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Bonhomie House

Inspection report

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Date of inspection visit:
30 May 2018
31 May 2018

Date of publication:
17 July 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 and 31 May 2018 and was unannounced

Bonhomie House is a care home with nursing. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Bonhomie House provides care and support for up to 78 people living with a wide range of complex healthcare needs. These include acquired brain injuries, neurological conditions, physical disabilities and mental health issues. At the time of our inspection there were 59 people living at the service. Bonhomie House provides a range of accommodation. The main house is spread over three floors. The people living in the main house receive a mixture of one to one and shared care provided by a team of nursing and care staff. Also on site are a number of both shared and single dwelling bungalows where people receive either shared care or one to one support. The service has an activity hall with a swimming pool and Jacuzzi which can be used for therapeutic and leisure activities.

This service has been rated as requires improvement since the introduction of ratings in 2014. At the last inspection in March 2017, we rated the service as requires improvement and found breaches of three Regulations. This was because risks to people were not always well managed. There were not always sufficient numbers of suitably skilled staff deployed to meet people's needs, improvements were needed to the accuracy of care records and to the robustness of the governance arrangements. An action plan was submitted which identified the steps that would be taken to address the breaches of the Regulations. This inspection checked whether the service was now compliant with the Regulations.

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

Most of the issues identified at the last inspection relating to how risks to people were assessed and managed had been adequately addressed. However, records did not reflect that action had been taken to adequately protect people against the risk of scalding from hot water.

We continued to receive mixed feedback about the number of staff deployed and the continuity of care provided. There continued to be a high use of agency staff to cover staff vacancies. People, however, told us they felt safe and that their needs were generally met.

We found evidence that infection control measures, such as wearing personal protective clothing, were not consistently followed. The systems to manage cross infection needed to be more robust.

Some relatives felt their family members did not consistently receive basic care effectively.

The completion rates for training were variable and action was still needed to help ensure that staff had all of the skills and knowledge needed to consistently meet people's needs effectively.

Improvements were needed to ensure that the food provided was enjoyed by people and consistently met their needs.

The care plans were more personalised and reflective of people's individual wishes and preferences.

Improvements had been made to the activities provided, however, some people, and some relatives felt more could still be done to support people to follow their interests and to take part in a range of activities. The registered manager was confident that through embedding an active support approach people would be provided with more regular and meaningful opportunities to engage in activities.

Whilst some improvements had been made, the quality assurance systems in place were still not being consistently effective at identifying areas where the safety of the service might be compromised.

Some staff felt that support from the senior management team was not consistently good. They felt they were not always valued for their hard work or that their concerns about not being able to perform their role effectively were being listened to.

Medicines were managed safely.

Systems were in place to report and review the incidents and accidents that occurred within the service and to ensure lessons were learnt from these events.
Relevant checks had been completed before staff worked unsupervised.
People were protected from the risk of abuse.

Staff received a suitable induction and a system of supervision and appraisal was in place, although we have recommended that the provider review the frequency with which supervision is provided.

There were systems in place to seek and document people's consent to their care and treatment. Where a person did not possess mental capacity, mental capacity had been assessed in line with legislation.

People's health care needs were met and there was some evidence that people's care was planned and delivered in line with current evidence based guidance. Staff worked effectively with other organisations to help ensure that people's move to and from the service was coordinated and effective.

Overall the design and layout of the premises met people's individual needs some aspects of the décor and fittings needed repair or replacement. We have recommended that the security measures of the building are reviewed.

People told us staff were kind and caring and overall, staff were observed to be attentive and reassuring to people.

We did observe a small number of interactions where the care could have been provided in a more person-centred manner.

People choices were respected and care was provided in a manner that mindful of people's need for privacy.

People's families were welcome to visit at any time and we saw a number of relatives sharing in aspects of their family member's care.

People's religious and cultural needs were recorded in their care plans an action was taken to meet these.

Complaints policies and procedures were now displayed within the home and accessible to people and complaints had been investigated and a response made to the complainant.

The registered manager had over the last year demonstrated a commitment to driving improvements within the service. They had worked effectively with a range of health and social care professionals to address the areas where concerns had existed about the quality of care provided.

A number of the professionals we spoke with talked of seeing positive changes within the service driven by the leadership team.

Improvements had been made which helped to ensure that people's views about the quality of the care and support provided were sought and used to drive improvements within the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

This is the third consecutive time the service has been rated Requires Improvement. Whilst this inspection has noted a number of improvements, the service is not yet consistently providing good care. We will meet with the provider to discuss the findings of this report and continue to monitor the service to ensure that improvements are ongoing.

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.

Whilst some improvements had been made, records continued to show that people were not being adequately protected against the risk of scalding from hot water.

We continued to receive mixed feedback about the number of staff deployed and the continuity of care provided. There continued to be a high use of agency staff to cover staff vacancies. People, however, told us they felt safe and that their needs were generally met.

We found evidence that infection control measures, such as wearing personal protective clothing, were not always followed. The systems to manage cross infection needed to be more robust.

Medicines were managed safely.

Systems were in place to report and review the incidents and accidents that occurred within the service and to ensure lessons were learnt from these events.

Relevant checks had been completed before staff worked unsupervised.

People were protected from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Some relatives felt their family members did not consistently receive basic care effectively.

Staff had not completed all of the training relevant to their role or to ensure that their skills and knowledge were fully reflective of people using the service.

Staff received a suitable induction and a system of supervision and appraisal was in place, although we have recommended

that the provider review the frequency with which supervision is provided.

There were systems in place to seek and document people's consent to their care and treatment. Where a person did not possess mental capacity, mental capacity had been assessed in line with legislation.

Improvements were needed to ensure that the food provided was enjoyed by people and consistently met their needs.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and overall, staff were observed to be attentive and reassuring to people.

We did observe a small number of interactions where the care could have been provided in a more person-centred manner.

People choices were respected and care was provided in a manner that mindful of people's need for privacy.

People's families were welcome to visit at any time and we saw a number of relatives sharing in aspects of their family member's care.

People's religious and cultural needs were recorded in their care plans an action was taken to meet these.

Is the service responsive?

Good

The service was not always responsive.

The care plans were more personalised and reflective of people's individual wishes and preferences.

Improvements had been made to the activities provided, however, some people, and some relatives felt more could still be done to support people to follow their interests and to take part in a range of activities.

Complaints policies and procedures were now displayed within the home and accessible to people and complaints had been investigated and a response made to the complainant.

