Alton Manor Limited

Alton Manor Care Home - Portsmouth

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 26 and 27 November 2018 and was unannounced. Alton Manor Care Home is registered to provide accommodation and personal care for up to 34 older people including people who may be living with dementia or other mental health conditions.

Alton Manor Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Alton Manor Care Home is situated in a residential area. The accommodation is arranged over three floors of a large, converted Victorian building with stair and lift access to all floors. At the time of our inspection there were 31 people living at the home.

There was a registered manager in place. 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.

We previously inspected Alton Manor Care Home on 10,11 and 26 May 2016 and rated the service as Good. At this inspection we found evidence that demonstrated risks or concerns. This was because risks to people were not assessed, monitored and mitigated effectively and medicines were not managed safely. We also had concerns that the principles of the Mental Capacity Act (MCA) 2005 were not followed and the requirements of the duty of candour had not been met. The provider did not have effective quality assurance processes in place to identify these concerns. The overall rating of the service has changed since our last inspection to 'Requires Improvement'.

Risks to people were not always managed effectively. Clear plans and records were not in place for people at risk of choking, falls and risks associated with specific health conditions. This meant staff did not always know about risks to people and how to manage or mitigate them.

The administration of medicines was not managed safely. This had not been identified by the service because effective checks had not been undertaken.

There was not a robust quality assurance process in place. Systems to assess the quality of service provision were ineffective in identifying some of the improvements needed. The provider had not followed legislation that required them to act in an open and transparent way when people came to harm.

Staff sought verbal consent from people, before providing support, but did not always follow legislation designed to protect people's rights when making decisions on their behalf. Care plans lacked mental capacity assessments and there was no record that people had consented to their care at Alton Manor Care Home. All people with the exception of one had a Deprivation of Liberty Safeguard (DoLS) applied for when necessary. Staff were not aware of who had a DoLS in place in the home.

Care plans contained information about how to support people but areas of these needed to be more personalised and detailed to ensure people received support in a person centred way. We have made a recommendation about this.

People's communication needs were recorded in their care plans. However, we have made a recommendation that the service consults guidance to further develop their practice in accordance with the Accessible Information Standard (AIS).

People had access to external healthcare professionals such as GPs and nurses when needed but were not referred to the falls prevention team or speech and language therapists when risks were identified in these areas. This meant appropriate guidance was not always sought to safely support people.

Accidents and incidents were recorded and monitored to determine if any trends were occurring for individuals but accidents and incidents were not analysed at a service level which meant improvements could not be made across the service because trends and patterns were not identified.

Feedback about the food on offer was positive and people were given a choice. Where people needed support to eat, this was given in a dignified way.

The home was visibly clean and staff used protective equipment when needed. Staff were seen to follow infection control procedures during the inspection.

People and relatives were complimentary about the staff. All interactions we observed between staff and people were positive. Staff promoted people's privacy and dignity and encouraged people to remain as independent as possible. However, people's confidential information was not stored securely which compromised their privacy.

Staff displayed good knowledge on how to report any concerns and could describe what action they would take to protect people from harm.

Safe recruitment processes, including pre-employment checks had been followed and sufficient staff were deployed appropriately. Staff were supported by regular supervision, appraisals and training.

People, relatives and staff were positive about the leadership of the home and told us the registered manager was supportive and approachable.

Due to the concerns we found we made a referral to the Local Authority. We requested that the provider took action to address some of the concerns we found. Following the inspection, we received confirmation they had reduced risks to people because they had improved their practice.

During our inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 that all risks to people's safety and welfare were assessed, monitored and mitigated appropriately.

Medicines were not always managed safely which put people at risk of not receiving their medicines as prescribed.

People told us they felt safe and staff were aware of the procedures to follow regarding safeguarding adults.

Staff were recruited safely and there were enough staff appropriately deployed to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always follow legislation designed to protect people's rights.

People did not always have access to external healthcare professionals to support them effectively when needed.

