Revitalise Respite Holidays

Revitalise Netley Waterside House

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

Summary of findings

Overall summary

This inspection took place on 2 and 3 February 2016 and was unannounced

Revitalise Netley Waterside House is one of three centres provided by Revitalise Respite Holidays, a national charity providing respite care in a holiday setting for people living with either a physical disability, learning disability, sensory impairment or dementia. The service provides 24 hour nursing care for those that need this. The service can accommodate up to 39 people, although at the time of our inspection there were 35 people staying. Thirteen of these were companions and therefore not receiving care. Two people lived at the centre permanently. Most people booked to come to the service for a week's break and would either come alone or with their main carer. The aim was that during the break, the carer also had respite from their role and was able to take a relaxing break. People staying at the service were referred to as guests and their carers as companions so throughout the remainder of the report we have used the same terminology. The provider operates a large residential volunteering programme and so in addition to permanent staff; guests were also cared for by a number of long and short term volunteers.

The guests staying during our inspection had all booked to attend a specialist stroke week which was being provided in conjunction with The Stroke Association. This was the first time that this particular specialist week had been run at the centre. Additional one day training had been provided for all staff on caring for stroke survivors, including communication techniques.

The service had a registered manager. 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. Throughout this report the registered manager is referred to as the 'manager'.

Improvements were needed to ensure that all of the risks to guest's health and wellbeing were adequately assessed and planned for. Risk assessments were not routinely used to provide additional guidance for staff about how they should manage guest's particular needs.

Risks at service level were not always managed safely. Harmful substances were not always stored securely and we found a fire door wedged open. Parts of the environment or equipment used by guests were not always clean and well maintained.

Guest's medicines were not always managed safely. Most medicines were safely stored. However, we were not assured that medicines were always stored within their recommended temperature ranges. We were also concerned that medicines were secondary dispensed by staff when some guests went on excursions. Information to support the administration of medicines was variable, for example, allergy information was recorded. However, additional information about 'how I take my medicine', 'if required', and 'variable doses' was not available. A care plan was not available to support one guest whose health could rapidly

deteriorate.

We could not be assured that staff were receiving regular supervision and staff did not have all of the training relevant to their role.

The provider was not complying with their responsibilities in relation the Mental Capacity Act (MCA) 2005. There was a reliance upon asking the guests companion to consent to the care plan or make decisions on behalf of the guest. This is not in keeping with the principles of the MCA 2005.

Improvements were needed to ensure that the admissions and care planning process incorporated a consideration of whether a guest had capacity to consent to the stay, and whether any aspects of the care being provided might amount to a deprivation of that guest's liberty. There was a risk that when guests were admitted, staff would not have a sufficient understanding of their individual needs and how these should be met.

Complaints were not always responded to in a timely manner. The provider was already making improvements to address this.

We could not therefore be assured that the systems in place for identifying and driving improvements were effective and the provider had not ensured that staff had access to policies and procedures which provided appropriate and up to date instruction to staff.

People were positive about the food provided and there was information available about the guests likes and dislikes, which enabled staff to plan to menu around guests needs and wishes.

There were sufficient numbers of staff to meet people's needs and guests told us they felt safe and that the staff were kind and caring. We observed a number of positive and warm interactions between guests and staff. Staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each guest.

Guests were supported to take part in a range of activities both within and outside of the home.

The manager had cultivated positive relationships with guests and the staff team and the organisation was committed to actively seeking the engagement and involvement of guests and staff in developing the service.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version 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 that risks to guest's health and wellbeing were effectively assessed and planned for.

Risks were not always managed safely and improvements were needed to ensure the proper and safe management of medicines.

There were sufficient staff to meet guests' needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not receiving regular supervision and did not have all of the training relevant to their role.

Staff had not received training in the Mental Capacity Act 2005 and did not display an understanding of the principles of the MCA 2005.

Guests were positive about the food and people were provided with support to ensure they were able to have enough to eat and drink.

Is the service caring?

Good

The service was caring.

Guest's told us that staff were kind and caring. We observed a number of positive and warm interactions between guests and staff.

Guests were supported to express their views and be involved in making decisions about their care.

Staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each guest.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The pre admission assessment was not robust enough. There was a risk that when guests were admitted, staff would not have a sufficient understanding of their individual needs and how these should be met.

Complaints policies and procedures were in place but complaints were not always responded to in a timely manner. The provider was already making improvements to address this.

Guests were supported to take part in a range of activities both within and outside of the home.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality Audits needed to be more effective at driving improvements.

The provider had not ensured that staff had access to policies and procedures which provided appropriate and up to date instruction to staff.

The manager had cultivated positive relationships with guests and the staff team and the organisation was committed to actively seeking the engagement and involvement of guests in developing the service.

Revitalise Netley Waterside House

Detailed findings

Background to this inspection

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

The inspection took place on the 2 and 3 February 2016 and was unannounced. On the first day, the inspection team consisted of two inspectors and a specialist nurse advisor. On the second day there was one inspector and a pharmacist specialist.

