Braemar RCH Limited

Regency Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 13 and 20 March 2018 and was unannounced. Regency Nursing Home provides accommodation and nursing care for up to 30 people. The home provides accommodation over five floors with passenger lifts to all floors, stair lift access to some floors and external wheelchair access to the grounds. The lower floor of the home provides areas for staff, kitchen area and laundry facilities.

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

At our last inspection in June and July 2015 we found that there were not always enough staff to meet people's needs. We made a recommendation about this. At this inspection we found there were enough staff on duty. We have, however, made a recommendation to the provider with regards to the ongoing monitoring of staffing levels.

During this inspection we found some shortfalls at the service with regard to record keeping. The provider used a range of quality assurance systems including audits; however these were not robust and did not pick up on some of the issues we found with records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff told us they felt well supported by the senior team, the registered manager and the provider, however there was not a regular programme of supervision or appraisal for staff which was recorded.

People and visitors felt the service was safe. People looked comfortable, relaxed and happy and were supported by staff that knew them well. The registered manager and staff had a good understanding of how to keep people safe. All staff displayed good knowledge on how to report any concerns and were able to describe what action they would take to protect people from harm. Risks were well managed. Accidents and incidents were recorded but were not monitored to determine if any trends were occurring. Safe recruitment processes, including pre-employment checks, had been followed. Health and safety checks on the building and equipment were regularly carried out.

Medicines were administered by trained staff. Lack of clear direction regarding as required (PRN) and topical medicines were addressed to ensure they were administered in line with people's needs.

Staff received training that enabled them to meet the needs of people they supported and deliver effective care. Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

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

dignified way. Food consistencies were not in line with national guidance and people did not have daily fluid intake targets recorded. The registered manager told us they had put this place following the inspection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Applications had been made for Deprivation of Liberty Safeguard (DoLS) authorisations, where it was considered that people would be unable to keep themselves safe if they were to leave the home unaccompanied.

Care plans in place were person-centred and included details about people's life histories and what was important to them. People's individual needs were assessed and most people had an up to date plan of care in place.

People told us staff were friendly and caring. They told us they were treated with dignity and respect. We saw that staff knew people well, and observed positive interactions between people and staff. Visitors told us they were welcome to visit at any time.

People spoke highly of the activities on offer. There were a wide variety of stimulating activities planned within the home. The activity coordinator spent time with people on a one-to-one basis as well as planning group activities.

Complaints had been responded to in line with the provider's policy although the recording of these could be improved.

We found two breaches of the Health and Social Care Act 2008. This related to Regulation 17: Good Governance. You can see what action we told the registered 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?

Good

The service was safe.

There were enough safely recruited staff deployed to meet people's needs, however we made a recommendation that the provider uses a systematic approach to always ensure the numbers of staff meet the needs of the people in the home.

Risk assessments were in place to keep people safe.

People were safe from harm because staff were aware of their responsibilities and able to report any concerns.

The management of medicines had improved and was safe.

The service was clean and practices were in place to minimise the spread of any infection.

Is the service effective?

Good

The service was effective.

Staff supervisions and appraisals were not always recorded but staff told us they were well supported and had the necessary knowledge and skills to undertake their role.

People were supported to eat and drink enough and people were complimentary about the food. Food consistencies were not in line with national guidance and people did not have daily fluid intake targets recorded. The registered manager told us they had put this place following the inspection.

The service was compliant with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were met and staff worked with health and social care professionals to help people access relevant services.

Is the service caring?

Good

The service was caring.

Staff provided the care and support people needed and treated people with dignity and respect.

People's views were actively sought and they were involved in making decisions about their care and support.

Staff recognised and promoted the role of family and friends in people's lives.

Information about people was stored confidentially.

Is the service responsive?

Good

Staff were knowledgeable about people's support needs and preferences and people received person centred care and support.

There were a variety of activities in the home that people enjoyed.

Staff had worked to ensure people had access to healthcare services.

Is the service well-led?

Requires Improvement

The service was not always well led.

The absence of a robust governance system meant records contained gaps and were not always reviewed regularly.

The provider and registered manager had an open, honest and transparent management style with staff and people who used the service.

People and their families were encouraged to provide feedback on the service through meetings and an annual survey.

Regency Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 13 and 20 March 2018 and was unannounced.

The inspection team consisted of two inspectors and a specialist nurse advisor.

Before the inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform us what areas we would focus on as part of our inspection. We also reviewed the previous inspection report and the provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements.