Is the service well-led?

Requires Improvement

The service was not always well led.

Whilst some improvements had been made, the quality assurance systems in place were still not being fully effective at identifying areas where the safety of the service might be compromised. Further improvements were needed with regards to records relating to people's care and treatment.

Some staff felt that support from the senior management team was not consistently good. They felt they were not always valued for their hard work or that their concerns about not being able to perform their role effectively were being listened to.

The registered manager had over the last year demonstrated a commitment to driving improvements within the service. They had worked effectively with a range of health and social care professionals to address the areas where concerns had existed about the quality of care provided.

A number of the professionals we spoke with talked of seeing positive changes within the service driven by the leadership team.

Improvements had been made which helped to ensure that people's views about the quality of the care and support provided were sought and used to drive improvements within the service.

Bonhomie House

Detailed findings

Background to this inspection

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

The inspection took place on the 30 and 31 May 2018 and was unannounced. On the first day, the inspection team consisted of three inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used a service similar to Bonhomie House. On the second day there was two inspectors.

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

During the inspection we spoke with 17 people who used the service and with six relatives. We also spent time observing aspects of the care and support being delivered. We spoke with the general manager, the registered manager, deputy manager, the chef and 15 nursing and care staff, some of whom were permanent staff and some agency workers. We also spoke with 10 health and social care professionals and asked their views about the care provided at Bonhomie House.

We reviewed the care records of eight people in detail. We reviewed the recruitment records of five staff. We also looked at other records relating to the management of the service such as audits, incidents, policies and staff rotas.

The service was last inspected in March 2017. At that inspection, we found three breaches of the legal requirements.

Requires Improvement

Is the service safe?

Our findings

Many of the people living at Bonhomie House were doing so because they had experienced a catastrophic brain injury or an event which had led them to develop complex healthcare needs. Others were living with chronic mental health problems. At times, this affected how positive they felt about their care and about living at the service. However, they all told us that they did feel safe living at Bonhomie. Their comments included, "Yes! Safe as houses", "They look after me like a bug in a rug" and "Honestly, from where I was living before, I did not feel safe there at all. This is so much better, I can't fault the staff".

Our last inspection we found that the quality and consistency of risk assessment and risk management was not sufficiently robust. This was a breach of Regulation 12 of the Health and Social Care Act. This inspection found that some improvements had been made but we also identified some continuing concerns. Our last inspection had found that some of the water being discharged from the hot taps in people's rooms or showers, was in excess of safe limits. It was not evident that action had been taken to address this. This remained a concern. For example, records showed that in May 2018, 20 of the showers tested recorded temperatures of between 45C and 51C. The Health and Safety Executive provide guidance which states that controls should be in place to ensure that water hotter than 44C is not discharged from outlets that may be accessible to people and where there is the potential for whole body immersion. Whilst thermostatic mixer valves were in place, there was no evidence that action or additional control measures had been taken to bring the temperatures within recommended limits. The registered manager told us that action would have been taken, but that there were no records available to reflect this. We could not be assured that people had been adequately protected against the risk of scalding. The arrangements in place were not being effective at supporting people to stay safe.

This is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

Other environmental risks were being managed. A fire risk assessment had taken place in June 2017 and checks were made of the fire protection systems and detection equipment. These were up to date and most staff were trained in fire safety. Fire drills took place periodically. People had personal emergency evacuation plans which detailed the assistance they would require for safe evacuation of the home and a business continuity plan was in place which set out how the needs of people would be met in the event of an emergency such as a fire or flood. The provider had liaised with local emergency planning agencies to enhance the plan. Systems were in place to prevent risks associated with legionella and there were current certificates confirming the safety of the gas and electrical items within the service and the equipment used for lifting. Emergency equipment, including a ligature cutter, was checked regularly to ensure it was in working order.
Overall risks associated with people's health were now well managed. Clear escalation plans were in place to help manage the risks associated with diabetes and epilepsy. People at risk of choking had been identified and care plans were in place to help manage this safely. We observed a number of people being assisted to eat and drink and this was provided in a safe manner. Staff could demonstrate an understanding of how to identify and respond to an incident of choking. Where people were at risk of poor nutrition or

hydration, systems were in place to manage this. For example, nationally recognised tools were being used to assess their risk of becoming malnourished. Food and fluid charts were used to monitor people's nutritional intake. Whilst the charts we viewed had been fully completed, three people's relatives told us they had concerns that these were still reflecting the amount of food or fluid offered rather than that which was eaten or drunk. We informed the registered manager of these concerns. He advised us that he would continue to monitor this and investigate any concerns of this nature brought to his attention by people or their relatives.

In the case of one of the records seen, the provider's post falls protocols had not been completed. The person had experienced a fall and sustained a head injury, but there was no record that staff had taken sufficient action to undertake neurological observations in line with procedures. Body maps were being used to report on skin damage or bruising. In a small number of cases, the cause of the bruising had not been established but this had not been escalated to the local authority. This is important to ensure that the local authority have oversight of potential risks within the service. We have discussed this with the registered manager and asked that he liaise with the local authority to develop a clear protocol on how unexplained bruising should be reported moving forward. This has now been completed.

Some improvements could be made to ensure effective infection control measures were operated. Whilst the providers policy stated that staff should wear uniforms and sleeves should be rolled up, we found this was not always the case. Some staff were not wearing uniforms and one member of staff was wearing a long sleeve jumper. One person's records indicated they were living with an antibiotic resistant infection, but there was no infection control risk assessment or care plan in place to guide staff to prevent possible future cross infection and no indication of the site of the infection. Since the inspection, we have been informed that the information was incorrect, however, appropriate measures should have been in place until this was clarified. However, the service was clean and free from malodours. There were hand hygiene stations around the home and hand basins contained hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Cleaning schedules were in place and those viewed had been fully completed. Appropriate records were being maintained which demonstrated good food hygiene practices in the kitchen.

Systems were in place to report and review the incidents and accidents that occurred within the service and to ensure lessons were learnt from these events. We could see that in most cases, action had been taken to address the cause of the incident or to help prevent similar incidents from happening again. For example, the service was embedding the use of post falls 'huddles' to reflect on what might have been the cause of the fall and to plan actions that might decrease the risk of future falls. We did note that whilst monthly audits were completed of the accidents and incidents, these did not clearly demonstrate that an overarching view of all falls within the service had been taken to establish trends or causality.

