

Hampshire County Council

Bishops Waltham House Care Home

Inspection report

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22 March 2016

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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?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Bishops Waltham House Care Home on 21 and 22 March 2016.

The service provides accommodation and support for up to 36 older people including people with dementia. At the time of our inspection 30 people used the service.

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 registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service is required by a condition of its registration to have a registered manager.

The registered manager had taken on management responsibility for two services in the past six months and the deputy managers had taken over the day to day running of Bishops Waltham House Care Home. The registered manager would solely manage the service again from 1 April 2016.

Governance systems were in place to monitor the quality of the service and identify the risks to the health and safety of people. However, the audits completed by the provider and staff had not always been effective in identifying issues of concern. Where these systems had been effective in identifying shortfalls, action had not always been taken to improve the quality of care and ensure the safety of people. □

People can be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA) 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). During this inspection we found where people lacked the capacity to agree to the restrictions placed on them to keep them safe, the provider made sure people would have the protection of a legal authorisation and had made the appropriate DoLS applications to the local authority. However, records did not show restrictions were only placed on people as a last resort, after less restrictive approaches had been considered. We have made a recommendation to support the provider to ensure the management team and staff would fully implement the provider's policy in relation to the MCA 2005 and DoLS.

The registered manager had not consistently followed the requirements of their registration to notify CQC of specific incidents relating to the service. We had not been notified of the outcomes of the service's applications to deprive people of their liberty so that we could monitor whether the service met the DoLS requirements.

The provider had a staff recruitment process in place to identify applicants who were suitable to work with people. However, the registered manager had not always followed this process through to completion to

ensure a full employment history would be readily available for all staff. We have made a recommendation to support the provider to improve the availability of staff recruitment information.

During our visit people using the service told us they felt safe. Staff were able to demonstrate their understanding of the risks to people's health and welfare and people told us that they received care that met their needs. However, we found that care plans did not always reflect individual risks to people and offer guidance and support to staff on how these should be managed. Staff we spoke with were confident of how to manage risks to people on a daily basis. New staff or agency staff may not have all the information they needed to know how to keep a person safe and meet all of their needs, wishes and preferences if reliant solely on the care plans for this information.

People were protected from unsafe administration of their medicines because staff followed the provider's medicines policy. Staff had received a programme of training to support them to effectively meet people's needs. Staff told us that they felt supported in their roles by their managers and had received regular supervision. The service had introduced a new electronic supervision system and was developing a way of effectively monitoring when supervision was due, to ensure action could be taken if supervisions had not been completed on time.

Staff told us senior staff provided clear and direct leadership. We found, from staff records and from speaking with them, they understood their roles and responsibilities and there was a clear structure of accountability.

There were enough staff to keep people safe and support people to do the things they liked. The service had identified that people's needs were becoming increasingly complex and was working with the provider to continuously review staffing levels.

The service promoted a culture which focused on providing individual person centred care. Staff were quick to respond to changes in care needs, however these changes were not always updated in the person's care records so that staff would know from people's records how their needs had changed. Staff were encouraged to raise concerns and were confident in doing so. The registered manager was keen to ensure that people were involved in the care provided at the home and had systems in place for receiving feedback from people and their relatives which they used to make improvements.

People were encouraged to participate in the lunchtime meal in the dining room or they could choose to eat in their rooms if they preferred. Staff had a good knowledge of people's nutritional needs and people were supported to eat and drink enough to maintain a balanced diet.

People were well supported to maintain good health and have access to healthcare services. Staff and the manager promptly engaged with other healthcare agencies and professionals to ensure people's identified health care needs were met. The service had a good relationship with the district nursing team.

Staff demonstrated that they knew and understood people's wishes and preferences. People told us they were happy with the care provided. We observed interactions between staff and people which were warm and caring and people's independence was promoted in accordance with their wishes. Staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times and were able to describe how they ensured this. People were encouraged and supported by staff to make daily choices about how they would like to have things done.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one

breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

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.

Staff recruitment processes were not robust. All the information required to inform safe recruitment decisions was not readily available prior to applicants starting in their role.

