Hampshire County Council

Harry Sotnick House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 and 7 August 2018 and was unannounced.

This was the first inspection of the service following a change of provider in April 2018.

We undertook a focused inspection following receipt of concerning information. The team inspected the service against two of the five questions we ask about services: is the service safe and well led. This is because the service was not meeting some legal requirements under the Health and Social Act 2008 (Regulated Activities) 2014. This report only covers our findings in relation to these key questions.

Harry Sotnick House is a 'care home with nursing'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this Sotnick House can accommodate up to 92 people living with dementia and physical frailty. There were 45 people at the home when we inspected.

There was a registered manager in place. 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.

People told us they felt safe living at the home. Staff understood their responsibilities to protect people from abuse and referrals had been made to the local authority when incidents or allegations occurred.

Where concerns had been raised and errors found, improvements had been made in the management of people's medicines. Actions had been taken to address medicine errors made by agency nursing staff, however the lack of permanent nursing staff and continued reliance on agency staff had led to issues with medicines. Supervisions and daily audits had been implemented to improve the management of people's medicines in the home.

Some risk assessments and management plans to minimise the risk of people falling were not always completed or sufficiently detailed. However, actions identified in risk management plans were followed by staff.

Permanent and experienced staff were knowledgeable about the risks associated with people's care. However, the information available to new and unfamiliar staff such as handover notes and care plans were not sufficiently detailed or consistent to guide staff on how to support people safely.

Staff assessed, managed and reduced risks to people's safety at the service and in the community. There were sufficient staff on duty to meet people's needs.

People were safeguarded from avoidable harm. Staff adhered to safeguarding adult's procedures and reported any concerns to their manager and the local authority.

Staff protected people from the risk of infection and followed procedures to prevent and control the spread of infections.

Equipment used to support people's needs, such as hoists and bed rails was checked and maintained to ensure they were safe for people. The premises were safely managed by maintenance staff. Protective equipment was in place such as fire safety equipment and the arrangements for the safe evacuation of people in an emergency was robust.

Sufficient staff were available to meet people's needs. The provider told us there had been changes to the number of permanent staff on duty and the more effective shift management and allocation of staff. However, people and their relatives told us they did not think there were always enough staff available.

The provider told us about the recent staffing changes they had made and were confident these would achieve improvements for people. These included recruitments to all vacant care posts and improved allocation of staff on duty, daily call bell audits to investigate and address poor response times. Further time was required to embed these changes into practice and ensure sufficient staff were available to meet people's needs and keep them safe at all times.

The registered manager adhered to the requirements of their Care Quality Commission registration, including submitting notifications about key events that occurred within the service.

An inclusive and open culture had been established and the provider welcomed feedback from staff, relatives and health and social care professionals in order to improve service delivery. A programme of audits and checks were in place to monitor the quality of the service and improvements were made where required.

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.

Medicines were mostly well managed, however issues with inconsistent staffing meant people were placed at risk.

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

Risk assessments were in place to keep people safe.

Systems had been put in place to keep people, visitors and staff safe.

Is the service well-led?

Requires Improvement

The service was not always well-led

A quality assurance system was in place and information from audits was used to inform a central action plan to drive continuous improvements.

The clinical governance was effective. Incidents were identified by staff and reviewed by the manager. They showed the actions taken to drive continuous improvements.

There was a new management team in place and feedback from staff and people was mostly positive about the leadership of the home. Some time was needed for the team to develop and embed the changes and improvements they had begun.

Although quality assurance survey results were not available at the time of our inspection. People, their relatives and staff were engaged through meetings to give their views on the service which were responded to by the provider.

Harry Sotnick 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 was prompted in part by notification of concerns regarding medicines.

This inspection took place on 6 and 7 August 2018 and was unannounced. The team consisted of two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their areas of expertise were older people and care of people living with dementia.

Prior to the inspection we reviewed the information we held about the service, including statutory notifications submitted about key events that occurred at the service. On this occasion we did not request 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.

During the inspection we spoke with twelve staff including the service manager, deputy managers, clinical leads as well as team leaders, care staff and activity staff. We also spoke with two visiting professionals.

We spoke with a total of nine people using the service and seven relatives. Some people who lived at the home had varying levels of communication, however, we were able to engage with them and ascertain from their mood and demeanour, how they felt living at Harry Sotnick House. We also observed interactions between staff and people using the service using SOFI a short observation framework.