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. A notification is where the manager tells us about important issues and events which have happened at the service. We asked the provider to complete a provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with ten guests who used the service. Their ability to communicate with us varied and some information was obtained with the help of their carer or companion. We also spent time observing aspects of the care and support being delivered. For example, we used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of guests who could not talk with us. We spoke with the manager, the deputy manager, the acting head of care, two registered nurses, the chef, four permanent members of staff and four volunteers.

We reviewed the care records of six guests in detail. We also reviewed the recruitment records of four staff. We looked at other records relating to the management of the service such as training and supervision records, audits, incidents, policies and staff rotas.

The last full inspection of this service was in September 2013 when no concerns were found in the areas inspected.

Requires Improvement

Is the service safe?

Our findings

All of the guests we spoke with told us that they felt safe staying at Revitalise Netley Waterside. One guest said, "I do not just feel safe here, we [their companion] are both safe here or we would not have come. The staff are qualified with the registered nurses and there is no staff shortage which you cannot say about many places. If I need anything, the staff are on call, I am very safe and we are both very happy". Another guest said, "There is always someone there to say, can I help you".

Whilst guests told us they felt safe, we found that some aspects of how risks to guest's health and safety were assessed and planned for required improvement. One guest's initial assessment explained that they were 'nil by mouth' and fed via a PEG. A PEG or percutaneous endoscopic gastrostomy is an artificial feeding device. The guest's care plan advised that they were able to take small amounts of puree food for taste only. The plan did not however, provide clear guidance about what was meant by this. Staff gave us inconsistent responses to what was meant by 'food for taste only'. We noted that the daily care records for this guest indicated that on one occasion during their stay they had eaten a full meal of soup mash and gravy when being assisted by staff. The care plan said that the guest could have some fluids orally which needed to be thickened, but it did not say by how much. We asked staff how much thickener needed to be added to guest's fluids, but they were unclear saying they would ask the guest's companion. The service was not able to demonstrate that they had checked with a healthcare professional or seen relevant healthcare assessments which clarified the current dietary requirements for this guest. We were concerned that this could have led to the guest receiving inappropriate or unsafe care. When we discussed the lack of corroboration obtained about guests clinical needs, a nurse said, "The thing is the carer …has taken care of the everything the guest needs, from medicines to wheelchairs, dressings and other treatments for a long time….so we trust them and it they tell us someone has certain types of food such a puree, we believe them". Informal or unpaid carers do hold a wealth of knowledge and expertise in managing their loved ones care and support needs and this should be acknowledged and valued. However, in regulated settings, this needs to be balanced with the provider's responsibility to provide safe care and treatment, adequately assess the risks to the guest's health and safety and do all that is reasonably practicable to mitigate those risks. Where guests had identified clinical risks such as this guest, care plans did not always contain sufficient clinical or professional guidance to support that provided informally by the guest's companions.

Where guests required hoisting or assisting with transfers, they did not have moving and handling risk assessments. Where a guest was known to be at risk of falling, they did not have a falls risk assessment. Another guest was known to be at risk of leaving the safety of the building. They did not have a risk assessment around this. This meant that we could not be assured that relevant measures had been put in place to limit the risks resulting from these needs. Some of the guests had difficulty swallowing which is also known as dysphagia. This condition can be life threatening and the risks associated with this need to be very carefully assessed and managed. Where guests were known to be at risk of choking, relevant risk assessments were not in place. We spoke with four permanent staff and four volunteers and asked them what they would do if a guest experienced an episode of choking. Their responses were variable and not always consistent with best practice. We spoke with the manager about this. They advised that staff had been trained as recently as January 2016 on emergency first aid, however, upon checking out our concerns;

they agreed that staff did not appear confident and said they would arrange for refresher training to be made available.

Risks at service level were not always managed safely. We observed a cleaning trolley containing harmful substances left unattended. We observed that a sluice room and a room containing electrics, both of which had signs on them saying 'fire door keep locked' were open. We also found that a fire door to a linen cupboard located near to laundry had been wedged open. This would prevent it from closing in the event of a fire which was of concern as it contained combustible materials.

Risks to people's health and wellbeing were not always adequately assessed and planned for. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

We looked to see that guest's medicines were managed safely. Most medicines were stored securely. However, medicines requiring refrigeration were not secure. Whilst controlled drugs (CD) were not held when we inspected, the CD records indicated they had been held. However, the controlled drugs cupboard was not compliant with the legislation. When we made staff aware of this, they ordered a replacement CD safe. Controlled drugs are prescription medicines controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. The medicines refrigerator temperature records were incomplete and did not provide assurance that the refrigerator had remained within the recommended temperature range. An insulin pen was being stored in the medicines trolley, as it lacked the date when it had been removed from the refrigerator we were not assured of how long it could be safely used for.