People were provided with a range of nutritious food and people were positive about the meals.

Staff were appropriately supported in their role and arrangements were in place for them to receive training, supervisions and annual appraisals.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had not always ensured that people received a caring service because of their lack of oversight.

The provider had not considered how to implement the guidelines of the Accessible Information Standard and we have

made a recommendation about this.

People were encouraged to be independent. People's privacy and dignity was mostly respected but information about people was not stored confidentially.

People and relatives told us staff were kind and caring. Observations reflected people were comfortable and relaxed in staff's company

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were needed to ensure care plans were detailed and personalised. People's specific health conditions were not always included in care plans. This meant that staff did not always have guidance on how to support people's individual needs and preferences. We have made a recommendation about this.

The service was not supporting anyone at the end of their life; improvements were needed to ensure end of life care planning was person centred.

People knew how to make a complaint and complaints were investigated and resolved for people.

People were supported to take part in a wide range of activities and people told us they enjoyed these.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audit and monitoring systems were not effective in ensuring that the quality and safety of care was consistently assessed, monitored and improved.

Feedback about the service was sought but there was no system in place to ensure feedback had been acted on.

People had not been supported in line with the requirements of the duty of candour when they had sustained a serious injury.

People, their relatives and staff were positive about the leadership at the service. Staff felt supported by the provider and registered manager.

The provider was responsive to our concerns and put measures in place to improve the quality and safety of the service, however further work was needed to embed this.	

Alton Manor Care Home - Portsmouth

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 was unannounced and was carried out on 26 and 27 November 2018 by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of services supporting older people and people living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 12 people and three relatives of people living at the home. We spoke with five members of staff, the registered manager and the providers representative. We observed care and support being delivered to people in the communal area of the home.
We looked at the care plans for six people and medicine records for all the people in the service. We additionally looked at other records related to the running of the service, including staff recruitment, rotas, supervision and training records, accidents and incidents, complaints, policies and procedures and quality assurance records.

We asked for some information to be sent to us after the inspection visit. This information was received.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they were safe living at Alton Manor. One person told us, "Oh yes, I've felt very safe here, all the staff help us to be safe" and another person told us, "I feel absolutely safe here". Despite people's positive feedback, we found areas of care which were not consistently safe.

Risks for people had not always been assessed, monitored or mitigated appropriately. Sufficient action had not been taken to reduce the risk of choking for people living in the home. For example, the registered manager told us that one person was at risk of choking, however there was no risk assessment in place and we found staff were not always aware of the type of food this person could have. The registered manager told us that two further people were having a pureed diet because they struggled with food but they were not at risk of choking, however, some staff members told us they were at risk of choking. There was insufficient information in these peoples care plans about the type of food they needed, the reasons why and what support they needed. Staff provided us with conflicting names of people at risk of choking and this information was not provided on the handover sheet or in any other accessible area. A choking screening tool had not been used for any people at Alton Manor and the Speech and Language Therapy Team (SALT) had not been consulted about how to support people who required a modified diet. This meant people were not protected from the risk of choking.

Risk assessments regarding people's health conditions were not in place. For example, one person lived with diabetes but there was no risk assessment in place despite the person's pre-assessment detailing they were at risk of their blood sugar falling too low. If a person's blood sugar falls too low, they are at risk of having a hypoglycaemic episode and could become critically unwell. They would require staff to know the signs to look out for and to take immediate action. Whilst staff had received diabetes training, this training did not provide them with the underpinning knowledge required to safely identify the symptoms and causes of a hypoglycaemic episode. Robust care plans had also not been implemented to guide staff which posed a risk of people not receiving safe care and treatment.

The risk assessments that were in place were not always reflective of people's current needs. For example, on one person's falls risk assessment it was recorded that it was unlikely this person would fall and the risk was low but they had fallen twice in the last month. Another person had a skin integrity assessment tool in place but this was completed incorrectly. This scored the person as being at no risk of skin breakdown, but if the assessment had been completed correctly, the risk of skin breakdown would be classed as 'At risk'. Guidance was available on the skin assessment tool for people at risk of skin breakdown but this was not followed because the assessment had been completed incorrectly. This meant that effective measures were not in place to reduce the risk of harm for these people.