We reviewed the care records for five people including risk assessments, plus staff records such as recruitment and training. We reviewed medicines management arrangements and records relating to the management of the service, such as audits, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with said they generally felt safe living at Harry Sotnick House. Some visitors said they sometimes felt uneasy themselves, or on behalf of their relative, because some people walked around and entered other people's rooms. People and relatives said these concerns had been raised with the management and were known about. Everyone said if they had concerns they would have no hesitation speaking out.

Comments from people included: "I like it here. They're very kind to me." Another person told us; "In general I feel safe, however there are little things that happen that have given me a fright. Last night, [5th August] someone brought in a drink. I'd asked for one earlier but had nodded off. All I remember is someone shaking my hand and calling my name. They then tried to put the drink into my hand. I didn't realise it was a drink at the time and thought someone was going to punch me. It was very frightening." A third commented, "Oh, yes, I feel safe. There always seems to be somebody around that you know. The staff are very nice, we have a laugh. I'd speak to one of the helpers if I didn't feel safe. My personal belongings aren't always safe. I'll tell you why, some people don't know what they're doing. It's not their fault. You just have to accept it."

Comments from relatives included: "It's safe enough here. It's a well-planned home and easy to get around. They use a hoist for [name] and she has a special sling for her big chair and they are very competent at that, which is important, because they don't just have to put it on safely, they have to make her feel safe too. They have to move her every four hours." Another relative told us, "Generally, yes, I'd say it is safe here. He has 1:1 a lot of the time. He's kept safe in his chair [wheelchair] because he has a seat belt on. I think they care for him quite well. If I had any concerns I would speak to someone, but if I didn't my daughter certainly would." A fourth said; I feel wonderfully safe here. They're very careful and caring. All you have to do is call for a carer and you'll get a carer. I want for nothing."

The staff we spoke with felt people were safe living at the home. One staff member told us, "The home is secure but people can move around freely within the home since we opened up all the units".

We were given a lot of very positive feedback regarding care, facilities, and ambience of the home. However, there was a general feeling from most that there were not always enough staff, particularly at mealtimes, to facilitate people who needed to go to the toilet and required two people to assist. We asked people if they had to wait longer at night if they rang their call bell and we were as told it was variable; sometimes very quick, sometimes longer if the staff were with someone else.

People and relatives told us, "No, I don't think there are always enough staff and I get concerned. There are only two in this unit. There are eight in here that need a hoist. On Saturday [4th August], someone went sick, so they had to pull someone else in here, which will leave them short. I have to say though, with regard to the call bell, I have used it on her [relative] behalf and they did come straight away. [Name] has fits and as soon as they saw, the meds were immediately brought round and ready to go at the appropriate moment, the fit has to last about 5 or 6 minutes before they do it, and she was then given them. Everything was kept

very calm. It was a contract [agency] nurse who was brilliant. I know all the regular staff by name. Sometimes we get the same contract people and I know their names."

Another relative told us, "Some days are better than others. Most days there's enough on. [Name] needs a hoist. If two are seeing to someone else then you have to wait your turn. There's quite a few people here with complex needs. They can't feed themselves and need attention. It all takes time. There's also quite a bit of training going on, which is a good thing, but it leaves them short on the floor. [Name] doesn't have the bell beside him. If he needs the toilet during the night, he has a pad on. They can't get to everyone. They'll check him and change him when they can."

A third relative told us, "I never think there are enough staff. It takes two people to hoist [name] in room. Also, there's [name] who tries to push wheelchairs and goes into people's rooms. [Name] is not able to use the call bell because they don't give it to him. It always seems to be on the wall and he can't reach it there. There's phases of lots of agency staff. The staff regularly walk past but don't look in, I can understand why they're doing it, they may get caught up. I am troubled about the number of agency staff."

One person told us, "I have a buzzer and it all depends on if they're attending another patient. Probably it'll take just under 10 minutes, maybe longer. I understand it can't be immediate. I accept that. There's not always enough staff sometimes when they're off sick or on holiday. I know the staff and those I don't know I get to know. We have a good laugh. I try to be as independent as I can." "No, there's not enough staff. When they take you to the toilet at lunchtime I have to wait sometimes for half an hour. It's not like it was when I was younger and had control. When I need to go, I need to go and I need two people to help me. It's not something that only takes a few minutes. By the time they hoist me up and let me do what I have to do, then back into my wheelchair it's 15 or 20 minutes for the next person to wait. There's quite a lot of us who need two people." "No, not really enough staff. If all here it's okay, but not always everyone, they go off sick or just don't come in. If I'm in the dining room I'll just shout out I can't reach the call bell."

