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St Ronans Nursing and Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 22 November 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. St Ronans Nursing and Residential Care Home is registered to provide accommodation, support and nursing care for up to 46 people. At the time of the inspection, there were 44 people living at the home.

At the last inspection on 26 November 2013 we found the service to be compliant with all of the regulations we assessed at that time.

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

People living at the home said they felt safe. The visiting relatives we spoke with also said they felt their family members were safe as a result of the care provided.

We looked at four staff personnel files and there was evidence of robust recruitment procedures in place. Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. People living at the home said they felt there were enough staff working at the home and did not have to wait long periods for assistance.

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. The home had a whistleblowing policy in place and this told staff what action to take if they had any concerns. The staff we spoke with had a good understanding of safeguarding, abuse and how they would report concerns.

We saw people had risk assessments in their care plans in relation to areas including falls, pressure sores, and malnutrition. Accidents and incidents were recorded correctly and included a record of the accident or incident, a summary chart and action plan.

The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use.

We saw that quarterly infection control audits were in place and an annual infection control statement was produced. Staff were aware of precautions to take to help prevent the spread of infection. The premises were clean throughout and free from any malodours. There was an up to date fire policy and procedure.

Medicines were managed safely. Medicines which were stored on the medication trolley and treatment room were stored safely and at appropriate temperatures which were monitored daily. There was

information available to guide nurses when a variable dose of medicine was prescribed to support nurses to administer the most appropriate dose of medicine. Documentation of creams didn't enable staff to sign each time it had been administered as it was only documented on the chart once.
Shortly after the date of the inspection the service contacted us to identify a number of actions they intended to take to rectify the issues we identified.

People told us they felt staff had the sufficient skills, knowledge and training to care for them effectively. Staff told us they received an induction when they first started working at the home which gave them a good introduction to working in a care environment.

Comprehensive staff training records were in place and staff had completed training in a variety of other areas relative to their job role, such as food hygiene, dementia, infection control, fire safety, first aid, safeguarding, equality and diversity and medicines handling.

Staff had access to regular supervision and appraisal as part of their on-going development.

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 that the service was complying with the conditions applied to the authorisations. Staff demonstrated a good understanding of MCA/DoLS and told us when they felt a DoLS authorisation might be required.

People living at the home told us staff always sought their consent before delivering care to them. Staff were aware of how to seek consent from people before providing care or support and told us they would always ask before providing care.

The people we spoke with told us the food provided at the home was of a good quality. People had nutritional care plans in place and care plans also contained records of visits by other health professionals. We saw that staff provided assistance to several people at meal times. Conversations were warm and unrushed and staff ensured they were at the same eye level of the person they were assisting. The atmosphere was calm and there were no intrusive noises or unnecessary interruptions.

We saw there were some adaptions to the environment, which included pictorial signs on some doors.

We saw staff showed patience and encouragement when supporting people. We observed people were treated with kindness and dignity during the inspection. Care staff spoke with people in a respectful manner. The people we spoke with told us they received good care whilst living at St. Ronans. The people we spoke with described the staff as kind and caring.

People said they felt treated with dignity, respect and were given privacy at times they needed it. Staff were also able to describe how they aimed to treat people in this manner when delivering care. We saw staff knocked on people's bedroom doors and waited for a response before entering. We saw people living at the home were well groomed and nicely presented.

Throughout the course of the inspection we overheard lots of chatter and laughter between staff and people and there was a positive atmosphere within the home. We found the service aimed to embed equality and human rights though good person-centred care planning. People said staff tried to promote their independence when delivering care and allow them to try and still do things for themselves.

Staff were also clear about how to promote independence when providing assistance to people. People's

care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this. Staff told us they involved families when developing care plans or carrying out assessments.

People living at the home told us they received a service that was responsive to their needs. Care plans we viewed all had a range of thorough initial assessments. This enabled staff to establish what people's care needs were and the type of individual care people required. Within people's care plans, it identified who was important to the person and what they wished to be involved in.

The home had systems in place to seek feedback from people living at the home. We looked at the most recent feedback received and saw it was positive and complementary from all groups involved.

There was a system in place to handle and respond to complaints. We saw the home had an appropriate policy and procedure in place, which informed people of the steps they could take if they were unhappy with the service they received. The people we spoke with said they would feel comfortable speaking with staff and raising concerns and one person told us they had recently raised a complaint about a staff member.

The home employed an activities co-ordinator who told us they carried out group based activities such as bingo and arm chair exercises, trips to the sea front, and card/board games. Information regarding activities was displayed throughout the building on various notice boards.

People living at the home said they knew the manager and thought highly of them and the care staff. The staff we spoke with told us they enjoyed working at the home and that there was an open transparent culture. We found the registered manager was very approachable and engaging and facilitated our requests throughout the inspection. Staff also told us leadership and management at the home was good. Staff said they felt able to approach the manager, report concerns and also felt supported to undertake their roles to the best of their ability.

