Amesbury Abbey Limited

Sutton Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 17, 20 and 21 June 2016 and was unannounced. Sutton Manor Care Home provides nursing and personal care for up to 38 older people including those who have a sensory impairment or physical disability. At the time of our inspection there were 30 people living in the home.

The home is located is Sutton Scotney on the outskirts of Winchester and is situated within private parklands and gardens. People were accommodated in single rooms or suites with en suite facilities. Communal areas included; a drawing room, library and dining room.

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

People told us they felt safe with staff and the staff we spoke with demonstrated their understanding of how to safeguard people and report their concerns. People were protected from the risk of abuse.

People had risk assessments in place that detailed their individual areas of risk and how these should be managed to keep people safe. Risk management plans were not always evident for people who were assessed as at risk of falls. Falls were not routinely monitored to identify any developing trends so that remedial actions could be identified. Accident and incident reports did not always identify the actions to be taken to prevent a reoccurrence. This meant the system in use to review, manage and monitor the risks to people from falls was not consistently applied and could leave people at risk from recurring falls.

There were processes in place for the safe ordering, storage and disposal of medicines and medicines were administered to people by trained staff. It was not evident that reviews had taken place to evaluate the safe regular use of medicines that were prescribed to be taken 'as required'. We found some unexplained gaps in the recording of people's medicines. The registered manager took action to address these issues following our inspection.

There were sufficient levels of suitably skilled staff available to meet people's needs. Agency staff were checked for their suitability to work with people and as far as possible the same agency staff were used to provide a continuity of care for people.

Staff completed an induction into their role to ensure they were competent to carry out their responsibilities. Staff were supported by the registered manager, group trainer and senior staff through a range of training courses, regular supervision and annual appraisal to develop the skills and knowledge they needed to meet people's needs. Records showed staff had completed most of the provider's mandatory training and were supported with their continuing and professional development.

The registered manager had identified a number of people who they believed were being deprived of their liberty and had made applications to the supervisory body for authorisation. Staff understood the principles of the Mental Capacity Act 2005 (MCA 2005) and people's consent was sought prior to care and treatment being provided. People rights under the MCA were upheld.

People were offered choice by staff regarding the support they required and where people had made decisions, these were respected by staff. Staff were knowledgeable about people's preferences and acted to ensure these were met.

People were supported with their nutrition and hydration needs and where people required assistance with eating and drinking this was provided. People told us and we observed the food was good quality and people were offered choice to meet their dietary needs and preferences.

People's healthcare needs were attended to promptly and people were seen by a range of healthcare professionals as required.

People and their relatives spoke positively about the caring approach of staff and told us staff were caring, compassionate and thoughtful in their approach. Staff completed training in dignity and respect and we observed that staff treated people with dignity and respect. People's decisions for their end of life care were known and respected.

People's care plans were person-centred and included their preferences for how their care should be delivered. Care plans were regularly reviewed and updated with people's changing needs to ensure they remained current and appropriate.

A range of activities was available for people to participate in if they chose to do so and people told us they enjoyed these. This included group and one to one activities if preferred.

A system was in place for people to raise their complaints and concerns and these were acted on quickly and appropriately.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. This included feedback from people, their relatives and staff. Actions identified as a result of quality monitoring were taken to drive continuous improvement.

There was a positive culture in the home and staff were aware of and acted in accordance with the provider's values to provide high quality care. Staff and people spoke positively about the management and leadership in the home and staff were supported to be clear about their roles and responsibilities through supervision, training and team meetings.

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.

Risks to people had been assessed and actions were taken to ensure their safety. However the system in use to review, manage and monitor the risks to people from falls was not consistently applied and could leave people at risk from recurring falls. Action was being taken to ensure the system was consistently applied and effectively monitored, but it would take time for the service to be able to demonstrate this had been implemented and embedded within staffs practice.

Some people required medicine reviews to ensure the safe and appropriate continued use of medicines prescribed to be taken 'as required'. People's Medicine Administration Records (MAR) were not always fully completed to evidence the safe and proper management of their medicines. The registered manager took action to address these concerns following our inspection, but it would take time for the service to be able to demonstrate the improvements had been implemented, embedded and sustained.