We asked staff if they thought there were enough carers on duty to provide safe and effective care. One staff member said, "Yes, there are I think. The number of residents is much less than it was and that has helped a lot, especially as we've closed off one area of the home." Another staff member told us, "There's no clinical leadership at the weekends; none of the clinical leads work weekends. There is an on-call service but they don't know the home."

Whilst our observations demonstrated that staffing levels were sufficient and staff had time to spend with people in a meaningful way. People told us they often had to wait for personal care especially at certain times of the day. We spoke with senior managers about this, who were aware of the need for clinical oversight and staff were aware that this was coming into place soon. The rotas demonstrated there were enough staff on duty, the provider was aware that although people had said there were insufficient staff, concerns related to deployment of staff.

We looked at the Medicines Administration Records (MARs) for all people living at the home. There were no gaps in these records, including those prescribed and administered topical creams. All but one of the MARs contained relevant information, such as photographs for identification purposes, whether the person suffered from allergies or preferred to take their medicines in a particular way. One person's MAR charts did not have a front sheet, we brought this to the attention of staff. It had been misplaced and was returned during the inspection.

We asked how the assessment of staff competency in medicines administration was managed. We were shown documentation related to this, in the form of formal competency assessments for eleven staff

members. The documentation stated that all staff should have their first competency assessment within two weeks of training. However, this had only been done in two cases out of the eleven. The service manager said the assessment was delayed giving staff more time to get used to the processes and procedures used by the provider, before they undertook the assessment. We were assured that no staff member managed medicines alone until this process was completed.

The administration of medicines followed guidance from the Royal Pharmaceutical Society. Staff did not leave the medicines trolley unlocked when unsupervised and did not sign MARs charts until medicines had been taken by the person. Medicines rounds were completed promptly, which meant sufficient time was left between rounds to ensure that people received their medicines when indicated on MARs. Medicines were signed for after dispensing. However, we did observe one staff member not following protocol. New staff, whether permanent or agency, were accompanied by another member of trained staff when undertaking medicine rounds. On the morning of our first of the inspection, we noted an agency staff member dispensing medicines alone. We asked the staff member how long they had worked at the home. We were told this was only their third shift and had not worked on day duty since April 2018. We brought this to the provider's attention who took immediate action.

We looked at how medicines given on an 'as needed' basis (PRN) were managed. PRN protocols were in place for all medicines taken this way. They outlined how, when and why they should be taken and included maximum doses over a 24-hour period. Where a person could be given varying numbers of tablets, for example one or two painkillers, this was clearly recorded on their MAR chart. People at risk of experiencing pain who could not express it verbally were frequently assessed; care plans and MARs gave information how pain manifested itself in each person.

The provider told us that when they took over the service there were several people who could not express themselves verbally. Staff undertook an assessment of their needs as they were concerned that they might be experiencing pain which was contributing to other behaviours they were displaying. For example, one person was refusing to eat, drink, go to bed and displaying behaviours which challenged. After a assessment of their needs, they were prescribed pain relief by their GP. The administration of pain relief improved their quality of life. Staff told us the person now ate and drank and the behaviours which challenged minimised.

There was clear information for staff concerning the management of creams and topical medicines. Body maps and MAR charts were kept in people's rooms. Non-prescription items were also kept in people's rooms. Those requiring prescriptions were stored safely in clinical areas. Medicines requiring refrigeration were stored in a fridge which was not used for any other purpose. The temperature of the fridge and the room in which it was housed was monitored daily to ensure the effectiveness of medicines.

Suction machines were checked weekly for patency and subject to a cleaning schedule. The clinical order for medicines was placed four weekly, completed solely by the deputy manager to prevent overstocking. There were clear protocols for the management of 'homely remedies', the use of which were formally authorised by the person's GP.

The monitoring of therapeutic drugs was undertaken to ensure concentrations of the drug in the person was 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 for staff concerning the management of people taking all other types of medicines, such as anticoagulants (blood thinning medicines), drugs for the management of cardiac arrhythmias and Parkinson's Disease. Two people were taking 'time critical' medicines. To ensure this was done on time, the folder containing the MAR charts had a note in front reminding staff to commence their medicines round with these people. We found no gaps in

MARs or evidence of errors in the management of these.

