Hollybank Rest Home Limited

Hollybank Rest Home

Inspection report

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Date of inspection visit:
15 February 2017
16 February 2017

Date of publication:
27 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hollybank Rest Home is located in the village of Botley, on the outskirts of Southampton and can accommodate up to twenty three older persons. The accommodation is arranged over two floors with a passenger lift and stair lift available to access the upper floor. All of the rooms are ensuite with three offering shared accommodation. The home does not provide nursing care. There were 20 people living in the home when we inspected.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager had been appointed and was in the process of applying to become registered with CQC. They had been working within the service full time since December 2016.

Medicines were not always being managed safely. Whilst medicines audits were undertaken, these were not being fully effective at driving improvements to ensure the safe use of medicines.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Staff were confident the manager would act upon any concerns they raised.

People had risk assessments and where risks had been identified, measures were in place which helped to ensure that the risk was minimised.

Safe recruitment practices were followed and appropriate checks had been undertaken which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

Staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support. The manager was making improvements to ensure mental capacity assessments were more clearly documented and completed in line with relevant legislation.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were either in place or had been applied for

New staff received a service based induction which involved learning about people's needs and key policies and procedures. Staff felt the training provided was adequate and helped them to provide effective care.

People told us the food was tasty and that they were supported to have enough to eat and drink.

People were cared for by staff that were kind and caring and with whom they had developed good relationships. Staff showed people kindness and patience and showed a genuine interest in the people they supported.

People were involved and engaged in making decisions about the care and support provided and were treated with dignity and respect.

Care plans contained the information needed to support staff to provide people's care in a manner that was responsive to their individual needs.

People were supported to take part in a range of activities and make choices about how they spent their time.

People spoke positively about how well organised and managed the service was. There was an open and transparent culture within the service and the engagement and involvement of people and staff was encouraged and their feedback was used to drive improvements.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have asked the provider to take at the back of this report.

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.

Improvements were needed to ensure the proper and safe use of medicines.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.

Staffing levels were adequate to meet people's needs. Risks to people's health and wellbeing were assessed and systems were in place to manage these.

Is the service effective?

Good

The service was effective.

Staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support.

Staff received training, supervision and an induction which ensured they had the skills and knowledge to support people appropriately.

People had their healthcare needs managed in a way that was appropriate and their nutritional needs were well supported.

Is the service caring?

Good

The service was caring.

People were cared for by staff that were kind and caring and with whom they had developed good relationships. Staff showed people kindness and patience and showed a genuine interest in the people they supported.

People were involved and engaged in making decisions about the care and support provided.

People were treated with dignity and respect and were encouraged to live as independently as possible.

Is the service responsive?

Good

The service was responsive.

People received care that was responsive to their needs and wants.

People took part in activities of their choice which they enjoyed and helped to reduce the risk of social isolation.

People and their families were asked to give their views and feedback about the care and support they received. Information on how to make a complaint was readily available within the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

We found a breach of the legal requirements regarding the safe and proper use of medicines. The provider's medicines audits were not being fully effective at driving improvements.

The manager was approachable and accessible to staff who valued her support and guidance.

There was an open and transparent culture within the service and the engagement and involvement of staff was encouraged and their feedback was used to drive improvements.

Hollybank Rest 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 over two days on 15 and 16 February 2017. The inspection was unannounced. The inspection team consisted of one inspector and an expert by experience.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by managers to tell us about important issues and events which have happened within the service. We used this information to help us decide what areas to focus on during our inspection.

We spoke with eight people who used the service and three relatives. We also spoke with the manager, deputy manager, the chef and four care workers. We reviewed the care records of five people in detail and the recruitment records for two staff. We also reviewed the medicines administration records (MARs) for all 20 people. Other records relating to the management of the service such as audits, meeting minutes and policies and procedures were also viewed. Following the inspection we received feedback from three health and social care professionals.

The last inspection of this service was in April 2014 when no concerns were found in the areas inspected.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Hollybank Rest Home. One person said, "I like it here, if there was anything I didn't like I would tell the staff… We have a buzzer that is like a remote control so I feel totally safe knowing I have it as I stay in my room most of the time". Another person said, "I always feel safe….it's a safe secure home to live in so for me there isn't anything that would make me feel unsafe".

