The Park Gate Care Home LLP

Hamble Heights

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The inspection took place over two days on 30 and 31 October 2017. The inspection was unannounced.

We last inspected the service in September 2015 and rated the service as good overall. This inspection found that the service remained good overall.

Hamble Heights is a purpose built care home with nursing located in Park Gate, near Southampton. The home can accommodate up to sixty people who require either residential or nursing care. Some of the people using the service lived with dementia. At the time of the inspection there were 59 people using the service. The home is arranged over four floors with each of the main floors or units being led by a unit manager who was a registered nurse.

The service had a registered manager. 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 legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

There were a range of systems and processes in place to identify and manage risks to people's wellbeing but also environmental risks. However, some improvements were needed. Post falls protocols were not being consistently followed. Food and fluid charts used to monitor risks to people's nutrition hydration had not always been fully completed.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. However, some incidents which raised potential safeguarding concerns had not been escalated to the local authority safeguarding teams. The registered manger told us they would seek further advice from the local authority to support their understanding of expectations around reporting and escalating concerns.

Additional checks are being put in place to ensure that all of the required pre-employment checks are consistently completed before new staff start work at the service.

There were suitable numbers of staff deployed to meet people's needs. The provider will continue to review staffing levels with people who use the service and is shortly implementing a new tool to facilitate consistent evidence-based decisions about staffing levels.

The home was clean and staff were observed to be using appropriate personal protective equipment (PPE).

Overall systems were in place to ensure the safe and responsive use of medicines.

Staff were provided with opportunities to develop their skills and knowledge and performed their role

effectively.

Staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support.

Staff worked in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were applied appropriately.

People were supported to have enough to eat and drink. Plans were in place to improve the dining experience.

The premises were suitably adapted and pleasantly decorated. There were landscaped and fully accessible gardens which included a variety of areas for people to enjoy including sensory plants and seating areas.

Where necessary a range of healthcare professionals including GP's, community mental health nurses, dentists and speech and language therapists, had been involved in planning peoples support to ensure their health care needs were met.

People were cared for by kind and compassionate staff. Staff were very motivated and spoke with enthusiasm about providing a family environment where people and their relatives felt safe, valued and cared for. Staff knew people well and had developed a meaningful relationship with each person.

Staff supported people to maintain the relationships and friendships with people who were important to them. Relatives felt involved and told us they could visit at any time and share in their loved ones care. Relatives felt a particular strength of the service was the care they too were shown by the registered manager and staff team.

People told us they were treated with dignity and respect. Staff focussed on meeting people's individual wishes about how they would like their care and environment to be managed in their final days. They were supportive of families and loved ones both during end of life care and following a person's death.

Care plans continued to provide a detailed record of people's individual needs, preferences and choices. This enabled staff to have a good knowledge and understanding of the people they were supporting and helped to ensure people received care and support which was responsive to their needs.

Staff provided creative opportunities for people to be engaged in a range of activities that were meaningful to them and met their needs in a person centred way.

People and relatives told us they were confident they could raise concerns or complaints and that these would be dealt with.

The service was well led. Staff were positive about the leadership of the service and felt well supported in their roles. Staff morale was good and staff worked well as a team to meet people's needs.

The registered manager and provider were proactive in driving the service forward to improve outcomes for people and there were robust systems in place to monitor and improve quality and safety within the service. The provider sought feedback from people, their relatives and from staff and used this to continually improve the service.

The registered manager demonstrated knowledge, passion and enthusiasm. Their commitment to the service, the people in their care and to the staff team was clear to see. They fostered a homely, friendly and person centred culture within the home and spoke enthusiastically about their vision and future planned developments for the service.

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.

Post falls protocols were not being consistently followed. Food and fluid charts used to monitor risks to people's nutrition hydration had not always been fully completed.

Some incidents which raised potential safeguarding concerns had not been escalated to the local authority safeguarding teams. The registered manger was taking action to seek further advice from the local authority to support their understanding of expectations around reporting and escalating concerns.

Additional checks are being put in place to ensure that all of the required pre-employment checks are consistently completed before new staff start work at the service.

The inspection found that suitable numbers of staff were deployed to meet people's needs.