We brought the above concerns to the attention of the providers representative who was responsive to our concerns. Following the inspection process, they began putting measures in place to ensure risks to people were assessed, monitored and mitigated for people in a safer way. Support was also sought from the local authority.

Records demonstrated that people had experienced unwitnessed falls in the service and had also sustained an injury to their head following a fall. The National Institute of Clinical Excellence (NICE) guidance states medical advice should be sought if staff are not clinically trained to undertake neurological observations themselves. This is to ensure appropriate action is taken if an actual or potential head injury has occurred. The staff were not clinically trained to undertake neurological observations and they confirmed they did not request a review of medical attention for people when they had experienced an unwitnessed fall, or when they had sustained a head injury. This meant people were at risk of harm caused by a lack of clinical advice following an unwitnessed fall or head injury. Following the inspection, the providers representative informed us they had updated their falls protocol which included ensuring people were clinically assessed following an unwitnessed fall or head injury.

There was an accident and incident book in place and the registered manager had investigated the accidents and incidents that were recorded in it. An analysis of falls for individuals took place on a monthly basis and some measures were put in place to reduce the falls for people. However, we found that accidents and incidents were not analysed at a service level. This meant that trends and patterns such as times or places that people fell had not been considered and therefore, measures could not be put in place to reduce accidents across the service.

The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, for other people, comprehensive plans were in place to reduce their individual risks; they had been provided with specialist equipment where needed and staff took all necessary action to protect them from harm. For example, some people had falls prevention technology in their rooms after experiencing a number of falls. Risks posed by the environment were also managed effectively. A programme of health and safety checks was conducted; this included regular testing of electrical equipment, hoists, call bells, hot water temperatures and fire safety. A risk assessment regarding the environment was in place. Staff were clear about the action to take in the event of a fire and people had personal emergency evacuation plans (PEEPs) in place. PEEPs describe the support and assistance that people require to reach a place of safety when they are unable to do so unaided in an emergency.

People were not adequately protected against the risks associated with the unsafe management of medicines. We reviewed the Medicine Administration Records (MAR). We found occasions where medicines had not been administered for the length of the MAR cycle even though the MAR stated they were prescribed for people to take. For example, two people were prescribed a nutritional supplement but this had not been administered and another person was prescribed Paracetamol but this had not been administered. A staff member told us this was because it stated, 'None supplied this month' on the MAR so they felt these medicines were not to be administered. The registered manager confirmed that these medicines were not required for these people but unclear directions on MARs could cause confusion. We discussed our concerns with the registered manager and they told us they would make the MARs clear.

We noted that some medicines had been handwritten onto the printed MARs from the pharmacy by staff administering medicines at the home. Most had not been signed by the member of staff adding the medicine or countersigned by another member of staff to confirm the instructions were correct, as is best practice considered by The National Institute for Health and Care Excellence (NICE). Some tablets were prescribed to be taken as either one or two. Staff had signed the MAR but had not recorded whether they had given one tablet or two. This meant that it could not be determined how many tablets people had taken.

Some medicines are prescribed to be taken when required. These are used to treat short term medical conditions or long-term conditions when people may experience increased symptoms such as medicines to manage agitation, anxiety and pain. Records showed that when people were prescribed these medicines, information was not always available to guide staff as to what the medicine was for, when and how much to administer. This meant there was not guidance in place for staff to know when and how much of a medicine to administer for a person. When staff had administered these medicines, they had not recorded the outcome for the person after receiving the medicine. This meant the efficacy of the medicine could not be reviewed.

Some people were prescribed creams to alleviate skin conditions, these were usually applied by care staff. We found gaps on the topical MARs which indicates people may not always have had these creams applied.