Some areas of how medicines were being managed required improvement. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. We noted, however, that one person's MAR recorded they had an allergy to a particular medicine; however their MAR showed they were being prescribed that medicine. Subsequent discussions with the prescriber found the allergy to be incorrectly recorded, however, staff had not identified this discrepancy or taken action to check the information with the prescriber. People were not always receiving their medicines as prescribed. For a period of over two weeks, one person had not received prescribed pain relief as they had been asleep at the time of the medicines round. This had not been raised with the prescriber. No action had been taken to seek a review of the person's medicines. Similar issues were found in relation to three other people's medicines. Some people had handwritten MARs, but these had not been checked for accuracy by a second member of staff. This is not in keeping with best practice guidance. Medicines administration was not always recorded in line with the provider's policies and procedures. For example, the provider's policy required staff to record on the back of the MAR, when PRN or as required medicines were given. This was not happening. We found four examples where there were unexplained gaps in the MAR. Senior staff auditing the MARs for signature gaps had left a note asking colleagues to retrospectively sign the MAR. There was no evidence that the reason for the missed signatures was being investigated so that remedial actions could be taken to help prevent this from happening again.

Medicines were not always managed safely. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects of medicines management were safe. People were supported to self-administer their medicines where able. Relevant risk assessments were in place to support this. We observed staff undertaking a medicines round. They assisted people with their medicines in a person centred manner such as offering them a drink of their choice or asking them if they would like some pain relief. They stayed with people until they had taken their medicines, however, long this took. One person told us, I'm on lots of medication; I have 7 tablets in the morning, 2 at lunch time, 2 at dinner time and some more at bed time, so yes I get my medication regularly and if I need more [pain relief] I just have to ask".

Medicines were stored within a locked trolley or designated medicines fridge, kept within a locked cupboard. The temperature records for both the cupboard and medicines refrigerator were being monitored. We carried out a stock check of Controlled drugs. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. The CD register tallied with the medicines being stored in the CD safe. Where people were prescribed 'as required' or PRN medicines to manage pain relief or behaviour which might

challenge others, there were suitable and personalised PRN protocols in place. Staff were aware of these and were able to consistently describe the circumstances in which they would administer PRN medicines. Staff administering medicines had received training and had an annual review of their competency to administer medicines safely.

Risks to people's wellbeing had been identified. For example, we saw that people had moving and handling and falls risk assessments. Each person had a risk assessment which highlighted their risk of being exposed to abuse. Nationally recognised tools had been introduced to monitor whether people were at risk of poor nutrition. Where necessary food and fluid charts were used so that people's food intake could be monitored. Staff used body maps to record bruising or skin damage and then completed daily evaluations which remained in place until the damage had healed. Where risks had been identified, measures were in place which helped to ensure that the risk was minimised. For example, one person at high risk of falls had an alarm mat in their room to alert staff they were mobilising so that they could check on the person and offer support as necessary. People at high risk of falls had been referred for additional support and assessment when required. A falls register was kept and incident forms completed and a monthly falls data sheet logged the number of falls that occurred in the service. We did note that these records could be used more effectively to show what actions staff had taken following a fall and what remedial actions were being taken to prevent similar incidents happening again. The manager told us they would take action to improve how incidents and accidents were monitored.

Staff completed a range of health and safety checks to help identify any risks or concerns in relation to the environment and equipment used for delivering people's care. The lift was regularly serviced and checks were made of the safety of electrical and gas appliances. Weekly and monthly checks were undertaken of fire safety within the service. A fire drill had taken place in November 2016, although we did note that the records relating to this could be more robust. We spoke with the manger about this, who told us that moving forward they would ensure that improvements were made to the records relating to fire drills. A fire risk assessment had been completed in October 2016, the majority of actions resulting from this had been completed. People had personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. A business continuity plan was in place and set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies.

