The Park Gate Care Home LLP

Hamble Heights

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

Overall summary

The inspection took place over two days on 3 and 4 September 2015. The inspection was unannounced.

Hamble Heights is a purpose built home located in Park Gate, near Southampton. The home is arranged over four floors and can accommodate up to sixty people who require either residential or nursing care. Some of the people using the service are living with dementia. At the time of the inspection there were 56 people using the service.

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

People and their relatives were positive about the care and support they received. Staff knew people well and understood how to meet their individual needs in a

Summary of findings

person centred way. We observed positive relationships between staff and people living at the home. Staff showed concern for people's wellbeing and people told us this helped them to feel like they mattered.

We received mixed feedback about the staff arrangements within the home. Most people told us that there were enough staff to meet their needs in a timely way; however on one floor, some people told us there could sometimes be a delay in their needs being met because staff were supporting other people. The manager was taking action to review and adapt the deployment of staff and equipment in order that they might continue to improve the ability of staff to be responsive to each person's individual circumstances. However, this is an area for improvement.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These measures helped to ensure that only suitable staff were employed to support people in their homes.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Staff had clear guidance about what they must do if they suspected abuse was taking place.

Individual risk assessments had been completed for people who used the service and covered a wide range of activities and tasks. This helped to protect them from harm.

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

New staff received a comprehensive induction which involved learning about the values of the service, the needs of people using the service and key policies and procedures. The induction also introduced staff to the fundamental standards and aimed to ensure that the new staff member had a clear understanding of their role and responsibilities within the organisation.

Staff completed a range of essential training which helped them to provide effective care. More specialised training specific to the needs of people using the service was also provided, for example some staff had received training in continence care, and pressure ulcer prevention. This helped to ensure that staff were equipped with the right skills and knowledge to meet people's needs.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration. The provider had a range of measures in place to seek the views of people about the quality of the food provided and planned to use this information to make on-going improvements to the dining experiences within the home.

People told us they were able to raise any issues or concerns and felt these would be dealt with promptly. Information about the complaints policy was available in the service's welcome guide.

There was an open and transparent culture within the service and the engagement and involvement of people, their relatives and staff was encouraged and was used to drive improvements. The manager had a clear vision for the service which focused on the delivery of person centred care. The provider and manager demonstrated a commitment to making the staff team feel valued and appreciated for the care they provided. There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

Summary of findings

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.

Staffing levels on one floor could be improved to ensure that staff were consistently able to provide care that was responsive to each person's individual circumstances and wishes.

Medicines were administered safely by staff who had been trained to do so. There were procedures in place to ensure the safe handling and storage of medicines.

Staff knew how to recognise and respond to abuse. They had a clear understanding of the procedures in place to protect people from harm.

Assessments were carried out to identify any risks to people using the service which helped to protect them from harm.

Is the service effective?

Good

The service was effective.

Arrangements were in place to provide new staff with a comprehensive induction. Staff had access to relevant training which helped them to deliver effective care.

Staff had a good understanding of the principles of the Mental Capacity Act 2005. They acted in accordance with people's wishes and choices.

People's nutritional needs were met and people had access to healthcare professionals when this was required.

Is the service caring?

Good

The service was caring.

People told us the care provided was outstanding and that staff 'went the extra mile' to meet their needs.

Staff had a good knowledge and understanding of the people they were supporting. Staff were able to give us detailed examples of people's likes and dislikes which demonstrated they knew them well.

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

Is the service responsive?

Good

The service was responsive.

Summary of findings

Care plans were personalised and contained detailed information about people's needs, their choices and preferences, this ensured staff had the guidance they needed to be able to deliver responsive care and give people the right support.

People and their relatives told us they were confident they could raise concerns or complaints with the leadership team and that these would be dealt with appropriately.

Is the service well-led?

Good

The service was well led.

Significant improvements had been made since our last inspection in September 2014. Staff felt supported by the leadership team and described the home as a good place to work. Staff told us their involvement was encouraged and their feedback was used to drive improvements.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

Hamble Heights

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 checked 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 was an unannounced inspection which took place over two days on 3 and 4 September 2015. On the first day of our visit, the inspection team consisted of two inspectors, a specialist nurse advisor, with expertise in the care of frail older people living with dementia, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. Our expert had experience of caring for people living with dementia and of using health and social care services. On the first day, we focused on speaking with people who lived in the home and their visitors. We also spent time observing how people were being cared for and speaking with staff. On the second day, the team consisted of two inspectors. We spent time with the manager and also examined records relating to how the service was organised. We also were also joined by a pharmacy inspector who focused on how medicines were managed with the home.