During the inspection we spoke to nine people and three relatives. We spoke to 11 staff and the registered manager. In addition we spoke with two visiting health and social care professionals.

We looked at the care records for 10 people who used the service and the personnel files for eight staff members. We also looked at a range of records relating to how the service was managed. These included training records, complaints, quality assurance systems and policies and procedures.

Good

Is the service safe?

Our findings

People told us they felt safe living in the home and staff were available to help them. We asked "Do you feel safe?" One person told us "Oh yes" while another person replied "Absolutely".

At our last inspection in September 2015 there were concerns that the registered provider had not deployed sufficient numbers of staff to meet people's needs. We made a recommendation that the provider sought guidance on identifying the numbers of care and nursing staff required to meet the needs and dependency of people in the home. At this inspection, we found there were enough staff to meet people's needs and keep them safe. We looked at the staff duty rota for a four week period around the time of the inspection. They confirmed what staff told us; that there were one or two nurses, one team leader and six care staff on duty. In addition, there were housekeeping and kitchen staff and activity staff. Our observations showed people were responded to quickly and staff did not appear to be rushed. Most people, relatives and staff told us they thought there were enough staff on duty. However, one person told us the care staff were often rushed and another person told us they had to wait their turn to get up in the mornings.

It is recommended that the provider uses a systematic approach to ensure the numbers of nursing and care staff meet the needs and dependency of the people in the home.

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. Checks were also undertaken with the Nursing and Midwifery Council (NMC) to confirm that nurses were registered with them and were able to practice.

There was a record of staff being interviewed to assess their suitability for the post. Each staff member completed a 'probationary' period when they started work where their abilities and suitability to continue their employment were formally assessed. Newly appointed staff that did not have prior experience in care were enrolled on the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. All staff who were new to the service received an induction which consisted of shadowing a more experienced member of staff, reading relevant policies and procedures and getting to know people's needs. We noted that one induction record was not complete.

Staff said they had received safeguarding training and knew how to report any signs of abuse. Additionally, staff were familiar with the term "whistleblowing" and said 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 said "I've had safeguarding training; if I had a concern I would go to the clinical lead, the manager or take my concern to safeguarding or CQC". Another said; "I would escalate any safeguarding issues until I knew they were resolved". Two members of staff said they weren't sure of the official process but they would be confident to whistle blow and would take their concerns to the police if necessary.

Care plans contained risk assessments for areas such as mobility, falls, skin integrity, malnutrition and bed rails. Where risks were identified, the plans contained guidance for staff on how to reduce the risk of harm to people. For example, one person had been assessed as being at risk of falling from their bed and wheelchair. The plan detailed steps staff should take, such as 'ensure (Name) is not left unsupervised while in the lounge, (Name) is safer on low bed with crash mat'. Where people had been assessed at being at risk of developing a pressure sore, guidance was in place to reduce this risk including daily checking of all pressure areas, application of topical creams and repositioning. Pressure relieving equipment was also put in place.

Some people displayed behaviours that challenged. People had care plans that clearly detailed how to safely manage behaviours that challenged. A behaviour chart outlining triggers, behaviours observed and action taken was in some people's care plans but these lacked specific details around episodes of behaviours. 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 and said they did not want to get into their bed, the staff members used a successful de-escalation technique and an appropriate solution was found which calmed the person.

Staff supported people to take their medicines. The provider had a policy and procedure for the safe receipt, storage and administration of medicines. Storage arrangements for medicines were secure and were in accordance with appropriate guidelines. Medicine profiles were in place. These included photographs of people, their preferences in how they liked to take their medicines and a record of any allergies.

We observed part of a medication round. The nurse administering the medicines checked people were happy to have their medicines, didn't rush them and waited until they swallowed their tablets before signing the Medicine Administration Record (MAR).

MARs were up to date with no gaps or errors which documented that people received their medicines as prescribed. Topical medicine administration charts, however, lacked guidance for staff. Care staff applied some creams for people and on their MARs which were kept in people's rooms it stated the creams should be applied 'as directed'. There was no instruction about where on the body to apply the creams or when. A member of staff told us they knew how to use the creams because they knew the person well. However, newer staff may not have known this. We discussed this with the registered manager and they asked the prescribing GP to add specific guidance to the prescription. Following the inspection, the registered manager had included body maps in people's files so staff have clear guidance in place.

People were prescribed when required (PRN) medicines. On the first day of inspection PRN protocols were not in place. We discussed this with the registered manager and on the second day of inspection clear protocols had been implemented. MARs showed these medicines were not used excessively.