A check of the water system in September 2016 did not detect any legionella bacteria, however, the provider had not undertaken a full legionella risk assessment as recommended by the health and safety executive. These help to ensure that there are adequate ongoing measures in place to identify and control any risk of legionella being present in the water system. The manager confirmed that action would be taken to ensure an appropriate risk assessment was in place.

People told us there were sufficient staff to meet their needs. There were usually four care workers on duty during the day. Night shifts were staffed by two care workers. Both the duty manager and manager were also available to step in and provide additional support if necessary. The provider also employed a full time maintenance person, a chef, kitchen assistants and an office manager. Cleaning staff were also available each day. The manager was confident these staffing numbers were sufficient to meet people's practical and social needs. We reviewed a sample of the staffing rotas for the month prior to our inspection and found that the service had been staffed to the levels described above.

Records suggested that people's care was provided by a small and consistent staff team with minimal agency use. This helped to ensure that people were cared for by staff who knew them well. Care workers did not raise any concerns with us about staffing levels. They told us people's needs were met appropriately and that people were able to choose when to go to bed and when to get up and that the staffing levels

supported this. One care worker said, "It works well, we can manage the care and activities, there is always someone in the lounge, we work well together, we do something every day, quizzes, bingo". Another staff member said, "There are a very good number of staff here". We observed that staff were able to provide support to people in a timely manner and were able to carry out their role and responsibilities effectively.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks. These measures helped to ensure that only suitable staff were employed to support people in their homes.

People and relatives were positive about the cleanliness of the home. One relative said, "The cleanliness is second to none, there are never any odours". The manager had made arrangements for an 'outbreak pack' to be put in place to ensure staff were informed about the actions they should take in the event of an outbreak of an infection. The home had an infection control lead and an annual infection control statement was produced.

Staff had received training in safeguarding people from harm or abuse and had a good understanding of the signs of abuse and neglect. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. People were also equipped with the information they needed to keep themselves safe, for example, the service user guide included the provider's safeguarding policy and contact details for all relevant local agencies that would have a role in responding to any safeguarding concerns. An 'Alerters' guide was available on the notice board. This is a guide produced by the local safeguarding board and is aimed at members of the general public and those working within voluntary and community services in the Hampshire County area and provides guidance on how they should respond to any concerns about abuse or people's safety.

The manager displayed a good understanding of local safeguarding policies and procedures and explained that handovers, staff meetings and supervisions were used to reflect upon the importance of safeguarding people from harm. Each staff member was confident the manager would take prompt action to address any concerns about a person's safety or any allegation of abuse. They were also aware of other organisations with which they could share concerns. A social care professional told us that the manager had been very proactive in investigating some recent concerns regarding medicines management.

Good

Is the service effective?

Our findings

People, their relatives and health and social care professionals told us the service provided effective care and supported people to maintain good health. One person said, "I feel perfectly safe here…although I can't walk and I need help, so the staff use a stand aid…I wouldn't want things any other way, it's really good here". A social care professional told us, "I have known the service a long time and I have never had any cause to worry, they keep me informed". A health care professional said, "Yes they recognise and respond correctly [to health concerns]".

We observed that staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support. For example, we heard staff asking people whether they would like help with cutting up their meal. Staff asked people, "Have you finished" and "Have you all had enough" before clearing away plates at the end of a meal. People were asked where they would like to sit or whether they would like the television on. A staff member told us, "It is important to respect people's wishes….if someone refuses a bath, I'll check again later, talk it through with them, but if they still refuse it's their decision, you can't force them".

People's capacity to consent to their care and treatment was considered during the care planning process. For example, people had mental capacity assessments regarding their ability to be involved in decisions about their care and personal expenditure. Staff had a basic understanding of the key principles of the Mental Capacity Act (MCA) 2005 and were able to describe how they made best interests decisions for people, when the person was not able to express how, for example, they would like their day to day care to be provided. We did note, however, that for one person the records relating to the use of covert medicines needed to be more robust and we also saw examples, where relatives had signed consent forms, on behalf of a person who lacked capacity, without it being clear that they had the legal authority to do so. 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. The manager was currently taking action to update all of the mental capacity assessments and associated care plans to ensure they more clearly documented how the mental capacity assessments had been undertaken, what decisions had been reached in the person's best interests and who had been involved in this process. Arrangements were also underway to ensure that where people were receiving covert medicines, their care plans included a clearer record of how this was being done in line with relevant legislation.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home and were either authorised or waiting to be assessed by the local authority.

