Firtree Associates Limited

Hazeldene Residential Care Home

Inspection report

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

Summary of findings

Overall summary

The inspection took place on 23 and 24 November 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Hazeldene Residential Care Home in May 2014, at which time the service was compliant with all regulatory standards.

Hazeldene Residential Care Home is a residential home in Gosport providing accommodation and personal care for up to 26 older people. There were 25 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

We found people's topical medicines (creams) and people's 'when required' medicines were not always managed properly or safely.

We found some examples of good practice with regard to other medicines and senior carers demonstrated a good knowledge of people's medical needs.

We found risk assessments were not sufficiently detailed or clear about how staff were to minimise the risks people faced, particularly with regard to the use of bed rails, fluid intake and repositioning.

We found that there were sufficient numbers of staff on duty in order to meet the needs of people using the service, as well as to ensure premises were clean and well maintained. Two bathrooms were clean and well equipped, whilst one was in need of refurbishment, as was the laundry room. We saw both these rooms were included in the registered provider's refurbishment plan. People's bedrooms, communal areas and the kitchen were found to be clean and well maintained.

Staff displayed a good knowledge of safeguarding principles and indicators of abuse. They were clear what to do should they have any concerns. People we spoke with, their relatives and healthcare professionals consistently told us the service maintained people's safety.

There were effective pre-employment checks of staff in place, including Disclosure and Barring Service checks, references and identity checks.

We saw that, whilst staff consistently asked people for their consent on a day-to-day basis, care files contained conflicting information about whether people had capacity to make specific decisions, meaning the service did not always act in line with the Mental Capacity Act 2005 (MCA).

External professionals had confidence in the experience and knowledge of staff and we saw there was regular liaison with GPs, nurses and specialists to ensure people received the treatment they needed.

Staff completed a range of training the registered provider considered mandatory, such as safeguarding, health and safety, moving and handling and dignity. Staff displayed a good knowledge of the subjects they had received training in and had a good knowledge of people's likes and dislikes.

We saw people had choices at each meal as well as being offered alternatives. People spoke positively about the food and drinks they had and we observed people experiencing a relaxed lunchtime in the dining room. We observed staff supporting people patiently to eat and drink and offering people drinks throughout the day.

Staff were regularly supported through supervision and appraisal processes as well as ad hoc support from management when required.

The premises benefitted from some aspects of dementia-friendly design, such as bold signage and contrasting hand rails in the two completed bathrooms and communal areas. Dementia care-planning was detailed although we found activities were focussed on group activities and could be improved by focussing on people's individual preferences more.

The atmosphere at the home was welcoming. People who used the service, relatives and external stakeholders agreed that staff were caring and compassionate. We saw numerous instances of warm, inclusive interactions.

Group activities were varied, coordinated by a member of staff who demonstrated a good understanding of people's interests and their communicative abilities.

Reviews of people's care needs took place, although these were not adequately documented or accessible during the inspection.

Records of people's care needs had recently been moved to an online care file management system and we found a number of inaccuracies in these care records, as well as previous paper-based recording systems.

We found that auditing of the service needed to improve as, whilst regular audits were conducted by the registered manager and monthly visits by the registered provider, they had not identified a number of issues.

Staff, people who used the service, relatives and external professionals we spoke with expressed confidence in the registered manager as well as care staff.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks people faced were not always adequately assessed nor were clear actions set out in care plans to protect people against those risks.

'When required' medicines and prescribed creams were not always administered properly or safely.

There were sufficient staff on duty to safely meet the needs of people who used the service and pre-employment checks of staff reduced the risk of unsuitable people working with vulnerable adults.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff consistently asked people for their consent on a day-to-day basis, although care files contained contradictory information about whether people had capacity to make specific decisions, meaning the service did not always act in line with the Mental Capacity Act 2005 (MCA).

A range of training the registered provider considered mandatory was in place, as well as additional training tailored to the needs of people who used the service.

The premises had undergone some recent refurbishment, which incorporated aspects of dementia-friendly design, such as contrasting fixtures and fittings. Further refurbishment was needed and we saw the provider had a refurbishment plan in place.