Seventeen guests had consented in writing to self-administer their medicines or to have them administered by their companion. However, risk assessments were not available in line with the services medicines procedure. We have been advised since the inspection that risk assessments had been completed but these were not made available to us at the time and so we could not assess the robustness of these. A further five guests had their medicines administered by nursing staff. On arrival, nursing staff would complete a separate medicines administration record (MAR) forms for medicines contained in original packs and monitored dosage systems. Limited information to support the administration of medicines was available. Information on allergies and 'administration difficulties' were on each guest's MAR. However, written information about how a guest would like to take their medicines' and supporting information about 'when required' and variable dose' medicines was not available.

The provider organised daily excursions for guest's, which usually required off site access to medicines for administration later on in the day. We observed a nurse preparing medicines for later administration. They put the relevant tablet or capsule into a bag on which they had written the guest's name and added their photograph. This can be described as "secondary dispensing" and can only be undertaken in exceptional circumstances. Staff on the excursion would record any medicines administered on a second copy of the MAR.

The effectiveness of medicines were not appropriately monitored. We reviewed the records of one guest prescribed a medicine that required their blood to be monitored. Test results were recorded along with records of the exact dose to administer. However, staff had relied on verbal confirmation of the dose by the guest's companion. They had not sought confirmation of this dose from the prescribing healthcare professional. The guest's health could rapidly deteriorate, and their care plan lacked any details on how to manage the situation.

The provider had not ensured the proper and safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Aspects of the environment were not always clean. We noted in the dining area there were two metal chairs which had parts of the metal missing. This meant it would not have been possible to clean these appropriately between use or after spillage. We spoke to the deputy manager about these chairs and showed them to her. They told us they would have them immediately replaced. At the end of the visit on the first day the chairs were still where we had first noticed them. Three large radiators on the ground floor had sections that were loose and these also had rust on them making them impossible to clean thoroughly. The floor of the medicines room was in need of cleaning. A registered nurse was unable to show us cleaning records that provided reassurances that the medicines and clinical areas were regularly cleaned. We have been advised since the inspection that these records were completed but not made available to us at the time. There were two storage rooms where bed sides and be side bumpers were stored. The bumpers we looked at had staining and soiling on them. In one of the bed rooms we found three urinary bag supports. Two of these had marked areas of rust which meant they would not have been able to be cleaned effectively increasing the risk of transferring infections.

In the sluice on the top floor, the basin was deeply discoloured and unpleasant and there was a strong malodour in the room. In a nearby female toilet, there were female sanitary products by the side of the toilet. While they had not been used the covering was clearly very wet which meant they would have been unhygienic to use and should have been discarded. The toilet was faecally stained and also had marked lime staining in the bowl. We looked in six toilets and found the light pull cords were discoloured. Some were badly discoloured. We were concerned that this could mean a risk of bacterial colonisation on areas potentially touched by guests or staff after washing their hands. This would increase the risk of infections being transferred.

Infection control audits were not taking place and the service did not currently have an infection control lead. This meant there was no oversight of infection prevention and control within the service.

We could not be assured that there were effective measures were in place to prevent, detect and control the spread of infections. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

The manager had developed a business continuity plan for unforeseen emergencies. This contained key information about how staff should manage events such as loss of power or flood that might make the building uninhabitable. The manager told us that in the event of a fire, the shift leader would gather a ruck sack containing the business continuity plan which was stored at reception and the folder containing the initial assessments undertaken with each guest. They advised that these served to ensure that they were able to provide information to the emergency services about the number of guests on site and their moving and handling needs. Staff received training in emergency fire procedures and we saw that a fire evacuation drill had taken place in November 2015. A fire risk assessment had been completed. Checks were being undertaken of the water safety within the service and regular checks were completed to ensure that equipment such as bed rails, slings and hoists were safe and fit for purpose. The emergency lighting, fire doors and call system were also checked monthly. Motor insurance was in place for the mini buses operated by the provider and staff had undertaken relevant training in order to be able to drive these. This helped to ensure that guests were protected against risks associated with the premises and equipment used for providing care.

The guests we spoke with felt there were sufficient numbers of suitably skilled staff available to meet their

needs. The registered manager told us staffing numbers were based upon the number of guest's staying each week and their level of dependency. They explained that throughout the week, staffing levels would be reviewed on a regular basis and if additional support was required, this would be put in place. During the week of our inspection, there were six care staff and two nurses on early shifts and four or five care staff and one nurse on late shifts. Overnight there was one nurse and two care workers on duty. The late shifts worked 3 – 11pm and night staff came on at 10pm which meant that was an hour when both shifts were working so that guests could be supported to bed after the evening entertainment. The manager explained that they also limited the number of guest's who required hoisting to 12 each week. This reduced the risk of there not being enough trained staff available to meet their needs. All of the staff we spoke with said there was usually enough staff on duty; however, our observations during the inspection did indicate that call bells were at times ringing for extended periods. We spoke with the manager about this. They were not currently undertaking call bell audits but agreed that these would be reinstated to monitor response times and ensure that guest's needs were being met in a timely manner.

