Alverstoke House Nursing Home

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Alverstoke House is a family run 'Nursing home'. People in nursing homes receive accommodation and nursing or 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 inspection. The home is registered to provide accommodation for 29 people. There were 24 people living at the home at the time of the inspection.

The home was based over two floors, connected by two stairwells. Bedrooms had en suite facilities and there were toilets and bathrooms available on each floor. There was a choice of communal spaces comprising of two communal lounges, a dining room and a conservatory where people were able to socialise.

The inspection was conducted on 30 November 2017 and was unannounced. There was a registered manager in place, however, they were on holiday on the day of the inspection. 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.

At the last inspection of the home we identified that the service had breached a regulation in relation to medicines management. At this inspection we found action had been taken to address all areas of concern and there were no longer any breach of the regulations.

Medicines were administered by staff who had received appropriate training and assessments. People received their medicines at the right time and in a way that met their needs.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the providers' safeguarding policy and explain the action they would take if they identified any discrimination or concerns.

Staff knew the people they supported and were able to explain the risks relating to them and the action they would take to help reduce the risks from occurring.

The home was clean and hygienic and staff followed best practice guidance to control the risk and spread of infection.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs.

There were enough staff to meet people's needs in a timely way. Appropriate recruitment procedures were

in place and pre-employment checks were completed before staff started working with people.

Staff sought consent from people before providing care. Although nobody at the home lacked the capacity to make a decision staff were able to explain the action they would take to ensure they followed legislation designed to protect people's rights.

Staff developed caring and positive relationships with people and were sensitive to their individual communication styles, choices and treated them with dignity and respect. People were encouraged to remain as independent as possible and maintain relationships that were important to them.

People were supported to have enough to eat and drink. Staff who prepared people's food were aware of their likes, dislikes and dietary needs. Mealtimes were a social event and staff supported people, when necessary in a patient and friendly manner.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff took account of people's end of life wishes and preferences. They supported people to remain comfortable and pain free.

There was an opportunity for people and their families to become involved in developing the service. They were encouraged to provide feedback on the service provided both informally and through resident and family meetings and a bi-yearly survey. They were also supported to raise complaints should they wish to.

People told us that they felt the home was well-led and were positive about the registered manager and the provider who understood the responsibilities of their role. The provider was fully engaged in running the home and provided regular support to the registered manager.

The provider's clear vision and values underpinned staff practice and put people at the heart of the service. Staff were aware of the vision and values, how they related to their work and spoke positively about the culture and management of the home.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received their medicines at the right time and in the right way to meet their needs.

Staff were aware of the risks to people and the action they should take to reduce those risks.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

There were appropriate systems in place to protect people by the prevention and control of infection.

There were plans in place to deal with foreseeable emergencies and staff were aware of their responsibilities to safeguard people.

Is the service effective?

Good

The service was effective.

Staff received an induction and on-going training to enable them to meet the needs of people using the service. Staff were supported appropriately in their role and could gain recognised qualifications.

Staff sought consent from people before providing care and followed legislation designed to protect people's rights.

People across the service were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

The registered manager explored people's cultural and diversity needs during pre-admission assessments.

People were encouraged to maintain their independence, friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and staff were responsive to people's changing needs.

People's wellbeing was enhanced through activities that were focused on individual's abilities and preferences.

There was a process in place to deal with any complaints or concerns if they were raised. People told us they knew how to complain.

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

People, their families and staff were actively encouraged to become involved in developing the service.

The provider had suitable arrangements in place to support the registered manager and there were systems in place to monitor the quality and safety of the service provided.

Alverstoke House Nursing 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 checked whether the provider was 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 unannounced and was carried out on 30 November 2017 by an inspector, a specialist advisor in the care of older people and those living with dementia and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events, which the service is required to send us by law.

We spoke with nine people using the service and two relatives. We observed care and support being delivered in communal areas of the home. We spoke with three members of care staff, two nurses, the chef, an activities co-ordinator, the deputy manager and the provider. At the time of the inspection the registered manager was on holiday and we spoke with them by telephone on their return, after the inspection had been completed.

We looked at care plans and associated records for seven people using the service, staff duty records and other records related to the running of the service, such as, three recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in December 2016, where we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in respect of the safe management of medicines and it was rated requires improvement.

Good

Is the service safe?