We looked at the systems in place to monitor the quality of service. The registered manager undertook regular audits covering areas such as infection control, staff performance, systems and processes, finance systems, health and safety management systems and care files.

Staff had access to a wide range of policies and procedures. These could be viewed by staff if they ever needed to seek advice or guidance in a particular area.

The service worked in partnership with a number of organisations and was a member of the Hampshire Care Association (HCA) executive board. St Ronans also facilitated seminars and invited guest speakers to deliver presentations on topical issues in addition to organising local workshops on a specific needs basis.

At the time of the inspection the home was sharing their experience of developing and embedding the Level 3* nursing assistant role to help other providers develop this resource within their organisations. The Home was 'research ready', working with Portsmouth University and the National Institute for Health Research. Partnership working with other relevant professionals took place at multi-disciplinary team (MDT) meetings.

To keep up to date with best practice the senior team regularly attended care events and seminars to ensure the service keep up to date with current and future changes in legislation.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service.

The service had appropriate systems and procedures in place which sought to protect people who used the service from abuse.

The service had appropriate arrangements in place to manage medicines safely.

Is the service effective?

Good

The service was effective.

People who used the service told us they felt that staff had the right skills and training to do their job.

There was a comprehensive process of staff induction in place and staff had completed training in a range of areas and received supervision and appraisal from their manager.

Before any care and support was given the service obtained consent from the person who used the service or their representative.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us that staff were kind and treated them with dignity and respect.

Staff attitude to people was polite and respectful using their names and people responded well to staff.

The service aimed to embed equality and human rights through well-developed person-centred care planning.

Is the service responsive?

Good

The service was responsive.

People who used the service and their relatives told us they were involved in developing and reviewing care plans.

People who used the service had a care plan that was personal to them.

Regular reviews of care needs were undertaken by the service.

Is the service well-led?

Good

The service was well-led. Audits had been carried out in a number of areas.

People who used the service and their relatives told us the manager was very approachable. Staff told us they felt supported and were able to put their views across to management.

The service had policies and procedures in place, which covered all aspects of service delivery.

St Ronans Nursing and Residential Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 22 November 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. At the time of the inspection, 44 people were living at St Ronans Nursing and Residential Care Home. At the last inspection on 26 November 2013 we found the service to be compliant with all regulations we assessed at that time.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents. We also contacted Portsmouth City Council contracts/commissioning and safeguarding teams who monitored the service and Portsmouth Clinical Commissioning Group (CCG). This was to see if they had any information to share with us in advance of the inspection and to help inform our inspection judgements.

During the inspection we spoke with five people who used the service, a visiting relative, six members of staff including a nurse, the matron who was also the registered manager and deputy manager, one kitchen staff member and two care staff and a visiting healthcare professional.

We also looked at records held by the service, including four care files and four staff personnel files. As part of this inspection we 'case tracked' records of four people who used the service. This is a method we use to establish if people are receiving the care and support they need and that risks to people's health and well-being were being appropriately managed by the service. We also looked at medication administration records (MAR's) for eight people.

We observed care within the home throughout the day including the medicines round and the breakfast and lunchtime meal.

Good

Is the service safe?

Our findings

People living at the home said they felt safe. The visiting relatives we spoke with also said they felt their family members were safe as a result of the care provided. One person said, "I feel safe, I've had no falls since being here." Another person told us, "I feel safe. I've no worries like that. Only staff come in to my room." A third person commented, "I'm safe. The staff are always there for you." A visiting doctor said, "I have no concerns regarding people's safety here. This is one of the best homes I visit."

We looked at four staff personnel files and there was evidence of robust recruitment procedures in place. The files included application forms, proof of identity and references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. We asked people who used the service and staff if they felt there were sufficient staff on duty. One person commented, "There are usually two nurses on, not three as there are today." The management confirmed that this was correct and explained that the Deputy Matron had come in on her day off to ensure that there was sufficient management available to help with the inspection. We found that having two nurses on duty was sufficient to meet people's needs. People living at the home said they did not have to wait long for assistance. One person said, "There seems to be enough staff. I don't wait long when I ask for something." Another person told us, "There seems to be enough staff. Staff always answer my call bell quickly." A third person said, "The carers answer the bell timely so there must be enough."

We looked at the staff rotas for September and October 2016 and these consistently demonstrated that there were sufficient care staff on duty to meet the needs of people using the service. Staffing levels were determined on a daily basis based on the changing needs of each person and were increased if there was a change in need that required this.

Staff told us they felt staffing numbers at the home were sufficient. A staff member said, "I personally think there is enough staff. Each day varies as to what we achieve but people here don't have to wait to get their care needs met." A second staff member commented, "When we have a full complement of staff, we have enough. People's needs change and if we're struggling the nurses will help us. The nurses also help at busier times like lunchtime when people need support with eating their meals." A third staff member told us, "I've no concerns regarding staffing levels. If we needed more because of a change in someone's need, we'd just need to raise this with management."

