard them seeking consent from people throughout the inspection.

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 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. We found staff were following the necessary requirements and had access to up to date information about any restrictions that had been authorised.

People expressed mixed views about the quality of the meals. Some described the food as "alright" and one person said it was "lovely". However, others were less complimentary. One person told us, "The food's not very good. It's not cooked properly." Another person complained that the vegetables were "undercooked". A further person said, "I don't like the food, but we're allowed to bring our own food; tins of soup and things." During lunch on the second day of the inspection, two people complained that the meat in the goulash was "as tough as old boots" and left it on the side of their plates. A family member told us, "[My relative] had casserole with stewing steak last week. She couldn't cut it and I couldn't. It was very chewy. She left it on her plate. She left the meat [again] today."

Staff were available to support people in the dining rooms and also supported people to eat on a one-to-one basis in their rooms where necessary. However, people did not always receive appropriate support with their meals. Although one told us, "I need a lot of help eating food because I'm shaky. I get help whenever I ask", a family member said their relative did not always receive support they needed to cut up their meal. They said, "I wanted to thank a member of staff today for cutting it up for [my relative] last time [I visited].

They don't always cut it up for her."

Staff monitored people's weight and put plans in place when people started to lose weight. However, we found the plans were not always followed. This resulted in two people who required fortified diets not receiving them during the inspection. Care staff said they relied on kitchen staff preparing appropriate meals for people based on dietary information they held; but kitchen staff said they expected care staff to bring this to their attention. Information about the need to provide fortified meals for one person was not recorded in the kitchen, so they had not received these. A further person who needed fortified meals, for whom information was recorded in the kitchen, only received a standard meal that was not fortified. We discussed this with the registered manager who undertook to clarify the arrangements with staff. They also said they would review the quality of the meals, in light of the above comments.

Staff encouraged people to drink well. A variety of drinks was available and in reach for people at all times. One person told us, "They [staff] are constantly telling us to drink, especially if you suffer from headaches like I do."

People's needs were met by staff who were suitably trained. One person said of the staff, "They seem to be very well trained. I feel comfortable with them". A family member said, "[My relative] got over a bad chest infection; I put that down to the care he gets here." Another family member said, "Staff are brilliant. They seem well trained, so I let them get on with it." A community nurse who had regular contact with the home described staff as "well informed". They added, "[Staff] always know why I'm there and who I need to see."

A comprehensive training programme was in place for all staff. New staff completed an effective induction into their role. This included time spent shadowing, (working alongside experienced staff) until they felt confident they could meet people's needs. Staff who were new to care were supported to complete training that followed the standards of 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. Experienced staff received regular training in all key subjects and praised the quality of training they received.

Nurses were supported to undertake additional training and continued professional development to meet the requirements of their professional registration. They were also supported by the provider's practice development nurses to help ensure they followed best practice guidance and remained clinically competent.

Nurses demonstrated an evidence based approach to their practice. For example, they used recognised tools to assess people's nutritional needs and their skin integrity. They also demonstrated a sound understanding of diabetes management and the use of equipment. This included medical devices, such as percutaneous endoscopic gastrostomy tubes (PEGs). These are tubes that allow food and medicines to be given directly into the stomach. Staff had received additional training in the management of PEGs following an untoward occurrence during the previous year, showing that learning had been taken from the incident.

Since the last inspection, the provider had introduced 'Assistant Practitioners' to support nurses in the nursing unit and to lead shifts in the residential unit. They were experienced, senior care staff who had received additional training to enable them to administer medicines, undertake care planning, take blood samples and deliver wound care. The provider's service manager told us the introduction of assistant practitioners provided career progression opportunities for care staff and enabled nurses to spend more time focusing on people's clinical needs.

Staff were appropriately supported in their role. They described managers as "supportive" and

"approachable". One staff member told us, "I feel really supported by loads of training and supervision [meetings] with [the deputy manager]." Another staff member said, "[The registered manager] is very supportive to me. [When I was unwell] they were very good and we sat down and had a good chat about it." Staff were also supported through the use of one-to-one sessions of supervision with a supervisor or manager, up to six times a year. These followed a structured format and were used to discuss topical issues as well as the staff member's progress and any concerns they had. Each staff member also received an annual appraisal to assess their performance and set objectives for the coming year. In addition, staff had access to an 'employee support line' to seek confidential support if needed.