We brought the above concerns to the attention of the providers representative who was responsive to our concerns. Following the inspection process, they began putting measures in place to manage medicines in a safer way and support was also sought from the local authority by CQC.

The failure to protect people from the risks associated with the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Some people displayed behaviours that challenged. People had risk assessments that detailed how to safely manage those behaviours. A behaviour chart outlining triggers, behaviours observed and action taken was currently not used for people with behaviours that challenged. This meant that learning may not have always been achieved because successful techniques to de-escalate behaviours had not been recorded. Despite a lack of detail around specific incidents we saw that staff interacted well with people who displayed behaviours that challenged, for example one person was becoming agitated at lunch time and a staff member used a successful de-escalation technique which calmed the person.

People were protected from the risk of abuse because staff understood how to identify and report it. Staff told us they had received safeguarding training and knew how to report any signs of abuse. Additionally, staff told us they felt confident to raise any concerns about poor care. All of the staff said they believed that any concerns they raised would be taken seriously. One member of staff told us, "I've had safeguarding training; if I had a concern I would go to the manager or take my concern to CQC". Another said; "I'm confident any concerns would be dealt with by the manager".

Staff had been recruited through a recruitment process that ensured they were safe to work with people at risk. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks would identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Suitable references were obtained and any gaps in recruitment history were thoroughly explored. There was a record of staff being interviewed to assess their suitability for the post.

There were enough staff deployed to meet people's needs. People were happy with the amount of staff who were available to support them. Staff told us staffing levels were satisfactory but they did need to rely on agency staff at times, particularly at the weekends. Throughout the inspection observations reflected that staff responded promptly when people needed their support.

People were cared for in a clean home. Cleaning schedules were in place and records confirmed these were followed. Staff were clear about how they processed soiled linen and appropriate laundry procedures were in place to prevent cross contamination. Staff were seen to use personal protective equipment (PPE) where

this was needed and staff had received training to ensure they had knowledge of infection control procedures.

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care from staff. One person told us, "The staff are well trained" and another said, "The staff are very good, they are attentive to my needs".

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 as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us that staff always gained their consent before providing care or treatment. However, signed consent for care and treatment was not clearly documented before people started living at Alton Manor. It was not always clear if a person had capacity to make decisions or not. The care plans that we looked at contained the following statement at the beginning of each section; '(Name) has some capacity to understand and make simple care decisions, however, there are some aspects in this care plan where staff need to make best interest decisions because understanding is limited'. The care plans of these people did not have any mental capacity assessments in place to determine their level of capacity to make decisions about these areas of care and support. There were also no examples of best interest decision making on behalf of people who may lack capacity to agree to the delivery of their care. For example, the registered manager told us that one person was having a pureed diet because the staff at the service decided it was easier, however, there were no consideration of the MCA 2005 when this decision was made.

The only mental capacity assessments in place were in relation to the use of sensor mats. Where it was determined that people lacked capacity to make a decision regarding the use of these, a letter was written to the person's representative to sign their consent. However, there was no record in people's care plans that these representatives had the legal right to make decisions on their behalf. The registered manager told us that some evidence of this was in another file but sometimes families did not tell them who had the legal right to make decisions on behalf of people. This meant that consent may have been sought from people who did not have the legal right to do so.

DoLS authorisations had been obtained, or were in progress where needed for all people in the home with the exception of one. We saw that one person had a DoLS applied for in 2016 which had not been authorised because they were assessed to have capacity to make a decision about their living arrangements at that time. We asked staff during the inspection process if this person would be able to leave the building unaccompanied and they told us that they would not, because they would be unsafe. This meant that this person may not be legally deprived of their liberty. We discussed our concerns with the registered manager who confirmed a DoLS had not been resubmitted when the person's needs had changed. They confirmed

that they had applied for this person's DoLS following the inspection.