People were safeguarded from the risk of abuse. Staff had completed relevant training and understood their roles and responsibilities in relation to protecting people from the risk of harm.

People were supported by sufficient and suitably skilled staff to meet their needs safely. The same agency and bank staff were used to cover staff vacancies as far as possible to ensure a continuity of care for people.

Is the service effective?

Good

The service was effective

Staff received appropriate training, supervision and appraisal to ensure they were adequately supported and competent to meet people's needs.

Staff sought people's consent prior to providing care and treatment. People's rights under the MCA 2005 were upheld in

decision making where people lacked the mental capacity to agree to their care and treatment.

People were only deprived of their liberty where an application had been made to the local authority for authorisation. This meant the correct legal processes were being followed.

People were supported with their nutrition and hydration needs to minimise and address risks from malnutrition and de-hydration. People were provided with a good quality and choice of food to meet their dietary needs and preferences.

People were supported to achieve good health outcomes by nursing staff on site and other healthcare professionals as required.

Is the service caring?

Good

The service was caring

People experienced kind and compassionate care and enjoyed positive relationships with staff.

People were involved in making decisions about their care and these were respected by staff. People's preferences were met as far as possible.

People received dignified care and their right to privacy was respected.

Is the service responsive?

Good

The service was responsive

People's care and treatment plans were person centred and reflected their preferences and decisions. People were supported in line with their care and treatment plans.

People's activity and social needs were met through a range of group based and individual activities provided by an activities coordinator and staff.

A system was in place for people to raise their complaints and concerns and these were acted on.

Is the service well-led?

Good

The service was well led.

Quality assurance processes were in place to enable the provider and registered manager to monitor and audit the service and drive continuous improvement to the service people received.

There was a positive, open and inclusive culture in the home. Staff were aware of and acted in accordance with the provider's values to provide high quality care for people.

Staff were supported to understand their roles and responsibilities. People, staff and their relatives spoke positively about the registered manager and the leadership within the home which inspired confidence and motivation.

Sutton Manor Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 17, 20 and 21 June 2016 and was unannounced. The inspection was conducted by one adult social care Inspector. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, for example, previous inspection reports and statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with five people, two people's relatives, 11 members of staff, including care and nursing staff, activities, training and kitchen staff, a health care professional, the registered manager, the deputy manager and we spoke briefly with the provider's managing director. We looked at 5 people's care plans and their associated daily care notes, five staff recruitment files, staff training records and people's medicine administration records. We also looked at the staff rotas for the dates 9 May to 19 June 2016, quality assurance audits, policies and procedures relating to the running of the service, accident and incident records, maintenance records and quality control questionnaires.

During the inspection we spent time observing staff interactions with people which included a lunch time sitting. After the inspection we were provided with additional feedback from the relatives of four people.

This was the first inspection of Sutton Manor Care Home since the new provider registered to deliver care from this location in March 2014.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Sutton Manor Care Home and a person said "I feel very safe and secure". Staff we spoke with demonstrated their understanding of safeguarding and their responsibilities. A staff member told us how they had reported a concern and this had been acted on and said "I have a lot of faith in the registered manager and deputy manager and I am confident they would act". We discussed the management of safeguarding concerns with the registered manager who evidenced they had taken the appropriate action when required. Records confirmed that staff had completed training in safeguarding and staff had access to policies and procedures for guidance should this be needed. People were protected from the risk of abuse.

People's care plans evidenced that risks to people had been assessed in relation to a number of areas such as the risks from falls, moving and handling, developing a pressure ulcer, malnutrition, the use of bed rails, and risks from medicines such as the risks from self-administration. People told us they were supported to manage risks safely. For example; a person told us how they were supported safely with their moving and handling needs and had the specialised equipment they required for their health needs. Another person told us how they used a walking aid to support them to mobilise safely and carried a mobile pager so they could alert staff if they needed them. People's moving and handling needs were individually assessed and detailed the number of staff and the equipment required to support the person safely. The moving and handling assessor was based on site and provided guidance and training to staff as required. The assessor described themselves as "Passionate and tough" on moving and handling and addressed people's needs promptly. We saw examples of actions they had taken to improve people's equipment, staff practice and environmental changes to ensure people's safety and comfort needs were met.