When we last inspected the service in March 2017, we found that there were not always sufficient staff deployed to meet people's needs. This inspection found that some improvements had been made and that the legal requirements were now being met, although further improvements were needed to embed new initiatives and to address ongoing recruitment challenges.

A number of new initiatives been implemented. For example, care team pods had been set up in the bungalows. This meant that a small team of staff were responsible for caring for a particular group of people. A mental health professional told us, "Pods' had a positive effect which enabled residents to engage with staff they know and trust and have built up relationships with". Other health and social care professionals told us that the changes in the way in which staff were deployed had been positive with one saying, "The atmosphere on the units is calmer and more focused this year and it feels a much more

cohesive team from the outside when I visit" and another telling us when asked about staffing, "This appears to have improved considerably…Since changes in approach to nursing teams where consistency has been adopted there have been more positive therapeutic relationships between resident and staff". A third professional said, "During the review I noted that the care home staff were very responsive to a client and attended to her needs straight away".

The majority of people we spoke with felt there were sufficient staff with comments including, "There's always somebody to find" and "There's lots of staff here, I feel safe here, they're busy but they chat sometimes". A third person said, "There's enough staff, If I call them they come when they can, but I don't wait long" and a fourth told us, "Yes, I'm safe, someone would come if I called, it's alright here, the staff are alright, there's enough of them".

Some relatives raised concerns about the lack of suitably qualified staff to enable their family member to make regular use of the pool onsite and about the lack of staff who were qualified drivers and therefore able to take people out on a regular basis. Some people told us they did not always receive a prompt response to their call bell at night and a number of relatives felt strongly that staffing levels at weekends needed to improve further. Staff also spoke of weekends being challenging due to the number of agency needed to cover gaps in the rotas and the demands this then placed on them as the permanent staff. Despite this, staff told us that they did not feel this impacted upon the quality of care people received. For example, one staff member said, "We are short staffed, its stressful, but the impact on the guys [people using the service] is not so bad, we still give the same care, but it's a lot harder" and another told us, "Staffing is always an issue…we have got some very good staff, they pull together as a team". Another staff member said, "I have worked in a lot of care homes in the past. I would say this is one of the better ones. The manager will always get agency staff in if someone is off sick. It's difficult if someone rings in on the last minute but that's not the manager's fault". Other staff told us that the staff shortages were improving and that there were more regular agency staff being allocated wherever possible.

During the inspection our observations indicated that, overall, people's needs were being met in a timely manner and where people had been assessed as needing to be supported on a one to one basis, records and observations showed that this was provided. However, a review of rotas demonstrated that there were times when the staffing levels in the house at weekends fell below planned levels due to sickness or staff not turning up for their shift. We also found that there remained many staffing challenges that the provider and registered manager needed to continue to address. For example, there were currently 38 staff vacancies, 30% of the overall workforce. This was an increase since our last inspection. This meant a high number of agency staff were still required daily. Wherever possible these agency workers had been seconded to work at the home on a regular basis and this did help with continuity of care, however, the need for better continuity of care was a common theme in the feedback we received from relatives of people living in the main house. Whilst 31 new staff had started working at the service, (11 of whom were agency staff who after a period of six months would become permanent employees) in the twelve months prior to out inspection, 24 staff had left, including the deputy manager and clinical lead. This meant that turnover of staff was also a challenge. To address these ongoing concerns the registered manager had employed an additional five care practitioners to provide support at weekends and arrangements had been made with a third agency to provide a team of regular or seconded staff to the service. They were hopeful that this would address some of the staffing challenges and provide increased stability to the staff team.

Relevant checks had been completed before staff worked unsupervised. For example, staff had provided an application form, references, a full employment history and attended a competency based interview to check their suitability and competency for the role. DBS checks had taken place. These checks alert the provider to any previous convictions or criminal record a potential staff member may have which helps

them to make safer recruitment decisions.

Medicines were managed safely. There were appropriate facilities for the storage of medicines. For example, in the main house people's medicines were stored in a locked medicine trolley. Other medicines were safely stored in locked cupboards. Medicines requiring refrigeration were stored in a lockable fridge which was not used for any other purpose. The temperature of the fridge was monitored daily. Those living in the bungalows kept their medicines in locked cupboards or fridges in their bungalows.

We looked at the medicines administration records (MARs) for 25 people living at the home. These contained no gaps. All MARs contained a front sheet with a recent photograph for identification purposes, along with relevant information, such as whether the person suffered from allergies or preferred to take their medicines in a particular way. Staff did not leave the medicines trolley unlocked when unsupervised and signed MAR charts only when the person had taken their medicine. The topical medicines administration records (TMAR's) viewed were fully completed.
Protocols were in place for PRN or 'as required medicines'. The protocols outlined how, when and why the medicine should be taken. Where a person could be given varying numbers of tablets, for example one or two painkillers, that this was clearly recorded on MARs. People at risk of experiencing pain who could not express it verbally were frequently assessed using a formal tool. Staff were knowledgeable about how pain manifested itself in these individuals.

The monitoring of therapeutic drugs was undertaken to ensure concentrations of the drug in the person were safely maintained. This was done either in the form of blood tests or in monitoring the person themselves, for example, glucose levels for those living with diabetes. There was clear guidance in place for staff concerning the management of people taking other types of medicines such as drugs associated with the management of psychiatric disorders. These included when taking the medicines was indicated and the signs and symptoms of potential side effects.

Several people living at the home had percutaneous endoscopic gastrostomies (PEGs) in place. PEGs are a way of providing food and medicines to people who are unable to take this orally. Staff were knowledgeable about the management of these. We observed a person receiving their PEG feed; it was conducted appropriately in line with the provider's policy and appropriate hygiene practices were followed.
Three people received their medicines covertly, that is without their consent or knowledge. Mental capacity assessments had been carried out in each case and best interests' meeting held, with relevant parties present. The storage and disposal of medicines were managed safely, in accordance with the provider's policy. We noted stock balances were kept to a minimum and disposal procedures were in place.

All the staff we spoke with knew how to keep people safe. They were aware of what actions they should take if they thought anyone was at risk of harm or abuse. Staff told us they were confident the registered manager would be supportive and take action if they raised concerns, for example, one staff member told us, "I would speak to the manager if I thought care was bad or there was abuse. They would do something". The registered manager maintained a safeguarding log and checklist which included a reflection upon what had been learnt from each safeguarding incident or concern. During the inspection, some information of concern was disclosed to a member of the inspection team. The registered manager took prompt action to address this to ensure people's safety, although the concerns were found to be unsubstantiated. A social care professional told us they were confident that the registered manager was proactive in managing safeguarding concerns saying, "[person] made a recent allegation, which I raised as a safeguarding alert, [the registered manager] was all over it, he couldn't have been more responsive, he was very professional".