Staff had received training in the Mental Capacity Act 2005 and DoLS, however, staff had a limited understanding of the Mental Capacity Act 2005. One staff member told us, "I think I've done some training on it but I can't remember what it really means". Additionally, the staff in the home were not sure who in the home had a DoLs in place. This meant that people's rights in relation to making decisions could be compromised.

Following the inspection, the providers representative responded to our concerns and told us they had organised further training for staff and would review their procedures and records to ensure the principles of the MCA were followed.

The failure to work within the principles of The Mental Capacity Act was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An assessment of need took place prior to people living at Alton Manor Care Home. Staff completed regular assessments of people's ongoing needs using recognised tools for areas such as nutrition and skin integrity. However, evidence based guidance was not followed in relation to other areas such as choking, the management of falls and medicines management. This meant people were placed at risk of harm. The providers representative confirmed following the inspection that they had begun to use evidence based recognised guidance to ensure effective outcomes for people.

People and relatives spoke positively about the meals, one person told us, "I've always enjoyed the food, never complained about anything" and a relative told us, "Mum eats well, she seems to like the food and has put on weight". We observed lunch on the first day of inspection. Some people ate in the dining room, others in the lounge area and some in their room. The atmosphere was pleasant and relaxed. Staff were on hand to support people to eat as needed.

If people did not want the meal they had selected, staff told us they could make an alternative choice. One person confirmed this and told us, "You can have something else if you don't like what's on the menu". People told us they had enough to drink and could have tea or coffee whenever they wanted. We observed that people were offered refreshments on a regular basis throughout the inspection.

Staff monitored people's weight regularly and records demonstrated people maintained a stable weight. Some people's fluid intake was being recorded if they were at risk of dehydration and we saw from these records that this was monitored well and people had enough to drink to remain hydrated.

People were supported to access some external healthcare services. We saw people regularly saw doctors, specialist nurses and mental health professionals. However, people were not always referred to SALT and the falls prevention service where risk was identified. This meant guidance was not sought to support people effectively in these areas. Following the inspection, the provider told us they had referred people to external healthcare professionals in line with their needs. Staff felt they worked well as a team to ensure everyone was aware of a person's support needs or any change in these. Handovers took place between shifts and a communication book was used each day to share messages.

The service met people's needs by suitable adaptation and design of the premises, which included appropriately adapted bathrooms to manage people's needs effectively. Efforts had been made to make the home dementia friendly. People's names and some pictures were on their bedroom doors, pictures of film stars were put on the wall in the lounge and people's artwork was displayed in the dining area. Some

signage was in place to help people orientate themselves and a date/time/weather board was on display. People were also able to personalise their rooms as they wished. However, more was needed to continue with this. For example, using different colours to distinguish areas and using sensory and comfort items to stimulate thoughts and memories, which are important when caring for people with dementia.

New staff completed an induction when they first started which consisted of a local introduction to the service as well as the completion of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Staff told us they felt the training they received supported them in their roles and enabled them to work well with people. The registered manager held a record of all staff training and we saw that the provider offered training in a variety of subjects including safeguarding, fire safety, first aid, choking and moving and handling training.

Staff told us they received regular supervisions and had an annual appraisal. Supervision and appraisal records were in place and confirmed what staff told us. This was a formal process which provided opportunities to check performance and ensure staff were being appropriately supported. All staff told us that these were useful and also felt able to raise issues or concerns with the management team in between supervision times.

Requires Improvement

Is the service caring?

Our findings

People, relatives and staff told us people were supported by kind and caring staff. One person told us, "The staff are lovely, they are very caring", a relative told us, "Most of the staff are very caring, yes, they are very good". However, despite people's positive comments about the staff team, we identified areas of practice which were not consistently caring. The provider and registered manager had not ensured people were adequately supported in terms of protecting their rights or ensuring that medicines and risks were managed safely. We have discussed the associated risks of this within the 'Safe' and 'Effective' section of this report.

Under the Accessible Information Standard (AIS) it is a requirement that the provider consider the communication needs of all people, ensuring that information is presented in a way that meets their individual needs and preferences. People's communication needs were documented in the care plans. However, the provider had not always considered how to make information accessible for people and the registered manager was not able to provide any examples of how this act was adhered to.