Staff had received training in infection control and safe infection control procedures were followed. For example; we observed one nurse wash their hands before they started the medicine round and when they supported a person in the middle of their round, they washed their hands before continuing. We saw care staff wash their hands before assisting people with their meals. Staff had ready access to protective gloves and aprons (PPE) and we saw these being used appropriately.

Individual slings were used for people who needed to use the hoist to transfer to prevent the spread of infection. The environment was clean, tidy and welcoming. Housekeepers had clear cleaning schedules to follow; they recorded most of the cleaning they had completed although there were gaps in some of the cleaning charts. Staff were clear about how they processed soiled linen and appropriate laundry procedures

were in place to prevent cross contamination.

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 which included an individual one for each person's bedroom.

People had personal emergency evacuation plans (PEEPs) in place. PEEP's 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.

We saw that accidents, incidents and safeguarding concerns were investigated thoroughly and measures had been put in place to try and avoid future occurrences. For example, one person had fallen while using the toilet so the service had put a high rise toilet seat in place while another person's feeding tube had not been rotated adequately so the service had discussed this with the nurses during a meeting and organised specialist training.

The use of surveillance cameras was in place in communal areas. These were used overtly and there were signs in prominent places of the home to alert people that they were in use. Only authorised staff members had access to the data. The registered manager told us that they enhanced the safety and security of the premises as well as protecting the safety of people. Call bell response times were also monitored so the provider could ensure that people were being responded to in a timely manner.

Good

Is the service effective?

Our findings

People received care and support from staff who knew them well and who had the skills and training to meet their needs. People described staff as "terrific" and "very good.

We looked at the staff supervision and appraisal file and found that there were few records available of supervision taking place within the service. Records also indicated that appraisals were not up to date. Staff told us they had received supervisions and appraisals with their line manager; however we found the regularity of these differed amongst the team. One member of staff told us they received supervision sessions "every three months or so", a second told us they had supervisions every six months and a third member of staff told us they had not had a supervision in the last year. All staff members told us that although supervisions may not be carried out formally, they had plenty of informal discussions with their line managers and any training, learning and development needs were addressed.

We discussed this with the registered manager and they told us that staff did receive supervisions and appraisals but often these were not recorded. The registered manager was unable to provide a reason as to why supervision and appraisal records were not kept.

Although formal supervisions and appraisals were not always recorded we found that this did not have a negative impact on staff or how people were supported. All staff that we spoke with told us they felt well supported and staff had the skills and knowledge to support people effectively because they knew them well.

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 and moving and handling training. In addition, training was provided in specific needs such as diabetes, dementia and catheter care. Staff told us the training they received helped them in their roles and in understanding the support needs of people who used the service.

The home had a training and development coordinator who had the lead role of ensuring staff were up to date with their training and development needs. One member of staff told us that the home had supported them to progress to a senior team member through training and support.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 Regency. We discussed this with the registered manager and they told us that they were confident people did consent to their care at Regency prior to admission as they signed a contract. The registered manager contacted us after the inspection to tell us that they had put appropriate consent for care forms in place.

Care plans contained capacity assessments and consent forms for some areas of people's care such as the use of bed rails. This documentation was clear and showed that where people did not have capacity to make a decision in this area other healthcare professionals had been involved in the decision making process. We saw that the least restrictive option in relation to this had been considered.

The provider had fully completed 11 Deprivation of Liberty Safeguards (DoLS) applications and there was a robust process in place to ensure that applications were renewed when required. Some of these applications had been authorised and were identified in people's care records as having Deprivation of Liberty Safeguards in place. Other Deprivation of Liberty Safeguards applications were awaiting authorisation. We found the home was meeting the requirements of the Deprivation of Liberty Safeguards.

We asked staff about issues of consent and about their understanding of the MCA. Some staff had a good understanding of the MCA while others understanding was more basic. However, all staff told us they would ask a more senior staff member about issues of capacity if they were unsure.

People were supported to eat, drink and to maintain a healthy balanced diet. People said they were happy with the food they received and that they received a choice. One person told us that the best thing about living in the home was the food. Another person told us "The chef is great, we are very spoilt".

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 assisted those that needed it and this was done sensitively with staff telling the person what the food was, asking if they enjoyed it and were they ready for more.