The home was clean and staff were observed to be using appropriate personal protective equipment (PPE).

Overall, systems were in place to ensure the safe and responsive use of medicines.

Is the service effective?

Good

The service remained good.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained responsive

Is the service well-led?

Good

The service remained well led.

Hamble Heights

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 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 was an unannounced inspection which took place over two days on 30 and 31 October 2017. On the first day of our visit, the inspection team consisted of two inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. On the second day, the team consisted of two inspectors.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 11 people who used the service and the relatives of a further seven people. We spoke with the registered manager, the deputy manager and a member of the provider's training team. We also spoke with three registered nurses, seven care workers and one agency care worker. We reviewed the care records of seven people in detail and aspects of another eight people's care plans. We also looked at the records for five staff and other records relating to the management of the service such as audits, incidents, policies and staff rotas.

Following the inspection we sought feedback from seven health and social care professionals and asked their views about the care provided at Hamble Heights.

The last inspection of Hamble Heights was in September 2015. That inspection did not find any breaches of the legal requirements, but did highlight some areas where improvements could be made such as the deployment of staff and the completeness of some of the records used to monitor aspects of people's care.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Hamble Heights for example, one person said, "I am very safe, if I have a problem I only have to speak with the staff." Another person told us, "I feel very safe here and would not want to be anywhere else".

Overall recruitment practices were safe and relevant checks had been completed before staff worked in the service unsupervised. These included identity checks, obtaining references and Disclosure and Barring Service checks. A psychometric test was also used to determine the individual's levels of empathy and caring to ensure they had the right attributes for the role. These measures helped to ensure that only suitable staff were employed to support people in the service. Checks were also made to ensure that the registered nurses were registered with the body responsible for the regulation of health care professionals. We noted that in the case of two staff members, a full employment history had not been obtained. We spoke with the registered manager about this who took immediate action to obtain and document the information. We also found that in the case of one person, more could have been done to seek appropriate references from the candidate's previous health and social care employer. In future, the registered manager told us they would do a final check of recruitment documentation prior to allowing a new employee to start working with people who use the service. Plans were also being put in place for the provider's recruitment manager to provide additional training to ensure recruitment procedures were being operated effectively.

There were a range of systems and processes in place to identify and manage risks to people's wellbeing but also environmental risks. Staff completed a range of health and safety checks to help identify any risks or concerns in relation to the environment and equipment used for delivering people's care. For example, the lift was regularly serviced and checks were made of the safety of electrical and gas appliances, the call bell system and window restrictors. Regular checks were undertaken of fire safety within the service. A fire risk assessment had been completed in June 2017, the actions resulting from this had been completed. People had personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. A business continuity plan was in place and set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies. A legionella risk assessment had been completed and regular checks were being made of the water safety within the service including the temperature of water being discharged from the taps in people's rooms.

Each person had a range of individual risk assessments which had been evaluated regularly. For example, moving and handling risk assessments were in place. These were detailed and well written and considered a range of factors that could impact upon the person being moved safely and efficiently such as their cognition, behaviour and pain levels. Risk assessments were also in place which helped predict whether people were at risk of falls, developing pressure ulcers or absconding from the home. Assessments were undertaken to determine whether people could use their call bells. Where this was not the case, regular observations were undertaken. Where people were at risk of choking, risk assessments had been completed and a choking care plan was in place. This included a choking algorithm or flow chart which provided clear instructions about the actions staff should follow in the event of a choking incident. Staff were well informed about these. Bed rail risk assessments had been completed and regular checks made to ensure that the rails

were being used safely and the risk of entrapment reduced.