Our findings

At our inspection in December 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to identify medicine errors, take appropriate action and ensure information about medicines was available to staff. At this inspection, we found action had been taken and there was no longer a breach of this regulation.

People received their medicines safely, from staff who had completed the appropriate training and had their competency to administer medicines checked every six months. Although, only nurses administered medicines all care staff undertook medicine awareness training to ensure they had an understanding of how people's medicines were managed. The registered manager had developed their own quality assurance process and management systems to ensure people received their medicines safely and at the right time. Medicines administration records (MAR) were completed correctly. Each person had a MAR sheet with a photograph of the person and information about any allergies. The MAR chart provided a record of which medicines were prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Staff made daily checks of the MARs to make sure people had received their medicines correctly. Staff were aware of the action to take if any mistakes was found, to ensure people were protected. Records showed that people's medicines were consistently available for them. Staff engaged with people to check that they were happy to take their medicine. Staff supporting people to take their medicines did so in a safe, respectful, and unhurried way. One person told us, "The nurse gives them [medicine] to me. I can ask for something if I have a headache." Another person said, "No, I don't have them [their medicine], the staff come in and dole them out to me." A family member told us, "The nurse gives out the tablets."

Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe storage and disposal of medicines and suitable arrangements were in place for medicines, which needed additional security. A refrigerator was available for the storage of medicines, which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place to ensure medicines were stored appropriately and a process for the ordering of repeat prescriptions and disposal of unwanted medicines.

People were supported to use topical creams, which were applied by care staff and stored, in people's rooms for ease of use. However, these were not kept in a secure environment and no risk assessments had been completed to assess whether they presented any risks to the people using them or other people within the home. We raised this concern with the deputy manager who took action to review the use and storage of topical creams, which were placed in a secure environment until the review was completed.

People told us they felt safe at Alverstoke House. One person said they felt safe and added, "I nearly collapsed on Sunday, if I'd been at home I don't know what would have happened." Another person said, "I can't stand anymore so have to be hoisted. I don't like having to use it but have to for safety's sake." Other

people told us they had lived at Alverstoke House for a long time and felt safe because they had a call bell and could ring for help if they needed to. One person said, "I don't tend to ring it very often so they know I must really need something." A family member told us they did not have any concerns regarding their relative's safety. They said, "[My relative's] safe here, she doesn't like to ask for help but she's in a safe place."

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff, including non-care staff and the registered manager had received appropriate training in safeguarding adults. Staff knew how to raise observed concerns and to apply the provider's policy. One member of staff told us, "I would go to the nurse [if I had any concerns]. If it was something to do with them, I would go the registered manager or you guys [CQC]." Another member of staff was able to tell us about the action they would take and gave us examples of where they had raised concerns in the past. They said they "felt confident to do so again if required." The registered manager conducted thorough investigations in response to allegations of abuse and worked with the local safeguarding authority to keep people safe from harm. Staff and the registered manager had received equality and diversity training, as well as training in respect of people's human rights. They were able to explain the action they would take if they felt someone was being discriminated against.

People were supported by staff who were aware of the individual risks relating to people while providing care and support for them. Staff also understood how to manage those risks effectively to support people to be safe while helping them to retain their independence and avoid unnecessary restrictions. The registered manager had assessed the risks associated with providing care and support for people, which reflected people's individual needs. One person had chosen not to use bed rails at night because they restricted their independence and ability to get out of bed when they wanted to. A risk assessment was in place to inform staff how to support the person and allow them to maintain their independence. All of the staff and the registered manager had received training on how to assess and manage risk and to write risk assessments. We saw there were risk assessments in place to help people to mobilise using equipment to help them maintain their independence. One person told us, "I have a walking frame and the staff help me."

The registered manager had also identified risks relating to the environment and the running of the home. These included fire safety, infection control and accessing the kitchen. They had taken action to minimise the likelihood of harm in the least restrictive way. There was a clear record made of when an incident or accident had occurred. These were reviewed by the registered manager and provided the opportunity for analysis and organisational learning and risk identification.

People and their families told us that there were sufficient staff to meet their needs. They said that if and when they needed staff, they were able to get help quickly. One person said, "No, I don't have to wait for long at all [when I ring my call bell]." Another person told us, "I don't use it very often but they come in regularly so I don't need to ring." A third person said, "I used it this morning, I felt so weak. The carer was very nice very good." The provider told us that staffing levels were based on the needs of the people within the home. They gave us an example where they had recently increased the staffing levels at night because they had identified that people's needs had changed. We observed that staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner.