People received a range of meal options, experienced pleasant mealtime interactions with staff and people's specific food preferences were taken account of.

Is the service caring?

Good

The service was caring.

People who used the service, relatives and external stakeholders agreed that staff were compassionate and patient. We observed numerous interactions which supported these opinions.

Care plans were written with the involvement of people who used the service and their relatives and staff displayed a good knowledge of people's needs.

People who used the service could pursue their religious beliefs thanks to regular visits by the clergy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The regular review of people's care needs was not adequately documented.

Staff liaised with external healthcare professionals and acted on their advice to ensure people's changing healthcare needs were met.

The service had in place a range of activities, which included regular group activities and visitors to the service. Aspects of person-centred care were delivered although there were further improvements to be made.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had recently moved to an online care file management system and we found inaccuracies in people's online care records, as well as paper-based recording systems.

Auditing of the service needed to improve as, whilst regular audits took place, they had not identified a number of issues.

The culture was a caring one, with staff at all levels taking a genuine interest in people's wellbeing.

Hazeldene Residential Care Home

Detailed findings

Background to this inspection

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

We visited the service on 23 and 24 November 2016 and the inspection was unannounced. The inspection team consisted of two Adult Social Care Inspectors and one expert by experience. An expert by experience is a person who had personal experience of using or caring for someone who used this type of care service. The expert in this case had experience in caring for older people and people living with dementia.

We spent time speaking with people who used the service and observing people in the communal areas of the home. We spoke with nine people who used the service and three relatives of people who used the service. We spoke with 13 members of staff: the registered provider, the registered manager, two senior carers, six care assistants, the administration assistant, the cook and the head of housekeeping. Following the inspection we spoke with one social care professional and two health care professionals on the telephone.

During the inspection visit we looked at six people's care plans, risk assessments, five staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. We spoke with professionals in local authority commissioning teams, safeguarding teams and the local Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

Requires Improvement

Is the service safe?

Our findings

We reviewed the systems in place for administering medicines. We saw previous feedback from a staff survey had suggested there needed to be information in people's rooms so carers knew what topical medicines (creams) to apply and when. The registered manager and staff described the system in place, whereby written details regarding where and when to apply creams were contained in people's wardrobes. We reviewed this information, the daily records of whether the creams had been applied and the medication administration records (MARs) which also required senior care staff to sign to confirm they had been told that the carers had applied these creams.

We identified four instances of people's cream applications not being signed for in line with the instructions set out in care plans. For example, we found days where there was no signature indicating a cream had been administered, yet the person required the cream daily. We also found one instruction which stated the cream had to be applied to a person's legs, arms and neck, but the daily notes indicated the cream had only been applied to the person's legs. Another cream was to be applied to a person's "upper" and "lower" body but there was no specific guidance for staff regarding whereabouts on the upper and lower body this meant. We also saw that when creams were opened there were no dates of opening noted, meaning staff would not know when the creams should be discarded.

MAR records showed that all cream applications had been signed for by the senior carer, having received confirmation from carers that they had performed this task. When we spoke with staff they demonstrated a good knowledge of what cream people needed and why, but the registered manager confirmed the system was not working and presented a risk of unsafe medicine administration.

We also reviewed the service's use of PRN or 'when required' medicines. We found these were not supported with specific plans or protocols regarding when and why they should be administered. For example, one person was prescribed paracetamol 'when required' but it was unclear from the paperwork what a member of staff would look for when considering whether to administer the medicine. The National Institute for Health and Care Excellence (NICE) recommends in 'Managing Medicines in Care Homes' (March 2014) that care homes should have a specific process to document all aspects of 'when required' medicines administration. This includes, "The reasons for giving the 'when required' medicine," and, "What the medicine is expected to do." The registered manager was unaware of this good practice and committed to reviewing the NICE guidelines and reviewing their 'when required' practices. The 'when required' practices we saw presented a risk of people receiving excessive medicines through a lack of clear planning.