However, some improvements in the assessments of risk were needed. For example, when people fell, post fall protocols in place were not always followed. Following falls, including those resulting in head injuries, post falls protocols were not being consistently followed. These protocols ensure that people are appropriately monitored following falls in case their condition deteriorates allowing medical advice to be sought. A small number of people had food and fluid charts which were being used to monitor risks to people's nutrition hydration however these were not always fully completed. This was noted an area for improvement at our last inspection also. The fluid charts also did not include a target fluid intake and there was no evidence that these were being monitored on a daily basis. This is important as it helps staff to assess whether people are taking in the recommended fluid level. We were therefore unclear how concerns about a person's fluid intake could be escalated. Staff reassured us that people did have regular drinks but acknowledged that this was not always accurately recorded. The registered manager responded promptly to our findings. They asked staff at a daily heads of department meeting to reflect on how the accurate completion of fluid charts might be better managed to ensure effective monitor people's fluid intake. Arrangements were put in place for the hydration champions and registered nurses to oversee these on a daily basis.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The provider had appropriate policies and procedures which made explicit links to the Local Authorities multi-agency safeguarding procedures. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. However, following a review of people's care records, we found incidents which raised potential safeguarding concerns had not always been escalated to the local authority safeguarding teams. Whilst the incidents had been investigated, escalating concerns is important as it helps to ensure that the relevant agencies have oversight of potential risks within the service. Following our discussions with the registered manager, they have confirmed that they are taking action to seek further advice from the local authority to support their understanding of expectations around reporting and escalating concerns.

Information about whistleblowing procedures was available at each nurse's station and in the staff room. Staff were aware of whistle-blowing procedures and were clear they could raise any concerns with the manager of the home and other organisations if they were concerned about poor practice or abuse in the service.

Staffed employed to work at the home included the registered manager and a deputy manager who was a registered nurse. Each of the three main floors had a unit manager who was a registered nurse and along with the other registered nurses they oversaw the clinical care within the home. A team of four care workers were based on each of the main floors and two care workers on the smaller lower ground floor. In addition there was currently one more 'floating' care worker between 8am – 2pm. Some people needed one to one care and their needs were met in addition to above staff numbers. The home also employed a team of housekeeping and laundry staff, an administrator and reception staff, chefs and kitchen staff and a wellbeing team. There were also two staff responsible for maintenance.

Most people told us there were sufficient staff to meet their needs and that staff responded promptly when they used their call bell. One person told us, "If I am worried, I press the button and someone comes straight away". However some people felt this was an area where improvements could be made. For example, one person said, "They are short staffed in the morning". A relative told us, "Staff shortage seems to be a problem; I have pressed the buzzer a few times when I am visiting and sometimes it can take them a while".

However, even when the home was short staffed due to sickness, people and their relatives felt that the quality of care was maintained. For example, one relative told us, "Even when short of staff, the care doesn't fail". Another said, "They still always have time to answer questions…..they always have time for [the person]". Staff were also mostly positive about the staffing levels. One staff member said, "We never rush anyone". Another said, "Sometimes, sickness can be an issue, but we have a good team and get through it".

Our observations during the inspection indicated that overall, people's needs were being met in a timely manner. For example, we heard one person calling out for staff; they were attended to promptly, reassured and offered a drink. The registered manager and director of operations said staffing levels would be reviewed in light of our feedback and they explained that they would be shortly implementing a new tool to facilitate consistent evidence-based decisions about staffing levels. The registered manager told us that the provider was supportive of requests for additional staffing hours where this was required. Overall, people and their relative's feedback about the continuity of care provided was also good. The home had recently recruited a number of new care workers but continued to have some vacancies. Agency staff were being used to cover gaps in the rota and to provide much of the one to one care. We did observe that an agency worker supporting one person was not actively engaging with them. We spoke to them, they said they were not sure why the person required one to one and had not received a handover since starting their shift. We spoke to the unit manager about this, who immediately spoke with the care worker and provided a handover. The registered manager told us they would remind the senior staff of the need to thoroughly induct agency staff and to use the systems in place to support this.

Systems were in place to ensure the safe and responsive use of medicines. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. People also had a medicines profile which included details such as how the person preferred to take their medicines. We viewed the MARs on both the Nightingale and Garden Cottages units and found that these were generally fully completed. We did identify one administration error which the deputy manager advised would be investigated.

Protocols and escalation plans were usually in place which described the circumstances within which people might need their 'variable dose' or 'if required' (PRN) medicines. For example, one person who had seizures had a detailed escalation plan in place clearly documenting how and when their rescue medicines should be given. We did see some examples where PRN protocols were not yet in place. We discussed this with the registered manager and deputy manager who provided reassurances that this would be addressed as a matter of urgency. We also saw some examples where staff were administering PRN medicines but had not recorded the reason why these were given on the reverse of the MAR in line with the provider's policy.