There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime, some bank staff and agency staff. One member of staff said, "There is enough staff but we have a lot of sickness and that can cause a problem [managing the absence at short notice]." The deputy manager told us that they and the registered manager were available to step in and cover if they were needed.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were appropriate systems in place to protect people by the prevention and control of infection. Staff had attended infection control training. They had access to personal protective equipment (PPE) and wore this whenever necessary. The home was clean and well maintained Cleaning schedules were available to help ensure cleaning was done consistently, using appropriate products.

There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire. Fire safety equipment was maintained and tested regularly. Emergency information was available, including contact details for staff and management out of hours. Personal evacuation plans for people were available in a file, which was kept in a fire 'grab bag' in the foyer for easy access if people needed to be evacuated in an emergency. Staff had received fire safety training and had been trained to administer first aid.

Good

Is the service effective?

Our findings

People and their families told us they felt the service was effective, staff understood people's needs and had the skills to meet them. One person said, "He [the provider] has a very good lot of staff here." Another person told us, "I'm happy here the carers are very good. I'd rather be at home but this is the next best thing."

Prior to admission to the home a member of the management team undertook an assessment of the person's needs to ensure these could be met at Alverstoke House. This would help ensure all needs were known and met on admission. One person told us, "My daughter came in to talk to the staff before I came in. She told them about the falls I'd had so they knew in advance." Another person said, "Someone came to my home to meet me, I think she was the manageress." A third person explained how the planning for their care had started in hospital and how the staff at Alverstoke House were including the person and their relative throughout decision making.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. Care files held information to support people who needed to go to hospital. The home had just started a new 'hospital bag' initiative. A blue bag clearly labelled with details of the home and patient was used when a person was transferred for care out of the home. This included all the relevant information about them, including any medication they were prescribed and would be passed over to the hospital to ensure a continuity of care. There was also a laminated explanation of why the bag was being used and easy to comprehend instructions.

People across the service were supported by staff who had received training and an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff who were new to care, received an induction and training, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. There were systems in place to support nursing staff revalidate the skills. Revalidation is the new process that all nurses and midwives in the UK will need to follow to maintain their registration with the Nursing Midwifery Council.

Staff had access to other training focused on the specific needs of people using the service, such as, positive behaviour support, dementia awareness, mental capacity act and deprivation of liberties safeguards. Staff were supported to undertake a vocational qualification in care and were able to demonstrate an understanding of the training they had received and how to apply it. For example, how they supported people to safely mobilise with the support of equipment. One staff member told us they felt the home

provided "good training including mandatory, which is covered in house by a lead trainer." They said they had spoken with the registered manager and the training lead and was going to be trained as the diabetic lead as this was their particular area of interest. Another member of staff described how they had started work at the home in an ancillary role and had been supported to achieved a number of care qualifications, which has enabled them to progress to becoming a senior carer.

Staff had regular supervisions and staff who had been at the service for longer than 12 months also received an annual appraisal. Supervisions provide an opportunity for management team to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away. One member of staff said, "I do feel well supported by management. You can speak to [the registered manager] and she does address things."

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. The deputy manager told us that there were no people at the home who lacked capacity to make decisions for themselves. They were able to explain the action they would take if they needed to make a best interest decision on behalf of someone who lacked capacity.

Staff described how they sought verbal consent from people before providing care and support. One member of staff said, "I always check with people that they are happy for me to support them. I say 'is it okay if help you with', whatever I am doing." One person told us, "They [staff] are very polite-they ask me if they can help me into bed." During the inspection, we observed staff seeking consent from people before providing support.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. DoLS applications had been made to the supervisory body with the relevant authority when appropriate. Staff had been trained in MCA and DoLS and were able to explain the action they would take to support someone who was subject of a DoLS.

People were supported to have enough to eat and drink. People and their families told us they enjoyed their meals. One person said, "It's pretty good. It's cooked here which makes a difference." Another person told us, "I don't have much appetite at the moment. Sometimes I say I don't want any lunch but they persuade me to try." They added, "I quite enjoy my breakfast, I have cereals and toast but it's the main meal I'm not keen to eat anymore, no appetite." A third person said, "The food is excellent here, they do try hard. If you don't want what you ordered they will make you something else." A further person told us, "I do enjoy the food and I'm very fussy. For the past two months I've been eating a lot better than what I have had for ages."