We recommend the provider adheres to the Accessible Information Standard to ensure information is made available in a format that people understand.

The registered manager told us that people were involved in making decisions about their care and were involved in the implementation and review of their care plans. However, there were very few signatures from people in the space provided in the care plans to demonstrate they had been involved. People were not able to tell us how this process worked, it was therefore difficult to assess how people had been able to express their views and whether they had been acted on.

People's religious denomination was recorded on their care plans. However, we saw from the care plans we looked at that all people's spiritual care plans were very similar. Although it was documented that 'staff need to listen to (Name) if they wish to talk about their religion or help them access the church if they wished, there was no evidence that staff had actively explored people's religious needs with them or identified how they could support them in this area. People with dementia may not always be able to initiate these conversations and it would be important for staff to facilitate these conversations to ensure people's needs are met in this area. The registered manager told us a church service was held in the home every month, however, there was no record about who attended or whether people required any different or additional support to follow their faith.

People's needs in relation to the protected characteristics under the Equalities Act 2010 were not always taken into account when planning their care. The characteristics of the Act include age, disability, gender, marital status, race, religion and sexual orientation. However, we saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this. Staff received training in equality and diversity and they told us that people were treated fairly.

People confirmed they were treated with dignity and respect and their privacy was protected during personal care. One person told us, "The staff are respectful, they have never made me feel embarrassed". We

noted that all personal care took place behind closed doors and observed staff always knocking on people's doors before entering and seeking consent to enter. One person told us, "They do always knock on my door and are very polite and ask first if they can come in". However, we saw that personal information about people was left in a communal area. This meant that people's right to privacy and confidentiality was compromised. We discussed this with the providers representative and registered manager and they told us they would move this information to a secure place.

Staff encouraged people to remain as independent as possible. They encouraged people to mobilise at their own pace, using patient, supportive words and praising people for the effort they made. One member of staff told us, "We try and encourage the residents to be independent, for example, with personal care and walking". One person told us, "As far as possible, I feel I have my independence".

We spent time in communal areas observing interactions between staff and people who lived at the service. Interactions demonstrated that staff knew people well and were caring, kind and patient in their approach. People using the service reacted positively to the staff; they smiled and the atmosphere was warm and friendly. Staff made people feel they mattered by celebrating important events, such as birthdays and people received a birthday cake.

Staff placed value on the relationships they formed with the people within the home. One member of staff told us, "I love getting to know the residents, I love making them happy, we have so many great conversations". Another told us, "The residents are lovely, I enjoy chatting with them".

People and relatives told us relatives could visit whenever they wanted to. One relative told us, "I am made to feel welcome when visiting Mum" and a person told us, "Visitors can visit anytime and are made feel welcome".

Requires Improvement

Is the service responsive?

Our findings

People and their relatives felt staff had a good knowledge of the needs of those they supported. One person told us, "Staff understand me and what I want" and another person said, "I do get what I need here".

Assessments were undertaken to identify people's support needs and care plans had been developed outlining how these needs were to be met. Care plans contained information for staff about how to meet people's needs in a variety of areas, including washing and dressing, eating and drinking, communication and mobility.

Care plans were not always person centred. Care plans did not contain information about people's health conditions. There was no information about how these conditions affected people, any associated risks from their health conditions or guidance on how best to support them. These conditions included dementia, diabetes, stroke, angina and the need for a catheter. This meant there was a lack of information to guide staff on how best to support people.