Medicines were stored appropriately within locked trolleys or a designated medicines fridge, kept within locked cupboards. The temperature of the fridge was monitored and the medicines rooms were kept at a constant temperature through the use of a monitored air conditioning system. Some people required the administration of controlled drugs. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. The registered provider took appropriate actions to store, administer and record these medicines. Staff administering medicines had received training and had their competency to administer medicines safely assessed on an annual basis.

Homely remedies were available within the service. Homely remedies are medicines the public can buy over the counter to treat minor illnesses like headaches and colds. These medicines had been agreed with each person's GP and protocols were in place for their administration.

A number of people received their medicines covertly. Covert administration of medicines is the term used when medicines are administered in a disguised format, such as in food or drink, without the knowledge or consent of the person receiving them. Covert administration is only appropriate where a person has been assessed as not having the capacity to understand the consequences of their refusal and the medicine is deemed essential to the person's health and wellbeing. Where people were receiving their medicines covertly their MAR included an assessment of their mental capacity to make this decision. There was also evidence that a best interest's consultation had taken place. However we could not see these assessments were regularly reviewed in line with best practice guidelines.

We recommend that where medicines are being administered covertly, this arrangement is regularly reviewed in line with best practice guidance

The home was clean and staff were observed to be using appropriate personal protective equipment (PPE). Suitable cleaning schedules were in place. People gave us positive feedback about the cleanliness of their home. For example, one person told us, "I am very happy here, it's like a hotel…the cleaners keep my room nice and clean". The kitchen was clean and the catering team were completing appropriate food hygiene records.

Good

Is the service effective?

Our findings

People and their relatives told us the service provided effective care. One person told us, "The staff are good, they do their best". A second person told us, "I can only sing its praises I am very happy here". One relative told us, "I am a fan of this place". Another said, "I could not ask for a better place…they [the staff] are great to him [their family member]". A third relative told us, "I am absolutely over the moon with the home and would recommend it to others". A fourth relative said, "They have been in other homes, but this is the best". A healthcare professional told us, "I am not sure that I can think of anything that I would like Hamble Heights to do better, I would like other homes to be as effective".

Our observations indicated that staff provided effective care with kindness and in an encouraging and knowledgeable manner. For example, we saw staff supporting people to mobilise and to transfer. Staff completed this effectively and with clear instructions, supporting and reassuring the person throughout.

Staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support. People had signed consent forms in relation to their care plans, to having their photograph taken or for the use of bed rails or sensor mats. Where people had appointed a legal representative to make decisions on their behalf, copies of the legal documents were maintained within the service.

Where there was doubt about a person's capacity to make decisions about their care, mental capacity assessments had been appropriately undertaken and documented in line with the Mental Capacity Act (MCA) 2005 which ensured that the person's rights were protected. 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. Records showed that where it was determined a person did not have the mental capacity to make a specific decision a consultation had been undertaken to reach a shared decision about what was in the person's best interests. We did note that the provider's consent form, needed to be updated to reflect that relatives could not sign to give consent on behalf of a person unless they had the legal authority to do so. The registered manager confirmed that action has been taken to address this.

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). Relevant applications for a DoLS had been submitted by the home and had either been approved or were awaiting assessment by the local authority.

Staff were provided with opportunities to develop their skills and knowledge and perform their role effectively. Training and induction was overseen by the provider's training team who were based at the home. The induction programme currently consisted of two days face to face training which was mapped to the Care Certificate. The Care Certificate sets out explicitly the learning outcomes, competences and

standards of care that care workers are expected to demonstrate. Workplace observations were undertaken to provide reassurances that new workers were competent in a number of areas such as person centred care and privacy dignity.

Each staff member had an individual learning plan which set out the mandatory training that had to be completed. This also documented any additional training which was available to further enhance the staff member's skills and knowledge. The training was mostly completed online and included; safeguarding adults, fire prevention, infection control, Mental Capacity Act 2005 and food hygiene. Some of the training was held face to face such as moving and positioning training and emergency first aid. Staff completed training relevant to the needs of people using the service. For example, staff were completing training in managing behaviour which might challenge others. A six month programme of training in dementia care was being rolled out and staff had been provided with an opportunity to take part in a virtual simulation of the challenges that people living with dementia may experience in their everyday lives. Each month the training team produced a report which highlighted any training that was about to expire so that the registered manager had oversight of this.