An accident and incident reporting system was in place. Accident and incidents were recorded by staff and checked by the registered manager. Accident and incident forms did not always include details of the actions taken in response to an incident to prevent a reoccurrence and accidents from falls were not routinely monitored to look for developing trends. Although the risks to people from falls were assessed, falls management plans were not always evident to clearly identify the strategies in place to reduce the on-going risks to people from falls. Whilst we saw examples in some people's care plans that falls management plans were in place, the system in use was not consistently applied to evidence the appropriate guidance was available to staff to minimise on-going risks to all people from falls. The registered manager has confirmed action was being taken to ensure the system was consistently applied and effectively monitored, but it would take time for the service to be able to demonstrate this had been implemented and embedded within staffs practice.

Staff we spoke with told us about some of the risks that people faced and knew about the strategies in place to manage these risks. For example staff told us about people who required their food and drinks to be served in a safe consistency for their swallowing needs and we saw this was followed during lunch time. When people were at risk due to behaviours that may challenge others, staff recorded incidents and responses to monitor, review and act on people's safety and support needs. People were being protected against these risks and action was taken to prevent the potential of harm.

There were arrangements in place to keep people safe in an emergency. People's support needs in the event of an emergency evacuation had been individually assessed. Their support needs were described in a Personal Emergency Evacuation Plan (PEEP) which enabled staff and emergency services to identify their needs in an emergency. Staff practised evacuation procedures so they were aware of the routes and the support required by each person to evacuate the location safely.
A business continuity plan was in place which described emergency scenarios such as; a gas leak, power cut and lack of staff, and the actions staff should take in the event of these incidents. This meant risks to people in an emergency had been considered and a plan was in place to support people safely in these situations.

People told us there were sufficient staff to meet their needs. A person said "I think there are enough staff, the sisters (nurses) are excellent, some care staff are wonderful – they are all pretty good". Another person said "I am happy with the number of staff we are very lucky its equivalent of a five star hotel". Staff told us the staffing levels were sufficient and they had enough time to meet people's needs. A person's relative said "I have no concerns about the staff here, I've been here about an hour today and so far two staff have popped in so yes enough. Very rare for them not to pop in and mum uses (her) call bell. They have looked after her very well – they are conscientious and on the case". The provider used a dependency assessment tool to calculate the staffing levels based on people's needs. This showed the staffing levels provided met people's identified staffing needs with a small excess of staffing hours.

At the time of our inspection there was a staffing vacancy for one night nurse and one care staff. Recruitment was underway and the registered manager told us they used agency staff to cover the vacant shifts. They explained how they used regular agency staff wherever possible to provide continuity of care and the agency nursing staff who worked at night were required to complete a day shift prior to taking this responsibility. We looked at the staffing rotas for the period 9 May 2016 to 19 June 2016 and saw the staffing arrangements were as described. The registered manager told us they were able to increase staffing numbers when people's needs changed and as a registered nurse they were able to provide additional support to nursing staff if required.

The provider had completed some of the required recruitment checks to ensure the suitability of staff for employment during the recruitment processes. For example; staff records we reviewed did include a Disclosure and Barring check (DBS). The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. However, the provider had identified they had not carried out all the required checks. At the time of our inspection the provider was taking action to remedy this shortfall and mitigate the risk to people. Existing staff were being asked to provide a full employment history and confirmation of any gaps in employment where this was missing from their recruitment records by end of June 2016. New staff were completing all the required checks prior to taking up their role to ensure they were of suitable character to support people safely.