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 registered manager tells us about important issues and events which have happened at the service. 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 used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 12 people who used the service. We spoke with the registered manager, the deputy manager and the training manager. We also spoke with eight care staff and two agency care workers. We reviewed the care records of 11 people, the records for four staff and other records relating to the management of the service such as audits, incidents, policies and staff rotas.

Following the inspection we spoke with two health and social care professionals and asked their views about the care provided at Hamble Heights.

The last inspection of Hamble Heights was in September 2014 during which we found four breaches of the legal requirements. This was because the service was failing to ensure that people's care and welfare was adequately managed, medicines were not being managed safely, records relating to people's care were not always complete or accurate and the governance arrangements within the service were not sufficiently robust. The provider sent us an action plan in relation to these breaches of the Regulations saying they would have made the required improvements by 1 July 2015.

Requires improvement

Is the service safe?

Our findings

Each of the people we spoke with told us they felt safe living at Hamble Heights. They all felt the staff team were suitably skilled and provided safe care. One person said, "Yes I feel quite safe, the staff are fantastic". Visitors also said the home provided safe care. One visitor told us their relative was definitely safe. They said, "I wouldn't leave [the person] here if I didn't think they were safe". Another relative said, "We can't fault the place, they [the staff] go that extra mile to make everyone feel safe and well". A third relative said, "I can walk away from her and know [their relative] is safe and the staff love her".

At our inspection in September 2014, we had identified failings in how the service was managing people's medicines. This was because, medicines were not always stored safely and the medication administration records (MARs) contained inaccuracies or omissions. At this inspection, we found improvements had been made.

Medicines were stored securely and the temperature records for the medicines refrigerators and rooms provided assurance that medicines were kept within their recommended temperature ranges. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. People also had a medicines profile which included details such as how the person preferred to take their medicines. The MARs viewed had been completed accurately which indicated people were receiving their medicines as prescribed. Medicines were administered by the registered nurses. Nurses told us they had received training in the safe administration of medicines within the last six months and had undergone competency assessments within the last four months. They were all able to provide clear explanations about the contraindications of a range of medicines and the special instructions associated with them.

Where people had been prescribed covert or hidden medicines, their care plan contained an assessment of their mental capacity with regards to medicines. This was important as it helped to ensure that the person was not being denied the right to make a decision they were capable of making given appropriate support. There was also evidence that a best interest meeting involving the care home staff, the healthcare professional prescribing the medicine and family member or advocate had taken place. Advice had also been sought from the pharmacist. This was important as it helped to ensure that the medicines would continue to be effective despite being administered covertly.

Homely remedies were available within the service. The service had agreed a list of homely remedies with each resident's GP. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds.

The administration of topical creams was recorded on a topical cream medicine administration records (TMAR). Whilst two care workers were able to explain where and with what frequency they applied people's creams, we noted this information was not always replicated on the TMAR and staff were not always recording the administration of creams and ointments. This is an area which could improve.

Protocols and escalation plans had been introduced which described the circumstances within which people might need their 'variable dose' or 'if required' (PRN) medicines. For example, one person with diabetes had a clear escalation plan which described the action that should be taken if the person's blood sugar levels were outside of safe parameters. We saw four other examples where people whose health could deteriorate quickly had detailed care plans which ensured staff were able to manage these situations with the appropriate use of medicines. We did note that PRN protocols which supported the use of pain relief could also be more detailed about the indivualised signs that might mean the person was in pain. The escalation plans for people who were prescribed medicines to manage occasional episodes of agitation also lacked the level of detail we found in the other escalation plans. The deputy manager assured us that they would take immediate action to ensure that all PRN plans were sufficiently detailed.