The registered manager recognised the individual skills and knowledge of staff and encouraged them to extend their roles and responsibilities in order to ensure that care was provided to people by staff who were knowledgeable and aware of current best practice. Staff members had become champions (experts) in a variety of areas such as nutrition and hydration, medicines, infection control and tissue viability. Two staff had also undertaken accreditation training with a local hospice in delivering the 'Six Steps Programme'.

The provider was committed to supporting registered nurses to gain their revalidation and provided opportunities for additional training in a range of clinical skills. Revalidation is the way in which nurses demonstrate to their professional body they continue to practice safely and effectively and can therefore remain on the nursing register. A clinical lead was being appointed and they would be responsible for overseeing clinical governance meetings and providing clinical supervision. Staff told us the training provided was good. A registered nurse told us, "I have not worked for a company that offers as much training, if I ask it is provided".

Staff told us they received appropriate support, and had regular 'job chats' which are also often called supervisions or one to ones. These took place every six to eight weeks and challenged the staff member to think about what they had done to perform well in line with the provider's values. Training and development needs were also discussed and this fed into the organisations training needs analysis. The training team had also designed a new leadership programme for senior care workers and head of departments enabling them to train and learn together as a cohort with protected time for their learning.

People and their relatives were mostly satisfied with the quality of the food provided. Their comments included, "The food and drink is good," and, "Drinks are readily available… you can have beer and wine here". A new head chef had recently been appointed and oversaw the delivery of a 'four seasons' menu inspired by seasonal foods. Written and pictorial menus were available to support people with making their meal choices. Some staff felt that more could still be done to make people's food choices clearer and to support them to be as involved as possible in decisions about what they ate and drank. For example, staff suggested that it might be helpful to make use of 'show plates' to provide a visual way of aiding the person to understand the choice of meals.

We observed people having their lunch on the first day of our inspection. Meals were presented attractively and where people required a pureed diet, they were able to choose their meal from the main menu still and each of the elements of the meal had been pureed separately so that people could still taste the different

flavours. The dining tables were laid with place mats, cutlery, glassware, napkins and condiments and there was music playing in the background. A number of people chose or needed to eat their meals in their rooms and so on most floors there was only a small number of people eating in the dining room; however those present appeared to be enjoying the dining experience and chatted readily with one another and with the staff about the afternoons entertainment for example. We did note that there was a delay on one floor in some people in their rooms being served their meal due to staff helping others or supervising the dining room. We were aware that this unit was short of staff due to sickness and so normally more staff were deployed. A member of staff told us, "It normally works well, but we are short today". Where people needed support to eat and drink, our observations indicated that this was provided in a way that was dignified and respectful of the individual.

Kitchenettes were available on each floor with kettles and fridges where snack trays were available including fresh fruit cake and finger foods. A selection of hot and cold drinks were also available throughout the day and each person we visited had water or juice in their rooms. A hydration champion was appointed on each floor every day and their role was to ensure people were being encouraged to have fluids throughout the day. An ice cream machine was available on the lower ground floor for people and staff to use free of charge. Further improvements were planned to dining experience, for example, there were plans to introduce equipment which released food fragrances into the communal dining areas before meal times to stimulate the appetite of people, specifically those living with dementia. Themed fine dining days were being introduced and the catering team were undertaking a dignity in dining training course to promote person centred dining for those people who needed specialist diets.

The premises were suitably adapted and pleasantly decorated. There were landscaped and fully accessible gardens which included a variety of areas for people to enjoy including sensory plants and seating areas. On the first floor there was a pleasant patio area with outdoor furniture. The registered manager had recently arranged for a gazebo, lighting and patio heaters for the patio so that it could be used all year round. Corridors throughout the service were wide allowing good wheelchair access. Bedrooms were spacious which gave staff room to manoeuver any equipment that was needed to support people safely. Memory boxes were placed outside people's doors and contained pictures or memorable items that were meaningful to the person, helping them to identify their rooms. The manager was aware that further improvements could be made to enhance the environment to make this more enabling for people living with dementia and they advised that improved signage to help identify toilets for example, were being installed shortly.