Where needed, input from Speech and Language Therapists (SALT) and Dieticians had been obtained to ensure people were receiving an appropriate diet. People were receiving a high calorie diet if they had been assessed as being at risk of malnutrition. People had a soft or pureed diet if they had swallowing difficulties; however, food texture descriptors were not being used in the home. The descriptors provide standard terminology to be used by all food providers when communicating about a person's requirements for a texture modified diet and categorise food into four main consistencies. When we spoke with staff we were told that people received two different consistencies of food, either pureed or a soft diet. We discussed this with the registered manager and they told us that they would use the nationally recognised food descriptors going forward. People who were at risk of choking had a clear care plan in place detailing how to prevent choking and what action to take if someone was choking. Staff were clear about which people needed thickening powder in their drinks to reduce the risk of them choking and thickening powder and guidance was available for this purpose.

Some people's fluid intake was being recorded if they were at risk of dehydration. However, there was no daily intake target recorded on fluid charts to enable staff to evaluate people's needs. We discussed this with

staff in the home and they were confident that they could determine if a person was receiving an adequate fluid intake as they knew them so well and any concerns about people's fluid intake was handed over verbally. We discussed this with the registered manager and they told us that they would ensure clear documentation was in place.

Nationally recognised assessment tools were used effectively to minimise the risk of harm to people. These included skin integrity and nutrition assessment tools. A senior member of staff also told us they accessed the National Institute for Health and Clinical Excellence (NICE) website and shared new knowledge throughout the team in order to improve care.

Equality, diversity and human rights issues were acknowledged and supported. For example, where a person preferred to be supported by a staff member of a specific gender this was accommodated. The registered manager told us if a person expressed a particular need in relation to their sexuality, religion or culture these needs would be supported and would inform the development of a person's care plan.

Staff felt they worked well as a team to ensure everyone was aware of people's support needs or any change in these. Handovers took place between shifts and a diary and communication book was used each day to share messages. This ensured that where a person needed something, such as a health professional appointment, this was booked and staff were aware of when they were visiting so they could ensure staff availability.

People were supported to maintain good health and had access to external healthcare support as necessary and records reflected this. Staff were very knowledgeable about people's specific needs and able to recognise any slight change in these. Records showed that other professionals such as chiropodists, dentists and tissue viability nurses were involved to ensure people received the care they needed.

People's needs were met by the adaptation, design and decoration of the premises. The home and outside areas were fully accessible to people. Communal areas were bright and welcoming. People's artwork and photographs of recent events and outings were displayed in prominent places. Bedrooms were mostly personalised and reflected people's interests and things that were important to them. Equipment within the home supported people's needs. The home had a lift that accessed all floors of the home and a stair lift was also in place.

Good

Is the service caring?

Our findings

People were happy with the care and support they received. People said they were well looked after and that staff were kind. Comments from people included, "The staff are friendly and very caring", "The best thing about being here is the care" and "I'm well looked after". Relatives told us they were happy with the care and support provided and said the staff were kind and caring. One relative said "The staff are all so lovely and very kind".

We spent time in the communal areas observing interactions between staff and people who lived at the service. People appeared relaxed and there was a lot of chatting and laughing. For example, we heard a member of staff say to a person "I've still got the card you made me, I showed it to everyone when I got home". The person was clearly pleased by this comment and responded by saying "I will make you another one". On another occasion, we heard a member of staff encouraging a person to use their call bell; they said "You should press your buzzer, that's what we're here for". It was one person's birthday and the home had decorated the area in birthday banners; they had also made them a birthday cake. The person and their family told us they appreciated this.

Staff were seen to support people in a caring manner, staff engaged with people, made eye contact, bent down to their level and used touch appropriately to reassure and we saw that where people requested support it was provided promptly and discreetly.

We looked at how people's privacy and dignity were protected in the home. Staff were seen to knock on people's doors before entering their bedrooms. They also asked or waited for people's permission before entering. Some people shared a room and staff told us they used screens to protect people's privacy and dignity. A relative confirmed that the staff pulled the screen across when delivering personal care. One person told us that their privacy was always maintained during personal care. However, they went on to say that the communal area could be busy and people sometimes crowded around their visitors, they thought it would be a good idea to have a quieter visitors area in the home.

People were encouraged to be independent. Three staff members described how a person had become more independent since using the service. They told us that they used to have assistance to eat but now they could do it themselves. Care plans had information recorded which guided staff on how people could retain some independence, for example, on one person's care plan, it stated 'encourage (Name) to wash face, hands and front part of their body, they can choose their own clothes and can do their teeth and hair'.