We observed senior carers administering and recording medicines and found their practice otherwise to be in line with NICE guidelines, for example ensuring they asked for each person's consent prior to administering medicines, explaining what the medicines were, and recording the administration after supporting each person. We also saw there were no errors in the MAR documentation we viewed and documentation included people's photograph, allergy information and pertinent contact details. Medicines were securely stored in a locked room, with temperatures of the room and medicines fridge checked on a daily basis. On speaking with staff, we found them to have a good knowledge of people's medicinal needs.

People who used the service and their relatives told us they felt protected from harm. One person told us, "Yes I feel very safe here," whilst another person said, "Yes, there are never any problems. They are a good bunch and we're well looked after." When we spoke with external health and social care professionals they confirmed they did not have any concerns about the safety of the service. We also observed how people who used the service interacted with staff and found there to be no signs of anxiety or fear; people behaved in ways that demonstrated they trusted and felt safe around staff members.

We found there were sufficient staff on duty to meet the needs of people. Staffing levels were calculated by the registered provider, based on people's levels of dependency, and staff we spoke with, including night staff, felt levels were appropriate. People who used the service and their relatives agreed. We observed call bells were accessible and were responded to promptly throughout our inspection.

Staff knowledge of the risks people faced, through restrictions to mobility, sensory impairment and their medical conditions, was generally good. We saw however risks were not always effectively documented and that the provider had not always done everything that was reasonably practical to mitigate such risks. For example, we saw one person's bed rails were in use when we visited the service. The registered manager said this was an error on the part of staff and that the person did not require bed rails to keep them safe. We asked to see the bed rails risk assessment as we could not see it in the person's care file. The registered manager told us this was "archived and inaccessible". A new risk assessment was completed during the inspection, stating bed rails were not necessary. This meant the person had been at risk of injury through the unnecessary use of bed rails. There were no bumpers in place for this person, nor another person using bed rails. Bumpers help to ensure people do not harm themselves on the bare wood of the rail, and also prevent against people becoming trapped by a bed rail. These risks had not been considered in the other bed rails risk assessment we reviewed, which had been completed in 2013 and not reviewed since. This demonstrated that the risks associated with the use of bed rails had not been adequately assessed.

We also identified concerns regarding other risk assessments, or the lack of them. For example, two people at risk of skin deterioration had their fluid intakes monitored, but there was no specific risk assessment or plan in place to demonstrate what levels of fluid intake they required to help protect against the risks of dehydration and skin deterioration. We found the same to be the case for the same people's repositioning charts. Whilst these were in place, there was no specific risk assessment in place to establish how often people needed to be repositioned to protect against the risk of developing pressure sores. One care plan, for example, stated, "The following should be considered: Introduce a repositioning schedule that is tailored to (person's) current needs." We saw there was no specific repositioning schedule in place, but a 'night care' plan which stated, "Every hour, (person) needs a quick check to see he is okay." It was unclear from the documentation what this check involved and care records indicated positional changes occurred three-hourly at night and were not recorded during the day. The registered manager acknowledged that the risks presented by insufficient fluid intake, insufficient positional changes and the use of bed rails had not been adequately assessed. They and the registered provider produced an action plan in the days following the inspection detailing how they intended to make the necessary improvements.

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

Staff we spoke with had been trained in safeguarding and displayed a practical understanding of their safeguarding responsibilities. They described potential sources of risks, types of abuse and what they would do should they have concerns. These responses were in line with the service's safeguarding policy, which was readily available.

We reviewed a range of staff records and saw that in all of them pre-employment checks including enhanced Disclosure and Barring Service checks had been made. The Disclosure and Barring Service maintains records of people's criminal record and whether they are restricted from working with vulnerable groups. We also saw the registered manager had asked for at least two references and proof of identity from applicants. This meant that the service had in place a consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

People who used the service and their relatives commented on the cleanliness of the service and we noted it was generally clean. We saw bathroom inspection charts in place indicating two-hourly checks and found these to be up to date. We saw the laundry was in need of reviewing in terms of how space could be used most effectively and hygienically. Currently the sink was in a poor condition and there were tiles missing on the splashback area. We also saw the first floor bathroom, one of three bathrooms in the service, was in need of refurbishment. We saw the review and refurbishment of the laundry room and the first floor bathroom was on the provider's refurbishment plan, due to be completed by March 2018. The other two bathrooms we viewed were in good order, clean and equipped with contrasting fixtures and fittings, meaning people with impaired eyesight would be better able to use the facilities safely.