People were protected from abuse and avoidable harm. Risks were identified and managed in ways that enabled people to lead fulfilling lives and remain safe. However, people's care records did not include all the information staff unfamiliar with people's needs would need to know in order to keep people safe.

Staff followed safe medicines administration procedures and people had received their medicine as prescribed.

Is the service effective?

Requires Improvement ●

The service was not always effective.

It was not always evident that decisions about people's care were made in accordance with the legal requirements of the Mental Capacity Act. The Best Interest decision making process was not recorded. It was not apparent that opportunities and appropriate support had always been provided to people who lacked capacity to be involved in decisions about their care.

People's needs were met by staff who had received an induction, training and supervision to develop the required skills and knowledge.

Staff were aware of nutritional or hydration risks to individuals and how to manage these. People with specific nutrition and hydration needs were supported to eat and drink enough.

People were supported to stay healthy and staff ensured people had access to healthcare professionals when needed.

Is the service caring?

Good ●

The service was caring.

People told us, and we observed, that staff were kind and caring. Staff were motivated to develop positive relationships with, and do their best for, the people living at the home.

People were encouraged to express their views and were able to make choices about how they like things done.

People received care which was respectful of their right to privacy whilst maintaining their safety and dignity.

Is the service responsive?

Good ●

The service was responsive.

People received care that was individual to their needs and the service responded quickly when people's needs changed. People were supported to pursue their interests and given opportunities to remain socially active.

There were processes in place to enable people to raise an issue or concern they had about the service. Any issues, when raised, had been recorded, responded to and investigated.

People's views and opinions on how to improve the quality of the service provision were actively sought and improvements implemented as a result.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

The provider's quality assurance and risk management systems had not been operated effectively. Shortfalls in the quality of the service had not always been identified and action had not always been taken to consistently drive improvements across the service.

There was an open and caring culture throughout the service. Staff understood the provider's values and practised them in the delivery of people's care.

Leadership was visible at all levels of the service. The registered manager and deputy managers were approachable and supportive to people, relatives and staff.

Bishops Waltham House 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.

This inspection took place on 21 and 22 March 2016 and was unannounced. The inspection team consisted of two adult social care inspectors. We previously inspected the service on 23 September 2013 and found no concerns.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events which providers are required to notify us by law.

We did not request a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information on the day of our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spoke with nine people using the service, the registered manager, one deputy manager, an activity co-ordinator, seven staff and the service manager. We reviewed care records for five people using the service and the medicine administration (MAR) records of all 30 people. We also reviewed training records for all staff and personnel files for seven staff, and other records relevant to the management of the service such as health and safety checks and quality audits. We also spoke with the district nurse and nurse practitioners who were visiting the service during our inspection and spoke with a mental health professional after the inspection.

Is the service safe?

Our findings

People told us that they felt safe at the service. One person said "My family always say when they go away they know I am safe here and do not need to worry about me". Staff knew what to do to keep people safe from harm. Staff had received first aid training and knew how to keep people safe when they fell until the emergency services arrived. When people fell, staff implemented post falls safety practices, observing people regularly to identify any possible health complications that would require an urgent referral to health professionals or emergency services.

People were supported by staff who knew how to manage the risks relating to their health needs. They understood the risks around diabetes and knew the signs that would indicate a person's blood glucose levels were becoming unstable and what action to take. One staff member told us "The district nurse comes in everyday to give one person their insulin injection and we discuss with them what to do if their blood sugar reading is higher than we would anticipate it to be". Staff understood the risks related to people's mental health conditions. Staff could describe how they would recognise if people's mental health was to deteriorate and what they would do to keep them safe. Records showed, and the community mental health nurse confirmed, that staff had contacted the community mental health team when they identified one person had become agitated and their mood seemed elevated. Staff action ensured the person's medicine was reviewed promptly and their mood stabilised before their behaviour could put them at risk.