Emsworth House had been designed and adapted to support people's needs. Corridors were wide and uncluttered; rooms were spacious and had en-suite bathrooms; most bathrooms had ceiling hoists to support people whose mobility was compromised. Handrails in contrasting colours provided support to people in communal areas. Large signs helped people to navigate around the home and each bedroom had a picture or a photograph on the door, relevant to the person, to help them find their room. Staff also created a relaxed environment in which people felt at ease. A family member told us, "The atmosphere is a happy atmosphere. You feel good in this place and [my relative] is happy here as a result. Everywhere is calm and quiet." Another family member said, "There's a kind of peace around and [staff] seem friendly."

People's health was monitored and they were referred to other healthcare professionals when required. These included doctors, specialist nurses, chiropodists, opticians and dentists. A person told us, "They [staff] usually let the doctor know when I need to be seen." A family member said, "[My relative] was whipped into hospital when they complained of chest pains and [staff] kept us informed." A community nurse who had regular contact with the home told us staff called them appropriately and always followed their advice. They added: "For example, we were treating one person and we asked staff to put the person's feet up and I've seen that they always do that now."

Requires Improvement

Is the service caring?

Our findings

Most people told us they were supported by kind, caring and compassionate staff. Comments from people about the staff included: "They are very considerate"; "Mostly they're very nice"; "They're always pleasant and friendly"; "They call you by your Christian name. It's nice"; and "Everyone speaks to you and you have a laugh". A family member told us, "They [staff] are all friendly and talk to [my relative] nicely." Another family member said, "They are very patient with [my relative] and seem to have a way with her. She has a good relationship with them." A letter sent to the service by a family member said, "Not only did [my relative] constantly tell me how wonderful you all were to her but I also saw it for myself. She couldn't have been better cared for if she had been the Queen." A community nurse who had regular contact with the home told us staff were "lovely with their residents" and showed compassion. As an example, they described a time when they had had to visit regularly to provide dressing changes for a person that were very painful. They said, "You could see [staff] were upset at what they were seeing and really cared about the person. They were lovely with them."

However, one person was less positive and said of the staff, "Sometimes I think they think I'm a bit of a nuisance. I ring the bell if I can't get comfortable in bed. Naturally it annoys them. They say, 'I've only just seen to you, I can't deal with you now', but they come back. I'm scared they won't come back. I don't want to wet the bed. You can't control yourself like you can when you're young."

Whilst observing lunch, one person asked for some butter. A member of staff said they would get it, but complained to other staff members saying, "She wants butter. What does she want that for?" When they brought the butter, the person explained that they wanted it on their potatoes, to which the staff member replied, "That'll make you fat". The staff member was later heard using inappropriate language when referring to a person they were going to support to eat, saying they were "on a feed". These examples demonstrated a lack of consideration and respect for people.

In contrast, another staff member interacted positively with a person they were supporting to eat. They held the person's hand, used their name and encouraged them to focus on eating their meal, joking that it would make them "big and strong". They later interacted positively with other people in a warm and friendly way, for example providing effective reassurance when two people became upset and anxious.

Other staff provided assistance in a patient, caring and respectful manner when providing drinks and supporting people to mobilise. When people struggled to make choices, due to a cognitive impairment, staff supported them by making suggestions and giving them time to respond. Staff supporting people with activities were also attentive and encouraged people to take part. One person thanked and kissed a staff member for taking them to the bathroom during an activity, which showed a close affection between them. Before removing dying flowers from a person's room, a member of the housekeeping team checked this was okay with the person. The person chose to keep the flowers and their decision was respected in a good humoured way.

Staff described how some colleagues had gone "over and above" in the support they provided to people.

For example, one staff member noticed that a person's bracelets were too big for them as they had lost weight, so bought them a low-value bangle to wear. The person was delighted with this and reportedly mentioned it every day to colleagues. Another staff member attended in their own time to take a person to church on their birthday. 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 and demonstrated compassion.