We saw the handyman was responsible for general maintenance of the premises, which was in good order generally. We saw Portable Appliance Testing (PAT) had been undertaken, whilst all hoisting equipment and lifts had been serviced. We saw emergency systems such as the call bell system and emergency lighting were tested regularly, fire extinguishers/equipment had been serviced and window restrictors in place. We saw water temperature checks had been undertaken regularly to protect against the risk of burns. This meant people were not placed at risk through poor maintenance and upkeep of systems within the service.

We saw incidents and accidents were recorded and acted on in a manner that allowed for easy analysis to identify any trends and patterns and saw that such analysis happened regularly.

We found the disciplinary policy to be clear and, where action had been taken. We found this had adhered to the policy.

With regard to potential emergencies, we saw there was an easily accessible emergency file and that people had personalised emergency evacuation plans (PEEPs) in their care files. These explained how people would need to be supported in the event of an emergency. The registered manager moved copies of these PEEPS into the emergency file in order that members of the emergency services would be better able to support people in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

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

We found the registered manager had not ensured people were supported in line with the MCA and they acknowledged there were contradictions in people's care files in this regard. For example, people had documents in their care files indicating they had capacity to make decisions, but decisions had been taken by relatives, with no evidence to suggest people's capacity had diminished and that they were now unable to make such decisions. Where decisions are made for people who lack capacity to do so, these decisions should be made in line with the MCA, with a 'best interests' decision taken by those who know the person best, as set out in the Mental Capacity Act 2005 Code of Practice (2007), section 5. Likewise, mental capacity assessments should be regularly reviewed. The registered manager agreed their approach to the MCA and their understanding and application of the act in relation to people's capacity and ability to consent required a full review. They committed to do so and included this in the action plan sent to CQC following the inspection.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff sought consent from people who used the service on a day-to-day basis, for example to be helped up a set of stairs, or to be given medicine. We found people who used the service received care from staff who had a range of knowledge and skills, and who understood their needs. We saw staff had been trained in a range of subjects, such as safeguarding, moving and handling, first aid, fire safety, dementia awareness, infection control, medicines administration, end of life care and dignity in care. This demonstrated the registered manager had ensured people's needs were met through the provision of relevant training.

Staff consistently told us they were well supported to perform their role, through the training provided and through supervisions. Supervisions are meetings between a member of staff and their manager to identify any areas to improve or goals for future development. We saw these took place regularly and were planned for the coming year, as were staff appraisals and team meetings. One staff member told us, "We get plenty of backing. You get all the initial support and it keeps going."

Relatives who used the service expressed confidence in the competence and capabilities of staff. One relative told us, "A lot of the carers have been here a long time so they know people," whilst a person who used the service said, "Yes, they're good at what they do – I'm in safe hands."

We observed a staff handover on one morning of our inspection, between night staff and day staff, and

found all staff present displayed an awareness of people's needs. For example, deciding to ask for a urine sample to be taken for someone who's level of confusion had increased recently.

When we spoke with external professionals they were complimentary about staff knowledge, with one stating, "They are a friendly and knowledgeable group and they're able to meet a range of mixed needs," and, "Their knowledge is good." Speaking specifically about staff knowledge of maintaining and monitoring people's skin integrity, one professional said, "They know the difference between a developing pressure sore and when it's something less serious that they can manage. They are good in that respect and ask if they're not sure."

We spoke with the cook who displayed a good knowledge of people's needs who required specialised diets, such as soft diets, and why these diets were necessary. They had recently completed a nutritional training course delivered by a nurse and were enthusiastic about providing people with adequate nutrition but also ample choice. People who used the service told us, "I can eat what I like," "I've had a nice breakfast now I'll have a coffee and a snack later – they're always coming by," and, "Very good – I've put on weight!" One relative told us, "There is always a choice," and, "(Person) chooses to eat in their room – you can please yourself, which is wonderful."