Staff who prepared people's food were aware of their likes and dislikes, allergies and dietary needs. Meals were appropriately spaced and flexible to meet people's needs. A person who attended a regular hospital appointment said, "They are lovely here. When I come back in tonight they ask me if I'd like something to eat

and they get it for me. They also give me a packed lunch to take with me." People were offered a choice of hot meals. The chef told us they used a three week rotational menu based on what they knew people liked. They explained that every Friday the provider brought a meal for people, of their choice, from the local fish and chip shop. One person told us, "On Fridays we have fish and chips from the chip shop I look forward to that." Another person said, "Tomorrow is a lovely day, we have fish and chips from the chip shop. I love them but can't always finish them all. It's a real treat."

People were also offered a choice about the size of the meal they preferred, small, medium or large. Drinks, snacks and fresh fruit were offered to people throughout the day. One person told us, "Last evening, I asked for a toasted sandwich. They made sure the cheese was cooked through nicely, it was delicious." Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. When the meals arrived, they were served on china plates. Plates were covered if they had to be carried out of the dining area. Drinks were offered to each person and condiments were available. People had cloth serviettes or larger clothes protectors. Staff were aware of people's needs and offered support when appropriate. We observed two people being assisted to eat their lunch. Staff supported these people in a positive way engaging them in conversation to ensure the meal was an enjoyable experience.

Good

Is the service caring?

Our findings

Staff had developed caring and positive relationships with people. One person said, "There's a man carer here he's very good. He brought his new baby in to see us and I had a cuddle, it was lovely." Another person told us, "One of the girls [staff] who does the activities paints my nails. She noticed I was struggling to cut them and offered to file and paint them." A third person said, "I don't go downstairs much, I think it's me not them they do try, they're very nice to me." A further person told us, "I'm quite happy here, the staff are lovely and they are very good with the other lady [who they shared a bedroom with] over there."

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. We also observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited for a response before entering. Staff told us the action they took to ensure that people's privacy and dignity was respected when supporting them with personal care. This included making sure doors and curtains were closed and people were covered as much as possible. One person told us staff respected their dignity and added, "When I came here I was asked if I minded having a male carer, I said I didn't mind."

Staff understood the importance of respecting people's choice. On the day of the inspection we observed one person ask to go outside to sit in the garden for a while. He was not wearing a coat and refused offers by the staff to fetch him one. It was a very cold day and the staff were worried about the person. They were observed checking with the person several times that he was alright and arranged for them to have a call bell so they could request assistance if they wanted it. We saw another person's bedroom door was open. They told us, "I like it open most of the time, I get to know people who come in to visit as they pass by." Other comments regarding people's choice included, "I fancied a day in bed so I won't get up to-day, I'll have my lunch in bed" and "I stay in here [their bedroom] a lot, I'm happier in here" A family member confirmed that their relative preferred to sit in the bedroom. Staff spoke with us about how they cared for people and we observed that people were offered choices in what they wanted to wear, what they preferred to eat and whether they took part in activities. Choices were offered in line with people's care plans and preferred communication style. Where people declined to do something, take part in an activity or wanted an alternative, this was respected.

People and where appropriate, their families were involved in discussions about developing their care plans. We saw that people's care plans contained information about people's life history and interests to assist staff in understanding their background and what might be important to them. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes. Information in people's care records confirmed that they, and family members, where appropriate, were consistently involved in developing and reviewing their care plans.

People were encouraged to be as independent as possible. One person told us, "I got dressed [by myself] yesterday but not to-day it's too much trouble." They added that they try not to ask for assistance to dress because "I don't want to lose my independence." During the inspection, we observed staff supporting people, who used a walking aid to mobilise. They encourage them to take their time and followed nearby

providing reassurance to them to continue to mobilise. Another person's care plan describe how they liked to be supported when they received personal care and which parts of their care they could do by themselves.