Everyone was well groomed and dressed appropriately for the time of year. One person who had their nails painted told us "I love having my nails done, the girls do them really well".

Many of the staff had worked in the home for a considerable length of time and knew people well. Staff spoke about people fondly and with respect. One member of staff told us "I love them, I know their needs very well and I've got a good rapport with them" while another member of staff said "The best thing about my job is putting a smile on their faces".

Staff explored people's cultural and diversity needs during pre-admission assessments and included people's specific needs in their care plans. For example, staff talked about people they had supported with particular dietary needs based on their culture. Staff also supported people to follow their faith. People were able to visit the local church on a weekly basis. On the second day of inspection we some people were receiving communion, this was well attended.

Relatives and friends were welcome to visit any time. People were also supported by staff to maintain relationships with friends and family outside of the home. For example, a staff member told us that they assisted a person to 'Sykpe' their son who lived abroad, they went on to say "It's lovely that they can talk to each other despite the distance".

We looked at care plans and noted that staff involved people and their families with their care as much as possible. For example, one person said that using a walking frame had made them feel old so the service had organised for the person to see a physiotherapist with the aim of using a tripod which was the person's preference. This goal was reached and the person felt better about using a walking aid.

Staff understood the need to respect people's confidentiality and we did not observe any person's information being discussed in a public area. Any information that needed to be passed on about people was passed verbally in private, at staff handovers or put in people's notes. This helped to ensure only people who had a need to know were aware of people's personal information.

Good

Is the service responsive?

Our findings

The provider had completed an initial assessment of people's needs before they moved into the home to ensure the service could meet their needs. A care plan was then developed for each person. 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. There was information about the person's life history, preferences and activities they enjoyed so staff could support people to meet their wishes.

Care plans were person-centred and demonstrated a good understanding of people's individual needs, for example; one person liked to drink their tea using a cup and saucer and another liked their sleeping tablet at 23:00.

People received support from staff with their communication needs. For example, we saw in one person's care plan that they needed assistance to wear their hearing aid and in another person's care plan it stated that they needed reminding to wear their glasses.

Most care plans were regularly reviewed, updated and evaluated. However, there was a group of care plans that hadn't been reviewed regularly. We saw that one of these care plans hadn't been reviewed since November 2017 and another since December 2017. We discussed this with the registered manager and they told us it was due to a change of staff. They assured us that the care plans were still reflective of people's needs and we saw the clinical lead was in the process of updating them when we were carrying out the inspection.

People and their relatives were involved in care planning and the review process. A relative told us "They (the home) always let us know if there are any change to mum's needs".

There was a supplementary care plan for each person in place. This held a summary of people's needs for ease of reference for staff. A member of staff explained that it helped them find important information about people quickly such as their dietary needs.

Staff completed monitoring records where those were required due to people's individual needs, such as repositioning charts, food and fluid intake charts and daily records. We noted some occasional gaps in records. For example, one person had gaps in their bowel chart record and another person's post fall assessment tool was not completed. The registered manager told us that staff knew people so well that they would be able to identify if there were any concerns about people.

Records and feedback demonstrated peoples' changing needs were promptly identified and kept under review. For example, at the time our inspection one person was distressed. Staff took immediate action to contact other health professionals and ensure the person's concerns were reviewed by the appropriate people.

People and their relatives were complimentary about the activity coordinator and the activities in the home.

Planned activities, outings and events were displayed in communal areas. We observed an arts and crafts activity; this was a social event with people chatting and laughing amongst themselves. Records of activities were kept and showed that people who spent a lot of time in their rooms were included in activities. The activity coordinator told us "(Name) hardly mixes with anyone but he loves it when I massage his hands". The lake opposite the home was a popular place for people to go and one person told us that they enjoyed feeding the swans. People were able to suggest different activities and one person was pleased to be helping the activity coordinator arrange a film evening.

All staff took part in some activities when time allowed. A member of staff told us they enjoyed reminiscing with people and another said "I enjoy going to the lake with people". A person told us that a staff member was teaching them Spanish.

The provider's complaints policy was on display in the entrance hall. All people we spoke with told us they would be confident to raise any concerns or complaints with the staff, the registered manager and the provider. A relative told us about a niggle they had had and this had been swiftly resolved. On the first day of inspection we asked to view the complaints file but this could not be found. On the second day the registered manager told us they did not have a file but had printed off two complaints from the computer for us to view. These two complaints were adequately investigated and appropriate action had been taken in response to these.