Hollybank Rest Home provided a comfortable and homely environment that was appropriate to people's needs and assisted them to remain as independent as possible. The home was clean, nicely decorated and equipped with all of the necessary equipment needed to meet people's needs. Some of the people living at the home were living with dementia, and so improvements had been made which helped the environment to be as dementia friendly as possible. For example, there was clear signage directing people to toilets. People's bedrooms had a personalised sign decorated with pictures of their choice, helping them to identify their room. Large wall clocks and calendars were also in place, helping people to remain orientated to the time of day and the date. Pictures were displayed of each of the staff team and their role within the service. In addition to the large communal lounge, there was a smaller lounge without a television where people could spend some quiet time. The lounge and other areas of the home were decorated with age appropriate pictures. The gardens were well maintained and contained seating areas and lots of bird feeders which provided interest for people throughout the year.

New staff received a service based induction which involved learning about the care philosophy within the home, people's needs, daily routines and key policies. New staff also spent time shadowing more experienced staff. Before they worked independently, new staff were observed and assessed as competent in a number of key areas such as providing personal care and in the use of moving and handling procedures. Staff were supported to complete the Care Certificate. This was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. In addition staff were issued with a detailed handbook which included information about their role and responsibilities including the safeguarding and whistleblowing procedures.

Staff felt the training provided was adequate and helped them to provide effective care. The training was mostly completed online and repeated on a three yearly basis. It included topics such as moving and handling, safeguarding people from harm, the Mental Capacity Act 2005, infection control, health and safety, fire safety, first aid and food hygiene. Additional training relevant to the needs of people using the service was also undertaken. For example, staff undertook online training in subjects such as diet and nutrition, diabetes, dementia care, person centred care and death dying and bereavement. Whilst most staff felt the range of training provided was good, a number expressed a wish for more face to face training. We also noted that the frequency with which some of the training was provided was not in keeping with recommended best practice standards published by Skills for Care. For example, Skills for Care recommend that the competency of staff to perform moving and handling with people is undertaken on an annual basis and that subjects such as first aid and basic life support is also undertaken annually. The manager told us plans were being made to revise the training programme and introduce annual face to face training in both these areas. There was evidence that staff were encouraged to undertake nationally recognised qualifications in health and social care and a number of staff were currently studying for these.

Staff received supervision and an annual appraisal. The manager had recently redesigned the supervision template to ensure that this prompted discussion of best practice in key areas such as safeguarding people from harm and dignified practice. The staff member's training needs and any areas for development were also explored. All of the staff we spoke with told us they received adequate supervision and found this a useful and supportive process. They also told us the manager was always available to support and guide them in between formal sessions. For example, one staff member said, "Their door is always open, any questions will be answered". Staff also had an annual appraisal which included feedback on their performance and a review of how they were working toward learning and development goals.

People told us the food provided was tasty. One person said, "The food is excellent, the chef comes round and asks what you want, if you don't like it, they will find something else". Another person said, "It has never happened that I don't like the food, we have snacks in between our meals with tea and coffee, I'm satisfied

and happy". A third person said, "Breakfast here is a big meal, we have a good choice. I prefer to have Cheerio's each morning….there is a good level of choice".

We reviewed the menu for the week of our inspection. This showed that people could have a variety of breakfast foods including a cooked breakfast. There was a choice of two main meals at lunch time. For example, on the first day of our inspection, people could choose from either quiche and vegetables or tomato pasta and garlic bread. Dessert was rhubarb crumble or ice cream. Some people chose to have wine with their meal, but a variety of squashes was also available. Tea and coffee was served following the meal. Staff were available throughout the lunch-time meal offering condiments and drinks. Supper was usually sandwiches or soup. A selection of hot and colds drinks were provided throughout the day and a bowl of fresh fruit was readily available for people to use as they wished. Tables were laid with cloths, fresh flowers, serviettes and condiments. Each person had a named place card. Plate guards and adapted cutlery were used by some people and helped them to continue to eat independently.