People were supported to understand risks relating to their care and how to stay safe. One person told us staff had told them what they needed to do to use their equipment safely. They said "Staff know how to manage my oxygen and how to check that it is safe to use, but I can do this myself because they showed me how. I check the tubes are straight, I keep my window open and make sure the machine is not too close to the heating". Another person told us staff reminded them to check their bath water temperature so that they remained in the habit of doing this every time they had a bath.

However, although people's risks had been identified, were understood by staff and arrangements put in place to keep them safe, people's care plans did not adequately reflect the risks to people's health and safety. Staff who were not familiar with people's needs would therefore not have all the information they would need in order to know how to keep people safe. For example, although staff knew how to manage the risks relating to three people's diabetes, their care plans did not inform staff how often they needed to test people's blood glucose levels and what the acceptable blood glucose readings for these people were. Their care plans did not inform staff about how to identify if a person's blood glucose levels became unstable and what action they needed to take to keep the person safe. Another person's care plan did not inform staff about how to identify if their mood was to become unstable and to contact the Mental Health Team to ensure their behaviour would not put themselves or others at risk. Risks relating to the use of a person's oxygen machine were not included in their care plan so that staff would know how to support them to use their oxygen safely.

Although we found no evidence that people had experienced any harm as a result of their incomplete records, there was a risk that new staff recruited by the provider and agency staff would not have all the

information they needed to keep people safe. The provider had not maintained an accurate and complete record in respect of the care provided to each person. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that some staff recruitment information was not readily available. The provider had completed and documented some recruitment checks, such as proof of each applicant's identity, the applicant's qualifications, investigation of any criminal record, and declaration of fitness to work. However, two of the recruitment files did not evidence the applicants' full employment history, which meant that periods of possible employment may be unaccounted for. Although the registered manager provided us with the information we needed the day after our inspection, we could not be assured that this information had been readily available for all prospective staff prior to an offer of employment having been made. The provider had a system in place for checking this information was available. This system had not been effective in ensuring the registered manager had all the necessary information required to employ staff who were suitable to work at the service.

We recommend the provider reviews the effectiveness of its current system for ensuring all recruitment information is readily available to support them to make safe recruitment decisions.

The service operated an effective accident and incident reporting system. Following safety incidents, staff documented what had happened and the action they took to keep people safe. The registered manager reviewed the incident records and assessed if any further action was required. The district nurses told us that people had been referred to them for review following an incident, if required, and noted in people's records.

Staff had been trained in safeguarding. They had a good understanding of how to recognise if someone was at risk of abuse and what to do if they suspected this. Staff told us they were confident any concerns they raised would be dealt with appropriately by the registered manager. One member of staff told us "I will always speak with the manager if I have any concerns, he will always act on it." Staff understood whistleblowing procedures and were comfortable in raising concerns and challenging bad practice. Where safeguarding concerns had been raised, these had been handled appropriately and reported to the local authority and CQC.

People would continue to receive appropriate care in the event of a service emergency. The registered manager was on call and had an experienced deputy manager in place for when he was not available. The service also had access to the providers Out Of Hours duty team if additional support was required. Staff had received training on fire safety and there were regular and documented fire drill practices in place and the fire alarm was tested weekly. We saw that people had Personal Emergency Evacuation Plans in place so staff would know how to safely evacuate people in the event of an emergency.

People told us there were enough staff on duty to meet their needs. One person said "There are enough staff. I don't call them often but when I need them they always come quickly." From our observations we were satisfied that there were sufficient staff. We did not notice any people being left waiting to be attended to by staff. Staff were present in the communal areas throughout the day and on the occasions when we saw people asking for assistance they were responded to promptly.

The registered manager and deputy manager explained that recruitment had been a challenge for the service since the middle of last year and they have needed to use some agency staff. They told us that they were increasingly able to use a regular team of agency staff and found this provided continuity of care for people. Some staff told us they felt stretched at times, particularly as people's care needs were becoming

more complex, however the registered manager was responding to this. The provider's quality monitoring visit on 15 March 2016 had identified the need to regularly review people's dependency to ensure adequate staffing would be provided. The registered manager told us they were working with the provider to develop a staffing tool which would help them plan and review staffing levels in accordance with people's dependency and support needs.