There was an up to date safeguarding policy in place, which referenced legislation and local protocols. The home had a whistleblowing policy in place and this told staff what action to take if they had any concerns. The staff we spoke with had a good understanding of safeguarding, abuse and how they would report concerns. One staff member said, "I've had safeguarding training. Signs of abuse may be bruises, markings, a skin flap not in an area consistent with another explanation could be a sign that somebody was a victim of physical abuse. Emotional abuse could be recognised if the person stops eating/drinking, becomes violent

or there was another change in their mood. Financial abuse would be recognised if person's bank statements were going missing or they didn't have money when they usually would."

A second staff member told us, "If management were involved in the safeguarding, I'd go higher. If I didn't feel anything was being done about my concerns, I'd go to the local authority and CQC." A third staff member said, "I've completed safeguarding training and touched on it again in NVQ 5. It could be physical, verbal, financial, neglect. Signs could be bruising, change in person's personality, money missing."

We asked staff what they would do if they suspected abuse and one said, "If I suspected any of these things, I'd report it straight to my manager." A second staff member told us, "If I suspected financial abuse, I could go to the finance manager. Owners. Local authority, management, GP and CQC." A third staff member commented, "We've all had training. Safeguarding could be anything. It's best to air on caution and report anything you are concerned about. I'd tell management and they'd look in to it straight away."

We saw people had risk assessments in their care plans in relation to areas including falls, pressure sores, and malnutrition. Accidents and incidents were recorded correctly and included a record of the accident or incident, a summary chart and action plan. We checked historical accident records and found that they had been appropriately completed and included a body map identifying the area of injury (where applicable) and the action to be taken to reduce the potential for further injury in the future. There was also a monthly accidents tracking chart in place.

During the inspection we looked around the premises. The home was adequately maintained and we saw evidence recorded for the servicing and maintenance of equipment used within the home to ensure it was safe to use. Comprehensive records were in place and up to date regarding the safe management of the premises and these were recorded in separate files called health and safety records; equipment current records; building service records. Historical maintenance records were also held in the administrator's office.

We looked at how the service managed the control of infectious diseases. We saw that quarterly infection control audits were in place and an annual infection control statement was produced. Previous scores achieved identified a steady increase in achieving the required standards and the last audit had achieved a score of 98%. Personal protective equipment such as gloves and aprons were available throughout the home and hand gels, soap and towels were situated in all of the toilets/bathrooms. There were different coloured bins for collecting different types of laundry depending on their state of cleanliness. Cleaning schedules were in place and up to date.

Staff were aware of precautions to take to help prevent the spread of infection and information about infection control was posted in the staff room. For example, staff said they would wash their hands regularly and use different coloured cleaning cloths for different areas of the home. There was an infection control policy and procedure in place that identified to staff what actions to take to minimise the potential for an infectious outbreak and the action to be taken in the event of an outbreak. Guidance on reducing the potential for the spread of infections was also posted in bathrooms and toilets and in the staff room. Two members of staff had completed a Train the Trainer course in infection control which meant they could deliver update training to staff.

The premises were clean throughout and free from any malodours. We saw that bathrooms and toilets had been fitted with aids and adaptations to assist people with limited mobility. The bathrooms were well kept and surfaces were clean and clutter free and the home was clean throughout. Cleaning products were stored safely and Control of Substances Hazardous to Health (COSHH) forms were in place for all the

cleaning products in use.

There was an up to date fire policy and procedure. Fire safety and fire risk assessments were in place and fire evacuation drills were carried out regularly and staff attendance recorded to ensure all staff undertook regular drills. People had an individual risk assessment regarding their mobility support needs in the event of the need to evacuate the building and a personal emergency evacuation plan (PEEP). Tests of the fire system were made regularly and the servicing of related equipment, such as fire extinguishers was up to date.

During the inspection, we looked at eight medication administration records (MAR) to see if medicines were administered safely. We found medicines were not always given as per prescriber's recommendations. Some medicines that needed to be given before food, such as medicines to reduce gastric acid, and hormone replacements and antibiotics we observed were recorded as being given at the same time as whilst people ate their breakfast. We asked the deputy manager why this had occurred and they acknowledged this was as a result of a lack of clear instructions from the pharmacy and all the medicines being in the blister pack together and given at the same time. The pharmacist had not separately packaged medications that needed to be given before and with food or instructed that some medications be given before food. The deputy manager told us they would contact the pharmacy and request these medicines be put in the blister pack separately to other morning medicines to enable the nursing staff to give these medicines prior to people receiving their breakfast. After the inspection, management confirmed that this had been done and the packaging and instructions for medication had been amended.

We also found there was information recorded to guide nurses when administering medicines which were prescribed to be given "when required" (PRN), this included medicines prescribed for anxiety, pain and constipation. There was information available to guide nurses when a variable dose of medicine was prescribed to support nurses to administer the most appropriate dose of medicine and the provider explained that the nurses and staff were not only well-trained in the administration of medication but were also experienced in giving these sorts of medications, which are commonly used in care homes.