The provider operates a large residential volunteering programme and so in addition to permanent staff; guests were also supported by a number of long and short term volunteers. The volunteers were not included in the daily staffing quotas but were in addition, the aim being that they added an extra dimension to the support, companionship and practical help that guests and their companions received. Many of the volunteers undertook the same role as the paid staff and did support guests with all aspects of their personal care. In addition to the nursing and care staff, the service also employed a team of housekeeping and catering staff, administrators and maintenance staff. The service employed a guest relations manager whose role was to prepare and plan a weekly programme of excursions, entertainment and activities. In addition up to six excursions staff were employed whose role was to escort guests out on the planned excursions. Whilst there was no designated activities staff we were told that funding had been agreed to develop this role to support the provision of activities within the service.

Appropriate recruitment checks took place before staff started working at the home. Records showed staff completed an application form. The manager had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) or equivalent to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. We did note that in one of the records we reviewed, a full employment history had not been obtained. This information is important as it allows relevant background checks to be undertaken. Many of the volunteers working at Revitalise Netley Waterside House were foreign nationals. Before commencing their volunteering they were required to obtain a 'Certificate of Good Conduct' from the national Police agency of their home country, giving details of any previous criminal convictions. Once they had been volunteering at the service for four weeks, they then had to undertake a DBS check also.

Staff had received training in safeguarding adults, and had an understanding of the types of abuse and neglect. They had a positive attitude to reporting concerns and to taking action to ensure guest's safety. One staff member said, "Safeguarding is about keeping guest's safe…there is always the possibility that guest's do not get the right care and it is up to us to defend them and ensure they get the protection they deserve, we have a good team here, we are all supportive and we trust each other so we would always work together on something like this, none of the team would tolerate it and would want it put right". Another staff member said, "If the manager did not take us seriously we could refer to social services safeguarding team, but nothing would get this far here, the managers are good, they listen to what we have to say". We did note when reviewing the complaints that some of the concerns raised could have indicated a safeguarding concern. Whilst these had been investigated and resolved to the guest's satisfaction, the concern had not been escalated to the local safeguarding authority. We have spoken with the local authority and the manager about this. We are aware that they have met and are working together to ensure that when

incidents or complaints identify potential safeguarding concerns that these are appropriately escalated and preventative actions taken.

Requires Improvement

Is the service effective?

Our findings

Guests told us they received effective care. One companion said, "I had a phone call, they asked if there was anything he needed….his needs are being met, we are really happy, its been brilliant for him, he has got stronger and more confident in the last few days, I've been able to let the reins off". Another said, "I can't think of anything they could do better, I'm satisfied with everything". A guest told us, "Its nice being here with other guest's [affected by a stroke] and being able to discuss it. I have seen staff bending over backwards to try and understand Guest's [who could not verbally communicate]". Another guest said "It's good so far, you're not under pressure, we didn't know what to expect, staff seem to know what they are doing".

Newly recruited staff and volunteers had completed an induction. This included information about the organisation, guidance and advice about the range of disabilities they might encounter working at the service and a period of shadowing more experienced staff. The service had introduced the new care certificate, which is a recognised induction for care workers into care and three staff members were enrolled on this. Staff told us that their induction was helpful and adequately prepared them to perform their role and responsibilities.

Each January, the home shut down for a week to enable staff to undertake their annual training refreshers. Staff training was mostly delivered face to face and included safeguarding, health and safety, infection control, basic first aid, food hygiene and fire training. In additional staff had completed an online course on stroke awareness. Mini bus drivers had relevant training and some staff had undertaken a more detailed one day first aid course. The chef had completed a level two hospitality and catering qualification and a course on nutrition. We saw that two of the nursing staff had completed training in the Deprivation of Liberty Safeguards, wound care, catheter care and gastronomy tubes. We were told that all of the nursing staff had completed training on the safe management of medicines in December 2015, but we were not able to see any records confirming this. The permanent staff we spoke with were generally positive about the training available and told us that this helped them to perform their role effectively. It was not however, clear to us that staff completed all of the training relevant to their role. Staff did not undertake equality and diversity or Mental Capacity Act 2005 training. We were concerned that in some instances registered nurses were cascading training to care workers in topics that they themselves had had no recent formal training in. The service offered specialist breaks for Guest's living with Alzheimer's disease and their companions, but staff did not have training in dementia. These are areas where improvements are required.

We looked at the support and training offered to the volunteers. Many of the volunteers live on site in their own accommodation. Some are long term and come for periods of 6 – 12 months, others just for one or two weeks. The volunteers were trained to different levels. Level one volunteers provided opportunities for social interaction only. Level two volunteers supported guests with personal care tasks, but only after they had been observed and declared competent to do so by three permanent members of the care team. They were still only able to support guests alongside permanent staff members. Level three volunteers underwent a more in depth assessment, but once completing this were able to support guests independently with most aspects of personal care including manual handling and assisting guests known to be at risk of choking or aspirating with eating and drinking. There was no requirement that level three volunteers complete all of the

provider's mandatory training programme or the Care Certificate. They did complete formal moving and handling training and we were advised that they could complete the full refresher training programme undertaken in January each year, if they were available. Some of the volunteers had been given units of the care certificate to study. Volunteers were positive about the support they received. One volunteer said, "You have to prove you are ready, you are not forced into being a level three volunteer". Another said, "I was offered level three, but wasn't quite ready so I was offered more shadowing". Guests told us that the volunteers appeared able to meet their needs effectively. One said, "The volunteers are really keen, you wouldn't know the difference between them and real staff". However, we were concerned that without a completing a comprehensive programme of training and development, it was not possible to be assured that the volunteer's demonstrated acceptable levels of competence to carry out their roles unsupervised.