It is recommended that the provider establishes an effective system to keep accurate records of complaints so they are easily accessible.

The service supported people and their families in relation to end of life care. People's preferences and choices were detailed in care plans if they wished. Where appropriate, there were Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place. The registered manager told us that the home worked with the local hospice to ensure people received appropriate care at the end of their lives. The registered manager and two members of staff were undertaking the six steps programme. This is a nationally accredited course which aims to develop staff knowledge and enhances end of life care for people. People and staff were supported to attend an annual memorial service which took place at the lake opposite the home.

Requires Improvement

Is the service well-led?

Our findings

We identified areas within records that contained gaps or were not up to date that had not been identified by staff in the service. For example, we found some gaps in the cleaning schedules and on some monitoring records for people. Improvements were needed regarding the recording of people's PRN and topical medication as well as fluid charts and a small sample of care plans had not been regularly reviewed. Additionally, there were few records of appraisals and supervisions. There was a risk that if robust records were not put in place and maintained, this could negatively impact on people and the effective running of the service, particularly if the service recruited new staff or needed to use temporary staff.

A failure to maintain an accurate, complete record in respect of each service user and the management of the service was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A general monthly audit tool was in place, this looked at areas such as safeguarding concerns, complaints, pressure sores, DoLs, staffing, accidents and incidents. Although individual issues were acted on we did not see that this information had been used to analyse concerns at a service level or identify patterns and trends.

A range of audits were carried out by the clinical lead or a nurse which included care plan audits, medicine audits and infection control audits, however as these were only conducted every three months and were a sample of records, they did not identify all of the areas that we found needed improvement on inspection. The registered manger told us that they monitored the audits that were carried out by the clinical lead and nurses, however, there was no evidence of this and issues with records had not been identified. The provider did not use an action plan in the service and told us that they used meetings to act on areas that needed improvement. We saw that the records of staff meetings did not address all of the areas that we found needed improvement.

The absence of a robust governance system to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and provider were consistently described in a positive manner by staff, people and relatives. They were described as open, supportive, approachable and caring. One member of staff said, "[Provider] is really supportive, if you ask for something, it happens". A visiting professional told us they felt the service was well run. They said "The managers are always around, there is a stable staff team who are knowledgeable about people and everyone is always friendly and helpful".

The registered manager told us they had high standards and promoted the ethos that staff should always deliver high quality and personalised care. During the inspection staff demonstrated this ethos and it was clear they were dedicated to ensure people's experience in the home was as positive as possible. All the staff expressed commitment to the people living at Regency. They used comments such as "The best thing about

working here are the residents, I love going round their rooms and chatting with them" and "We have a special relationship with the residents". Staff were also complimentary of each other. They said "We're a good team", "I love my team" and "We all support each other".

The provider had a clear staffing structure in place which provided clear lines of responsibility and ensured people's care was overseen by an allocated member of staff. Staff understood their roles and responsibilities within the home and strived to ensure they delivered a service that people wanted and that met their needs. The registered manager held regular staff meetings to support staff to understand their roles. Staff we spoke with told us they felt valued and were able to share ideas on how to improve the service. Staff felt they were engaged and listened to. For example, one member of staff gave an example of where they suggested the idea of colour coding supplementary care folders which would quickly highlight certain needs of people to staff. This idea was taken forward and used effectively in the home.

Staff described the communication in the home as good. Staff received verbal handover meetings in between shifts and they also received daily handover sheets. These meetings and handover sheets were effective in ensuring important information was communicated to all staff.

The provider engaged people and their representatives in the running of the service and invited feedback through the use of questionnaire surveys and meetings. Feedback was predominantly positive and we saw where people had fed back changes they wanted, these had been done. For example, one person had requested the heating to be turned up in the evenings and another asked for a remote control for their television which was implemented.

The provider worked in partnership with other organisations to make sure they were providing appropriate care for people. These included social services and healthcare professionals such as G.Ps, dentists and opticians. Additionally, the registered manager had organised for the home to work in partnership with the Solent NHS Research Team which aims to improve the quality of life for older people and people with a dementia. The service was also a member of the National Activity Providers Association (NAPA), which supports services to provide creative and innovative activities for people receiving care. The registered manager also told us that students from the local college undertook work experience at the home; they said it was beneficial for the students as well as the people who lived in the home.

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.

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 17 HSCA RA Regulations 2014 Good governance The failure to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users, as well as the failure to maintain securely an accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (b)(c)