No-one living at the home managed their medicines independently. Five people received their medicines covertly. This is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them. Where people received their medicines covertly, mental capacity assessments had been completed alongside best interest's meetings and decisions had been made and documented with all relevant parties involved.

There had been a number of medicine errors since the new provider had taken over the management of the home in April 2018. We looked at these in detail. There had been 36 medicines administration errors in that time. For example, in April 16 errors had occurred. In May seven errors. June four had occurred and in July nine had occurred of the 36 errors recorded, 20 were made by agency staff. The errors fell into one of nine categories: six under dose; six overdoses: eight not given/missed, five tablets missing, three delayed doses (two of which were insulin), one wrong MAR signed, one MAR not signed, three wrong medicines given and three syringe driver management errors.

The provider had taken a number of measures both to ascertain why medicines errors were on the rise and to reduce them in the future. We discussed these with senior staff and examined documentation. These included: syringe drive training/retraining for registered nurses. A food supplement review carried out on 1 August 2018, to ensure all care plans and kitchen documentation contained up to date information about the use of food supplements and thickeners. A weekly medicines audit, looking specifically at the dispensing of medicines. All MARs charts to be peer reviewed by registered nurses after each medicine round.

The provider had held a medicines management meeting on 30 July 2018, attended by senior staff, convened to discuss the recent rise in medicines errors. We looked at the minutes of this meeting and discussed it with senior staff. The provider had identified three main reasons for medicines errors. The failure of staff to double check stock counts. The failure of staff to consistently check MAR charts for gaps. The rise in the number of newly employed agency registered nurses.

A number of measures were put in place to resolve these issues. The expansion of the use of permanently employed team leaders in medicines management. We were told 90% of team leaders were now accredited to do this. Regular spot checks on medicines management by senior staff including hourly checks of syringe drivers, when in use. The separation of the home into three units to ensure a consistent staff presence in the management of medicines. Only senior staff to manage the recording of opening and expiry dates of medicines. All new agency staff to receive a formal induction to the home and to medicines management. This demonstrated that whilst there were medicines errors the provider had put measures in place to monitor this and had learnt by the mistakes that had been found and the number of errors had decreased since April when 16 were found. There was clinical oversight of the administration of medicines.

We asked people and relatives about medicines as we were concerned about the safety of medicine management within the home. Some of the comments confirmed issues lay with the number of agency nursing staff the home had. Comments included, "I know what medicines [name] takes and what they're for. They do it and I'm happy she gets what she should be getting on time." "They tell me what my tablets are for. 99% I get them at a regular time. There's lots of different staff giving them." "Sometimes I say, 'What's that for?' and they will tell you, or I just accept it." "They come around regularly. I just leave it to them and I'm happy for them to do it. I don't know if I could do it myself. If I needed a painkiller I'd press my buzzer and tell whoever comes and they'd get something." "They do my medicines. I know most of what I'm getting." "I'm happy with what they do, I think it's all correct." This demonstrated that most people were happy with medicine administration.

Staff members had undertaken adult safeguarding training within the last year. They understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local adult services safeguarding team should be made, in line with the provider's policy.

We observed staff assisting people to move using a variety of hoists and stands. We noted there were enough staff to do this safely; staff were evidently competent in managing this and treated people with dignity and respect whilst supporting them with their mobility.

We also noted that those whose mobility was restricted, or were bedbound, had access to their call bells. Those who could not use their call bells, for example, people living with advanced dementia, were risk assessed and measures put in place to ensure they had ready access to staff should they need it. Call bells were not audible within the home as the provider had introduced a pager system to alert staff when a call bell was pushed. This was done with the express purpose of reducing noise and promoting a calmer, homelier atmosphere. We looked at the providers call bell logs and could see that calls were answered within minutes of being pressed. This meant the provider could monitor staff response times.