People were supported to maintain friendships and important relationships; their care records included details of the people who were important to them. All of the people we spoke with talked about how their friends and family visited them at the home and that they were able to go out to visit with them in the community. One person told us their relatives could visit any time they wanted and added, "My daughter can go downstairs and make herself a cup of tea. There's a place under the stairs." A family member said, "I'm welcome here, I come in every day and they don't mind if I stay for a meal." They added, "I was shown the little kitchen where I can make a drink. They said to me this is [my relative's] home and yours as well." People's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

The registered manager explored people's cultural and diversity needs during pre-admission assessments and included people's specific needs in their care plans. For example, they were aware that one person wanted to receive communion once a month and had made arrangements for them to visit the local church, people were also asked their preferred gender of staff supporting them with personal care.

Information regarding confidentiality formed a key part of the induction training for all staff. Confidential information, such as care records and only accessed by staff authorised to view it. Any information, which was kept on the computer, was also secure and password protected.

Good

Is the service responsive?

Our findings

Everyone we spoke with told us they felt the staff were very good and responsive to people's needs. One person said, "I can't have a shower or bath as mustn't get my legs wet. So staff help me to sit and wash at the basin." Another person told us, "I wouldn't feel safe in a shower; I'm not very steady standing for long." They told us staff supported them to have a bath and added, "The bath is nice is eases my joints."

People received care and treatment that was personalised and met their needs. Staff were knowledgeable about people's needs and the things that were important to them in their lives. Staff's understanding of the care people required was enhanced through the use of care plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. For example, one person's care plan included 'Uses spray deodorant', 'does not like a vest on', 'once dressed likes a spray of aftershave' and 'Able to brush bottom set of teeth with verbal prompting.' The care plan for one person, who occasionally behaved in a way that staff or other people using the service may find distressing, included, 'Speak to [named person] and try to discover what is causing [the person] to become distressed. People's daily records of care were detailed, up to date and showed care was being provided in accordance with people's needs.

Staff were able to describe the care and support required by individual people. For example, one member of staff was able to describe the support a person required if they had a seizure. They were also able to describe the pre-cursor symptoms. This corresponded to information within the person's care plan. Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. A record of the handover information was recorded on a handover form and available for staff who were unable to attend the handover.

Staff spoke positively about their desire to provide people with high quality care at the end of their lives, to help ensure they experienced a comfortable, dignified and pain free death. People's end of life wishes were discussed with them and their families and recorded in their care plans. A family member who told us their relative had come to the Alverstoke Home for end of life care said, "The level of care [my relative] gets here is very good." They added, "They are so caring and patient. From the nursing and care staff to the ladies who come into clean the room." The deputy manager told us they had good working relationships with the local doctors, community nurses and the community pharmacy. They said this helped them advocate for people and helped ensure they had access to anticipatory medicines to manage people's symptoms. One person's care plan confirmed that their end of life wishes had been discussed with them and their family and that their faith and spiritual needs had been considered.

People had access to activities that were important to them. One person said, "I go down to lunch occasionally, I'll stay down there after lunch and we play games." They added, "Sometimes [the provider] plays the grand piano downstairs, he's very good." Where people did not want to join in activities this was respected. One person said, "I've got nothing against other people but like to be on my own and I like my puzzle books; I spend my time doing them." Another person told us, "I did go to the activities when I first came in but don't always want to go downstairs." A family member said, "[My relative] refuses to join in but

she might do one day." An activities co-ordinator told us, "We offer different activities to people but not everyone likes to do them, I read books to two of the people, one likes me to read from her bible. The other person loves the royal family currently we are reading about Princess Diana." They added, "I come in on Christmas Day to give people their gift from the Home. It's usually toiletries, depending on whether they like showers or a bath. We tried giving people jigsaw puzzles one year but it didn't go down well. We listen to what people tell us and act accordingly." They also explained that they that they had come in to take people out for a walk if they wanted to go. They said, "We usually go the local public garden as people like that."

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. The information on how to make a complaint also included details of external organisations, such as the Care Quality Commission and the Local Government Ombudsman. The registered manager told us that family members or staff would support people to raise any complaints initially and people also had access to independent advocacy services if they needed them.

People and their families told us they knew how to complain if they needed to. One person gave an example of where a member of staff had bruised their hand when supporting them. They told us this had been investigated by the registered manager and said, "Matron took a photograph of my hand and they kept an eye on it." They told us they were satisfied with how their complaint had been dealt with and the action taken. Another person said, "You can always go and see the matron, [if you have a complaint] all of them are always very friendly." A third person told us, "I don't have any [complaints] but [the provider] has an office up the corridor and I can talk to him and [the deputy manager]."