Most people were able to eat and drink independently, but staff were aware of those who might need a little extra encouragement and provided this where needed. People's weight was monitored regularly to assist in identifying whether they were at risk of malnutrition and each day a member of staff was given the lead role of ensuring that people received regular fluids. Where people had lost weight this information was shared with the chef so that fortified diets could be offered and if necessary food and fluid charts were completed. We did note that fluid charts did not include a target fluid intake and the daily total fluid intake was not being recorded. This limits the effectiveness of the charts as a monitoring tool. The manager told us they would ensure changes were made to improve this.

Where necessary a range of healthcare professionals had been involved in planning and monitoring people's support to ensure this was delivered effectively. The provider had made arrangements for the GP surgery to undertake a weekly clinic at the service. Records showed that staff referred people to the clinic if they had concerns about issues such as weight loss, increased confusion or to discuss falls. Clear records were maintained of the consultations. A healthcare professional told us, staff were "Timely and appropriate when seeking help" and were "Very willing to learn and provide appropriate [healthcare] observations…..I really believe the [weekly clinic] has improved the residents' care as well as helping with education of staff".

People were also supported to see other healthcare professionals such as the community nursing team, opticians, oral hygienists, and chiropodists. One person told us, "I have had a few falls which is why I have my frame but the staff are always very good…I know if I were to speak with staff about being in any pain they would help me, they are all so good and if I have any worries or problems the staff are there and they listen to me". A relative explained how staff had recognised that their family member had been unwell and had arranged for the GP to see them that day. They told us, "They [the staff] were on to it so quick". Staff had developed a hospital pack that was sent with the person in the event that they needed to be admitted to hospital. The pack contained key information about the person, including their medicines and family contacts. This helped to ensure that the transfer of care was managed in an effective manner.

Good

Is the service caring?

Our findings

People told us they were cared for by staff who were kind and caring. One person told us, "The staff are very kind and caring, nothing is too much trouble". Another person said, "The carers are so lovely and kind, I couldn't wish for more. I have introduced three people to come and live here, the most important thing is the care you get and how you are treated, and it really is perfect the best! The manager pops in and has a little chat with me, at lunch time she asked if I like the new menu…I feel like one of the family, staff bring in their children and show me pictures of them, it's like one big family really". A relative told us, "Yes the staff are kind and caring, I have never heard anyone lose their temper, they stay calm…I wouldn't want mum anywhere else, they have a good reputation in the local community". Another relative told us, "They [the staff] make a big fuss of people on their birthdays, make them feel special". A staff member said, "Without a doubt [staff] are kind and caring, if not I would stop it immediately or the residents suffer".

Our observations indicated that staff showed people kindness and patience. For example, we observed that throughout the first day of our inspection, one person was frequently anxious and sought constant reassurance from the staff. Each time, staff responded to the person in an attentive manner, holding their hand, reassuring them in a kind and caring manner. At no point did staff dismiss the person's anxieties; each repeated interaction was person centred and comforting, enabling the person, for a time, to become a little more settled.

The manager and staff all showed a genuine interest in the people they supported. We saw a considerable number of warm and friendly exchanges between staff and people and the atmosphere in the communal areas was good natured and sociable. People looked relaxed and happy in the company of the staff who throughout our visit appeared attentive and happy in their work. The wider staff team were also observed to be kind and caring. For example, we saw the chef holding one person's hand, reassuring them when they were upset. The maintenance man greeted each person, asking how they were and engaging them in conversation. A member of staff told us, "The maintenance man is brilliant with people". We observed that one staff member ate their lunch with people, sharing conversation with them. Staff spoke fondly about the people they supported and it was clear that they knew them well and had developed a meaningful relationship with each person. A staff member said, "We know them well, we always have a little joke".

Relatives and visitors were free to visit at any times and told us they were warmly welcomed by staff. They praised the homely nature of the service which was also commented on by people. One person told us, "There is nothing better, its not too high brow, so friendly… you can do what you want". This was echoed by a staff member who told us, "I love it here, it's not institutionalised at all…it's a home from home".