We looked at five people's care plans and daily records to ensure the risks to people's safety were properly assessed and managed. In most cases this was being done but was not always the case. For example, one person's care plan contained contradictory information concerning their ability to make decisions for themselves, including risk taking and making potentially unwise decisions. The person had been assessed and a DoLS authorisation made on 30 March 2018. The document stated that the person "Lacked capacity to make decisions about their accommodation and care needs". However, their support plan stated on 27 April 2018 that the person "Does have capacity to understand, consent and contribute to the care described in the support plan". Therefore, it was not possible to ascertain from the documentation how much capacity to make decisions the person possessed. Staff were aware of people's ability to make decisions about their care.

There was inconsistency in the assessment and management of falls risks. For example, one person had undergone screening which indicated that a falls care and action plan should be completed; however, a care plan had not been implemented. Another person did have a falls care and action plan in their support plan but it contained no meaningful information concerning the measures needed to prevent or reduce the risk of falling. However, we found a third person's support plan did contain up to date and relevant information in the management of falls. The provider told us when we gave feedback that the care plans were still a work in progress and they would address these issues as a priority.

There were detailed manual handling assessments in all the support plans we looked at. The documents contained up to date and relevant information concerning the risks associated with movement. There were manual handling assessments and bed rail risk assessments in care plans. These described in detail how people should be safely helped to move and reposition. We noted the provider made use of equipment, such as hoists, which were serviced and maintained appropriately. Staff were knowledgeable about individual people's needs in this regard.

The provider also managed the care of people who displayed behaviours that could challenge others in a safe and sensitive manner. For example, one person was occasionally verbally aggressive to staff. Their support plan contained a detailed behavioural support strategy which outlined how staff could minimise risks to other people and themselves if de-escalation techniques failed. We observed staff interacting with this person in a calm and professional manner throughout our visit and saw no incidents of stress or aggression in the person.

Staff were aware of the process to follow if there was an incident or accident at the service. All incident records were reviewed by the registered manager, and support was amended for example, additional staff support provided. This enabled the staff to minimise the risk of recurrence. Staff discussed any incidents to identify any learning for the individual involved or for the service.

We attended a lunchtime clinical handover meeting, in the presence of a registered nurse and members of the management team. The purpose of this was to update managers on day to day developments concerning people's care and for managers to update staff on the wider picture of the home's management. We noted the content of the meeting reflected this purpose and was clearly focused on the wellbeing of people living at the home. We looked at weekend handover reports from 8 and 16 June, 6, 13 and 27 July 2018. They contained relevant and up to date information for staff concerning the clinical management of people's care and handover records contained information about individuals' mood, state of mind and activities they were engaged in.

Records confirmed the provider had undertaken robust employment checks to ensure the suitability of staff employed. Staff records contained two references, work history, an application form and a Disclosure and Barring Services (DBS) check. A DBS is a criminal records check employers undertake to make safer recruitment decisions.

There was a wide variety of audits undertaken by the provider. They were conducted both weekly and monthly. They looked at the wider aspects of medicines management, such as ordering and disposal. No areas of concern had been recently identified. The provider was also subject to an annual audit, undertaken by the dispensing pharmacist on 7 June 2018. The latest of these had identified a number of minor to moderate issues, such as the management of recording opening dates of medicines. The provider had devised an action plan to deal with these and had completed all work by the end of the same month.

We asked people if they thought the home was kept clean and whether they noticed any offensive odours. Seven people including relatives said, "I don't have any problems at all about the cleanliness of the place. I've never smelt any lingering odours." "It's very good, done very well. Done every day." "They try hard to keep it clean. They clean up quickly when there's been an accident." "Oh, yes, it's kept clean. There's no smells." "Oh, yes, I think it's clean. I haven't noticed any [offensive odours]." "Yes, it nice and clean. Nothing smelly. It smells nice." "It's spotless. They're cleaning all day from early morning to late evening."

The home was clean. There were no malodours during our visit. The provider put preventative measures in place where necessary, for example, ensuring the adequate provision of personal protective equipment (PPE) for staff, such as aprons and gloves. There were also individual infection control risk assessments in people's care plans.

We undertook a 'walk round' of the home. We noted all areas, both communal and clinical, were clean and tidy. There were ample hand hygiene stations throughout the home. All hand basins contained hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff had a good understanding of infection prevention and control issues.

The premises were purpose built and as such did not present significant difficulties in evacuating people in the event of an emergency. We noted there were Personal Emergency Evacuation Plans (PEEP) in care plans which outlined how people could be removed or kept safe in the event of an emergency, such as fire and flood.

Requires Improvement

Is the service well-led?