We saw menus were taken to each person by the activities co-ordinator, who asked people what option they would like for each meal. Where people wanted something that was not on the menu, the cook prepared it and we found people experienced a responsive approach to nutrition by staff. We observed people being offered drinks and snacks throughout the day via a tea trolley, and encouraged to drink in communal areas, where jugs of juice were available. One person told us, "I had marmite on toast – I love it. They come and ask you if you'd like another slice." Another person said, "I enjoy my cup of tea and then they bring another."

We saw people were regularly weighed to protect against the risk of malnutrition through the use of the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. We saw a number of people had successfully retained or gained weight.

With regard to the dining experience, we found interactions from staff to be patient and warm, encouraging people to eat and not rushing people who required more time.

With regard to the premises we saw there was an ongoing programme of refurbishment. Two of the bathrooms had been fitted with contrasting hand rails and toilet seat in order to help people with limited visibility, whilst there was a choice of a shower or a bath. Signage on the outside of the bathrooms was clear, large and colourful. We saw that handrails in corridors contrasted well with walls and, whilst the age of the building meant some corridors were narrow, there was sufficient space for people who used the service to move around the building, along with a lift we observed people using during our inspection.

We reviewed the content of care files and saw there had been involvement from external health and social care professionals, for example from the Speech and Language Therapy Team (SALT), opticians and GPs.

Good

Is the service caring?

Our findings

When we asked people who used the service about staff, they told us, "They are very kind and friendly," "The staff are very, very good," "It's very comfortable, very nice staff and they listen to you," and, "The girls are wonderful - we have some fun. I think they are made for this job." One person who used the service told us, "Some of the staff boss you around a bit. They think they know better than you and you have to remind them you're paying for the privilege." We found however the strong consensus of opinion was that staff behaved in a dignified, patient and professional manner with people who used the service.

One relative told us, "The carers are so good at motivating. You never see a miserable face," and we received feedback from external professionals stating that they were always welcomed by staff and had observed staff interacting with people who used the service appropriately and in a warm manner.

During our observations we saw all staff, including non-care staff, interacting in a patient and sensitive manner with people who used the service. We also saw one person who needed assistance with personal care being helped to promptly and discreetly move away from a communal area by a member of staff.

A range of thank-you cards presented further evidence of the caring attitudes of staff. Representative comments included, "Thank you for looking after [person]. I could they were settled and I could leave happy with all I had seen," and, "Thank you for looking after [person] with so much care and compassion." This demonstrated the director and registered manager had successfully ensured the culture at the home was one of genuinely caring about people's wellbeing.

We noted in the Provider Information Return (PIR) that the turnover of staff was low. One relative and one external professional stated they thought this was important to ensure people received a level of continuity and familiarity in their care and we found all staff we spoke with had a good knowledge of the people they cared for. The registered manager confirmed they had only used agency staff workers on three occasions. We asked people who used the service about whether they knew their carers and people confirmed they did, and that they got on with them well. This demonstrated the registered manager had ensured people who used the service received a continuity of service from carers who knew them well, and vice versa.

We saw that people's religious beliefs were respected and upheld. For example, the home held a church service monthly in the home for people who wished to attend. This coincided with one day of our inspection and we observed people partaking in the service, supported sensitively but enthusiastically by the activities co-ordinator. This demonstrated the registered manager ensured people's diverse beliefs could be respected in a practical way.

Through our observations we saw staff taking time to ask people how they were and to patiently wait for a response. We saw staff giving people a range of options and waiting for them to choose. We saw people's bedrooms had been personalised with their own belongings, photographs and memorabilia.

External professionals we spoke with were complimentary about the ability of staff to sensitively support

people at the end of their lives, citing good relationships with district nurses. One nurse told us, "We take the lead but they're confident in supporting and all the staff are sensitive to people's needs at that time."

We saw people's personal sensitive information was securely stored in locked cabinets and on a password protected IT system, in line with the confidentiality policy.

Requires Improvement

Is the service responsive?