Requires Improvement

Is the service effective?

Our findings

People and their relatives had mixed views about the effectiveness of the care provided. Some people were satisfied with their care and support, for example, one person told us, "All my needs are met effectively, I've been here over a year now and it suits me". Another person told us, "I can tell you, the staff here know what they are doing". A third person told us, "It seems to look after its residents well. I think they are all pretty happy, the ones I know are, we usually chat in the mornings, Yes I would recommend this home to my friends". Another person told us how a pressure ulcer they had developed in hospital was now healing. They said, "They have done well for me". People told us of individual staff who were "Brilliant" or "Go the extra mile".

Whilst we did not identify such concerns during the inspection, some relatives and visitors felt people did not consistently receive basic care effectively. They gave examples such as their family member not receiving their afternoon drink and staff not consistently making use of equipment that could enhance people's ability to communicate. One relative said they would often visit and find their family member's stoma bag "Full to bursting". Another relative told us that whilst there had been jugs and tablecloths on the lunch tables during our inspection, this was not always the case. Some relatives told us they raised their concerns with the management team, but were not always confident that this brought about improvements whilst others told us they were beginning to see improvements in the effectiveness of the care provided.

We looked at how staff were supported and provided with opportunities to develop their skills. When new staff started at the service, they were provided with a suitable induction. The induction was competency based and involved an explanation of the staff members role and responsibilities and a range of practical training and observations in areas such as moving and handling, communication techniques and infection control. All staff were required to complete the Care Certificate unless they could evidence that this had already been successfully completed and there was now a member of staff assigned to lead on this. We could see records which evidenced that staff were being supported to complete this in a timelier manner. The Care Certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate.

It was the provider's policy that staff receive a minimum of two supervision sessions a year and an annual appraisal. Most staff had received an appraisal and records showed that most, but not all staff had received supervision in line with the frequency determined by the provider. The general manager told us that where necessary staff would have more supervisions and the registered manager told us that in addition to the twice-yearly supervisions and appraisal, they were confident that their open-door policy and staff meetings allowed staff to express any concerns they might have. 'Pod' discussions also took place during which a group of staff working in the relevant pod undertook a focussed discussion about their role and responsibilities and the care being provided to a specific person. We were concerned that the policy of providing two supervisions a year was not in line with best practice guidance. For example, 'Skills for Care' recommend that experienced staff working in health and social care settings have supervision every four to six weeks. Whilst staff told us they did feel able to seek advice or guidance, when needed, we recommend that the provider review this policy to ensure it is in line with best practice guidance in the health and social

care sector.

Staff were generally positive about the training provided, for example, one staff member told us, "The training I've received [since coming into post] and the support has been brilliant". However, it was difficult for the inspection team to obtain a clear overview of what training staff had as the training completed was recorded on a number of different matrices or spreadsheets and these were not always fully up to date. For example, training that had been evident at our last inspection, was no longer reflected on the current training matrix. Since January 2018, the training provided was mostly online and staff were able to access training in approximately 100 subjects including key areas such as safeguarding people from harm, maintaining privacy and dignity, communication techniques, infection control, first aid, moving and handling techniques and health and safety.

However, the completion rates for the online training was variable. For example, over 50% of the staff working in the bungalows had not completed training in privacy and dignity or in nutrition. Staff had either not undertaken food hygiene training or this was out of date. This included the kitchen staff. We discussed this with the deputy manager, who advised that this had been due to a misunderstanding and that this training had now been allocated to all staff to complete by the end of June 2018. The provider's infection control policy stated that staff would receive annual training in this area, but the training matrix had this recorded as being every three years. Even so, this was out of date for some staff including three of the four kitchen staff.

Many of the people living at the service were living with conditions such as Huntington's disease, multiple sclerosis and acquired brain injuries. New staff were provided with an introduction to these conditions during their induction, but we noted that the induction pack said staff would be provided with full training in these areas. Whilst this was available as online training, the records viewed did not reflect that any staff had completed this.

The provider had reviewed the take up of training since the online system was introduced and had already identified that this was not as good as they had hoped and plans were in place to address this, with letters being sent to staff reminding them of the requirement to complete the training. Three core subjects were being prioritised for completion by July 2018 when the progress would be reviewed again.

The provider was also continuing in their efforts to registered mental health nurses (RMN's) to help ensure that the staffing was fully reflective of the needs of people using the service. A mental health professional told us that training in mental health remained an area where ongoing improvements could be made saying, "There is an evident need to continue to educate in the management of residents with serious mental illness. This was noted when asking staff what a specific mental illness diagnosis meant to them. They acknowledged that their own knowledge was limited".

We did note some areas of good practice. The provider had introduced the role of care practitioner. This new role was performed by care workers who were provided with additional training allowing them to provide support to the registered nurses. Records showed that the care practitioners had been trained and assessed as competent in a range of skills including, handling and administering medicines, blood glucose monitoring, enteral feeding and stoma care. Champions had been appointed in specific areas and had undertaken additional training to allow them to role model and mentor staff in these areas such as diabetes, end of life care and mental health problems. Some, although not all, of the registered nurses had completed training in clinical skills such as catherisation and tissue viability. To ensure that staff were aware of their role and responsibilities and to raise staffs' awareness of the provider's policies and procedures, a 'policy of the month' system had been implemented.

There were systems in place to seek and document people's consent to their care and treatment. Where people were unable to make informed decisions about their care or to give consent, staff acted in accordance with the requirements of the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where a person did not possess mental capacity, we noted up to date mental capacity assessments were in place in addition to evidence of best interest's meetings with relevant parties present. For example, one person had a mental capacity assessment regarding their ability to manage their own medicines. Staff also acted appropriately when faced with issues of treatment and consent. For example, one person was refusing medicines via injection which was essential to manage their mental health and wellbeing. The person had been assessed as lacking capacity to understand the impact this could have on their mental wellbeing. There was evidence that the registered manager was working with relevant mental health professionals to constantly review the person's care who, if the refusal continued, would be detained under the Mental Health Act 1983 where treatment could be continued. One of the mental healthcare professionals we spoke with did voice an opinion that there was a tendency for staff to too readily assume that a person lacked capacity to make decisions until they could demonstrate otherwise. This was not reflected in our own findings and during the inspection, the registered manager demonstrated a passion to ensure that people were supported to make decisions even if these were perhaps unwise.