People told us that they received their medicine as prescribed. One person said "They always make sure I get my medicine" and another said "I have to get my tablets in the morning and at teatime. They always give them to me". People received their medicines from designated staff trained to administer medication. This helped ensure that medicines were managed safely at the home as only some staff carried this responsibility. The deputy manager told us that she completed a skills check every six months to ensure staff responsible for administering medicines remained competent to manage people's medicines safely.

People received their medicines in a safe way because staff followed safe medicines administration practices. People's Medicines Administration Records (MARs) were completed in full with no gaps and information relating to the individual, such as allergies, was available. Medicines, including controlled drugs were stored securely. Controlled drugs (CDs) are prescribed medicines that are usually used to treat severe pain and they have additional safety precautions and requirements. Staff were able to describe to us how medicines stock was managed and how they ensured that medicines were not used past their expiry dates. Staff wore "Do not disturb" aprons when administering medication and told us this system reduced the risk of them making errors when administering people's medicines as they were not interrupted. We observed staff were not interrupted when they administered people's medicines. The service worked closely with the dispensing community pharmacist, who carried out six monthly audits. We noticed during our inspection that not all handwritten entries on MAR sheets had been counter signed to decrease the risk of errors being made. This omission had also been identified during the community pharmacist audit, which was completed on 17 March 2016. The provider was taking action to ensure hand written MAR entries were completed in line with best practice guidance so that there would be a record of the staff members who had made changes to people's MARs.

We found that there were good standards of cleanliness in the service. Bathrooms, corridors and communal areas looked and smelt bright, fresh and clean. People and relatives were complimentary about the standards of cleanliness. One relative told us "It is always clean and you always see staff tidying up".

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.

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 and hospitals 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.

Staff we spoke with understood the importance of gaining people's consent before undertaking care tasks and what to do if people could not consent. One staff said "I always assume people can consent and we always check that people are happy to have their bath or take their medicine". Staff were observed seeking consent before carrying out tasks and explaining the procedures they were about to carry out, for example when asking a person if they wanted their medicines.

The service had made applications for thirteen people to have a DoLS authorisation. The local authority had granted six DoLS applications and the service was still awaiting the outcome of the other six applications and one application had been refused. Staff were aware of why people had been granted a DoLS authorisation and arrangements were in place to minimise the restrictions on people. People were able to leave the home when they chose with appropriate support. One member of staff told us "We always make sure people get the opportunity to go out if they have a DoLS". One person who was subject to a DoLS told us "I can't go out on my own without staff, I might get lost. They always take me out to the shop or just into town because they know I like chatting to people I know".

The registered manager understood when restrictions were placed on people where consent is not forthcoming owing to a person's capacity, then the best interests test set out in the MCA should be conducted. Relatives told us they had been consulted to inform the service's best interest decisions relating to people's care.

However, people's care records were not compliant with the MCA requirements. The service had placed restrictions on people to keep them safe. Some people were not free to leave without supervision and hourly night checks were completed for people who might not be able to consent to these arrangements. Records were not available of how and why the decisions that this would be in people's best interest were reached. Records did not show who was consulted and the factors that the service did or did not take into account, including any less restrictive options that had been considered. We could not be assured from care records that opportunities and appropriate support had been provided to people who lacked capacity, or how their representatives had been involved in decisions about their care, so that their rights under the MCA would be

upheld.

The provider's policy relating to the MCA and DoLS, as well as their capacity assessment and decision making recording tools, were available to the registered manager and met the requirements of the MCA best interest test. However, the service had not implemented these effectively. They had completed the part of the record relating to the mental capacity assessment for people. However they had not completed the best interest decision section to record how the decision had been made, with people's representatives, to adopt the person's care plan on their behalf. The provider had identified this as a concern during their quality monitoring visits and some action had already been taken to make the required improvements.

We recommend the provider seeks additional support and training from a reliable source to ensure the registered manager and staff fully implement the provider's policy in relation to the MCA 2005 and DoLS.