Our findings

We saw some aspects of dementia care were strong, for instance individual staff members' understanding of the varying needs of each person, and how they communicated with people who used the service to ensure people felt involved in the day to day running of the service. For example, one person who used the service enjoyed folding napkins, making tables and tidying up. We saw them being supported to do this during our observation. Dementia care plans we saw were detailed and gave person-specific information regarding how people like to be communicated with, and how they could best be supported.

We saw there was an example 'memory box' in the entrance hall. A memory box is a framed box in which people can put photographs or objects personal to them. The box is then put up on their door or outside their room so that they can associate with the room as their own. We saw that nobody using the service had their own memory box in place as yet. The Department of Health guidance document, 'Dementia-friendly Health and Social Care Environments' (March 2015) gives a range of examples of how memory boxes, memorabilia and rummage boxes can enhance people's involvement and meaningful inclusion in their environment.

We spoke with the activities co-ordinator, who worked between the hours of 11am and 5pm, Monday to Friday. They demonstrated a good understanding of the needs of all people who used the service, as well as their preferences, likes, dislikes and backgrounds. We observed the activities co-ordinator interacting warmly and sensitively with a number of people who used the service, tailoring their communicative style in order to put people at ease. They told us they used the daily process of asking people for their menu preferences as a means of spending one-to-one time with people, as this was not specifically planned as an activity. We saw they arranged a range of group activities such as entertainers, quizzes, bingo, church and carol services. We saw that staff also gave people hand massages and manicures and, where people wanted to pursue their own interests and hobbies, they were encouraged and enabled to do this. For example, one person regularly visited a nearby pub, whilst another person regularly attended a book club.

The activities co-ordinator acknowledged that they did not have a weekly plan for the activities they arranged, and that the activities were group orientated rather than specific to individuals' preference.

This demonstrated that, whilst there was evidence of the service being dementia-friendly in some respects, the registered manager had yet to fully establish a model of person-centred dementia-friendly care.

We found care files were varied in terms of how much content was available regarding each person's care needs, preferences and life history. The registered manager explained that the service was in the process of moving all information onto 'Care Docs', an online portal where all care information can be stored and updated. Staff we spoke with were able to demonstrate how they could access the information held on 'Care Docs', either via the laptop, or on two handheld pads.

We saw family members were invited to take part in people's annual care plan reviews, and that relatives were consulted when people's needs changed.

We found however monthly reviews of people's care needs were not currently clearly or systematically recorded. We asked the registered manager to demonstrate how people's changing needs were reviewed and recorded on a monthly basis and they acknowledged the system was not yet in place. They described that the process should involve staff documenting any changes in individual care plans, filling in the monthly review form and also printing off and placing behind this form any changed aspects of the care plan. In all people's care records we viewed on the 'Care Docs' system we saw none contained details regarding what had changed at the person's last review. We saw the review section in each case stated, "The following areas of the care plan have been updated," but then did not detail which areas had changed. The registered manager confirmed there had been changes to people's respective care plans following review, but that this had not been documented. The registered manager was unable to demonstrate via the 'Care Docs' system what aspects of people's care plans had changed at review. Whilst staff demonstrated a good understanding of how people's needs had changed, records were not accurate or up to date in this respect.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people's changing health needs were responded to and supported with the ongoing involvement of a range of healthcare professionals, for example GPs, visiting nurses, chiropodists and dentists. Professionals we spoke with were complimentary about the levels of responsiveness displayed by staff. One healthcare professional told us, "They do contact us as and when – I think they get the balance right of not being too dependent but making sure they check in with us." We saw emergency health care plans were in place detailing people's medical, mobility and communicative needs to better inform healthcare professionals, should a person need to receive emergency treatment outside the home.

Relatives we spoke with were positive about the ability of individual staff and the director and registered manager when talking about how they felt involved in the reviewing of care planning.

People we spoke with confirmed they were routinely involved in decisions relevant to them, for example the colour of new chairs in the lounge and conservatory area, the Christmas decorations, and menus. One person said, "We can go in the lounge, we can go for a walk. We've got a Christmas tree up and we'll be making paper things to put up. I like it here." Another person told us they enjoyed watching tennis in their room, whilst another said they enjoyed the games the activities co-ordinator organised, such as armchair golf.