Medicines which were stored on the medication trolley and treatment room were stored safely and at appropriate temperatures which were monitored daily. Documentation of creams didn't enable staff to sign each time it had been administered as it was only documented on the chart once. Some people required their creams applying multiple times a day, however records we saw did not demonstrate that this had occurred. The management explained that emollient cream was applied twice a day, as directed in care plans, and that they ensured that this was done by using spot checks. Shortly after the date of the inspection the service contacted us to identify a number of actions they intended to take to rectify the issues we identified.

Good

Is the service effective?

Our findings

People told us they felt staff had the sufficient skills, knowledge and training to care for them effectively. One person said, "Staff definitely know what they are doing." Another person told us, "They [staff] seem well trained." A third person commented, "They must be well trained. They are knowledgeable and know what they are doing. Everything happens as it should. They are well practised."

Staff told us they received an induction when they first started working at the home which gave them a good introduction to working in a care environment. We saw that a new employee induction checklist was completed for each new member of staff. A mentor was allocated to each new member of staff to assist them through the process of induction and probationary period. The mentor also ensured that the staff member received regular supervision and at least two formal supervisions and an annual appraisal each year. One member of staff said, "I've been here 10 years so I can't remember the full details of my induction but staff do the care certificate now." Another staff member who had also been in post for a long tome told us, "I did some training and shadowed other staff. The care certificate wasn't heard of then."

Comprehensive staff training records were in place and staff had completed training in a variety of other areas relative to their job role, such as food hygiene, dementia, infection control, fire safety, first aid, safeguarding, equality and diversity and medicines handling. Training was aligned with the requirements of the Care Certificate and Skills for Care Common Induction standards. We verified staff training information by cross-referencing training records and certificates. Each staff member had an individual training record and progress against the fifteen standards of the Care Certificate was tracked using a 'care certificate completions' document.

The staff we spoke with said they received sufficient training to help them undertake their role effectively. One staff member said, "I feel we receive enough training." A second staff member said, "We get loads of training. I'm currently doing my NVQ 5. There is no problem with training. They've supported me to do everything that I've asked for." A third staff member commented, "Training is encouraged. If we want to do outside courses, we just need to speak to matron and it gets sorted out. They let us pursue opportunities, even if it's not related to the role. I really like that about here."

Staff had access to regular supervision and appraisal as part of their on-going development. There was a supervision policy in place which identified the frequency of supervision meetings. One member of staff said, "I get supervision at least every three months and an annual appraisal. We have spot checks too. I feel very well supported. I know I could go to management any time. It may sound corny but this is like a second family." A second staff member told us, "We have regular supervision and a yearly review. We can also approach the management any time and just have a chat."

We looked at staff supervision and appraisal information. There was a staff supervision schedule and annual appraisal schedule in place, which identified meetings during the year. Annual appraisals had either taken place or where scheduled for after the date of the inspection. Supervision sessions for care staff were conducted by their line manager.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The management had created a DoLS matrix to monitor applications to the local authority which confirmed they were submitting authorisations timely and informing the required public bodies when an authorisation had been granted.

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 that the service was complying with the conditions applied to the authorisations.

Staff demonstrated a good understanding of MCA/DoLS and told us about when they felt a DoLS authorisation might be required. One member of staff said, "Mental capacity is always being discussed. It's something we consider all the time when providing care. Mental capacity is decision specific. It can involve us maintaining people's safety because people are not able to understand the risks or maintain their own well- being." Another staff member told us, "I always treat people how I would want to be treated. People may not be able to choose where they live but that doesn't mean they can't choose what they wear, eat or time they go to bed."

People living at the home told us staff always sought their consent before delivering care to them. One person told us, "They ask me most of the time." Another person said, "Yes, they wouldn't do anything without getting my agreement first." A third person commented, "I'm asked and then I agree or don't. Staff wouldn't do anything unless they had your agreement." We saw that people had consent forms in their care files that had been signed by them or their relative where applicable.

Staff were aware of how to seek consent from people before providing care or support and told us they would always ask before providing care. One staff member said, "I'd never do anything without explaining to the person first what it is that I wanted to support them with. I'd seek their consent by saying, is that okay? If they said No, I'd try again later or ask another member of staff to ask." A second staff member told us, "I always say; do you mind if I……..…..If somebody does mind, I give them time and go back and ask later." A third staff member commented, "We would never do anything without the person's agreement. People sign consent forms but we get verbal consent too."

The people we spoke with told us the food provided at the home was of a good quality. Comments included, "The food is nice enough," and "The food is good. Quite adequate," and "The food is good. We get more than enough to eat and its good quality food," and "It could be improved," and "Pureed food is presented well and always tastes good." A visiting doctor told us, "I visit at different times, I've always seen the food to be presented well and it's a pleasant aroma in the home at mealtime."