Relatives and people told us staff were knowledgeable about people's needs and supported them in line with their support plans. Comments included; "The staff are always confident and know about my mother's condition" and "I have no concerns with the staff, they know what they have to do".

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. We saw that new staff completed a comprehensive induction, elements of which were also available to existing staff on a refresher basis. We saw that most staff had up to date training in subjects such as safeguarding, MCA, moving and positioning, infection control and nutritional screening. Where there were gaps in the training record, the deputy manager was able to provide explanations and advise of dates when training sessions had been booked. The provider was in the process of arranging staff training on diabetes and administration of insulin with the District Nurses, to enable staff to help meet the needs of people with diabetes. Staff told us they were satisfied with the level of training they received and that this gave them the skills they needed to undertake their roles effectively.

The registered manager told us agency staff came to the service with a profile of the training they had completed. However, they had found some agency staff's skills and competence around procedures such as the use of the hoist to transfer people and catheter care did not always meet the service's standards. The registered manager ensured agency staff worked alongside permanent staff who had received the relevant training and were sufficiently competent to support agency staff to meet people's needs effectively. The registered manager had also discussed their concerns with the relevant agencies.

Staff told us they felt supported in their role and there was always a supervisor to talk to if they had any concerns. The deputy manager explained to us that arrangements for supervisions and appraisals now fell under the new "Valuing Performance" system adopted by the provider. This system gave staff the opportunity to self-assess their performance against their personal goals. Staff told us that the system enabled them to discuss their progress against their goals and their development needs as well as raise any concerns with their manager. However, the electronic supervision system made it difficult for the managers to have an overview of how regularly supervisions were taking place and to ensure staff received their supervision when it was due.

Kitchen staff had the information they needed to know people's food preferences. They also received a copy of people's nutritional screening records so they would know who was at risk of malnutrition and required enriched food to remain well nourished. People told us "The food is ok and they are always coming round with a drinks trolley". We saw that people had choice over their mealtime routines, either choosing to eat in their rooms or in the main dining hall. One person told us "I prefer being in my room, but they are always checking on me and bringing me something to drink or filling up my water jug". We observed an alternative

meal being offered to someone who had not eaten their lunch. Another person told us "I like my food; they always come and ask me what I want".

People received the support they needed during meal times. For example, we saw staff sitting with people who became restless during lunch time to support them to stay engaged until they had eaten their meal. Another person with a visual impairment was supported with a special sensory lamp to shine on their plate so that they could see their meal.

We saw two examples of people who were identified by the service as at risk of malnutrition who could not be weighed regularly because of their inability to stand on the scales. The service had continued to monitor their food intake and had ensured they received nutritionally enriched food while they were obtaining specialist scales.

People were supported to maintain their health, which included access to specialist health practitioners when needed. The service had good links with health care professionals; managers worked closely with the continence team, and there were close links with the GP surgery and the district nursing team. People told us they could see a doctor or nurse any time they needed to. One person told us "I always see the doctor when I need to, he comes every week and they just put your name on his list if you want to see him." The healthcare professionals we spoke with told us they did not have any concerns about people's wellbeing at the service. The nurse practitioner told us that the service was "one of the best I visit". She told us staff were good at early detection of potential health problems and contacted her at an early stage, for example if staff noticed a change in a person's skin quality. We saw records which confirmed that people had seen health professionals when they needed to.

Is the service caring?

Our findings

People told us that they liked the staff at Bishops Waltham House Care home. People's comments included "Staff always chat with you and help you out", "Staff are always very friendly and polite" and "My family can come and visit me any time and staff are always nice to them". Healthcare professionals told us that they found staff to be caring. We observed kind and caring interactions between staff and people at lunchtimes and at other times during the day.

We found that staff knew people well, but also checked daily notes and handover records to ensure they had all the information they needed to support people to make decisions about their care. Rooms were individual and personalised, with people's names and a picture relevant to their hobbies and interests on their doors to support people to identify their rooms. People's relatives and other visitors were welcomed into the home and relatives told us that staff treated them with respect when they visited. Relatives and people were happy to come into the office and chat openly with staff throughout the course of our inspection. We observed the deputy manager taking the time to chat through a relative's concerns and offering reassurance. The deputy manager explained to us that there were a few people using the service who did not have many relatives or visitors and therefore staff would endeavour to "do that bit extra" with them so that they did not become isolated.