We recommend that the service review its training programme to ensure it enables staff and volunteers to fulfil the requirements of their role effectively.

The provider's employee policies and handbook did not record how often a staff member should expect to receive supervision. When we reviewed the supervision matrix this showed that most staff had only received one supervision in 2015. Four registered nurses had just one documented clinical supervision in 2015. Formal supervision is important as it helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. The manager told us that staff had received more supervision than the records indicated, but that this had not always been formally documented. All of the staff we spoke with told us they felt adequately supported to carry out their role. One staff member told us that although supervision had not been as regular as it used to be they had their "Own supervisor and could talk to her about anything". The deputy manager met with the volunteer team on a monthly basis to provide support and we were able to see minutes of these meetings. The deputy manager was aware that the provision of supervision was an area which needed to be improved upon and explained that they were creating individual development plans for staff to support this and ensure they had opportunities to enhance their career path and skills.

Guests told us that staff asked them for their consent before providing care or support. Guests felt that their choices and wishes were respected and no one indicated to us that restrictions were placed upon them whilst staying at the service. Staff involved guests in decisions about their care, such as which meal choice they would like or whether they would like to go on an excursion or take part in an activity. We saw staff use gentle persuasion to encourage one guest to have a bath, but when this was refused their wishes were respected. From our discussions with the manager it was evident that the service had a commitment to support guest's to make their own decisions even when others might think these unwise. This helped to ensure that guests were empowered to express their choices and wishes.

However, the provider was not complying with their responsibilities in relation the Mental Capacity Act (MCA) 2005. 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. Whilst the registered nurses had a good understanding of the principles of the MCA 2005, care staff did not and had not completed training on the Act or its Code of Practice. Some of the guests staying during our inspection were living with a cognitive impairment and may have been unable to give consent to aspects of the care being provided by staff. However, they did not have a mental capacity assessment to determine this and best interest's decisions had not been documented. Instead there was reliance upon asking the guests companion to consent to the care plan or make decisions on behalf of the guest. This is not in keeping with the principles of the MCA 2005. Families cannot give consent to the care

and treatment of a relative without statutory authority to do so such as that provided by a personal welfare Lasting Power of Attorney. Due to the nature of the service, it is unlikely that in most instances, the assessment of capacity would be best done by staff at Revitalise Netley Waterside House as knowing the guest well and building up a rapport with them are key to undertaking a mental capacity assessment effectively, however, further work is needed to ensure that a guest's mental capacity is considered as part of the admissions and care planning process and that where necessary relevant mental capacity assessments have taken place.

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 guest from harm. The safeguards would likely only apply to a very small number of guest's using the service, but, for example, during the week of stay, we saw that one guest's care plan had noted that the they were 'not orientated to time or place and were prone to wandering' and 'needed to be watched all of the time'. It had not been considered whether this guest might require a DoLS. Improvements are therefore needed to ensure that the admissions and care planning process incorporates a consideration of whether a guest has capacity to consent to the stay, and the care being provided, and therefore whether the care being provided might amount to a deprivation of that guest's liberty.

We recommend that the service review its policies and procedures to ensure that these support staff to recognise when mental capacity assessments are required and whether the care being provided might amount to a deprivation of that guest's liberty.

Guests were positive about the food provided at the service. One guest said, "The meals are very nice, there are two choices every evening. I went to the desk and explained that I don't like the choices, one of the helpers said, no problem…I asked for a glass or orange juice, they brought me a jug, teas and coffees are available all day". A companion told us, "There is choice here and if I don't fancy something on the menu, the cook will make something else, no grumbles, they are happy to…and there is no washing up at the end of the day".

Each day there was a planned menu which included options of a cooked breakfast or cereals. Lunch was a selection from the light bite menu which included toasted sandwiches, salads or jacket potatoes. Packed lunches were provided for the guests going out on excursions. Dinner was a three course meal such as soup, pan friend chicken breast and a choice of desserts. There was a vegetarian option at each meal and fresh fruit was readily available. We spoke with the chef. They explained that they were provided with a diet sheet three days before a new set of guests arrived which contained information about their special diets which could be requirements such as dairy or gluten free or halal. There was also some information available about the guests likes and dislikes, this enabled them to plan to menu around guests needs and wishes but also buy in any special foods, for example, one guest had requested herrings and so these had been sourced for their stay. We observed lunch on the first day of our inspection. It was a small group and many guests were out on the excursion, but there was a good atmosphere with guests readily chatting with one another and being supported by staff as necessary.