People, and their relatives, were involved and engaged in making decisions about the care and support provided. For example, people took part in the recruitment of new staff. The menu had recently been adapted following discussion with people. One person told us, "The staff always talk to me about my needs, for example; when I needed the stand aid they talked me through it and explained how it would help, I am so happy here, obviously I didn't want to leave my own home but really it's so lovely here, the doctor or nurse is called in if need be and the staff always tell me before doing so, they keep me informed all the way".

People told us they could choose how to spend their time, for example, one person said, "They [staff] respect my privacy because we all need time to ourselves. I get up when I choose and go to bed when I choose; it's entirely up to me. My friends and family can visit when they choose, they are always made to feel welcome".

Staff supported people in a way that maintained their independence. For example, people were encouraged to get involved in daily chores such as laying the tables, folding linen and helping with serving the biscuits at coffee time. A care worker said, "[the person] likes to help giving out the sandwiches, it's nice for them to be able to". Care plans clearly noted the tasks that people could manage independently and those with which they needed help. For example, one person's dressing care plan stated, '[the person] is independent and will choose own outfits'. A staff member told us, "I encourage them to be independent; I will wet the flannel and ask them if they can wash their face". Another care worker said, "Some people like to dry certain parts themselves, I wouldn't just do it for them, its important they do as much as they can for themselves".

People felt that staff respected their privacy and dignity, for example, one person told us, "They [the staff] are respectful, understanding and know how difficult it is for a person to need help with their personal care". Another person told us, "The staff are aware that I like to be left alone and respect my privacy, they come and check on me and I also see them when they bring my meals to me". Staff were able to give examples of how they maintained people's dignity through the way in which they supported people. For example, one care worker told us, "I always keep [people] covered, always place a towel over their lower half when being washed". A healthcare professional told us how staff always ensured people were supported to a private area where their health needs were being discussed. The service user guide given to people when they first started to live at the home included information about the 'The Dignity Code'. This clearly described that people could expect to have their privacy respected and to have their choices and decisions respected. 'Show respect' posters were on display around the home, reminding staff and people of the central place of respect within the ethos of the service. Our observations indicated that staff acted in accordance with this ethos. The manager explained that it was their intention to appoint and train a dignity champion within the service who could act as a role model to the rest of the team. They also planned to get people and their relatives involved in developing a dignity tree. Dignity trees are a way for people to write down what dignity means to them and for their views, opinions and wishes to be displayed to remind staff why dignified care is so important.

People were supported to follow their spiritual beliefs. Once a month, there was a Christian communion service held. People were supported to attend other local churches if they wished. Arrangements were being made to work with people and their relatives to develop end of life care plans which gave the person, as far as possible the opportunity to plan and make choices about how and where they would like their care to be managed in their final days and what they would like to happen after their death.

Good

Is the service responsive?

Our findings

People and their relatives told us they received care that was responsive to their needs and wants. One person said, "They [the staff] are very competent, very responsive". Another said, "I have nothing to grumble about, if you ask for anything, they will do it, they deserve a gold medal, they are very, very nice". People were positive about the activities provided. One person said, "We do all sorts of things here, we play skittles, we do colouring and occasionally we have outings: We've been to Netley Shore, Haskins Garden Centre and the other day staff took me out for a walk into Botley. We have a man come in sometimes with Birds of Prey, he's coming in again soon, I think its tomorrow. We're never bored….If there is anything we would like to do we only have to ask and staff will organise it, oh yes, there are quiz evenings too!"

People's needs were assessed before they moved into the home. This helped to ensure that staff had key information about the person and helped to ensure they could meet their needs. The manager involved the person and their relatives, if appropriate, in the assessment and planning care process. Care plans contained information about the person's life before coming to live at the service and staff were able to use this to engage with the person in a meaningful way. For example, a care worker said, "I like reading about their life story, its something to talk with them about, for example if you speak with [person] about their sons they become a completely different person".