Independence was important to a lot of people at the home and staff encouraged and supported this. Staff were able to explain to us how they involved people in making decisions about their care, including choosing their clothes, their meals, whether they wanted a bath or shower or whether they wanted to join in with activities. We observed people being supported to make these choices. When people found it difficult to understand some of the information presented to them, staff spoke slowly using short sentences. Staff used their knowledge of people to remind them of the things they liked to support them to make a decision.

Staff understood when people required emotional support and took practical action to relieve people's distress or discomfort. We saw during lunch time that staff were quick to recognise when people became confused or anxious and responded promptly. Staff sat with people to reassure them and distracted them with a joke or a chat. One person told us "I can get very anxious at times, but staff are really good, they will come and chat with me and reassure me then I feel better".

We saw that staff treated people with dignity and respect. We observed an assistant unit manager administering medication patiently and discreetly, sitting with people at their tables and chatting while they took their medication. We observed a person being supported back into their chair and the care worker ensuring that their skirt did not ride up. People told us that staff respected how they chose to spend their time, especially if they wanted to spend time on their own. A person told us "Staff are very professional, they always shorten my name the way I like it".

Staff told us that they protected a person's privacy and dignity by knocking on doors and waiting for permission before entering. One care worker described how she would always cover the person discreetly

while delivering personal care. The service had a system in place where people were assigned key workers. This helped ensure continuity of care for people from staff with whom they had had the opportunity to develop a relationship, and minimised the number of staff they didn't know well being involved in the delivery of their personal care.

Is the service responsive?

Our findings

People were positive about the care they received and told us it met their needs and preferences. They benefited from knowledgeable staff who had been working at the service for some years. People told us staff knew them well, understood their needs and they received care in line with their individual wishes. One person told us "Staff know I am not keen on the food here so they have given me some fridge space so my family can bring me the things I like, I prefer it this way". Another person said "Many people here only like to bath once a week but I like to shower every day and the staff have assured me this isn't a problem and I can shower as often as I like". People told us staff supported them to remain in contact with people important to them, using various technology.

Staff gave us examples of how they had provided support to meet the diverse needs of people using the service, including those related to disability, gender, ethnicity, or faith. One person liked to follow their chosen religious practice and was supported by the service to be involved in external groups that shared their religious views. A Christian service was held every Sunday by one of the local churches to give people the opportunity to meet their faith needs. The provider's sensory team had sourced a special sensory lamp for a person with visual impairment to enhance their sight and maintain their independent living skills. One staff member told us "The lamp really helps them to be independent when eating and taking part in activities". We saw staff ensured this person had their lamp when needed and kept it charged and in working order.

People told us they had sufficient opportunities to stay active and pursue their interests. One person enjoyed art and told us staff ensured they had the supplies they needed. People had the opportunity to be involved with chores around the home if they wished and at the time of the inspection one person was helping with the tea trolley round. The deputy manager told us one person liked to save their newspapers for the local animal shelter and they accompanied them regularly to drop these off as this was an important part of the person's routine.

Activities were available for people to maintain their skills, remain involved and have a stimulating day. Activities were organised by two activities co-ordinators. One had recently left and a member of the administrative team had been stepping in to help in the short term while the service was recruiting a new activities co-ordinator. Staff, people and relatives felt activities were always taking place and told us they were well attended by people. One person told us "There is enough to do. I like the music activities here". Another said "There is plenty to do here, always something going on. Always some entertainment, quizzes and staff are always asking me if I want to join in". There were examples of people's art and craftwork all around the service. Staff knew who had done what and where their interests and skills lay. The deputy manager told us that they were looking into introducing more activities that would be of interest to their male residents such as a pool table and a carpentry class. People with dementia were supported to engage in sensory based activities, such as hand massages, as well as singing and music. The activities co-ordinator told us that she had done some reminiscence work that day and encouraged people to talk about what they did when they were younger. People told us this had made them recall their happy memories.