We noted that some people who were prescribed medicines to be taken 'as required' were taking these medicines regularly along with their routine medicines for over one year. 'As required' are medicines people take as and when needed for example; some pain relief medicines, medicines to aid sleep or medicines to help calm people if they became agitated or anxious. These medicines are usually prescribed to treat an intermittent or short term condition. The provider's policy stated that 'If PRN (as required medicines) are repeatedly requested they should request a review from the GP'. This is important to ensure people's medicines are regularly monitored for their safe and effective use. It was not evident that reviews had taken place to evaluate the safe regular use of 'as required' medicines. We spoke with the registered manager and deputy manager about this and following our inspection they confirmed the GP had been contacted to discuss medicine reviews. The provider required more time for this improvement to be fully implemented,

embedded and sustained.

We reviewed people's Medicine Administration Records (MAR). The MAR is used to record when people take their medicines or the reason why the medicine has not been taken. Accurate recording of people's medicines is important to ensure the safe and proper use of medicines administered by staff in a care setting. We found some unexplained gaps in the recording of people's medicines. We were assured through an investigation by the registered manager that these were recording errors and that the medicine had been administered as prescribed. Since the inspection the registered manager has taken action to address the shortfalls in recording and introduced a daily monitoring system to check records are accurately completed. The provider needed more time to fully ensure and demonstrate these improvements had been implemented and were embedded in staff practice

There were processes in place for the safe ordering, storage and disposal of medicines. Some prescription medicines are controlled under the Misuse of Drugs Act 1971. These medicines are called controlled drugs (CD's). Providers are required to have procedures in place to ensure CD's are safely managed and that staff follow these to keep people safe. We checked the arrangements for the storage, recording and administration of CD's, we found the processes to be appropriate and that legal requirements were met.

People's personal preferences for taking their medicines were respected. Some people were able to self-administer their medicines with the support from staff. Risk assessments were carried out to ensure people's preferences were safely met. When people were prescribed medicines with a variable dose, or used equipment such as oxygen or a syringe driver (which is used to help control pain by delivering a continuous flow of medicine to a person), staff completed training and had guidance available to support them in their safe use. There was a system in place to review and assess the on-going competency of staff to administer people's medicines. Records showed these were completed prior to staff administering medicines and annually.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. A person said "Nurses are very good indeed, yes well trained staff" and a person's relative said "My mother has been exceptionally well looked after ".

Staff told us they had the training they needed when they started working at the home, and were supported to refresh their training. Records demonstrated that new staff had undertaken the care industry recognised standard induction to their role to ensure they could provide people's care effectively. New staff did not work alone until they had been assessed as competent by their mentor a recently recruited staff member said "I feel confident and competent and I can always go to any level three staff (care staff with a higher qualification in health and social care), everyone is so helpful".

The provider had identified the training required for each staff member's role to ensure staff had the appropriate knowledge and skills required to carry out their role effectively. Records showed that most staff had completed the training identified as mandatory by the provider. This included training in subjects such as; fire safety, safeguarding, manual handling, equality and diversity, infection control and food hygiene. The provider monitored the completion of staff training weekly through a tracker system that enabled them to identify when training required completion or updating.

The provider employed two group trainers to coordinate and support staff training and development. From the records we reviewed and our conversations with staff it was evident that staff had access to the support and resources they required to address their learning and development needs. Each staff member completed a personal development review on the last day of their induction and this was monitored through regular supervision, observed practice and annual appraisal. When staff required additional support to achieve their learning objectives this was provided through study clinics and 'any reason supervision' sessions. For example, staff told us how they had been supported to achieve professional qualifications and additional support required with English as a second language.

Nursing staff were supported to achieve on going professional validation with the Nursing and Midwifery Council (NMC) and completed training to meet the healthcare needs of the people they supported. Nursing competency was assessed by other healthcare professionals as required such as observations of wound care. People were cared for by suitably trained and competent staff who were supported in their role.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA 2005). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body for authorisation.

The MCA 2005 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. When people lacked the capacity to agree to specific decisions about their care and treatment this was assessed and stated on their care plans. Care plans then described how the person should be supported in line with what was known about the person's choice and preferences. We noted the information recorded could have demonstrated more clearly the person's best interests had been fully considered. For example; by ensuring all the steps in the MCA 2005 statutory checklist have been followed including looking for the least restrictive option to meet a person's needs. This was brought to the attention of the registered manager who has confirmed the implementation of a decision making tool incorporating the MCA 2005 checklist for best interest decision making. We were assured that people's rights had not been compromised and appropriate action had been taken to ensure people's best interests were fully considered.