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. Some had been approved whilst others were awaiting assessment by the local authority. Two of the authorisations viewed were noted to have conditions. The registered manager could demonstrate how these conditions were being met.

The feedback we received indicated that further improvements could be made to the food provided. Relatives told us that the pureed meals could at times contain lumps or be of the wrong texture. This could present a choking risk to people. Staff again confirmed this did sometimes happen, but told us they would always return the meal to the kitchen. Some people were positive about the food saying, "Lunch was roast beef and dumplings and I had egg sandwiches this morning, I've got packets of crisps and I can help myself to fruit". Another person said, "The food is good, wholesome and carefully prepared". However, other people talked of the need for the pureed meals and desserts to be more varied. We were told that the dessert for those requiring a pureed meal was too often angel delight or cold custard. They also told us that they were not always aware what the meal was. Staff confirmed this did, on occasion happen. We met with one person, who showed us their pureed meal, it was on a plate covered with cling film and had been squashed. It did not look appetising. A relative told us the evening meals were not always sent up on the hot trolley which meant that they were not always hot. A number of people also told us they would like more choice of meal on a daily basis.

We discussed this feedback with the registered manager. They told us that a 'food committee' consisting of people and relatives and the chef had been set up to drive improvements with the food provided. One of the plans was that service of meals would take place on each of the floors rather than in the kitchen, but that additional equipment was needed for this which was being currently explored. The menu showed that each day there was one option for lunch and one option for supper, followed by a dessert. If people did not want

the planned meal then they could choose from the daily 'alternative menu' which included omelettes, salads, sandwiches or jacket potatoes.

We made several observations over lunchtime throughout the inspection. Some people ate in the communal dining areas whilst others ate in their room or bungalow. A variety of soft drinks were available and people were given the choice as to which of these they would like. Overall, staff assisted people to eat and drink in a safe and person-centred manner. They were patient and kind and spoke to people gently whilst helping them to eat and drink. Some people enjoyed some banter with the staff supervising the meal. We did note that there continued to be no condiments available for people to use to season their meal.

People living at this service had complex health and social care needs and so a range of healthcare specialists were involved in their care. A local GP visited the service once a week and staff also worked with other health care professionals such as the community mental health team and consultant psychiatrists when people's mental health declined. People were supported to have eye tests and where they were experiencing difficulties with eating or swallowing their food, they had been referred to specialists such as speech and language therapists. We observed that people's health care needs were met. For example, we observed that a registered nurse was informed of an abnormality in one person's blood glucose levels. They took prompt action in response and continued to observe the person throughout the day. One of the care practitioners was seen to advocate strongly for one person to be admitted to hospital for a review of their chronic cellulitis.

There was some evidence that people's care was planned and delivered in line with current evidence based guidance. For example, NHS pathways for diabetic care were followed and evidence based wound management guidelines and formularies were used. We looked at the documentation in relation to one person's wound. There were appropriate risk assessments and wound management protocols in place. Preventative measures such as the use of an air mattress and a regular turning regime were in place. The person was also under the care of the tissue viability nurse. Local health initiatives such as falls huddles were being used. The deputy manager explained that they also hoped to implement the national early warning system (NEWS) for assisting with the early detection of sepsis in people which can be life threatening.

There was evidence that staff worked effectively with other organisations to help ensure that people's move to and from the service was coordinated and effective. For example, staff were working to support one person move into a more independent living setting and in preparation for this had been working to assess and reduce the amount of one to one support they required. The ability of staff to support transition arrangements was commented on by a social care professional who told us, "I recently moved a lady from here to another home (residential) as a step down and staff were very accommodating in supporting the lady to view the other placement and stayed with her over a period of time over various visits to see whether she liked it and wanted to commit to moving there. They provided a seamless service in enabling her move on/step down which was positive".

Overall the design and layout of the premises met people's individual needs. In the main house the accommodation was arranged over three floors. Each person had their own room with ensuite facilities. People could decorate their rooms according to their individual tastes. Each floor had a spacious dining area and lounge. In the main house there was an activities room which could also be used for people to spend quiet time or to meet with their visitors. In addition, there was a larger activities hall and pool available for people's use. Outside there was a garden with seating areas and a smoking shelter. Chickens were kept onsite. We did note, when walking round the home and bungalows that some aspects of the décor and fittings were in need of repair or replacement such as kitchen units which were worn and drawers

with no fronts on them. Records showed that the provider continued to audit the suitability of the environment and highlight areas where maintenance was needed and take action to address this.

At Our last inspection, we expressed a concern that the main house was not secure. We were concerned that people might be able to leave the premises without staff being aware of this and that visitors or members of the public could enter the building by a side door without staff being aware of this. We discussed our concerns with the senior management team. They told us they did not feel that increased security measures were required and that sufficient safeguards were already in place to protect people. They wanted to avoid people feeling liked they were locked in or subject to too many restrictive practices. We recommend that this be kept under review to ensure that appropriate security safeguards are in place to keep people safe and meets the changing needs of people using the service.

There was some evidence that technology was used to enhance the safety and effectiveness of the care provided. For example, alarm mats were used to alert staff that people at risk of falls might be mobilising. Virtual assistants were being used as part of the activities programme to assist with quizzes and play music of people's choice. We did note some areas where improvements could be made. The Wi-Fi did not currently extend reliably across all areas of the home or the bungalows. This limited the ability of the service to make effective use of the virtual assistants. It also meant that currently, staff were unable to use tablet computers to input and read information about people's care needs contained within their electronic care plans. Since the inspection, the registered manager has told us that action is being taken to address this.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. One person said, "They [staff] are very nice" and another person pointed at one of their care workers and said, "This lady is just fantastic". A third person said, "I tell you what, if there were an award for caring, it would go to the permanent staff". A fourth person told us, "They're very kind and sensitive here". A health care professional told us, "The interactions I have observed when in Bonhomie have shown that the staff are kind, caring and they have tried to promote independence as much as is possible with the client group".