People had nutritional care plans in place and care plans also contained records of visits by other health professionals. We saw that a range of professionals including GPs, speech and language therapists (SALTs) and district nurses had been involved in people's care. We saw people's weights were being monitored on a regular basis where a need for this had been identified.

We observed the lunch time meal that was being served in two adjacent dining areas. We noted that when food was brought to the dining room from the kitchen each plate of food was securely wrapped in cling film to protect it and some plates had individual names on which would assist staff in ensuring it was given to the right person in accordance with their needs and wishes. We saw that staff provided assistance to several people during the meal. Conversations were warm and unrushed and staff ensured they were at the same eye level of the person they were assisting. The atmosphere was calm and there were no intrusive noises or unnecessary interruptions.

Food temperatures were recorded at each meal before serving. We observed staff taking breakfast to people who wished to stay in their room on nicely presented trays that helped to make the food look inviting to eat. We saw the food on these trays was covered with a protective film that helped retain heat and protect the food as it was being taken to rooms. There was a weekly menu in place and people's likes/dislikes and preferences regarding food was recorded in their care files and in the kitchen, which also had information regarding special diet types and nutritional supplements for each person who required them.

We asked staff about people's nutritional needs and how they were met. One staff member said, "People definitely get enough to eat and drink. The quantity of food given and the quality of the food is good. There is always something to eat outside of set meals if people are hungry and request it. The chef has a list of people's dietary requirements, whether their food is soft or pureed, likes and dislikes. We also know people's nutritional needs and it's also in the care plans." A second staff member commented, "The food is really good. If people want something else then it is provided. Today some people had brown toast and marmalade whilst other people asked for a full English breakfast and this was provided." A third staff member told us, "The food is lovely. All the staff have the meals too."

We saw there were some adaptions to the environment, which included pictorial signs on some doors. There were assisted bathrooms with equipment to aid people with mobility problems. The matron told us that the service had sought specialist advice on creating dementia friendly environments. The home told us that they had made changes to help people retain their independence and ability to do things. For example, they had changed the taps in one person's bathroom twice in order to find a set of taps that they could operate.

Good

Is the service caring?

Our findings

We saw staff showed patience and encouragement when supporting people. We observed people were treated with kindness and dignity during the inspection. Care staff spoke with people in a respectful manner. For example at the lunch time meal we saw staff gently encouraging people to eat their food.

The people we spoke with told us they received good care whilst living at St. Ronans Nursing and Residential Care Home. One person said, "This is the best home I have ever been to. I was somewhere else before here and that wasn't a patch on this place. I'd definitely recommend this home to others." Another person told us, "I can't fault this home. I have and get everything I want." A third person said, "It's beautiful living here. I've got a good home. I'd definitely recommend here to other people that need this level of care."

A visiting relative we spoke with was also complimentary about the care provided at the home. We were told, "As a family, we're all happy with the care [my relative] is receiving. We'd recommend this home to other families." A visiting doctor said, "This is a good home. It's not a home you need to be worried about."

The people we spoke with described the staff as kind and caring. One person told us, "The staff here are marvellous. I am staying here until I die." Another person said, "They are wonderful the staff on the whole. I can't fault them." However a third person commented, "Some staff are nicer than others. The morning staff dress me but then won't always take me downstairs even though I've asked several times to go down." A fourth person said, "Like everything there are some staff that are better than others. Some staff here really put themselves out for you."

People said they felt treated with dignity, respect and were given privacy at times they needed it. One person said, "Staff always knock on my door before coming in to my room. Staff turn away or leave my room when I do my under carriage." A second person told us, "Staff are very good. One of the male's in particular. They wash and shower me. I've never felt uncomfortable. They are sensitive." A visiting relative told us, "When I've visited earlier, if staff are supporting [my relative] to wash/dress they ask me to wait outside their bedroom until they've finished."

Staff were also able to describe how they aimed to treat people in this manner when delivering care, telling us it was extremely important. One staff member said, "I always knock on people's doors before entering their room. Greet people on entry and maintain eye contact. If people are in their beds, I make sure they can see me before I start a conversation. If I'm supporting somebody's personal care, I shut curtains/blinds. If they are in a shared room, make sure the screen is round. Before doing this, I'd explain to the other person in the room why I was doing that. When supporting somebody to wash, I always make sure the area that is not being washed at that time is covered." A second staff member told us, "Knock on doors, when washing people it's top first to tail and make sure the areas that you are not washing are covered."

We saw that the care staff knocked on people's bedroom doors and waited for a response before entering. We saw that people living at the home were well groomed and nicely presented.

Throughout the course of the inspection we overheard lots of chatter and laughter between staff and people and there was a positive atmosphere within the home. Staff interacted with people throughout the day and had a good understanding of the individual people who used the service. We observed many occasions where staff spoke privately on a one-to-one basis with people, for example one staff member explained to a person about a new razor that they had bought so they could use it independently and other staff asked people where they wanted to sit and explained what they were doing before moving people in their wheelchairs. Staff also used a screen when transferring people in communal area to maintain their dignity and privacy.