Staffed employed to work at the home included a manager and deputy manager. Each of the three main floors had a unit manager who was a registered nurse and along with the other registered nurses they oversaw the clinical care within the home. A team of four care workers were based on each of the main floors and attended to people's daily care and support needs. In addition, the home employed a team of housekeeping and laundry staff, an administrator and reception staff, chefs and kitchen staff and two full time activities co-ordinators. There was currently a vacancy for a maintenance person. The home had recently recruited a

Is the service safe?

number of new care workers but continued to have some vacancies and so agency staff were being used on a daily basis to cover gaps in the rota. The deputy manager explained that most of the agency staff were regulars and had been coming to the home for a number of months. This helped to ensure that people received consistent care from staff who knew them well. We spoke with one agency worker who told us they had worked at the home for around a year. They said, "I really like coming to work here, it is a good home with good staff".

We received mixed feedback about whether the staffing levels were adequate. Most people told us there were sufficient staff to meet their needs and that staff responded promptly when they used their call bell. However, on one of the floors, two people told us more staff were needed to help ensure they received their care and support in a more timely manner. Our observations indicated that staff on this floor were working hard but were struggling to always meet people's needs in a timely manner. For example, we noted there could at times be a delay in call bells being answered. We spoke with one person who told us, "Often they [the staff] answer the buzzer in the middle of helping someone else; they say we will be back in five minutes but that can turn into 15 minutes". They were anxious to stress that the staff were "really lovely… just stretched". Another person told us they liked to get up around 9.30am but often had to wait until 10.15 before staff could attend to them. We noted that people's morning personal care routines on this floor were not completed until just before lunch. Staff told us the dependency of people on this floor was quite high at present and therefore they felt additional staff were needed. One staff member told us people always received the care they needed, but they regretted not being able to always provide this in a timely manner. We spoke with the manager about the feedback from people and staff. The manager said staffing levels would be reviewed in light of our feedback and she expressed a confidence that if this indicated additional staff were required, the provider would facilitate this.

Appropriate recruitment checks took place before staff started working at the home. Records showed staff completed an application form and had a formal interview as part of their recruitment. The manager had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) 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. Checks were made to ensure the registered nurses were registered with the body responsible for the regulation of health care professionals.

There were a range of systems and processes in place to identify and manage risks to people's wellbeing but also environmental risks. Detailed pre-admission assessments were undertaken which helped the management team reach informed decisions about whether they could safely meet the person's needs. Each person had a range of individual risk assessments which had been evaluated regularly. For example, clear moving and handling risk assessments were in place. These were detailed and well written and considered a range of factors that could impact upon the person being moved safely and efficiently such as their cognition, behaviour and pain levels. Risk assessments were also in place which helped predict whether people were at risk of falls, developing pressure ulcers or becoming malnourished. Where people were at risk of choking, risk assessments had been completed and a choking care plan was in place. This included a choking algorithm or flow chart which provided clear instructions about the actions staff should follow in the event of choking occurring. It was not clear that all staff had received training in how to provide an emergency response to choking incidents. We discussed this with the manager who made immediate arrangements for all staff to receive/update their training the week following our inspection. A small number of people had food and fluid charts which were being used to monitor risks to people's nutrition and hydration. We noted two people's charts had not been fully completed and this is an area which could improve. The fluid charts also did not include a target fluid intake. This is important as it helps staff to assess whether people are taking in the recommended fluid level.

Most of the risk assessments had corresponding care plans which provided step by step information for staff and assisted them to provide safe care which protected people from harm. People had a range of pressure relieving devices that helped to reduce pressure on people's skin and reduce the risk of ulcers developing.

A number of methods were used to share information about risks to people. Handover meetings were conducted daily where staff shared information about any risks affecting the person's health and wellbeing. Each day the heads of department had a stand up meeting where

Requires improvement

Is the service safe?

clinical and environmental risks were discussed. During this meeting, the nursing staff reviewed each other's MAR charts to ensure any potential medicines errors were identified quickly. Each person had a personal emergency evacuation plan which detailed the assistance they would require for safe evacuation of the home. The provider also had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home.