During our inspection, most of the interactions seen were positive. For example, we observed one care worker, patiently encouraging a person to be involved in making a hot drink. When the person became a little agitated, the care worker was attentive and reassuring. We saw that some staff supported people to eat their lunch in a person-centred manner and they were attentive to their needs. They explained to people what the meal was and asked them if they wanted to wear an apron to protect their clothes. Staff readily spoke with people whilst supporting them to eat and drink, asking how the food was, would they like a drink, or another pudding. We saw that one person did not want to eat the lunch provided, but said they fancied a bowl of sprouts which the care worker readily got for them.

We saw a care worker dancing with one person and another person kiss their care workers hand. They were not able to verbally express their wishes, but this action indicated that they had developed a good relationship with their care workers and felt relaxed in their presence. One care worker summed up the importance of their relationship with people by telling us, "The bond with some of the residents is nice, sometimes you are more with the residents than at home so if one passes away it can be horrible."

However, we did also observe a small number of interactions which were not person centred. For example, at lunchtime on the first day of our visit, we observed one carer stand over and slightly behind a person whilst feeding them, with minimal interaction. The staff member was also assisting another person at the same time and was constantly moving between the two, with little conversation. At another of the lunch time meals we observed that staff were seen to stand back from people and had little interaction with them throughout the meal other than to replenish and clear their plates. Observations of staff continued and the management team reassured us that where concerns were noted this would be addressed through performance management processes.

People told us their choices were respected. For example, comments included, "I tell them to leave the door open so I can get in and out and I can have a cup of tea whenever I want one" and "I pick out what I want to wear all the time". One person said, "They don't tell me when to go to bed. I've got this place wrapped around my little finger, what I want, I get!" People's choices about the gender of their care workers had been recorded and people told us this was respected.

Care plans were seen to be written in a manner that recognised the importance of caring for people in a dignified manner and people told us that this happened in practice. People also told us that staff were usually respectful of their need for privacy. Staff told us they were careful to ensure people's doors were

closed when providing personal care and knocked on people's doors before entering their rooms. Where people chose to act in a manner that could compromise their dignity, staff had acted to try and limit the impact of this where able. A health care professional told us, "I have no evidence of my patients being treated without respect and their dignity is managed in practical ways (pulling of curtains for instance) and emotional ways (by interacting with them as if they can communicate even when they can't)".

People's families were welcome to visit at any time and we saw a number of relatives sharing in aspects of their family member's care. The staff appeared to know many of the visitors well and readily chatted with them about every day events.

The registered manager was keen to ensure that they only employed staff with the right values and aptitude for the role involved. To support this, the registered manager had adapted the recruitment process to include an all-day assessment of the candidate's ability to forge caring relationships with people, communicate well and be a team player. Candidates were also required to visit the service and meet people and get involved in activities. The registered manager felt this process was proving to be positive and was helping to ensure that the staff recruited were kind, caring and able to work in a person-centred manner.

People's religious and cultural needs were recorded in their care plans an action was taken to meet these. The staff caring for people, including the catering staff, were aware of their needs so these could be met. Alternative menus were provided where people had a specific dietary needed such as vegetarian and Halal foods. Representatives from the local churches visited the service.

Good

Is the service responsive?

Our findings

Most people told us they received care which was responsive to their needs. For example, one person said, "Yes the staff understand me" and another said, "I've got everything I need". A health care professional told us, "The new documentation has made staff think slightly outside of the box and get out of their automatic approach…. The most recent care staff I met were knowledgeable of my patient and her care plans. They now ensure that my patients have a change of scenery if appropriate and are more proactive in predicting change". This was echoed by a second healthcare professional who told us, "The Nurses/carers and [registered manager] have always appeared to know my clients, and have either been able to answer any queries or have located the information, when I have raised points regarding care plans, DOLs [deprivation of liberty safeguards] or other points they have addressed them".

We saw evidence that staff understood the needs of the people they supported and this enabled them to care for those people in a person-centred manner that was responsive to their individual needs. A member of staff was walking with one person. They told us, "She just loves walking and so do I really". We asked the member of staff about how she knew the person liked this activity. They told us, 'It's in her care plan and she lets me know with hand movements. We walk for ages". Another care worker told us, "There's a field where the horses are, one resident really loves that, I love to take her to see them". An agency worker was able to tell us about the condition another person lived with and how this impacted upon them each day. We observed the agency worker following the strategies that were contained within the person's care plans to manage their anxiety including distraction techniques such as a looking at favoured photographs.

The staff we spoke with were passionate about their role and spoke about the importance of developing a good relationship with the people they supported. For example, one member of staff told us the best part of their job was "Making sure the residents are secure, making them feel loved and happy". Another staff member told us how they enjoyed "Coming in and interacting with the residents, we feel like a family, it's about making their day". This was echoed by a third staff member who said, "I love it here, I love the residents, each have got their own personalities, every day is different, it's nice to work in an environment where you get to know them as people".

At our last inspection in March 2017, we found that care planning documentation was not consistently completed to a good standard. We were concerned that this increased the risk of people not receiving care that was responsive to their needs. This was a breach of Regulation 17 of the Health and Social Care Act. This inspection found that overall improvements had been made and the Regulation was now being met, although the improvements needed to be sustained in order to embed the improvements.

The service had recently transferred their care records to a new electronic care planning system and senior staff had received training on how to use this system to write and update care plans and risk assessments. Care staff had a 'read only' logon. Currently staff were still printing off paper copies of care plans as they were updated and a number of risk assessments also remained in paper format and were yet to be transferred to the electronic system.

Each person's care plan covered a range of areas including, communication, continence care, personal care, nutrition, medicines and mental health. Each care plan described the risks associated with the need and went on to describe how the needs should be met and the risks managed. The care plans we viewed were suitably detailed and described how the person's care should be delivered. For example, one person had a care plan which described the strategies staff should use to manage behaviours which others might find challenging. The care plans were more personalised and reflective of people's individual wishes and preferences. For example, we could see that people had expressed a wish for either male or female staff to support them and that one person liked to sleep with the door shut and lights off. The overall improvements to care documentation was commented on by the health and social care professionals we spoke with. For example, one said, "Care plans have improved considerably and although, some are still lengthy, they are more precise to the client's needs rather than generalised".

We did note some areas where further improvements could be made. We continued to note that information about people's care needs remained split over many different files and this did at times, make finding key information difficult or time consuming which was also commented on by some of the health and social care professionals we spoke with. We were told that further developments to the electronic care planning system were planned that would ultimately address this. Staff completed daily records to document the care provided. Overall, these had improved, but we did find some that were more variable in terms of detail and quality or remained task focussed and did not give a full insight into the person's mood or wellbeing. We also found that staff had not always recorded that care had been declined. The importance of completing care records in detail was being reiterated to staff by the management team and was part of the induction for new staff.