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs.

People said staff tried to promote their independence when delivering care and allow them to try and still do things for themselves. One person told us, "Staff leave me to do what I can. They support me with personal care but I do the areas that I can reach. Staff will do my back though." Another person commented, "I do for myself all that I can do." A fourth person said, "I have my own kettle and fridge so I can make my own drinks at night."

Staff were also clear about how to promote independence when providing assistance to people. One staff member said, "If people are able to do it, then we encourage them to do it. It may take people longer to achieve things for themselves but so what. There is no rush so if meals take an hour but the person has done it for themselves than that is better than me doing it for them." A second staff member said, "It's about engaging with people, asking questions like what do you fancy wearing, keep people's mind going." Another staff member commented, "We encourage people to do what they want to do for themselves. It can be difficult because people want to have things done for them and be looked after too."

People's care files contained end of life care plans, which documented people's wishes at this stage of life where they had been open to discussing this. Staff told us they involved families when developing care plans or carrying out assessments. The people we spoke with living at the home and a visitor to the service confirmed this was the case. At the time of the inspection no person was in receipt of end of life care and each care file had a section about advanced decisions. Where people had made an advanced decision regarding end of life care this was recorded correctly, dated and signed appropriately.

Good

Is the service responsive?

Our findings

People living at the home told us they received a service that was responsive to their needs. One person told us, "I have a sherry before my lunch and a Budweiser after. That meets my needs." A second person told us, "I'd been talking to deputy about liking old songs and films. They got them up on their phone for me to listen to." Another person commented, "Everything is our own choices. What time we get up, go to bed."

A visiting doctor told us, "Complicated and complex needs of people are managed very well here. Renal dialysis, catheters, they'll take bloods. Staff are consistent and we receive timely referrals because staff know people well. I have confidence in the feedback and staff are capable and reliable. I've noticed little things like the calendar and clocks are always set to the right date/times."

Care plans we viewed all had a range of thorough initial assessments. This enabled staff to establish what people's care needs were and the type of individual care people required. We saw these provided a focus on personal care, moving and handling, pressure care, nutrition/hydration, medication, social/emotional and family/staff involvement. One person said, "They visited me and did a pre-assessment before moving in to the home." Another person told us, "I had a full assessment and was asked about my needs before I came here." The relative of one person said,
"We visited the home first and then Matron did a comprehensive assessment with us before [my relative] moved in to the home. We have a copy of all [my relative's] care plans at home and we are invited to reviews to contribute our opinions."

The service was responsive to people's changing needs. The relative of one person told us, "[My relative] had a grade four pressure sore when they moved in to the home but it has healed well. They are turned every two hours and staff come in to do this when I am visiting." We looked at the care records for this person and saw that the pressure sore had been documented correctly and pictures taken of the wound which had visibly improved without any further infection.

Another person whose care records we looked at, had documented skin care needs and this was just a blister on their foot which had healed. Both people's skin changes were body mapped.

We checked the provision of equipment for three people identified as being at high risk of sustaining pressure sores and found all were either on a cushion or in bed on airflow mattress each time we checked on them through inspection which was in keeping with their care plan. This showed that the service had responded appropriately to identified risk.

Within people's care plans, we saw a person centred care plan which identified who was important to the person. A life history document captured details of what the person liked to be called, who their key worker was, important people, important dates, activities they enjoyed, TV programmes they enjoyed, details of any pets, their religious beliefs, their nutritional preferences, any allergies, if they had any hearing or vision problems, what help they needed to go to the toilet, how often they would like a shower, how well they slept at night, how many pillows they had, if they wore dentures, how they mobilised, family information and

things that worried the person or made them angry or frustrated. This meant staff had access to sufficient information about how to provide care to people based on their likes, dislikes, preferences and previous experiences.

People were given a choice about what they wished to be involved in. One person said, "I'm reliant on staff to achieve certain things but they do give me choices, I chose what I'm wearing and where I'd like to sit in the day." A staff member commented, "Everything is the person's own choice. Some people aren't motivated to choose from a full wardrobe what they want to wear that day but if you sense that, you can help them by selecting a few choices to pick from that takes in to account the weather. What people do, eat, when they get up, go to bed. It's all up to that person."

The home had systems in place to seek feedback from people living at the home. This included sending an annual questionnaire to people who used the service, their relatives, any associated professionals and the staff group. Results were analysed and used to inform the development of the service.

We looked at the most recent feedback received and saw that it was positive and complementary from all groups involved. Comments from visiting professionals included, 'The feedback I receive from families is usually positive and praises care. Where there are any issues raised the nurses respond straight away,' and 'I really enjoy coming to entertain at St Ronans. I'm always given a warm welcome and its great when the staff join us dancing and singing with the residents too.'