Records were maintained of incident and accidents within the home. The deputy manager monitored and analysed these each month so any trends or patterns could be identified. The progress of pressure ulcers was reviewed. Records relating to this were up to date and detailed and recorded the date of onset of the pressure ulcer, its location, classification and dressing and treatment. The outcome and date the ulcer healed was also recorded. We had identified as part of our inspection that wound care records could be improved by taking more photographic evidence of the wounds. The deputy manager said they would take immediate action to ensure this happened. We did note that some accident and incident reports had not been brought to the attention of the management team and remained stored on the units. This could limit the effectiveness of the systems in place to reflect upon the nature and cause of incidents and accidents and risks to people's health and wellbeing.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The organisation's training manager undertook group supervisions themed around safeguarding which further enhanced staffs knowledge. The organisation had appropriate policies and procedures which made explicit links to the Local Authorities multi-agency safeguarding procedures. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Information including the contact details of the local safeguarding team was readily available at each of the nurse's station. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. One member of staff told us, "I have been trained in safeguarding and I know what to do and who to report to if I saw something was wrong, the managers here would take me seriously if I raised any concerns". The manager had promptly shared information with the local authority and taken immediate action to safeguard people following a concern being brought to their attention.

Staff told us they were aware of the whistle-blowing procedures and were clear they could raise any concerns with the manager of the home, but were also aware of other organisations with which they could share concerns about poor practice or abuse. An agency care worker told us, "I know that things can go wrong sometimes, but nothing deliberate would happen here because the staff are too kind and good".

Good

Is the service effective?

Our findings

People and their relatives told us the service provided effective care. People told us staff were well trained and understood their needs. A visitor told us their relative had "Regular attention from very well trained staff". One relative told us "I think it's an amazing place for [their relative], they explained their relative could display behaviour which challenged, but she felt the staff dealt with this really well. This was echoed by another relative who said, "They handle [the person's] aggression very well, they don't aggravate this". People told us they received medical treatment when they needed it and this was confirmed by the relatives we spoke with. One relative said when their relative contracted a chest infection, "The doctor was called in the afternoon, they came out after surgery and drugs were given that evening".

Where people had capacity to consent, staff sought their consent before providing care and support and respected their choices. We saw staff asking people where they would like to sit, what drink they would like and what they would like to watch on the TV. Staff were clear they would respect people's decisions and choices. One registered nurse said, "Residents have the legal right to make their own decisions about things that affect them for as long as they are able and it is our job to help them make those decisions". Another staff member said, "Mental capacity is all to do with the legal right people have to make their own choices and their cognitive ability to do so. Even if we do not think their decision is wise, it is still their decision that counts". People had a 'moving in form' which considered whether the person had the capacity to make the decision to live at the home. People had signed consent forms for having their photographs taken, for flu jabs and for sharing information with other professionals. People had consent and capacity care plans and when reviews took place, the person's ability to continue to consent to their care was reflected upon.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. Staff had received training in the MCA and they were able to demonstrate an understanding of the key principles of the Act. Staff understood that any actions taken must be in the person's best interests when they lacked capacity to make informed decisions. Where the home had concerns regarding a person's ability to make specific decisions about their care, detailed and personalised mental capacity assessments had been completed. Where required, staff had worked with relatives and other professionals to reach 'best interests' decisions. Clear records were available to identify where relatives or friends had legal authority to make decisions about the person's health and welfare.

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

Training and induction of staff was overseen by the organisation,s full time training manager who was based at the home. They had developed a comprehensive induction which involved completing some mandatory training, learning about the values of the service, the fundamental care standards, and key policies and procedures. New workers shadowed more experienced staff, learning about people's needs and routines. The induction was mapped to the Care Certificate which was introduced in April 2015. The care certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate.

Staff were provided with opportunities to develop their skills and knowledge and perform their role effectively. They completed a range of essential training which included fire safety, infection control, nutrition and safeguarding people. More specialised training specific to the needs of people using the service had also been undertaken. For example, some staff had completed training on continence care and attended a pressure ulcer workshop. Some of the registered nurses had attended a falls workshop and completed training in the use of specialist equipment used to manage people's pain during end of life care. Some staff had been enrolled on work based qualifications at a local college and eight staff were due to attend training on managing behaviour which challenged in October 2015. The organisation was rolling out 'My learning cloud' where staff would be able to

complete online training. They were making computers available within the home to assist with this. Staff told us the training provided was good. One staff member told us, "I have had lots of training and I get lots of support". Another staff member said, "We get a very good induction and training". Staff told us they were now receiving regular supervision which was helpful and an opportunity to reflect upon their practice, discuss their personal wellbeing, issues regarding the people using the service and any safeguarding matters. The PIR indicated that each staff member would be receiving an appraisal of their performance in September 2015.