With regard to complaints, we saw information regarding how to make a complaint was clearly displayed in communal areas and in the service user guide. People we spoke with and their relatives knew how to make a complaint and who to approach should they have concerns. One relative told us, "I'd see the manager, but if it was minor I would speak to anyone. I'd have no problem raising anything." We saw, where complaints were made, these were responded to promptly and outcomes arrived at.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had relevant experience in health and social care and was supported by senior carers who demonstrated a strong understanding of people's medicinal, physical and emotional needs throughout the inspection.

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. We found the move from paper-based care documentation to the online platform had not yet been successfully completed and experienced some delays and difficulties in seeing the relevant information we requested. In some cases, this information could not be produced.

Not all information we reviewed was accurate or up to date. For example, the hard copy fluid intake charts and the repositioning charts, as described in the Safe section, were not completed accurately. Likewise, the topical medicines (creams) records in people's rooms were not accurate and contradicted the information found in people's individual medication administration records (MARs).

We asked about one person with diabetes, and whether they received specific foot care. People with diabetes are particularly susceptible to poor foot health and it is important they received regularly help in this regard. The registered manager confirmed this person received regular support from an external chiropodist but was only able to provide documentary evidence of this by way of an invoice. This meant any potential feedback, concerns or advice given by the chiropodist were not accurately recorded.

With regard to auditing and quality assurance processes, we saw the registered manager undertook daily 'walkarounds' of the service and there was evidence of some areas of the service being improved by this means, for example some routine maintenance. The registered manager also undertook medicines audits and audits of care files. The registered manager was required to send the monthly outcomes from the audits to the registered provider, with an update on any outstanding actions. We saw, from March to October 2016 there were no outstanding actions noted on the registered manager's return of this information. These audits had failed to identify the discrepancies with care file documentation identified during the CQC inspection. This demonstrated the auditing and quality assurance processes in place were not sufficient to identify areas of concern or drive service improvement.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On 28 November 2016 the registered manager provided CQC with an action plan regarding how they intended to rectify the breaches of legislation identified during the inspection.

We also saw the registered provided visited the service on a monthly basis and carried out visual checks of the building. We saw there was a refurbishment plan in place which had regard to the fact the first floor bathroom required refurbishment and the laundry room required review. Both of these rooms were

scheduled for completion by March 2018.

Members of staff we spoke with told us they had confidence in the registered manager and registered provider and we found the culture at the service was a caring one. This conclusion was supported by the conversations we had with people who used the service, their relatives and through our observations.

All staff we spoke with confirmed they received regular and adequate professional and person support from the management, and felt free to raise concerns or queries. We saw regular team meetings were held and staff were encouraged to discuss topics pertinent to them and people who used the service, such as rotas, uniforms, relevant legislation and possible activities.

External professionals we spoke with, including health and social care professionals, commissioning and safeguarding staff, all confirmed they had positive working relationships with the management at the home, with one stating, "They have always been a steady service rather than one that's up and down."

The registered manager had formed strong relationships with the local church, the Red Cross and also attended the Hampshire Care Association, a forum for sharing good practice.

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 11 HSCA RA Regulations 2014 Need for consent The registered manager had not always acted in line with the Mental Capacity Act 2005 to establish who was the relevant person to seek consent from when delivery care.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks people faced were not always adequately assessed nor had the registered manager and registered provider ensured clear actions were set out in care plans to protect people against those risks. They had therefore not done all that was reasonably practicable to mitigate risks. 'When required' medicines and prescribed creams were not always administered properly or safely.

The enforcement action we took:

A warning notice was served with a short time frame for the registered provider and registered manager to become compliant.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Information pertaining to people's care records was not always accurate or up to date. Auditing and quality assurance processes in place had not identified these errors, meaning the registered provider and registered manager had failed to successfully assess, monitor and improve the quality and safety of the services, as well as the risks relating to health, safety and welfare.

The enforcement action we took:

A warning notice was served with a short time frame for the registered provider and registered manager to become compliant.