People's care plans were written in a way that focused on the needs and wishes of the individual. Care plans included sections on "Things that are important to me", "What do people say about me" and "How best to support me" and "All about me and my life". These helped staff understand more about the person they are looking after. Relatives and people told us they had been involved in their initial care assessment and care plan reviews. One person said "I get to see my care plan and discuss with my key worker what I want to put in it". A key worker is a named member of staff that was responsible for ensuring people's care needs were met. This included supporting them with activities and spending time with them.

We found that the service was responsive to people's changing health needs, and looked for ways to accommodate these so that moving people out of the service (if they wanted to stay) was a last resort. The district nurse and nurse practitioner gave positive feedback about the end of life care provided by the service.

Relatives were viewed as an integral part of the service's community and the registered manager ensured that people and their relatives had opportunities to be involved in meetings, events and activities. The home regularly organised fundraising events, was running an Easter raffle at the time of our inspection and clearly publicised monthly 'dates for the diary' either on its noticeboard or in its 'Bishops Waltham House Bulletin'. There were regular opportunities for people and their relatives to influence the service, including residents' meetings and coffee mornings. People using the service also had the opportunity to be involved in recruitment of new members of staff. The service had taken action following people's feedback for example, a massage chair had been purchased following a suggestion made at a residents' meeting.

Records confirmed that complaints were recorded and investigated in line with the provider's complaints policy. The provider used learning from complaints to improve the service for example, when the effectiveness of the information sharing between the night and day staff was questioned, the service put in place a new daily handover form for all staff to complete and refer to when finishing or starting a shift. We saw the night and day handover information was discussed at the afternoon handover meeting. A staff member who had not worked for a few days told us this enabled them to know what support people might require on their shift.

People and their relatives told us that they had no concerns about the service; however they would know what to do if they wanted to raise a concern. One person told us "I will speak to the deputy manager if I had a problem, she will always discuss it with you and how they can help." Another told us "If they can't help you, if you have a problem like with your benefits, they always put you in touch with the right people and make sure it gets sorted".

We saw that feedback was actively sought on the quality of the food, with a box for "feedback on your dining experience" available at reception. A sausage tasting day had been held for people to choose their favourite sausage to be included in the menu when they said they wanted to consider alternative sausages to those on offer.

Is the service well-led?

Our findings

Systems were in place to support the registered manager to monitor the quality of the service and identify any risks or areas where the service might not be meeting the requirements of the regulations. The service and the provider had completed a programme of audits and checks. However, this system was not always effective in identifying shortfalls and driving continuous improvements within the service.

Audits had not always identified the concerns we found on inspection, to enable changes to be made before the quality of care was compromised. For example, a check had been completed to ensure the required staff recruitment information would be readily available. This audit had not identified the employment gaps we found on our visit. The service had completed a medicines audit on 7 March 2016 but had not identified that handwritten entries on people's MARs had not been countersigned to decrease the risk of errors being made. The provider had completed a quality monitoring visit on 16 October 2015 and again on 16 March 2016 during which the service's compliance with the DoLS requirements had been checked. Both these checks had not been effective in identifying that the registered manager had not submitted the required notifications to CQC. We could therefore not determine in a timely manner, whether the registered manager had taken appropriate action to keep people safe, whilst upholding their rights. Systems were not always effective in identifying service shortfalls and risks to the quality of the service.

Where audits had appropriately identified shortfalls, sufficient action had not always been taken to ensure the issues were addressed, and improvements made and sustained. The provider's quality monitoring visit on 4 December 2015 identified that the signature list of staff administering medicines was inaccurate. They noted the signature list was dated May 2015 and included the name of a member of staff who had left. People's MARs could therefore not be checked against a current signature list to identify who had administered people's medicines. The service had not acted on the provider's recommendation to update the list and the community pharmacist identified the same concern on 17 March 2016. When we inspected the service they were still in the process of replacing the list in the medicine room with the updated version.