We did note that only a small number of staff had training in caring for those living with dementia. The training manager told us all of the training delivered considered the specific needs of people living with dementia. They explained that they were currently also working with a PhD student from a local university who was holding workshops for staff on how they might effectively undertake activities with people living with dementia. The manager explained that the organisation was keen to source the best possible training in dementia care and so they were visiting other homes to see how they were implementing this. The Chief Executive Officer told us they had recently met with Beth Britton a campaigner, consultant, writer and blogger on dementia care and were investigating a range of options to develop the dementia training offered within the service but had not yet fixed upon one particular model.

Most people and their relatives were satisfied with the quality of the food and felt this was provided in sufficient quantities. Their comments included, "The food is very good" and "There is plenty of choice". Written and pictorial menus were available and people were given a choice of two cooked meals. People told us they could always ask for an alternative if they did not want the planned meal. A selection of hot and cold drinks were available throughout the day. Each person we visited had water or juice in their rooms. Snack plates were available in the kitchenettes areas on each floor and consisted of sausage rolls, baby tomatoes, carrot sticks and cheese straws in the morning and a selection of homemade cakes in the afternoon. Where people required a pureed diet, each of the elements of the meal had been pureed separately so that people could still taste the different flavours. The provider was working with a specialist food provider to enhance further the visual appeal of the pureed meals so as to make the dining experience more pleasurable and dignified for people requiring this type of diet. A hydration champion was appointed on each floor every day and their role was to ensure people were being encouraged to have fluids throughout the day. A number of people lived with conditions which affected them being able to swallow safely. They had been assessed by the speech and language therapy team who had provided guidance about the type of diet they required. We saw this guidance was being followed.

Improvements were being made to the dining experience. 'Family dining' had been introduced. The manager told us the aim of this was to make the meal time experience more meaningful and more of a social experience by encouraging staff to eat alongside the people they are caring for. The manager also explained there were plans to revise the menu to ensure it fully reflected the choices, likes and dislikes of the people using the service.

The premises were suitably adapted and pleasantly decorated. There were landscaped and fully accessible gardens which included a variety of areas for people to enjoy including sensory plants, seating areas and chickens. On the first floor there was a pleasant patio area with outdoor furniture. Whilst we did not see people using either of the outdoor areas, the manager assured us people did and very much enjoyed being able to spend time outdoors. The manager told us they had plans to convert a private dining area into a spa/ therapy room and develop an area on the ground floor into a shop for people to visit. We did note that some aspects of the interior design of the building could be enhanced to meet the needs of people living with dementia. For example, more signage would help people to readily identify the toilets and bathrooms. In the kitchenettes, we felt people living with dementia would find it hard to identify where utensils or the fridge were for example, as they were all stored behind uniform wooden doors. The manager was aware that further improvements could be made to enhance the environment to make this more enabling for people living with dementia and we saw that this was listed on the organisation's objectives.

Where necessary a range of healthcare professionals including GP's, community mental health nurses, dentists and speech and language therapists, had been involved in planning people's support to ensure their health care needs were met. When people were admitted to hospital, a member of staff accompanied them and a summary of information about their key needs, routines and

Good

Is the service effective?

preferences was provided. Each week, a GP attended a 'ward round' at the home, during which they were able to review people about whom staff had concerns or who were presenting as being unwell.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and compassionate staff. One person told us, "I like it here; the staff are always kind to me". Other comments from people included; "The staff are absolutely fantastic" and "They are caring… it's like a family, they are always here when you need them". One person told us how staff came and gave her a kiss before leaving at the end of her shift. They explained that it made them feel like they mattered and that they were cared about. Relatives were also positive about the caring nature of the staff team. One visitor said, "The staff treat my mum like she wants to be treated, they are respectful and make her laugh". Another relative said, They are carers, they are very caring, I have come in unexpectedly and seen a carer cuddling her because she was upset". Another said, "The staff are very caring and engage with people, when I am leaving someone will sit with mum to lift her spirits. They told us the staff really knew their relative, they said, "They know her likes, dislikes and fears, they make sure information is passed on to new staff". Another relative said, "The best thing about this place is the staff and I think the care is outstanding".