The provider was in the process of checking what specific legal authority other people may hold to make decisions or sign their consent to people's care and treatment as their legally appointed representative. This is important to prevent people from being at risk of inappropriate or unlawful decision making.

Staff understood the principles of the MCA 2005 and told us how they supported people to make choices in their day to day care. This included acting on people's known preferences, showing people objects and using short and clear explanations and questions. For example a staff member said "We've got people with mixed understanding, they can have minimal understanding of complex sentences so we use minimal sentences, I use objects to show them, I wouldn't just give someone a cup with a straw, I aim to help them keep their independence". We observed many examples of people being offered choice by staff throughout our inspection. A person said "They ask for my permission too much, none of that here (not asking)".

Most people told us they liked the food and were able to make choices about what they had to eat. Some people told us it was 'excellent'. One person said they thought the quality 'varied' and a person's relative thought there could be some 'simpler' options on the menu occasionally for people to choose from. We observed that people were asked for their choice of meal and their requests for alternatives to the menu were catered for.

People's dietary needs were documented and known by the chef and staff. People's weight and nutritional needs were monitored and action was taken when people experienced unplanned weight loss. The home's chef kept a record of people's needs which included the safe consistency of their food and those people who required a fortified diet to support their nutritional needs. Peoples care plans included information about their likes and dislikes and records showed that people who had been assessed as at risk of poor nutrition had been supported to gain weight and eat well.

We observed people who required assistance or prompting to eat were supported appropriately by staff. For example; a staff member noticed a person was struggling to eat from their plate and promptly offered them a plate guard which enabled them to move food onto their fork with ease and finish their meal. Food was freshly prepared and the kitchen staff provided home-made cakes for afternoon tea, birthdays and celebrations. We saw people were frequently offered drinks in communal areas and whilst in their rooms. Staff we spoke with understood the importance of supporting people to maintain good hydration. Action was taken to monitor and encourage fluid intake when people were identified at risk of poor hydration.

We spoke with a visiting GP who told us they were "Impressed" with the standard of nursing care at the home. They told us nurses took prompt action and followed the treatment advice and guidance given by the

GP's to ensure people's healthcare needs were met. People told us the nurses were "Knowledgeable" and they received a good standard of healthcare. A person's relative told us they were impressed at the quick diagnosis of their relatives healthcare needs and how following treatment they "Were better in two days". Guidance on people's health conditions was available to staff and where required specific management guidelines were in place to enable staff to give the appropriate care and treatment.

Records showed people received treatment from a range of healthcare professionals such as; district nurses, chiropodists, speech and language therapists (SALT), Community mental health team and hospital clinics. We saw that a new 'acute observation' tool had been introduced to provide a prompt assessment of people when they were unwell. This was used to closely monitor people's condition so the appropriate action could be taken when required. Relevant information was available to staff to report to emergency or other healthcare services as required. People were supported to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

People and their relatives told us they were happy with the care they received. A person said "Staff are caring, they couldn't be better, my goodness yes". People's relative's comments included; "All the staff are wonderfully friendly and caring, and they have always treated (person) with the greatest respect and consideration" and "The staff come over as caring, personal and friendly, (person) was particularly pleased when she received gifts on her birthday, Christmas Easter and Mother's Day. Thoughtful acts".

We observed that staff spoke to people with kindness and care. For example, a person who appeared confused was helped and escorted by a staff member to find their way to their room with reassurance. Other exchanges included staff commenting on people's appearance, assisting them to be comfortable and having a chat about subjects of interest to the person. A person's relative said "They (staff) are so sweet and nice with (person). I love the feel of it here as it is so homely".

Staff told us they had enough time to spend with people to get to know them. A staff member said "We get enough time to care and chat, I was with a person for over an hour the other day, there is no time limit". People's care plans included some information about people's past employment, family and social experiences that the person wanted staff to know about. Staff told us about people's likes, dislikes and preferences and what was important to the person such as; privacy or maintaining contact with their family.