Overall guests told us they were confident that the service and the registered nurses would help them maintain good health during their stay. Due to transitory nature of guests stays at the service, staff did not have routine contact with community healthcare professionals and specialist nursing services such as speech and language therapists or tissue viability nurses. However, if a guest became unwell, staff explained that they requested appointments for guests and their companions where needed with a local GP practice

where they would be registered as temporary patients for the duration of their stay at the centre. Before their first stay guests were required to obtain a medical certificate from their own GP which provided key information about their general health and prescribed medicines. We were advised that these were updated every two years or when the person's medical history changed.

Guests' views about the design and decoration of the building were mixed. One guest said, "It's a lovely room, there's a big shower, you can wheel the chair in and out, it's a comfortable large room with a lovely view". However another guest said, "The room is too hot and needs decorating. We saw from our review of the guest questionnaires that the standard of the accommodation was one of the areas which was frequently rated as an area which could improve. The service was built in 1977. The accommodation is arranged in wings and is a mixture of single or twin rooms and four larger suites. All rooms have an accessible ensuite shower room. Overhead or manual hoists, profiling beds and air flow mattresses are available for hire. There is a licenced bar and tea and coffee making area and a large dining area. There are a number of quiet areas where guests can go and sit including a library. There are accessible grounds with paths down to the beach and a viewing area. The provider is responding to feedback from guests an there is an on-going programme of refurbishment taking place with one of the wings to be closed shortly to enable the bathroom to be renovated and new carpets fitted. We did note that improvements would be needed before the balcony was safe to use, as there were several slabs up which could present a trip hazard.

Good

Is the service caring?

Our findings

Guest's told us that staff were kind and caring. One guest said, "The staff are respectful, I can't fault them, they are always helpful, do their best". Another guest said, "The staff are so nice, really friendly and smiley, they can't do enough for us". A third told us the staff were "Kind and patient". One guest explained that many of the volunteers came up at the end of their shift to say good bye which they valued.

Overall, we saw many examples, of positive and warm interactions between guests and staff. Our observations were that the general atmosphere in the home was calm and relaxed and guests seemed settled. Staff mostly responded promptly to guests or their companions who were requesting assistance and they did so in an attentive manner. We heard a staff member say to a guest, "Its fine, that's what I'm here for, I am really pleased to help out when I can, just say what I can do to help, its my pleasure". Although the guests had only arrived at the home two days earlier, they seemed to have developed a good rapport with the staff and volunteers. We spoke with the deputy manager about this who told us, "We change our guests every week so we have to be able to gain their confidence and trust as quickly as we can, we train staff to ensure their interpersonal skills are as good as they can possibly be and this seems to work quite well". We did see a small number of missed opportunities to engage with the guests in a person centred manner. For example, on the first day of the inspection we saw a guest with no verbal communication wheeled up to the breakfast table by a volunteer. The volunteer left the guest without interacting with them. It was 20 minutes before another member of staff approached the guest who then supported the guest appropriately with their meal.

Guest's choices and known wishes were respected. Staff used guests chosen names when addressing them. They knew which drinks guests preferred and also which preferred to retire to their rooms after lunch. This demonstrated that staff had knowledge about guest's individual choices and preferences and supported them to achieve these.

Guests were supported to express their views and be involved in making decisions about their care. Some guests were able to verbally communicate their wishes, whereas others could not communicate verbally at all. Staff seemed to have quickly developed a good understanding of how guests communicated and used this effectively to talk with them about their care and support needs, supporting them to remain in control where ever possible. For example, we saw one member of staff sensitively asking one guest what they would like for their breakfast. After each question the staff member waited for the guest to indicate their choice by raising either thumb or forefinger to indicate yes or no. The Stroke Association had also provided the service with communication booklet which included a range of communications aids, such as pictures. We were told that staff were using this with good effect to support guests to express their choices and decisions.

Staff demonstrated a good understanding of how to provide care in a manner that was respectful of guest's privacy and dignity. Staff told us they were careful to ensure guest's doors were closed when providing personal care and we observed that staff knocked on guest's doors before entering their rooms. A volunteer told us that it was important to check whether the guest wanted a male or female carer to provide their personal care. Any care needs due to the guest's diversity were assessed and planned for and when

speaking with staff they were aware if guests had any cultural needs and provided care to meet these. We were concerned to find confidential waste in a general bin in the staff room. We brought this to the attention of the head of care that removed the information and advised that staff would be reminded about correct procedures for disposal of confidential information.

Requires Improvement

Is the service responsive?

Our findings

It was clear that guests and their companions felt that staff provided person centred care that was responsive to their needs and helped them to enjoy and benefit from their weeks holiday. One companion told us, "We didn't want to come but got here and it's lovely….we didn't dream it could be like this". This was echoed by a guest who was overheard to say, ""I would never have thought it could be like this, if the rest of week goes like this it will be great".