Prior and during the inspection we received a significant amount of positive feedback about the caring nature of the staff team. One relative whose loved one had recently passed away told us, "The most important component for family members in a situation where a relative has to be admitted to a nursing home is the care and compassion of the staff. In the case of my mother, the staff could not have been more caring and dedicated to her welfare. Without exception they all treated her with respect, patience and compassion. They were also extremely kind and supportive to us as relatives". Another relative also praised the caring nature of the home. They said, "They have got to know us and care about us too, there is a rapport, we know [their relative] is safe and well looked after".

Our observations indicated that staff interacted with people in a kind and compassionate manner. We saw a considerable number of warm and friendly exchanges between staff and people. Staff appropriately used touch to demonstrate their concern for people and we saw people valued this. Staff described their colleagues as kind and caring. One staff member said, "There is so much love, the staff are so caring, they come in for people's birthdays on their days off, the staff are amazing". Another said, "This is just the best place to work, you could not find a better home, the staff are so caring and everyone works together helping out, it makes such a difference as we are one team with the same purpose which is to look after the residents in the very best way". Agency staff were also positive about the caring nature of the staff team at Hamble Heights. One agency worker said, "This is a brilliant home with lovely staff".

The manager was committed to providing a strong person centred culture. They explained that recruiting and retaining a caring staff team was key to this. One of the interview questions for new staff was, 'what qualities make a good carer'. The manager explained that if they did not say kind, she would not hire them. She said it was an ethos of the home to 'hire for the heart; train for the brain'. Part of the induction of new staff focused on ensuring they understood the organisation's values and felt confident putting these into practice. The manager talked of the importance of caring for and supporting her staff team and of making them feel valued. She had implemented a range of initiatives such as 'Fat Friday' to support this. On fat Fridays cakes and treats were bought for the staff team. An ice cream machine had also been ordered which would be available in reception for people and staff to use free of charge.

Staff had a good understanding of people's individual needs. Staff were able to give us examples of people's likes and dislikes which demonstrated that they knew them well. We were given examples of the types of food people liked to eat and what activities they enjoyed, what made them happy and what helped them to settle if they were anxious. This information was also reflected in people's care plans which were person centred. We observed one care worker ask a person if they would like a cup of tea which was declined by the person. The staff member then suggested "You usually like a nice hot chocolate". The person readily agreed to this.

People told us their decisions were listened to and their choices respected. For example, they told us they could choose what to eat or drink or whether to join in activities. One person told us how they liked to just spend time in their room, they said, "They respect this, they don't bully me". Another person said, "They don't say you must do this or that, they are very friendly". The importance of acting in accordance with people's consent and choices was highlighted throughout the care plans and there was

Good

Is the service caring?

evidence people had been involved in planning their care and support. Many had signed their care plan to confirm they had been involved in drafting this and agreed to its contents. Relatives also felt involved and told us they could visit at any time and share in their loved ones care. They told us they were always made welcome. A tea room had been created on the ground floor where people and their relatives could share an afternoon tea together. A new chef had just been recruited with the involvement of people and their relatives through a 'bake off' style competition.

People received dignified care and were encouraged to remain as independent as possible. In the recent residents and relatives survey, all 25 respondents either agreed or strongly agreed their dignity was maintained at all times and their diversity was respected. The service user guide included a philosophy of care which placed a strong emphasis on providing care that was person centred, dignified and respectful. Staff provided care in a manner which was in keeping with this philosophy of care; they were careful to ensure people's doors were closed when providing personal care; they knocked on people's doors before entering and addressed them by their chosen name. A dignity champion had been appointed and it was their role to ensure dignified care continued to be embedded within the service.

Good

Is the service responsive?

Our findings

When we inspected in September 2014, we had found that people had not always been protected against the risk of receiving inappropriate care and support because information kept about them was not always complete, accurate or person centred. As a result we issued a requirement. The service sent us an action plan which told us the actions they intended to take to make the required improvements. During this inspection we found that the required improvements had been made.

People's care plans had been re-written to ensure they provided a detailed and personalised record of their individual needs, preferences and choices. Each person's care plan addressed areas such as their ability to give consent to their care and the assistance they needed with personal care or moving and handling tasks. Dietary preferences were recorded as were the person's wishes in relation to the sex of the care staff that supported them. The plans were indivualised and included detailed information that helped staff to effectively support and care for the person. For example, one person had a continence care plan which contained detailed information about the care of their catheter, the associated risks and the signs and symptom's that might indicate medical advice should be sought. Where needed short term care plans were in place which described the additional care people required to address a specific or acute health care need. For example, one person had a short term care plan which described the additional measures needed to treat and monitor them whilst they had a urine infection. Care plans contained information about people's communication needs. We observed staff effectively using a communication system with a person who did not have verbal communication. They were able to ascertain the person had a headache which they reported to the registered nurse.