Whilst there was evidence that care plans were being reviewed regularly and despite a 'service user of the day' system being in place, most people and many relatives did not feel that they were sufficiently involved in the ongoing monitoring and development of care plans and felt this was an area where improvements could be made.

We looked at the activities provision within the service. Overall, we found that some improvements had been made for some people. The service had a planned programme of activities including, crafts, reviewing the news, coffee mornings, quizzes and board games. The service had a large activities hall. Records showed and we observed that people used the hall for leisure activities which they appeared to be enjoying. One person told us, "I go to the hall for table tennis and darts, I like hangman too, there is always staff there to help, we have some fun".

The activities room in the main house was now being used more frequently and had been equipped with a range of materials to support with the provision of activities. An activities coordinator had been appointed and currently worked two days a week. Activities were being organised to celebrate special occasions such as a world cup and trips had been arranged to the theatre and to other local events and places of interest such as the zoo. Some people were going swimming at a local pool. In May 2018, people had taken part in a boat trip and a BBQ had been held. People and staff were planning the second 'Around the World' event celebrating the range of different cultures and customs reflected in the workforce. Other external entertainers such as singers also attended the service. Music and exercise classes were run weekly and were well attended by people using the service.

We still however, received mixed feedback from people and their relatives about the activities. Some comments were positive, for example, one relative told us, "They've started doing a lot of activities with him. He's very excited about it and there's now a specially dedicated room. He goes to Beaulieu and he's just seen Warhorse". However, some people, and some relatives felt more could still be done to support people

to follow their interests and to take part in a range of activities. For example, one relative said their family member liked trips out of the home, but "just sits in her room reading books" and another said, "In my opinion, there are no efforts made to engage [the person]. She can be difficult to engage but it seems to me that no one perseveres". One of the people we spoke with said, "They could do with a few more activities for us, get some sewing machines, that would be good".

The records we viewed provided variable evidence of people being involved in meaningful activities. For example, some records were detailed and showed that individual people were getting involved in activities such as baking. The records noted how engaged the person had been in the activity and whether they had enjoyed themselves. Other records, however, did not reflect that people were consistently being supported to access meaningful and varied activities. Instead we saw regular references to 'watching tv' and 'walking round the garden'.

The registered manager explained that since our last inspection, the service had begun to embed an approach to care delivery called active support. Active support is a model of care aimed at enabling and empowering people with a range of physical and cognitive disabilities to be engaged with and participate in all aspects of their lives. Most of the staff had been trained in the approach and in engagement techniques and we observed staff using it to direct and encourage one person to make a hot drink. The registered manager was passionate about active support and was confident that with the correct levels of support people even those with the most complex disabilities were capable of achieving goals, albeit sometimes small goals. They were confident that this approach once embedded would help to ensure that people were being provided with more regular and meaningful opportunities to engage in activities but also develop their skills and where possible their levels of independence.

Health and social care professionals told us they felt that the new approaches to care were having a positive impact upon people describing how relationships had improved between people and staff and the attitude towards using medicines to manage behaviour had changed for the better. We observed the positive impact this approach was having. For example, we saw that one person had not needed any 'as required' medicines to manage their behaviour for over three months. One person had been supported to move onto a more independent living setting and other people were successfully having the number of one to one hours reduced, helping to ensure that their care was provided in the least restrictive way possible.

Complaints policies and procedures were now displayed within the home and accessible to people and there was also a comments box in the reception area. Where people or their family members had raised concerns about the care provided, the leadership team had tried to address the matter and there was evidence that complaints had been investigated and a response made to the complainant. Some people talked of the management team being proactive in addressing their concerns or comments. However, some of the relatives we spoke to, expressed a lack of confidence that lasting change or improvements were achieved. For example, we were told by one relative how they had needed to raise concerns about the deployment of staff at weekends on many occasions. They felt the investigation into their concerns had not resulted in positive changes. The registered manager told us it was frustrating for them too, that the measures they had put in place to address the concerns had not been as effective as they would have hoped, but they remained committed to using people's feedback to drive improvements within the service.

There was some evidence that the service had taken steps to provide information to people in a way in which they could understand. For example, people had access to an easy read version of the provider's complaints policy and to information about the Mental Capacity Act 2005. This helped to ensure that the service was complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people

with a disability or sensory loss can access and understand information they are given.

The care plans viewed contained basic end of life / advanced care plans which included information such as any religious or cultural needs the person might have at the end of their life. The plans also noted whether it was the person's preference to stay at the home, rather than be transferred to hospital for end of life care. The registered manager said that not everyone wanted to discuss their views and wishes for their final days, but that the conversations were facilitated where able.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been in post for approximately two years. They were currently supported by one deputy manager. People were generally positive about the leadership of the service. Comments included, "He [the registered manager] leaves everything and comes…. he's a very fair man, very understandable" and "The management and staff are all good and usually listen to me". A third person told us, "The management? Yes, they are good, very good". People were able to tell us who the registered and general managers were and that they came around to visit them on a regular basis.

Staff provided mixed feedback about the leadership team. One staff member said, "[The registered manager] is really good, he is very supportive…he is a compassionate man…. the residents mean a lot to him" and another told us, "It's a big home with a lot of people with problems, I think the manager does really well". Other staff felt that the registered manager needed to be stronger and more proactive in dealing with staffing issues within the home.

The registered manager was supported by a deputy manager, both of whom were registered nurses. In addition, there was also a part-time assistant manager and a full-time administrator. The care provision was overseen by the registered nurses supported by a team of care practitioners. The provider's general manager and other senior team also regularly visited the service to support the registered manager. Health and social care professionals were generally positive about the leadership of the home. For example, one said, "[the registered manager] took over management of Bonhomie at a very challenging time and I believe it was a steep learning curve for him, we have had conversations regarding safeguarding, strategies and planning in an informal way and I believe [the registered manager] has been a positive influence". A number of the professionals felt there was still more to be done and some raised concerns about ongoing changes in the senior leadership team and spoke of their hope that this did not lead to a loss of momentum in driving improvements. For example, the relatively new, second, deputy manager, who was also an occupational therapist had left the service recently as had the clinical lead. The registered manager told us there were plans to recruit to the clinical lead post, but that the vacant deputy manager post had been replaced with additional care practitioner roles aimed at providing visible leadership on the units. There were plans to recruit an occupational therapist to work within the home alongside the physiotherapist.