Care plans included some specific, individual information, about the person such as food likes and dislikes and their preferred routines including when they preferred to get up or go to bed. People's personal interests were noted and a record kept of their spiritual needs. For example, we saw that one person enjoyed hockey and that their faith was very important to them. Where necessary, people had condition specific care plans which described how staff might best support the person with this need. For example we saw that one person had a dementia care plan which guided staff to talk to the person about their family, their childhood and their time spent as an auxiliary nurse. Another person had an arthritis care plan which described their need for regular pain relief. This enabled staff to have a good knowledge and understanding of the people they were supporting and helped to ensure people received care and support which was responsive to their needs. The care plans viewed were up to date and reflected people's current needs.

People had key workers who worked more closely with the person so that they became very familiar with their needs and wishes. They were also responsible for supporting people to take monthly outings into the community and for ensuring that the person had all of the toiletries and personal items they needed. During each shift staff maintained records which noted the care that had been provided to each person, how they had eaten and what activities they had been involved in. Staff were prompted to record whether there were any concerns about the person's skin or whether anything out of the normal had occurred. A handover was held at each shift change which helped to ensure staff were kept up to date with people's changing health and welfare needs.

All of the people and relatives we spoke with were positive about the quality and quantity of the activities. One person said, "There are lots of things to do here, the garden is lovely we go out there when the weather is nice". A relative said, "There is something on every day, they get bingo or jigsaws out, try things with

them". They told us how staff had dressed up as elves on Christmas day which had helped make the day fun for people. Whilst there was no designated activities staff, the care staff were able to spend time leading a variety of activities and a range of outside entertainers also visited the home. We observed staff doing quizzes and art work with people. A rummage box was available and staff used this to engage people in discussions about the past which they appeared to be enjoying. A care worker told us, "[person] really likes chores, [person] really likes cooking and gardening, I got [person] knitting the other day". External entertainers were booked most days and included, singers, musicians, exercise classes and visits from animals such as birds of prey. Where people chose to spend time in their room, a member of staff was allocated to make regular contact with them to ensure they were well and not at risk of becoming isolated. If they wished, people were supported to take trips out into the local community. For example, during the inspection, one person visited the local pub for a hot chocolate. A relative told us how staff had taken one person out for a walk the previous Sunday and often took their family member to church on Thursdays if there was staff capacity. They explained that staff had also taken a group of people to a local remembrance day parade which they had valued. A health care professional told us that a particular strength of the service was "Lots of community activities which are well received by the residents".

Birthdays were celebrated and people had been invited to share their favourite meal so that the chef could prepare this on their birthday. Other special events were also celebrated. Roses had been purchased and had been arranged by a person and used to decorate the tables for Valentine's day. Green table clothes and themed food were put on for St Patrick's day. Burns night and Chinese new year had also been celebrated in January 2017. Staff facilitated a gardening club which had recently planted some hyacinth bulbs. Raised beds were available for people to grow vegetables or fruit and a 'Flower of the month' was chosen and samples of that flower used to decorate the lounge and to serve as a talking point. There were lots of photographs displayed which demonstrated that people enjoyed the activities provided, for example, there were pictures of people carving pumpkins. Themed afternoons were being introduced, celebrating people's travels by having music and food from particular countries. People had been asked to suggest which countries they would like to celebrate first. Staff had started producing a newsletter which was shared with people and their relatives. It contained updates on staffing and training that was taking place as well as information about the gardening club, birthday celebrations and any new faces joining the home whether it be a person or a staff member.

People and their families were asked to give their views and feedback about the care and support they received. The manager told us it was important to them that people really got involved in all aspects of the home and it was clear from minutes of meetings that their views were valued and acted upon. For example, people had discussed and proposed changes to the lunchtime menu, these had been acted upon. People had suggested place settings be available for mealtimes, the manager had put these in place. Two people had commented that they had enjoyed a particular activity and so this had been arranged and was taking place on the day we inspected.

People were provided with annual opportunities to give formal feedback about the service. We reviewed the responses from the most recent survey undertaken in February 2016. These were all very positive with comments including, 'Always offered ample food', 'Staff are aware of my preferences' and staff were 'Lovely and helpful' and 'Can't do enough for me'. The service had also received a number of compliments and thank you cards and letters. For example, a relative had written, 'The heartbreak was eased by knowing she had people who greatly cared for her as a person'.