Good

Is the service well-led?

Our findings

People knew the names of the management staff, they told us they were happy at Alverstoke House and thought it was well led. One person said, "This place was recommended to me by friends." Another person told us, "I know the man who owns the home. He comes in every week to make sure everything is all right. We couldn't wish for a better place it's so homely." A third person said, "I see the owner here, he comes to say hello to me."

There was a clear management structure with the provider, a registered manager, deputy manager, head of care, registered nurses and senior care staff. Staff understood the role each member of staff played within this structure and were confident to 'step up' when required to ensure people continued to receive a consistent level of service. For example, on the day of our inspection the registered manager was not available, this did not impact on the service provided and all staff we spoke to were able to provide comprehensive information on the running of the service. All staff described a culture of positive leadership within Alverstoke House and demonstrated enthusiasm throughout the inspection process. One member of staff said they were a good team and "you cannot fault the management."

The provider were fully engaged in running the service and people received care that reflected his vision and values, which were, "encouraging excellence in care; and ensuring dignity for residents who are the top priority." They told us the thing they were most proud of was the feedback they received from families regarding the support their relatives received during their end of life care. The provider showed us examples of the feedback including through a third party website. The feedback one relative had summited to the website included, 'This was the perfect home for [my relative]. It allowed her to have freedom and independence, which was very important. The staff were extremely kind and caring at all times and always had an extra five minutes to chat. Sadly [my relative] has recently passed away but she was allowed to do so with great dignity and consideration, which was so important to us as a family.' All staff clearly showed confidence in their roles and abilities and worked towards achieving and maintaining these values and vision.

The registered manager had an open door policy for the people, families and staff to enable and encouraged open communication. One member of staff said, "[The registered manager] is very supportive you can speak with her at any time and she will try and sort it out for you." Opportunities were available for people and their families to regularly contribute in a meaningful way to develop the service and help drive continuous improvement. The provider told us they sought feedback from people and their families on an informal basis whenever they met them. They held resident and families meetings, which covered items, such as residents' likes and dislikes, trips out, food, and complaints. They also sent out questionnaires twice a year to seek people's views on how the home was being run. We looked at the feedback from the latest set of questionnaires, which were mostly positive and included comments such as, 'All the carers are cheerful, helpful and do all they can to keep me comfortable', 'Impressed with the meals and [my relative] always feels welcome when she wants to stay' and 'Alverstoke does well on all aspects of care.' Where concerns were identified these were recorded and action taken to address those issues. For example, one person had indicated that they were unsure how to complain if they needed to. This was actioned by the provider who

visited the person and explained the complaints procedure. Another person feel that 'more activities would be a good idea.' The provider had subsequently recruited an additional activities co-ordinator.

The provider had suitable arrangements in place to support the staff and the registered manager. The registered manager, who had an office at the home, had regular meetings with the provider which also formed part of their quality assurance process. The registered manager told us that support was available to them from the provider who was "in most days and anything I need [for the home] I can get." They added, they had been supported by the provider to complete a level five vocational qualification in care. Staff were supported in their role though regular supervision and there was an opportunity for staff to regularly contribute in a meaningful way to develop the service at staff meetings. One member of staff told us, "Staff meetings are really interactive. We all get really engaged in them."

The provider had a system in place to monitor the quality of the service provided at the home, the safety of the environment and manage the maintenance of the building and equipment. The provider had identified key members of staff to act as the training co-ordinator and the infection control lead to ensure appropriate reviews and audits were undertaken in these areas. The registered manager also carried out a series of audits and reviews. These included medication and topical cream audits, care plan reviews, catering audits and accidents and incidents. Equipment, such as fire extinguishers and mobility aids were checked in line with manufactures guidance. They had a clear understanding with regard to legionnaires, water temperature management, safe storage of hazardous materials and infection control. The provider and the registered manager had also established their own quality assurance checks and carried out an informal inspection of the home during a daily walk round.

The home had a whistle-blowing policy, which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

The provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently in the entrance hall and on their website. A duty of candour policy was in place. This required staff to act in an open and transparent way when accidents occurred and to provide information and an apology in writing to the person or their relatives. Although the provider had been giving information and apologies verbally to relatives, they had not been providing the information in writing. We raised this with them and they took immediate action to ensure a letter was sent should an incident occur in the future.