Care plans contained some details about people's preferences in relation to how they wanted to be supported, however the level of detail was not always sufficient to demonstrate that the planning process was person centred. For example, although social care plans referred to people who liked to watch TV, their preferred programmes were not documented, nutritional care plans did not detail people's likes and dislikes in relation to what they ate and drank and all care plans stated, 'I prefer to have a shower weekly', but there was no information about a preferred time, what toiletries a person may prefer or the preferred temperature. We looked at the plan for one person's communication needs. It had been documented, 'Staff to be aware (Name) can get anguished. There was no detail for staff about what might trigger the person to feel anguished. The guidance for staff was limited to 'needs reassurance from us'. There was no specific guidance about the best way to reassure the person or how to deal with their emotional needs. We additionally noted that people's end of life and spiritual care plans were very similar each other's.

However, other areas of people's care plans were more detailed and person centred. For example, on one person's care plan it stated, ''(Name) prefers to wear dresses or skirts". There was information about people's daily routines which included when they liked to go to bed and where they preferred to eat their meals. There was also information about people's life history which helped staff get to know people. Additionally, people had a personal planning book which was used alongside their care plan. These contained sections such as 'About Me', 'Important People In My Life' and 'Things That Are Important To Me'. These additional documents went some way to provide staff with information about people that really mattered, however we found these needed to be more detailed to be beneficial.

During the inspection, we observed that staff knew people well and they were mostly able to tell us about people's needs and preferences. However, the service employed agency staff who would need to rely on the care plans to ensure people received care and support in line with their needs and preferences.

It is recommended that the provider seeks guidance from a reputable source to ensure people receive

personalised care that meets their needs and preferences.

People and their relatives were complimentary about the activities in the home. One person told us, "We have a varied programme of activities" and another said, "Staff do well at entertaining us".

We observed a ball game, bingo and a game of dominoes taking place throughout the first day of inspection. The people who took part clearly enjoyed these activities, there was a lot of chatting and laughter. Staff and people told us that events and outings were organised for people according to their preferences. The registered manager told us that one person went out every day as this was their choice. All staff took part in some activities when time allowed. A member of staff told us they enjoyed reminiscing with people and another told us, "I love the fact that we have time to spend with people, we do activities with people in the afternoons".

The provider's complaints policy was on display in the entrance hall. All people and relatives we spoke with told us they would be confident to raise any concerns or complaints with the staff, the registered manager and the providers representative. One person told us, "I've never needed to make any complaints but I do feel I can say something if I needed". We viewed the complaints file and saw that people's complaints were investigated and responded to. The registered manager had put measures in place to reduce the likelihood of these issues reoccurring. The registered manager told us that when they received concerns they did not record these in the complaints file. This meant that there was no system in place to understand any emerging themes or patterns of people's concerns. However, the registered manager told us that any concerns were addressed and resolved for people. One person confirmed this and told us, "I did have a few niggles about the food but they listened and sorted them out".

There was no one receiving end of life care at the time of our visit. We viewed people's end of life care plans and saw that people's wishes about their end of life needs had not been recorded. We discussed this with the registered manager who told us they discussed this area of support with people and their representatives "nearer the time". If people were not offered the opportunity to discuss what they wanted to happen at the end of their lives, before they reached this stage there was a risk that their wishes would not be known. We saw from a survey that a person had expressed a particular wish when it came to their end of life care but this had not been explored. The registered manager acknowledged that people may wish to discuss their end of life plans and said they would facilitate discussions about this with the people who wanted to do so. Where appropriate, there were Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place and staff were confident of the process in place around this. Staff had training in supporting people at the end of their life and the registered manager told us they were supported by district nurses and doctors when people needed end of life care and this worked well.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us they thought the service was well led. One person told us, "The place seems to be run well" and another person told us, "I am delighted to be here, they all make me feel at home and happy, it really is a marvellous place".

Systems and processes were not always effective in monitoring and improving the quality of the service. There were some quality checks in place which included the use of quality and monitoring forms. We found that this system had not identified all the concerns and areas for improvement that we found during this inspection. For example, medicines management, risk assessment, the adherence to the MCA 2005 and personalised care plans.

The registered manager told us care plans were reviewed on a monthly basis, but this did not include oversight of the overall quality of care plans in order to identify areas for improvement, such as including information about people's health conditions and ensuring all care plans were detailed and person centred. There was an additional medicines audit which was completed by the deputy manager but this had also not identified the shortfalls with medicines management.