Care plans described how people liked to take their medicines, the support they needed at night and their wishes in relation to their end of life care. Pain care plans were in place which recorded a range of interventions that could be used in conjunction with analgesia to manage the person's pain relief. We did note that staff were not using a pain assessment tool. This is important as it helps staff to judge the severity and frequency of pain experienced by people who are not able to verbalise this. The manager told us they were looking at options for introducing this. Tools were used to assess and monitor the emotional wellbeing of people. Where these highlighted concerns or changes in the person's mood or anxiety then a referral would be made to the GP.

Overall the structure of the care records was excellent, the information they contained was personalised. The unit managers had between 12 and 18 hours of office time each week, which helped to ensure people's records were reviewed and kept up to date. It was clear the organisation and staff team had worked hard to improve and enhance the care records. The home's manager had received feedback from a relative prior to our inspection. They wanted to acknowledge the time, attention and care staff had put into drafting the new care plans. They noted the deputy manager had "Gone the extra mile, sitting with [their relative] learning about them and then translating that into a care plan which really did reflect their needs". Staff told us they could refer to the updated care plans in order to understand people's needs and it was evident the care plans had been read by the staff we spoke with. This all helped to ensure that staff understood the needs of the people they supported and assisted them to provide responsive care.

We saw evidence that staff responded in a timely manner to changes in people's needs. Referrals had been made promptly to a speech and language therapist when staff identified they were experiencing difficulties swallowing. Another person who had lost weight had been referred to the GP and started on a food and fluid chart so that their nutritional input could be monitored. Staff also documented visits by the people's GP or other healthcare professionals so that a record was maintained of changes to treatment pathways.

Two full time activity co-ordinators provided a range of both group and one to one activities. A schedule of activities was advertised and included quizzes, home baking and vegetable preparation. During our visit we saw that people enjoyed a visit from an outside entertainer and a sing song around the piano. Further outside entertainers were planned for September including a magician and a golden oldie show. Some of the activities supported people to maintain links with the local community, for example, some people visited the local pub for lunch. Local scout groups visited as did a local church. The home took part in National Care Home Open day during which they hosted an

Good

Is the service responsive?

Alice in Wonderland Party. They had also hosted a fund raising event for the Alzheimer's Society which involved a tea party for people, their relatives and staff. Records were maintained of the activities undertaken by each person and these evidenced that people cared for in their rooms also supported to have one to one interaction with the activities staff. People were generally positive about the activities offered. Most of the relatives we spoke with also felt the activities were generally good. Comments included, "There is always evidence of things going on, making cards etc." This visitor said "The carers pop in and converse with my mum, she has her nails done; the activities are a lot better recently". The manager told us about further improvements that were planned to the activities programme within the home. The activities staff were booked to attend training on the Ladder to the Moon programme. This is an initiative aimed at improving the care of people living with dementia by enabling staff to understand how to better deliver a creative activity culture. Meetings had also been arranged with a service offering exercise and activity classes to see if these would be suitable for people living at the home. Other ambitions were to secure funding for a mini bus and seek more opportunities to involve the local community in visiting and supporting the home.

Complaints policies and procedures were in place and information about the complaints policy was available in the service's welcome pack. People and relatives told us they were confident they could raise concerns or complaints and that these would be dealt with. Records showed that when issues or complaints had been raised, these were investigated and appropriate actions taken to ensure similar complaints did not occur again.

Good

Is the service well-led?

Our findings

People told us they had no concerns about the leadership of the home, although some did express uncertainty about who the manager was. Relatives told us the service was well led and that the manager was making improvements. One relative said that since the manager had come into post there had been "Positive changes", they said she was "Pulling everyone together as a team… staff had had a lot more training, she is very approachable, there are a lot more residents meetings so now we know a lot more about what is going on". Another relative said they could go and see the manager any time. They told us, "She has chased the pharmacy on our behalf and has even sat with mum if she is not well". People and their relatives also praised the deputy manager. They told us he was "Brilliant". Staff were also positive about the leadership of the home. A registered nurse described the manager as "Supportive and a great leader". Another member of staff told us, "the manager and deputy are great, I know they would listen to whatever I raised and they would take me seriously". We also received positive feedback about the manager from the health and social care professionals we spoke with. One told us, "They seem like someone who wants to do the right thing".