The registered manager told us they operated an open door policy for people to see them in their office. They added "It is also useful to talk to people in their own surroundings (room)". They told us how they used these opportunities to check people experienced a caring approach from staff. The registered manager, deputy manager, head of housekeeping and group trainer were all dignity champions. Dignity champions check that care is compassionate and person centred and take action to challenge poor care. For example; the registered manager was acting on an allegation concerning inappropriate language used by a member of staff. The dignity 'do's' were displayed in the home, these are the values and actions that people should experience from care services such as respect, choice and control. Staff completed privacy and dignity care standards training as part of their induction and told us how they provided dignified and respectful care. A relative said "They (staff) are not brusque and they are good at privacy and dignity". Our observations confirmed staff treated people with dignity and respect.

People's records included information on how they preferred to be supported and their preferences for their daily routines. For example; when and where people preferred to have their breakfast and lunch and how they chose to spend their day. Staff told us how when people refused care, they respected their decisions and returned to check if people were happy to receive their care at a time they wanted. The registered manager told us how they had made changes based on people's preferences for their care such as; changing the time of staff handover to accommodate the preferences of people who liked to be supported with personal care at this time. People's preferences were respected by staff.

People's records evidenced their preferences and decisions about their end of life care were discussed with them including their spiritual needs. Nursing staff had completed end of life training and the deputy

manager explained how services and equipment were provided as and when needed. We saw people had recorded decisions about the circumstances in which they would prefer to receive resuscitation and hospital treatment and when they had chosen not to. People were supported to make decisions about their end of life care.

Good

Is the service responsive?

Our findings

People's care and treatment plans were personalised and the examples seen reflected people's needs and choices and whether the need presented any risks to the person. An example of this was a person's care plan for their personal care needs. This included what they were able to do for themselves, what they needed help with, what hadn't gone well, and how to manage risks in this area. Care plans were structured to include people's mental capacity to consent to their care and treatment, and the number of staff and equipment required to meet their needs. A person told us about the support they received with their personal care which was as described in their care plan and added "I am happy with the routine". Daily progress and evaluation notes were completed by nursing and care staff and these contained information about the care people had received to meet their identified needs. People received care in line with their care and treatment plans.

People's needs were reviewed monthly and when their needs changed. Care plan reviews included what had been achieved and any changes to people's care and treatment needs. For example; we saw a person's review reported their recovery from a health concern following successful treatment. Changes had been made to their care plan to reflect their changed needs in terms of staffing levels, risk levels and healthcare needs following their recovery. This meant care plans reflected people's up to date needs following their review. People's relatives told us they were kept updated about their relative's needs. The registered manager had recently introduced monthly updates by e-mail to relatives who were unable to attend people's reviews and a person's relative told us this was "A good initiative". Consent to share information and contact with family members or people's representatives was recorded in peoples care plans.

Sutton Manor Care Home is registered to provide accommodation, personal and nursing care for older people who may have physical and sensory disabilities. Some people living with dementia were also supported in the home. The registered manager explained that if people living with dementia had risks associated with behaviours that may challenge others an assessment would be made by the Community Mental Health Team (CMHT) and the home. This would determine if the person's needs would be better met in a dementia specialist home. Records showed staff monitored people's behaviours where necessary and the CMHT provided support, advice and assessment as required. Staff told us how they supported people to minimise their frustrations and reduce incidents of behaviours that challenged others. For example a staff member told us about the approach they used with a person which demonstrated they understood their needs. We observed this staff member approach the person in a positive and friendly manner, using short clear sentences and explaining choices as described in their communication care plan.

People had a range of activities they could be involved in if they chose to. There was an activities coordinator in post who provided group and one to one activities. People we spoke with were positive about the activities on offer. People's comments included; "Activities are marvellous" and "Activities are better than sitting in your room and doing nothing, I enjoy the activities". During our inspection we saw people were involved in activities such as; exercises, an afternoon film with tea and scones, a flower making demonstration and art work. A person showed us the activities schedule they kept in their room and said "We had painting and we had a quiz the other morning – I enjoyed that and I have a massage once a

month".