The service faced a number of unique challenges due to the nature of service that it offered. Each week, there could potentially be 37 new admissions. Some of the guests arriving might have visited the centre before, but in other circumstances, each guest might be completely new to the service. This was the case during the week of our inspection. These challenges meant it was important to ensure that the pre-admission arrangements were robust and enabled the development of a care plan that contained clear and concise information about the guest's needs and how these should be managed. We found that this was not always the case.

Prior to admission to the home, guests completed a booking form with head office. This identified any potential equipment or dietary needs they might have and also any 'nursing alerts' or concerns about their health. This might include issues such as having a history of choking or of falls. This was then sent to the service following which a registered nurse would ring the guest and complete an 'Activities of Daily Living Assessment'. This was a two page document which asked for information such as how the guest mobilised, their medical history, their dietary needs and personal care requirements. This information was then used to draft an extended care plan.

We reviewed four of the activities of daily living assessments and found that parts of these had not been completed robustly. For example, alerts or concerns that could have an impact upon the guest's safety or their health or wellbeing had not been adequately explored. For example, one guest's assessment ticked yes to epilepsy. No further information was added about what type of epilepsy, when the guest last had a seizure and whether they required any emergency medicines or protocols to be in place for this. The booking form indicated a nursing alert in relation to bowel care, but this had also not been explored further with the guest. This meant that there was a risk of guests arriving with more complex needs than thought. Staff told us that there had been times when they had been 'caught out' in this way. Improvements were needed to the information gathered at the pre-admission stage so that staff could fully determine whether the service had the appropriate resources and staff skills to meet the guest's needs.

The extended care plans were not always sufficiently detailed. This meant there was a risk of staff not being able to provide person centred and responsive care. For example, one guest's continence plan stated '[the guest] is continent, but requires assistance'. It was not clear to us what this meant. The guest's mental health plan stated that the guest 'does on occasion wander and requires supervision'. There was no guidance about how this was to be managed by staff.

Another guest's extended care plan indicated that they were living with epilepsy. The plan advised that

emergency medicines were to be given if the seizure was 'severe or prolonged'. This could be interpreted in a number of ways. Staff should have access to clear and precise protocols provided by a healthcare professional. Another guest was noted to be living with asthma and to be a type two diabetic, whilst recorded as self-medicating, there was no other information which might enable staff to respond to any potential deterioration in their health. A fourth guest, who had a history of swallowing difficulties, had a nutrition plan which said 'requires food to be cut up'. It did not say to what size.

The provider had not ensured that each person had a plan of care which clearly demonstrated their needs and how these should be met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person Centred Care.

From speaking with staff and guests it would appear that a lot of additional information was gleaned from the guest and their companion during the early stages of a guests stay and then shared with the rest of the staff and volunteer team through the four daily handovers that took place and this seemed to work effectively. One staff member told us, "The best way of learning about guests was to do their care, watch others; I've learnt a lot that way".

The current guests were very positive about the service and the staff. They told us they were receiving care that was responsive to their needs. One guest told us, "This place is 10 out 10, I could not fault it, the staff are kind, and do the very best they can at all times. Sometimes in the evening and at night it can take a little longer to have you call bell answered, but that is to be expected. This is a wonderfully warm home with caring staff. I am very happy here and do not want to go home". Recent guest feedback demonstrated that some guests did not always receive care that they felt was responsive to their needs. We saw recent comments relating to concerns where a guest was left alone for two hours to get hot and uncomfortable. Another had not being assisted to bed at a time of their choice and a third had complained about the lack of carers being available on their last two mornings. These comments were not in keeping with what guests told us during the inspection

Complaints policies and procedures were in place which described how complaints were handled and responded to. Any negative feedback received was also viewed as a complaint and responded to. We reviewed a number of recent complaints or concerns that had been raised toward the end of 2015. The majority of complaints had been dealt with promptly and where it was acknowledged that procedures or systems had gone wrong, we saw that an apology had been made in line with the provider's duty of candour. The manager advised that a complaints tracker had been devised which we were shown. The tracker will also serve to identify trends or areas of risk that may need to be addressed.

People told us that they enjoyed a range of activities and excursions. Guest could choose to attend themed weeks. For example, the week following our inspection, guests at Revitalise Netley Waterside House would be attending a 'World Food, Music and Dance' themed week. Later in February there were 'Viva Las Vegas' and 'Music Legends' weeks. There were youth weeks and breaks for guests living with Alzheimer's disease. In the summer guests could book a Hampshire Highlights week which included a boat trip across to the Isle of Wight. Guest's appeared to be enjoying the activities and excursions provided. One guest told us, "The singer at night is good; you can do quizzes, board games, and arts and crafts, watch TV or go for a walk. There are day trips every day and you can choose up to four trips per week, we went to the Titanic museum yesterday, I was in two minds about coming but it's been so nice". Guests were accompanied on the trips by staff and volunteers and a packed lunch was provided. A staff member told us, "The trips are good, in the summer we went to Brighton, we've done speed boating and wheelchair ice skating". Those that chose to remain at the centre were also offered activities and we saw a number of guests and volunteers were enjoying a cake decorating session. We also saw one to one activities taking place, with staff or volunteers chatting with

people, reading the newspaper or assisting people on the computer. A volunteer told us, "there is something for everyone here, it gives people a holiday, its more person centred and down to earth, some of the people haven't been out for years, they can relax with people around them, I think its brilliant, they are treated like friends. To further enhance the existing programme, we were advised that the service had plans to employ an activities co-ordinator for four or five hours each day.