Staff respected people's privacy by knocking and waiting for a response before entering their rooms. When providing personal care, staff described how they closed curtains and doors and kept the person covered as much as possible. Staff also told us people could choose the gender of the staff member who supported them with personal care, although we found these arrangements were not robust. For example, one person told us, "I prefer the ladies to help [with personal care]. I ask for women to help, but it's not always possible. I was told that when I was first here. They said I would be helped by men sometimes, it couldn't be avoided." The care plan for another person (living with advanced dementia) specified that they preferred female staff for personal care, but male staff we spoke with were not aware of this and said the person often accepted personal care support from them. We discussed this with the registered manager who agreed to clarify these preferences with the people concerned and ensure they were respected.

Staff respected people's beliefs and supported them to follow their faith. One person's faith meant they did not celebrate Christmas, so instead of giving the person a Christmas present, they used a fund allocated by the provider to help celebrate the person's wedding anniversary by providing a special, intimate meal for them. The person's faith also meant they should avoid certain foods and we found staff were aware of these and the information was available to kitchen staff. This showed respect for the person's faith. A family member told us, "[My relative] is very religious and they [staff] arranged for someone from one of the churches to visit her regularly." The registered manager told us two church groups regularly visited people at Emsworth House, one of which also held a monthly service on a Sunday. In addition, a small spiritual area was provided 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 most people living in the home, but staff told us it was available to, and used by, people of other faiths.

Staff encouraged people to be as independent as possible. For example, one person said of the staff, "They leave you alone. They let you do what you want. That's important to me." People's care plans encouraged staff to promote independence by explaining tasks people could manage for themselves, such as dressing or brushing their teeth. A staff member told us, "We encourage people to do as much as they can. For example, if they can still wash their upper half, we encourage that."

People and relatives told us they were involved in discussing and making decisions about the care and support they received. For example, one person said, "If I have any concerns they [staff] listen and are happy to meet with me and discuss it." A family member told us, "I can see [my relative's] care plan if I want to. They [staff] told me she was having a speech therapist in and later they showed me the file." Another family member said, "[My relative] has a dedicated [care staff member] who is an absolute joy. They keep us up to date with medical issues or changes." A further family member described how they "met with staff every few months to speak about the [medicines]" their relative was taking.

Good

Is the service responsive?

Our findings

People told us they received personalised care from staff who understood their individual care and support needs. One person said, "Every member of staff is so good; [they] make it very pleasant." Another person told us, "I wanted a bath [one day] and I saw one of the nurses. She said, 'I'll fix that.' She finished what she had to do and then she took me and I had a nice bath."

Assessments of people's care needs were completed by one of the managers before people moved to the home. The registered manager was clear that people were only accepted into the home if they were satisfied they could fully meet the person's needs.

Care plans provided comprehensive information to enable staff to deliver care and support in a personalised way and were reviewed regularly. They were centred on the needs of each person and took account of their medical history, their preferred daily routine and how people wished to receive care and treatment. They included information about people's medicines; continence; skin integrity; nutrition; and mobility.

When we spoke with staff, they demonstrated a good understanding of people's needs. They knew how each person liked to receive care and support. For example, they were able to describe the support people required to meet their personal care needs and how they should be supported with moving and repositioning. One person had a percutaneous endoscopic gastrostomy tubes (PEG). This is a tube that allows food and medicines to be given directly into the stomach. Staff understood the care required to keep the PEG operating effectively and to keep the person comfortable and this was clearly recorded in the person's care plan. Another person required the occasional use of oxygen, due to a medical condition; staff knew when this should be administered, as set out in the person's care plan.

Whilst staff could usually find relevant information within care records, they acknowledged that it was not always easy as most care plans comprised two large files. Some information, such as mental capacity assessments, had been filed in the second file but not in chronological order, so this was hard to locate. Other information was not always clear; for example, an assessment of a person's capacity to make decisions about what they ate was contradictory and did not answer the questions posed by the standard MCA assessment form used. Also, information about the monitoring of people's skin was not always recorded, so it was difficult to assess whether pressure injuries or wounds were improving or deteriorating over time. We discussed this with the registered manager, who addressed the individual issues and acknowledged that material in some care plans needed to be archived to make current information easier to find.