Comments received from people who used the service included, 'Generally happy with all aspects of care given,' and 'Very happy here,' and 'Overall very happy with living at St Ronans and content with most aspects of care.' We saw that the service responded to any negative comments received, for example one person had identified that food was sometimes cold when served and the home had purchased a hot trolley to ensure meals stayed hotter at serving time. The family of another person had reported missing items of clothing and the service had investigated this, determined the reasons and rectified the issue. Another example was when a person identified difficulties with using the taps in their room, the service had installed 'sensor' activated taps which the person did not like and so these were replaced with easy use tap handles which the person was happy with.

Comments received from people's relatives included, '[My relative] has settled in very well and is happy. I think largely due to the staff being happy and interacting with residents who all seem happy,' and 'Just carry on the way you are – it works,' and 'No complaints, everyone is always willing to help and always have a smile,' and 'Atmosphere is wonderful at St Ronans, always.'

We looked at the minutes from residents and relatives meetings which were held approximately every other month. This presented people with the opportunity to discuss the care they received and inform staff about any concerns or things they might like to change within the home. We saw that topics of discussion from meeting with people who used the service included activities, food, staff attitudes, laundry, music, and rising/retiring times. Discussion topics from relatives and friends support group meetings had included the same areas of discussion and each family member had been given the opportunity to discuss their relative on an individual basis. One relative told us, "I'm invited to residents and relatives meetings but it's not something that I want to attend."

There was a system in place to handle and respond to complaints. We saw the home had an appropriate policy and procedure in place, which informed people of the steps they could take if they were unhappy with the service they received. There was also information displayed around the building for people to read, information in their care files and also in the 'Residents User Guide' booklet that was given to each person

prior to the start of their residence.

Most people we spoke with said they had never felt the need to complain, but would feel comfortable speaking with staff and raising concerns. One person said, "Anything you need sorting, Matron does it." A second person said, "I've no complaints, never had any, in all the time I've lived here." Other comments included, "I've no complaints. The deputy does ask me quite often if I have any but I haven't. I would tell them if I did," and "I made a complaint to the Matron about another member of staff. Matron told me it would be sorted and they addressed it. I was happy with the outcome."

We looked at the activities available at the home and also how people were stimulated throughout the day. Each person's expressed likes and dislikes regarding activities were recorded in their files. The home employed an activities co-ordinator who told us they carried out group based activities such as bingo and arm chair exercises, trips to the sea front, and card/board games. We were also told that a number of 'one to one' activities took place for people who were cared for or chose to stay in bed during the day which included hand manicures/massages.

The home had a parrot and two budgies in one of the lounges which people were shown these at the point of referral to ensure they had no concerns or allergies to these. There was a room set aside for relatives to stay overnight if the need arose. There was a cinema room with a large pull-down screen which would assist some people with vision difficulties to more easily see the film they had chosen.

Information regarding activities was displayed throughout the building on various notice boards. Activities included relaxation, hairdressing, one-to-one sessions, sing-along, quiz, throwing hoops, minibus outings, music and movement, book reading, card games, pet therapy, birthday celebrations and spiritual activities. There was a sing-along activity taking place in the afternoon of the inspection which included an external entertainer. We observed people took part in and enjoyed this activity.

We asked people about their views of activities and if they had enough to stimulate them. Comments included, "There is definitely enough going on. We do singing and praying, Christmas carols at Albert Road. I really enjoy the Thursday trips out," and "I do go to the lounge in my chair if there is a show or something on. There is a lot going on but I pick and choose what I want to do," and "There are a lot of activities and definitely enough going on for people that want to join in. That's not my thing."

We asked staff about their views regarding activities and one staff member said, "There's always something going on. We have hairdressers and nail people, singers/bands that come in to the home. That's in addition to what the activities coordinator plans each day." A second staff member told us, "The activities are really good. The activities coordinator does what people want. They take people out weekly."

Good

Is the service well-led?

Our findings

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

People living at the home said they knew the manager and thought highly of them and the care staff. One person said, "The matron and the deputy are both excellent. Really lovely people. They make me laugh." A second person commented, "They are lovely, always jolly." Another person said, "I get on very well with the management. There is openness about them. I'd say we are friends, I don't just feel like a resident here." A visiting relative told us, "The management are very friendly and approachable." A visiting doctor said, "The management have a real positive, can do mentality."

The staff we spoke with told us they enjoyed working at the home and that there was an open transparent culture. One staff member told us, I love working here. I wouldn't have stayed so long otherwise." A second staff member commented, "its lovely here. People care about each other and the residents." A third staff member said, "I wouldn't hesitate to recommend this home. If it was me, I'd come straight here. There's nowhere else that I'd rather go. Everyone is so close. We are a good team and support each other. The owner's parent lived here. They weren't treated any differently than the other people and they were happy here."

We found the registered manager was very approachable and engaging and facilitated our requests throughout the inspection, as did the rest of the staff team. The manager told us they operated an 'open door policy' meaning people could discuss concerns with them at any point and these would be taken seriously.