The activities coordinator told us about the trips they organised and these included; a curry or pub trip for male residents, visits to Marwell Zoo and trips out to the shops. A car and a minibus were available for transport. Care staff also supported people with activities such as walks and nail painting. The activities coordinator worked Monday to Friday and care staff were responsible for weekend activities. The registered manager confirmed that additional care staff were being recruited to support people's activity needs at weekends.

The provider had a complaints procedure and this was displayed in the home and in the service user guide. We reviewed the complaints log and records showed complaints received had been responded to in line with the provider's procedure and to the satisfaction of the complainant. People and their relatives told us that when they had raised a concern these had been dealt with effectively and promptly. For example a person's relative said "The registered manager dealt with it very well" and a person told us how a concern they raised had been dealt with sensitively and promptly. A system was in place for people to raise their complaints and concerns and they were acted on.

Good

Is the service well-led?

Our findings

The service promoted a positive culture. The registered manager told us their vision was to provide people with "Continuity of care, in a homely environment with personal involvement and personalised care that was not institutional". The provider's values included; privacy, dignity, independence, choice, human rights and fulfilment. Value statements such as the six C's; courage, commitment, communication, competence, compassion and care were displayed in the home. Staff we spoke with were aware of the values and described how they acted to promote them in their work with people. For example a staff member said "Our values are to be caring, compassionate and professional, to put residents' needs first and work as a team to make sure people's needs are met". We saw examples of staff acting in line with the providers values by responding to people's individual needs and choices.

People and their relatives consistently described the culture in the home as positive. People's relatives' comments included "It's very well run – things happen when they are supposed to". "The home is extremely well run in a most efficient and friendly manner" The home is warm, clean and friendly and the staff come over as caring, personal and friendly". The provider operated a recognition scheme whereby people, staff, relatives and other professionals could nominate staff who had demonstrated a high standard of care. Staff we spoke with told us they worked well as a team and experienced good leadership and management that encouraged and motivated them in their work with people. Staff consistently described the registered manager and deputy manager as approachable, knowledgeable and responsive. Staff had confidence the registered manager would listen to their concerns and they would be received openly and dealt with appropriately.

The registered manager and management team supported staff to be clear about their role and responsibilities. Records showed this was achieved through staff supervision, team meetings and by taking action to address staff performance when improvements were required. For example; records showed concerns about staff performance were investigated and addressed to ensure people were supported safely and appropriately. The registered manager told us they were well supported by the provider's managing director who visited the home on a regular basis and provided line management supervision. The provider held monthly managers meetings and records showed these were used to review and update practice in the provider's homes.

An annual resident satisfaction survey was sent out to people and their relatives or representatives from the provider. Records showed the 2015 survey results had been collated and analysed by the provider and registered manager. A report on the feedback received and action taken was made available to people. Action had been taken to address the improvements requested such as; the recruitment of additional maintenance staff, improved lighting in the drawing room and a review of the menu. People and their relatives told us they could talk to staff and managers as required and felt they were listened to. For example; a person told us how the registered manager had made an important change to improve their experience in response to their feedback. People had recently been consulted about whether they would like to have a regular resident's meeting and had agreed they would. We saw the first meeting was planned to take place following our inspection. People were asked for their feedback on the service and it was acted

on to make improvements to the service.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. This included an audit to review and monitor the service against the five key questions asked by CQC during inspections. Records showed action was taken to make improvements based on the findings. For example; acting on health and safety risks identified to staff from the use of a ramp, replacing the kitchen flooring to maintain good environmental health standards, achieving recruitment targets and implementing safer recruitment practices.

A range of other audits were regularly completed and these included areas such as; care plans, medicines management, health and safety, wound documentation, infection control, complaints, dignity in the home and call bell response times. Records showed internal audits had identified shortfalls and action had been taken. For example; a call bell audit had identified some delayed responses and this was raised in the staff meeting, staff were allocated responsibility for answering call bells on identified floors and maintenance action was taken to ensure call bells were operating effectively. A system was in place to drive continuous improvement in the care and treatment people received.