Family members described staff as "responsive" to any changes in their relatives' needs. One family member told us, "Staff are on the ball. For example, they phoned me straight away about [symptoms of a stroke] my relative had and what they had done about it. They do their best and I'm more than happy with what they do." When we checked this person's care plan, we saw it had been updated to reflect the changes in their needs and staff were able to describe these to us. A community nurse who had regular contact with the

home told us, "I'm always really impressed. [The staff] are always helpful; patients are well presented and if something changes they are quick to call us." Staff provided examples of where they had acted to meet people's changing needs. For example, they found one person was usually asleep at the time a prescribed medicine was due, so they discussed it with the person's GP and arranged for them to receive the medicine at a different time, when they were usually awake. This demonstrated a person-centred approach to care.

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. A family member told us, "When [my relative] first moved in, we discussed end of life care. I have no fears as to how [my relative] would be cared for when the time comes." A doctor who had contact with the home told us, "I think [staff] are very switched on to end of life care. Once upon a time, we would be highlighting it to them; now they're alerting us to it. They are very responsive."

Emsworth House had recently been recognised for the quality of their end of life care by achieving accreditation with a national end of life training scheme. 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. A staff member had been designated as an 'End of life coordinator' and took responsibility for assessing the stage people had reached on their end of life pathway. This helped ensure appropriate resources were put in place in a timely way to avoid unnecessary hospital admissions and to enable people to remain at Emsworth House if this was their preference. A staff member experienced in end of life care described key aspects and said, "The main things is we don't want anyone to pass away on their own; someone will always be with them. I have a passion about this. I love sitting with people and will stay over my shift if needed." A letter sent to the service by a family member showed this support was valued. It said, "Our special thanks go to the member of staff who sat with [my relative] at the end. What you did for her, and for us, is priceless. Never doubt for one moment that you are truly appreciated."

People had access to a range of activities. These were primarily organised by activities coordinators and included word games, arts and crafts, movement to music, bingo and quizzes. One person had been supported to do some gardening and another person had been supported to paint. In addition, chickens were being reared in the home's 'sensory garden' to provide interest to people. A family member told us, "[My relative] loves the hens. I think it's an inspired idea. I arrived one day to find her with a hen in her lap and she loved it." On one of the inspection days, the weather was warm and people were invited into the garden to enjoy drinks and ice creams in a social setting. A family member said they enjoyed this as it was "what we would have been doing at home" if their relative was still able to live there, "sitting outside together enjoying the sunshine".

Some people told us the planned activities did not always go ahead. For example, a family member told us, "Some activities don't take place or they're not where they say they'll be. Today it was supposed to be arts and crafts, but instead we're out here [in the garden]. Not that it's not nice." On the second day of the inspection one person said they were disappointed as they had been expecting to have their nails painted [as this was advertised in the activity calendar] but "no one had come to do them".

The registered manager acknowledged that activities were not organised as efficiently as usual due to the absence of one of the coordinators. However, they had recently recruited an additional activities coordinator and were confident this would address people's concerns. They had also introduced a 'ten minute challenge' initiative to encourage staff to take ten minutes out from their normal roles to support people with activities. In addition, they had just negotiated the use of a minibus, owned by a community group, to take people on trips to local attractions.

People told us they felt able to raise concerns or complaints, although most said they had not had cause to complain. A complaints procedure was in place and was displayed on the home's notice board. One person said, "If I needed to complain, I would tell the carer if it was minor, or see the management." A family member told us, "If I have any concerns, I can have a confidential chat with [senior staff]." We viewed records of recent complaints; we saw these had been investigated thoroughly and responded to promptly, in accordance with the provider's policy. For example, one person had complained about the level of information they had received on admission and in response the registered manager had produced a simple information guide for them and for other people in the future.

Requires Improvement

Is the service well-led?