Our last inspection had found that the provider and registered manager had not ensured that there were robust governance arrangements in place. The quality assurance systems were not being effective at identifying areas shortfalls in the quality of care and with driving improvements. This was a breach of Regulation 17 of the Health and Social Care Act. This inspection found that whilst some improvements had been made, the quality assurance systems in place were still not being fully effective at identifying areas where the safety of the service might be compromised. Whilst checks of the hot water temperatures were being made, the registered manager did not ensure that they, or a person delegated by them, had sufficient oversight of these in order to reassure themselves that appropriate action was being taken when readings were in excess of safe limits. This meant that the governance arrangements were still not sufficiently robust.

This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014. Good governance.

The improvements noted in relation to the completeness of records concerning people's care and treatment, needed to be embedded and sustained. This report has identified a number of areas where the records relating to people's care were not yet consistently good. This included records relating to people's weight, records relating to activities and people's daily care.

Whilst a range of internal audits were taking place, some of these needed to be more robust and would benefit from clearly demonstrate how problems or concerns had been addressed. For example, the medicines audit for April 2018 was viewed. This had found that there were out of date dressings in stock. There was no action plan in place which described how this issue was to be addressed and prevented from reoccurring. Similar concerns were noted with the infection control audits that took place monthly. The audits had not identified the concerns we found. The provider has identified that changes in the electronic recording system used will ensure that actions completed as a result of audits are clearly identified as completed.

Other audits did contain an action plan. For example, the deputy manager completed care plan audits on an ad hoc basis. Where changes were needed, an action plan was drafted for the relevant nurse to complete. The registered manager produced a monthly report for the provider which detailed areas such as the number of supervisions completed, the number of new staff recruited and the training that had been completed. As part of preparing this report, the registered manager reviewed the complaints that had been received and the accident and incidents that had occurred to check for trends or causality. There was evidence that senior management conducted intermittent unannounced checks, including at night, to check the safety of the service. Daily audits were completed by care staff which checked that care food and fluid charts had been completed and water jugs replaced for example. Checks were also made to ensure that equipment such as hoists and slings were safe to use.

The registered manager had over the last year demonstrated a commitment to driving improvements within the service. They had worked effectively with a range of health and social care professionals to address the areas where concerns had existed about the quality of care provided. Following a visit to another care home, the registered manager had implemented a range of new initiatives to drive improvements such as the introduction of care practitioners. Positive behaviour support plans were being introduced for some people to help ensure that the care provided was as person centred as possible. These were based upon a model shared with the service by training organisation which was part of Hampshire County Council.

A number of the professionals we spoke with talked of seeing positive changes within the service driven by the leadership team. For example, one described how staff previously resistant to change were being presented with evidence by the management team of how the active support approach achieved positive change for people. They felt that the management team always ensured that key staff were available to participate in reviews allowing care to be planned in collaboration.

Improvements had been made which helped to ensure that people's views about the quality of the care and support provided were sought and used to drive improvements within the service. Records confirmed that 'Residents Meetings' took place and were an opportunity to discuss preferred activities and trips and items for the newsletter. People had requested that the home be decorated for the royal wedding and world cup and we saw that this had happened. One person told us, "I go to the resident meetings, I think they are useful and an opportunity to be social, they are good". A newsletter was produced updating people on events that were taking place and changes to staffing. These measures helped to ensure that people were kept informed of developments within the service and had an opportunity to comment on these.

The provider had redesigned the quality assurance surveys to make these more user friendly and had used a different method to distribute these to people's relatives. This had resulted in a much-improved response rate, for example, previous surveys had resulted in no responses from staff. In the most recent surveys in July 2017, 29 staff had replied, along with 39 people and 29 relatives. The responses were largely positive, for example, 95% of people were happy with the response time to call bells. Where issues were identified, action plans had been drafted to address these. For example, in response to comments about the quality and choice of food, a food committee had been formed consisting of the chef, people and some residents. Ongoing feedback was also sought via a comments box in reception and again we were able to see that action was being taken to address issues raised.

However, a number of staff still felt that support from the senior management team was not consistently good. They felt they were not always valued for their hard work or that their concerns about not being able to perform their role effectively were being listened to. For example, one staff member said, "Nothing really gets done, it gets jotted down but it's not acted on". Another staff member said, "We bend over backwards, literally the extra mile, and we are not thanked at all, we don't feel supported". A third staff member said, "We all pull together and the best we can, we don't get enough praise". Staff meetings were held and were used as a learning and development tool and an opportunity for staff to express their views about issues such as staffing matters, however records did not reflect that these were always well attended. One member of staff told us, "We're meant to have meetings once a month, but people won't come in on their day off and they can't cover the floors".

Measures such as handover meetings and twice daily '10 at 10' meetings were held to discuss any concerns relating to people using the service. These had been introduced following the visits by the registered manager to other services in order to implement best practice in the sector. Whilst these measures had been put in place to improve communication within the service, some staff felt communication was still not consistently good throughout the service. For example, one staff member said, "They shouldn't make decisions without us knowing, we're only told through other carers, this morning, a resident wasn't there, her bed was slept in and she was here yesterday…its makes you panic a bit, I asked where she was and I got told she was in hospital". Following some recent changes to the structure of the staff team, some staff told us they were no longer certain about their roles and responsibilities and that this was causing some low morale. One care worker told us, "Some days are good, some days are rubbish". We shared this feedback with the registered manager, they told us that staff responded to change in different ways but understood that further action was needed to help ensure that staff felt listened to, valued and consistently supported. To develop staff morale and demonstrate that staff were valued for the care they provided, the provider had introduced an 'employee of the month'. People, visitors and colleagues could vote for who they felt had made a difference or performed their role well. The staff member winning received a gift voucher.

We saw evidence that some people were being supported to maintain links with the local community such as attending local leisure facilities, libraries and shops. The service supported local charities and had recently fund raised to contribute toward the training of a guide dog the service was sponsoring.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that people had been adequately protected against the risk of scalding. The arrangements in place were not being effective at ensuring that all aspects of the premises were safe for people to use. This is a continuing breach of Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance systems in place were still not being fully effective at identifying areas where the safety of the service might be compromised. The registered manager did not ensure that they, or a person delegated by them, had sufficient oversight of the quality assurance systems in place in order that they might take action when necessary to maintain the safety and quality of the service. This was a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.