Our findings

An inclusive positive culture was being developed at the service. Staff we spoke with felt able to express their opinions, felt their suggestions were listened to and felt able to contribute towards service delivery and development. Staff told us the registered manager was "Hands on" and senior staff were "Not to posh to wash." There was a team approach towards supporting people. Staff told us "The home is better managed, I feel supported, if you ask to speak to them and they say come back in five minutes they mean only five minutes." The managers take note of what staff say, there is no working against us they work with us. We are a team now, we were segregated now we are more equal." There were some issues with communication on the first day of the inspection. However, on the second day of the inspection we saw that this was managed by senior staff and the nurse on duty.

Not everyone who lived at the home or visited it knew who the Registered Manager was but those who did were complimentary of their warmth and friendliness and commented, although they had only been in post a short while, they thought she came across as capable and needed time to make changes. A visitor said, "The new manager came in and introduced herself. I think she is very approachable, as are all the staff."

The new provider had begun work at the home at the start of April 2018. We received feedback from staff on the changes for example; one staff member told us, "It's so much better now. Things have improved so much I can't tell you. It feels like a different place." Another staff member said, "Lots of things have improved. If we need an item now, like furniture, we can get it, which didn't happen towards the end with the previous owners." A third said, "The new managers are really great. I've never worked anywhere where there's more clinical support."

We saw that the management had undertaken several audits when they became the provider at the home. One for example was a mattress and infection control audit, as a result new infection control measures were put in place and fifty new mattresses were ordered. The home was also waiting for ceiling hoists to be fitted to assist with the safe and comfortable moving and handling for several people. Visual observation and a visitor confirmed that new equipment had been ordered and put in place. One staff member told us, "It's an open door policy here. I did report something, I had a real kerfuffle getting a sling for [name]. The previous organisation told me they'd ordered one for her. When the new provider took over I asked what was happening, it turned out there was no record of it having been ordered. They got on to it immediately and it arrived quickly. They gave me regular updates of when it would be arriving."

People and relatives said there had been a recent resident and relative's meeting; others said they had received survey forms regarding the service to complete. Comments included, "A lady came around and introduced herself but I wouldn't know her now. I think we come under [Name] now. I think it's probably better now." "When [Name] took over we had meetings. My daughter attends those. We've not put in any ideas but we did ask for the small corner room, which had been turned into a nurse's station to be put back to a small meeting room and that has been done."

Another said, "There are times when they haven't got all the staff but you can't fault the care she is getting.

The only thing I think could be improved is the number of staff. I think they are short staffed, there is only two on and one has to have a break so then they are down to one, or get someone from another unit. Also, I'd like to see just a bit more continuity with the staff. Yes, I know who the manager is, she's very approachable and I like her open door. I think she needs to be given time to make improvements. It's impossible to change everything at once."

A third person said, "I've spoken to the new manager. She says she's trying to improve things. She's lovely but she's got an uphill struggle on her hands. This is such an airy, clean home, the continuous staff are lovely. When they have all the staff here it is very good."

A fourth visitor told us, "Yes, I filled in a survey a few weeks ago. We had a resident meeting last week and a relatives one about a month ago. I spoke up because I'm not really happy about the changing of the names of areas here. That's only my opinion of course, it has to be with the majority and I'll accept that. I've been one of the Friends of HSH for about a year. We do our best to raise money for things to make improvements to people's lives here. I've heard that there's no budget for activities so we're going to have to be raising funds to get people in to entertain. There's a meeting of the Friends on Friday to discuss this and there's a fete on Friday which we're all looking forward to."

The provider had systems in place to review, monitor and improve the quality of service delivery. This included a programme of audits and checks, reviewing medicines management, quality of care records, support to staff and environmental health and safety checks.

Staff had signed to confirm they had read the provider's policies and procedures. From speaking with staff, we identified their knowledge was up to date with good practice.

The service manager shared an improvement plan but said there are discussions regarding the future management of the home to include a mix of residential and nursing residents.

The registered manager and provider worked with other agencies. This included the local authority and clinical commissioning groups who funded people's care. The registered manager kept representatives from the funding authorities up to date with people's care and support needs and where there were any changes in their health. Staff informed the funding authorities about how funded one to one support was used. The registered manager also liaised with other departments at the local authority to support people and their staff, including the safeguarding adult's team and through accessing learning and development opportunities.