Staff also told us leadership and management at the home was good. Staff said they felt able to approach the manager, report concerns and also felt supported to undertake their roles to the best of their ability. Comments received from the staff we spoke with included, "I can't praise the management enough. The matron, deputy and nurses are all open and honest. They are very good. I'd regard them as a friend but there are boundaries, I respect that. Matron has a good balance. They are approachable but we know to do our job properly or we'll be answerable to matron," and "its good leadership. We're always having job chats and having our competency checked to keep standards up," and "Firm, fare and approachable. All I'd want really."

We looked at the systems in place to monitor the quality of service. The registered manager undertook regular audits covering areas such as infection control, staff performance, systems and processes, finance systems, health and safety management systems and care files. Data was also submitted on a monthly basis to the clinical commissioning group (CCG) including admissions and discharges, aids appliances and equipment, staff attitudes, clinical care, communication, DoLS, consent, falls, duty of candour complaints, privacy and dignity food, procedures, pressure sores, any infectious outbreaks, visits and activities and

people's current status. These systems meant that the manager could identify and potential shortfalls at the home and take appropriate action to ensure people received an improved quality of service.

We looked at the minutes from recent staff meetings which had taken place. These were held amongst staff in different staff groups such as care assistants, nurses, catering staff and domestic staff. This presented the opportunity for staff to discuss their work in an open setting, raise concerns and make suggestions about how the service could be improved. One member of staff said, "Team meetings are regular. At least every six months but more often if there is something that needs discussing, an issue or changes. I feel the deputy and matron listen and I get to have my say about things." A second staff member told us, "We do try to have them bi monthly but they do sometimes slip a bit. The meetings are good and the management implement things that have been raised at the team meeting. We didn't have anywhere to put our belongings so they got us all lockers. People looking at their phones during shift has been raised so we're all getting fob watches so we have a means to tell the time and don't have our phones out."

Staff had access to a wide range of policies and procedures. These included medication, nutrition, moving and handling, safeguarding, health and safety and infection control. These could be viewed by staff if they ever needed to seek advice or guidance in a particular area. The registered manager understood their role in sending notifications to CQC and had sent us notifications as required by the regulations. People's care records were kept securely and confidentially, and in accordance with legislative requirements. All systems relevant to the running of the service were well organised and reviewed regularly.

The service worked in partnership with a number of organisations. The service was a member of the Hampshire Care Association (HCA) executive board. HCA represents the views, concerns and interests of its members to commissioners, government and regulatory bodies. HCA is represented on Local Authority Safeguarding Boards, negotiates fees and other issues, participates in the Southampton, Hampshire, Isle of Wight and Portsmouth workforce development group (SHIP), and works in close partnership with Skills for Care. At these meetings the voluntary executive members and professional management team shared their knowledge and expertise with wider members to help them deliver and maintain the highest level of care.

St Ronans also facilitated seminars and invited guest speakers to deliver presentations on topical issues in addition to organising local workshops on a specific needs basis, as well as organising regular meetings of local care homes, and, separately, regular meetings with council officers. The senior team also worked actively with commissioning bodies to promote best practice.

The home was committed to driving up standards and promoting best practice throughout all services in the City, supporting other providers with trouble shooting / problem solving, developing safe systems of work, innovation, shared training, external verification (specifically but not limited to the Gold Standard Revalidation). This foundation work had led to the development of an informal support network between local service providers.

At the time of the inspection the home was sharing their experience of developing and embedding the Level 3* nursing assistant role to help other providers develop this resource within their organisations. The registered manager attended registered manager meetings; the deputy manager attended the deputy matron leadership and management meetings and recent work undertaken had contributed to the development of the Integrated Care Pathway for NHS England; registered nurses attended an up skilling course designed with providers and health care professionals locally and were being supported through their revalidation.

The Home was 'research ready', working with Portsmouth University and the National Institute for Health

Research. The latest research was with Solent NHS Trust where the home was participating in analysis in bacteria carriage and antibiotic resistance.

Partnership working with other relevant professionals took place at multi-disciplinary team (MDT) meetings. These were attended as required by the Parkinson's nurse, the palliative care team, the older people's mental health team, the continuing health care team (CHC), speech and language therapists (SALT), physiotherapists, dieticians, occupational therapists, the community matron, safeguarding leads, DoLS specialists, pharmacists, discharge planners, doctors, social workers and practice nurses to ensure best practice.

The business manager at St Ronans sat on the Hampshire Domiciliary Care Providers (HDCP) executive group and was the representative for the Portsmouth area. The business manager also undertook local provider meetings, and liaised with the local authority, the CCG, Skills for Care (SFC) and Healthwatch.

To keep up to date with Industry best practice the senior team regularly attended care events and seminars to ensure the service keep up to date with current and future changes in legislation and best practice. The service received regular information from employment and industry specific publications, including medical alerts. Clinical governance was kept up to date through internet research, National Institute for Health and Care Excellence (NICE) guidance and Royal College of Nursing (RCN) guidance.