Requires Improvement

Is the service well-led?

Our findings

Guests and staff were positive about the leadership of the home. One person said, "I know the manager, they are helpful". A staff member said, "[the manager] tries to sort things out". Another told us that the manager was "Really welcoming" and had "Always helped me". A third staff member said, "Yes it is definitely well led…they know what they are doing".

Whilst the guests we spoke with were positive about how well led the service was, we found some areas required improvement. A number of the provider's policies needed to be reviewed or updated. The safeguarding policy still, made reference to 2010 Regulations of the Health and Social Care Act. The 2014 Regulations came into force in April 2015. We also noted that the local multi-agency safeguarding policies and procedures available within the service dated back to 2008. The most recent policy is dated May 2015 and provides guidance on the new safeguarding duties arising from the Care Act 2014. The policy also clarifies the roles and responsibilities of staff and managers in all agencies who have responsibilities to support adults with needs of care support who are at risk of abuse or neglect. The provider's Deprivation of Liberty safeguards policy had recently been updated but made no reference to the supreme court judgement of March 2014 and the 'Acid Test' as to what might constitute a deprivation of a person's liberty. The manager was not able to provide us with a policy in relation to the Mental Capacity Act 2005. We were told that the provider was aware that many of their policies and procedures required updating but we were concerned that provider had not ensured that staff had access to policies and procedures which provided appropriate and up to date instruction to staff.

The manager was unable to demonstrate that there was a robust programme of audit in place that was used to monitor the effectiveness of aspects of the service and drive improvements. The manager was not routinely undertaking any audits within the service. They advised that approximately four times a month, the providers, Director of Quality and Care, visited the service and undertook audits of the care plans, medicines, pressure area care, incidents and near misses, complaints and safeguarding alerts. However, they were not able to show us any recent records of these audits or what specific areas the audits had looked at. Our inspection highlighted a number of areas where improvements to the safety and effectiveness of the service were required. These had not been identified by the provider's audit system. We could not therefore be assured that the systems in place for identifying and driving improvements were effective.

The provider had not demonstrated that there were robust systems and processes in place to monitor the quality and safety of the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

We were able to see that the provider sought people's views about their experience of, and the quality of care delivered by the service. Following each guests stay they were asked to complete a questionnaire and rate aspects of the service and the care they had received. A high number of these were returned and any negative feedback given was treated by the service as a complaint and was responded to. The feedback was also used to inform a plan of improvements across the service to enhance the guest experience. We

reviewed the plan for 2016/17 and saw that a range of measures were planned to improve for example the dining experience and guest accommodation.

The manager was aware that there needed to be a more robust programme of supervision in place both for the care staff and the leadership team and arrangements had been made to ensure that this was provided over the coming year. This will help to ensure that the manager continues to be aware of day to day issues within the service affecting staff and that staff are supported to understand that role and responsibility

Staff and volunteers told us there was an open and supportive culture in the service and that staff morale was good. All of the staff and volunteers we spoke with told us they loved working at the service and felt supported by the management team. Staff meetings were held on a regular basis. These were used both as learning and development tool and an opportunity for staff to express their views about issues such as staffing matters. One staff member said that the staff meetings were useful, "You can take ideas, issues, the management team listen, they are responsive". We saw that there was a 'Extra mile club' in place. If staff were mentioned by guests as having gone the extra mile when providing their care, they were awarded a £25.00 voucher. Meetings were also held on a regular basis with the volunteers. These discussed a range of issues but also explored with the volunteers what they wanted to get from their time at Netley. We were told that the clinical leads or heads of care, of each of the provider's three services, also met on a regular basis with the Director or Quality and Care to review clinical issues arising from people's care.

The provider had a very clear vision which was to provide respite care in a holiday setting for people with disabilities and their carers. This vision was understood by the manager and the staff team and we observed that they were committed to ensuring that guests enjoyed their stay and that companions benefitted from the break. Guests told us that the service met their need for a much needed break or holiday and their companions told us that the support enabled them to feel revitalised. One told us, "It's been marvellous so far….they have taken the responsibility away…I'm getting a rest".

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that each person had a plan of care which clearly demonstrated their needs and how these should be met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and wellbeing were not always adequately assessed and planned for. The provider had not ensured the proper and safe management of medicines. We could not be assured that there were effective measures were in place to prevent, detect and control the spread of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not demonstrated that there were robust systems and processes in place to monitor the quality and safety of the service. The provider had not ensured that staff had access to policies and procedures which provided appropriate and up to date instruction to staff.