Information about how to make a complaint was freely available within the service and within the service user guide. One person told us, "I know I have nothing to complain about but if I did I would speak to the Manager, she regularly tells me to tell her if I'm not happy with anything. She is most concerned for us all

and wants us to be cared for and be happy". Whilst no complaints had been made, the manager was able to describe how these would be documented, investigated, acted upon and used to improve the service.

Requires Improvement

Is the service well-led?

Our findings

Further improvements were required with regards to medicine management. Whilst medicines audits were undertaken, these were not being fully effective at driving improvements with regards to the safe use of medicines. We found a breach of the legal requirements regarding the safe and proper use of medicines. We have therefore rated this key question as requires improvement.

Other aspects of how well led the service was were good. The manager had only been working within the service full time since December 2016, but already, people and their relatives spoke very positively about them and about how well organised and managed the service was. One person told us, "I know the Manager well, we all talk together, she comes to see us and asks how we are. We all know each other here and everyone is friendly". Another person said, "The Manager is just a nice person, full stop! She is approachable and you can chat with her, she's one of us. I can't see in any way how the home could be improved, so much has been done along the way, it's really good." A third person said, "The manager is always around somewhere, she's very approachable and nothing is too much trouble for her. I can't honestly see how there could be any improvements made to the home, it's all so good, I have no complaints". A relative said, "I know I can talk to her [the manager], she responds to queries".

Staff were positive about the leadership of the service. One staff member told us, "Yes they are a good leader, more hands on…will come and help". A second member of staff told us, "It's an amazing service, the things I have seen here are great…there's no limitation on budget, everything is provided. Another staff member said, "I am really proud to work here". Staff told us they received regular support from the management team and that morale amongst the staff team was good. One staff member said, "I am really happy, we have tiny little bickers, but we all get along". Staff were aware of the provider's whistleblowing policy and felt confident going to the manager with any concerns or ideas. They all felt the manager would listen and take action when necessary. Staff meetings were held on a regular basis and were used to discuss matters such as the standards of care within the service and to reinforce best practice. For example, we saw that the last staff meeting had been used to reflect upon the actions needed in the event of an outbreak of an infection within the service". Staff felt the manager communicated with them well, for example, one staff member said, "We are kept in the loop, they [the manager] are very good with communication, we feel able to make suggestions, [the manager] loves ideas".

There was evidence that the manager understood their role and responsibilities. They had notified the Care Quality Commission (CQC) about important events, which the provider is required to send us by law. This enabled us to effectively monitor the service or identify concerns. The manager had worked effectively with health and social care professionals to investigate and learn from events that could impact upon the safety of people. There were systems in place to assess and monitor the quality and safety of the service and to ensure that people were receiving safe and effective care and support. A range of audits had recently been completed and were designed to assess whether the service was safe, effective, caring, responsive and well led. The audits included speaking with people as well as reviewing records and therefore helped to ensure that people's views about their care remained an important focus for the audits. Where the audits had highlighted that improvements could be made, an action plan had been developed. For example, we saw

there were plans to work with people to develop end of life care plans by March 2017.

The manager had already gained a good insight into the strengths of the service and the areas where further improvements could be made. They told us they were proud of how person centred and homely the culture was within the home. They told us they wanted to build on this by continuing to ensure that people were at the centre of the service and involved and consulted about matters that might impact upon them. The manager had a clear vision for the future of the service, which they said was shared by the provider. They had developed an action plan which detailed the areas where further improvements could be made, the steps needed to deliver these and a clear time scale for completion. These future improvements included; developing a team of volunteers, looking at options to take on a local allotment, appointing staff to particular lead roles, updating the care plan format and involving the senior care team in writing and updating care plans. The overall aim though was to maintain the homely nature of the home and through careful assessment, ensure they achieved the best balance possible between people who were more independent and those living with more complex needs, so that this did not negatively impact on either.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safe and proper use of medicines. Regulation 12 (2) (g).