People and staff told us the provider was in the home frequently and they knew them. However, there were no documented quality checks in relation to the safe and effective running of the home which had been undertaken by them. The provider told us they had enlisted the help of a consultant who carried out quality and safety checks for the service. We saw that when the consultant had identified areas for improvement, measures were put in place to achieve this. However, not all the shortfalls identified at this inspection had been picked up by this process.

The provider engaged people, their representatives, staff and health professionals in the running of the service and invited feedback through the use of questionnaire surveys. Feedback was predominantly positive, however there was no evidence that when individual issues were raised, these were explored or resolved for people: for example, we saw comments such as; 'I would like a catholic priest at the end of my life' and 'I get upset when I wait to go to the loo'.

Meetings were held every six months for people and every three months for staff. The registered manager told us they were used to find out how everyone was, listen to any suggestions and to update people and staff with any changes in the home. People told us they were confident to express their opinion during meetings. One person told us, ""Every few months we have a resident's meeting and we are able to have our say". However, when people expressed an opinion or made suggestions, these were not always followed up. For example, one person had suggested a pub evening but the registered manager told us this had not taken place. Other people had asked for particular meals but there was no recorded evidence that these had been made for people. No action plan was developed following these meetings or surveys, this meant there was no structured system to ensure people's feedback was acted upon or that the provider had used the feedback to drive improvement in the home.

Whilst we acknowledge the providers representative responded and acted during and after our inspection to rectify some of the shortfalls found, the current arrangements for monitoring the quality of the service need to be reviewed and embedded. This is to ensure all areas for improvement are identified, and a clear action plan is put in place to address concerns and evidence continuous improvement.

A failure to have effective systems and processes in place to monitor the safety and quality of the service and to drive improvement was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to act in an open and transparent way when people come to harm. We identified examples of where people had received serious injuries following falls, but there were no records to confirm that they or their relatives had been given information, support or an apology about the incident, as required by the regulation. We discussed the requirements of this regulation with the registered manager and although there was a policy in place regarding the duty of candour, they confirmed that this had not been engaged.

The failure to act in an open and transparent way when people came to harm was a breach of Regulation 20 of the Health and Social Care Act 2008.

The provider did not always work in partnership with other organisations to make sure they were providing effective care for people. People were not referred to the falls prevention team when people were at risk of falls or the speech and language therapists when people were having difficulty eating. The Portsmouth Quality Team had offered to work with the service to help it improve but they told us this was declined. When we asked the provider about this, they told us they were not aware of this offer but would like to work with them in the future. The provider worked with other agencies such as social services and healthcare professionals such as GPs and nurses.

The registered manager and providers representative were consistently described in a positive manner by staff, people and relatives. They were described as open, supportive, approachable and caring. One person told us, "The manager is marvellous and one relative told us, "The manager is very approachable, I'm glad she is here". Staff described the culture in the home as good. One staff member told us, "It's like one, big, happy family here, it's like coming home". Staff members were also complimentary of each other. One staff member told us, "We all work well together, everyone knows what they are doing" and another member of staff told us, "The team is great".

Registered persons are required to notify CQC of significant events that occur in the service. This includes any allegations of abuse, incidents reported to the police and serious injuries. We found that this had been done in line with legal requirements. Providers are required to display their CQC rating at their premises and on their website if they have one and we saw that this was prominently displayed.

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant person. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to ensure risks were assessed and effective plans implemented to mitigate these; to ensure staff had the skills, knowledge and competence to manage risks; and a failure to ensure safe management of medicines. Regulation 12 (1)(2)(a)(b)(d)(e)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The failure to act in an open and transparent way when people came to harm

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to have effective systems and processes in place to drive continuous improvements, to assess, monitor and mitigate risks relating to the health and safety of people.

The enforcement action we took:

We imposed a condition on the provider.