Our findings

A comprehensive quality assurance system was in place to assess, monitor and improve the service. However, this was not always robust as it had not identified the concerns we found during the inspection. For example, it had not identified the absence of some pre-employment recruitment checks or that medicines were not always managed safely. It had not identified the failure to document mental capacity best interests decisions consistently or people's dissatisfaction with some meals.

Senior staff completed a comprehensive range of audits and some of these had been effective in driving improvement. For example, a focus on oral care in the monthly reviews of care plans had led to improvement; also, infection control audits identified a need for increased hand hygiene and this had been addressed. Audits by the service's service manager had also led to improvements, including to the information held within people's care plans that we saw had been added as a result of reviews they had conducted.

Assistant practitioners conducted 'care practice monitoring' by working alongside care staff to observe their practice. As a result of this, they had identified improvements to the way soiled linen was handled and these had been put into practice across the home. Managers conducted unannounced checks at night and these had helped ensure standards were met consistently out of hours.

People who could express a view told us they were happy living at Emsworth House, felt it was well-led and said they would recommend it to others. Comments included: "I think the world of it here" and "You couldn't wish for anywhere better". Family members echoed these comments. Their comments included: "I can't fault it. It's so lovely. [My relative] landed on his feet [moving here]. If I had to give stars, I'd give it ten out of ten"; "It all seems to run nice and smoothly. I'm glad [my relative] is here"; and "I'd give the home twelve out of ten. [Staff] do a great job. I'd recommend it to anybody with no hesitation whatsoever". A community nurse who had regular contact with the home told us, "As far as I can see, everything runs well. Some [people] have an injection every three or six months. [Staff] have to order them a month before and they are always ready when we visit."

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. Staff worked in teams to support people; for example, in the nursing unit, each person had a named nurse, an assistant practitioner and a care worker to focus on their individual needs and act as a point of contact for the family. In the residential unit, a nominated key worker was allocated instead of a nurse, but the same principle applied. This provided resilience and helped ensure continuity of care.

Staff were organised and communicated effectively between themselves to ensure people's current needs were known and met. This was supported by handover meetings between each shift and regular staff meetings. Most staff said they enjoyed high levels of morale. Comments included: "It's a nice home, everyone gets along"; "We have our ups and downs, but morale is good and there's low turnover [of staff]

which says a lot"; "[The managers] genuinely listen and are willing to try new things to [improve outcomes for people]; and "Apart from the odd moan, staff are happy; and happy staff means happy residents."

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. We observed that most staff worked to these values, including one who told us, "I feel very passionate about the place. There is compassion here. If I had to place a loved one [in a home], I'd happily let them live here."

People were consulted in a range of ways about the way the service was run. These included monthly "residents meetings", yearly questionnaire surveys and individual discussions with people and their relatives. With the exception of one family member who felt their views were not listened to, everyone else told us issues raised in meetings were acted on promptly. For example, one family member told us, "They had an agenda last time because they were bringing in a new menu. We said there should be menus on the tables, so they brought them in. We thought some of the wording on the menu didn't make sense [and] it was changed so everyone could understand it. The hairdresser wasn't regular, so they made sure she would come every Friday." Another family member said of the meetings, "They are very well handled; they are jolly occasions and everyone is included."

People and relatives described an open and transparent culture where they had ready access to the management and were encouraged to share their views. Visitors were welcomed at any time and could stay as long as they wished. A family member told us, "I can come in any time I like and I'm always made welcome." Positive links had been developed with the community, to the benefit of people. For example, a volunteer had been recruited to help run a small shop in the home and two young people had supported people with activities as part of their Duke of Edinburgh award. In addition, a local community group frequently raised money to buy equipment and fund events at the home.

The provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently on the home's notice board. A duty of candour policy was in place; this required staff to act in an open and transparent way when accidents occurred. The registered manager showed us examples of where this had been followed and family members confirmed that they were always updated when their relative had an accident.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way that they could understand. It is now the law for the NHS and adult social care services to comply with the AIS. The provider's service manager told us all the information given to people, including the complaints procedure, was available in large print and easy read formats. They said, "We've tended to rely on giving [information] to people when they've asked for it, but have recognised the need to put it out there more proactively." They said they were working towards this objective across their organisation.