The provider's quality visits in October 2015, December 2015 and March 2016 as well as the service's internal care plan audits completed in February 2016, identified that parts of people's care plans required updating. We found that this was still a concern, as parts of some people's care plans had not been updated since 2012 and care plans did not always include all the information staff would be required to know in order to manage people's risks and provide care in line with their preferences. The service had not acted on the recommendation of the provider's quality monitoring visit in October 2015 and did not ensure where decisions were made on people's behalf this met the requirements of the MCA. Monitoring systems did not always ensure action would be taken to manage the identified risks and drive improvements within the service.

The provider did not implement robust quality assurance systems to assess, monitor and improve the quality and safety of the home. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not consistently followed the requirements of their registration to notify CQC of specific incidents relating to the service. We found some notifications had been sent to us as required. For example, in the event of safeguarding incidents, the notifications showed the registered manager had taken appropriate action to notify the relevant agencies and keep people safe. However, we had not received notifications for the seven known DoLS application outcomes as required by law to support us to monitor whether the service was meeting their requirements relating to DoLS. We discussed this with the registered manager who told us they would ensure these notifications would be submitted.

The provider had not notified CQC of the outcome of their applications to deprive people of their liberty. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

People and their relatives told us the management team was visible and approachable. Comments included "The deputy managers are always available", "The deputy always make sure things get sorted out" and "The deputy always keeps me informed of any issues or changes". The office door was open and people and staff were seen to drop in and speak with the deputy managers at will about anything they wished to discuss. This provided an opportunity for social interaction and to talk with people about how their day was going and to discuss any issues that they had informally. The registered manager encouraged an open culture where people and staff could speak with the management team as required.

There was a registered manager in post, however, they had managed two services over the past six months and the deputy managers had taken on increased responsibility for the day to day management of the service. The service manager told us this had been a project to see if the registered managers could oversee more than one service but they had found this did not provide sufficient management cover and the registered manager would solely manage Bishops Waltham House Care Home again from 1 April 2016. They told us this reduced management oversight over the past six months might be the reason why some of the governance functions had not been completed effectively and they would be taking action to ensure outstanding actions were completed.

The registered manager ensured staff were aware of their responsibilities and accountability through regular supervision and meetings with staff. Staff felt able to make suggestions to improve people's care or the service. A daily meeting took place for shift leaders where important information about people's care or the running of the service was discussed. We found, from staff records and from speaking with them, they understood their roles and responsibilities and there was a clear structure of accountability. Staff told us the deputy managers had provided them with sufficient direction and support whilst the registered manager had managed a second service over the past six months.

The management team and staff had promoted a culture that put people at the centre of the work they did. The service's values centred on people's needs and wishes. Staff understood the provider's objectives of maximising people's life choices, promoting dignity and supporting people to live active and meaningful lives. Throughout our inspection staff demonstrated they worked in a manner consistent with these values. Staff were committed to the service and were positive about the quality of care provided to people and their involvement in the service. Staff comments included; "It is all about the people here, it is like family" and "People get good care, we work hard to know how people like things done". One district nurse told us they found staff to be motivated, hardworking and committed to making people's lives better. The service had won the provider's award for providing person centred care in 2015.

The management team had developed a culture of learning, development and problem-solving. The service has had to adjust to supporting people with changing and more complex health needs in the past year. The staff team had embraced this change and had developed their skills in end of life care, supporting people

with increased mobility needs and mental health needs. The deputy manager told us "We have learnt so much through the involvement of the district nurses and nurse practitioner from the GP surgery in how to support people to remain living at the service for as long as they want". The service continued to develop staff's skills in line with current best practice.

Arrangements were in place to ensure people's information would be kept confidential. Care records were locked away and only accessed by staff who had been given the authority to view people's care records.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 Registration Regulations 2009 Notifications of other incidents</p> <p>The provider had not notified CQC of the outcome of their applications to deprive people of their liberty. This was a breach of Regulation 18(4B)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not implement robust quality assurance systems to assess, monitor and improve the quality and safety of the home The provider had not always maintained an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to each person and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17(1)(2)(a)(b)(c)</p>