The manager had been appointed in February 2015 and was undergoing the process of applying to the Care Quality Commission to be the registered manager. Prior to the appointment of the current manager there had been a number of changes within the leadership team and this had impacted upon morale and satisfaction levels within the service, however, all of the staff we spoke to told us they were seeing improvements under the leadership of the current manager and that staff morale was improving. Staff told us they felt valued by the manager and the organisation. This was also reflected in comments from the August 2015 staff survey which included, "I feel very valued and recognised within this organisation, it's truly a pleasure to work within Hamble Heights" and "I find my job very rewarding, management are efficient and any issues are dealt with promptly". Some staff did comment that they would value the manager being more visible within the service on a daily basis, but they all agreed that she had an open door policy and that they could speak with her or the deputy any time they wanted to.

There was an open and transparent culture within the service and the engagement and involvement of people, their relatives and staff was encouraged and their feedback was used to drive improvements. Meetings were held with people and their relatives to obtain their views about the service, for example, a food survey had been held which resulted in the development of an improvement plan. People had also been involved in the choice of new flooring for the communal areas on one of the floors. A satisfaction survey had just been undertaken with people to which there had been 25 responses. The feedback was largely very and reflected a growing confidence in the leadership of the home and a belief that improvements were being made.

Regular staff meetings were also held. Staff were encouraged at the meetings to contribute their ideas for developments which might help make the care provided outstanding. Opportunities were available for staff to gain further qualifications and extend their skills and knowledge. The staff we spoke with had a clear understanding of their role and responsibilities which was also detailed in the staff code of conduct. Staff had been involved in workshops to develop the values and vision of the organisation. The organisation had an awards scheme to recognise staff for the quality of their work. This all helped to ensure that people were cared for a supported by motivated, suitably trained and skilled staff.

At our last inspection in September 2014, we found that the service did not have an adequate system in place to monitor the quality and safety of the service. We issued a requirement notice. At this inspection we found that the necessary improvements had been made. There were now robust systems in place to monitor and improve quality and safety within the service. For example, the service had a system in place to report, investigate and learn from incidents and accidents. Each month the deputy manager completed an analysis of these to identify any trends or patterns so that remedial action could be taken which might reduce the risk of similar incidents happening again. A range of audits were undertaken to monitor the effectiveness of aspects of the service including care documentation, tissue viability, nutrition and medicines management. The manager undertook unannounced checks at night to help ensure that the support being provided to people was safe and effective. The organisation had a quality and operations director who made regular visits to the home and undertook detailed quarterly audits which were mapped to the key lines of enquiry used by the Care Quality Commission during our inspections. This

Good

Is the service well-led?

helped to identify what the service was doing well and the areas it could improve on. It also helped to ensure that the organisation was meeting the Regulations and fundamental standards of care. The organisation had engaged a health and safety consultant to undertake a full audit of the home to help identify any risks or concerns in relation to the environment and equipment used for delivering people's care. Detailed checks were also being undertaken of the fire and water safety within the service.

The manager had a clear vision for the future of the service which was underpinned by the aim to achieve continuous improvement and provide outstanding care. Plans included developing the environment, enhancing the training programme, particularly with regards to dementia care. They wanted to continue to develop the staff team, recruit a stable night care team and appoint a night manager to oversee the delivery of care at night and develop the skills and knowledge of the night care team. They told us they were proud of the care provided by the home and of the staff team who had worked so hard to drive improvements and provide people with personalised care. They told us they wanted to make Hamble Heights as much the person's home as possible. The manager knew there was still more to be done and demonstrated a good understanding of the challenges her role presented. They explained they were committed to continuing the transition from task orientated care to person centred care and to ensuring that communication both with people, their relatives, the staff team and with other professionals continued to develop to ensure its effectiveness.. The manager told us that the organisation was supportive and shared her vision of continual development and a commitment to becoming an 'outstanding' service. The provider had a service improvement plan which set out its objectives for the coming year, which included aims such as implementing a nurse development programme, a dementia training programme and to 'future proof' the design and layout of the home.