Where necessary a range of healthcare professionals including GP's, community mental health nurses, dentists and speech and language therapists had been involved in planning peoples support to ensure their health care needs were met. Each week, a GP attended a 'ward round' at the home, during which they were able to review people about whom staff had concerns or who were presenting as being unwell. There was evidence that staff recognised changes in people's health and wellbeing. People who had lost weight had been referred to the GP and started on a food and fluid chart so that their nutritional input could be monitored. We were told that where necessary short term care plans would be put in place which described the additional care people required to address a specific or acute health care need and where people had a urine or chest infection, monitoring charts were used to record their improvement until the infection resolved. A relative told us their family member had been unwell, they said, "They got the doctor in right away, I knew they would look after him".

Good

Is the service caring?

Our findings

People told us they were cared for by kind and compassionate staff. One person told us, "The staff are always very friendly". A second person told us, "The staff are very friendly and the manager is one nice guy….you could not ask for anymore, I am treated how I like to be treated". A third person said, "Everyone is kind to me and talks to me….people are kind and gentle". Relatives were also positive about the caring nature of the staff team and of the friendly and welcoming nature of the home. One relative told us they had chosen Hamble Heights as they had wanted a home with "Banter". They told us, "Hamble Heights made the connection….they have been creative and there is no talking down to you".

Health care professionals were positive about the caring nature of the service with one telling us, "What I really like about Hamble Heights is the delivery of very gentle dementia care. I worked with a health care support worker…she approached residents with a very calm, gentle manner that I felt soothed and I thought if I was going to be cared for by someone I would choose her. All the staff have a lovely approach to residents [they are] calm respectful and try very hard to give holistic care….I felt a very genuine sense that the staff I came into contact with really did care about what they do and wanted to give the best possible care".

Staff were confident that all of their colleagues were kind and caring and were clear that if this was felt not to be the case, they would raise their concerns and this would be addressed. For example, one care worker told us, "Yes, they [colleagues] are all kind and caring if they weren't I wouldn't think twice about putting them straight". Prior to and during the inspection we received a significant amount of positive feedback about the caring nature of the staff team. There was also a folder containing a large number of thank you cards from people, and relatives of current and past residents of the home. A central theme to many of these was the kind and caring nature of staff.

Staff interacted with people in a kind and compassionate manner. We saw a considerable number of warm and friendly exchanges between staff and people. We observed that staff spent time with people; nothing appeared to be rushed, even when staff were busy, and people seemed relaxed and contented. Staff bent down to speak with people at their level and when at times people became distressed or agitated, staff responded, calmly and reassuringly. Staff appropriately used touch to demonstrate their care and concern for people and people valued this. For example, we saw one person sleeping cradled in the arms of a staff member who was stroking their hair. The person looked secure, and settled. At lunch time, we saw a staff member encouraging a person with little verbal communication to dance. The person responded positively to the staff member and smiled. They indicated they wanted a kiss which the staff member provided. The interaction was clearly meaningful for the person. Another relative told us how staff had fun names for their family member which staff encouraged the person to try and say. The relative told us that when the person was able to say the names, "It made him beam".

Staff were very motivated and spoke with enthusiasm about providing a family environment where people and their relatives felt safe, valued and cared for. For example, one staff member said, "I love it here, it's a close knit family environment, like a second family". Another said, "We are all part of the furniture, it's my

second house, I love the caring, it's like a family". Staff spoke fondly about the people they supported and it was clear that they knew them well and had developed a meaningful relationship with each person. One staff member told us, "It's good, we get to know their [people's] cheeky side". To support people and their relatives developing relationships with staff, each staff member had a picture frame on the wall containing pictures of them and sharing information about the things that were important to them. A staff member told us, "There is friendship and community here, I don't want to go, I'm in the right place".

Staff supported people to maintain the relationships and friendships with people who were important to them. For example, when they first moved into the home, the wellbeing team supported people to send out 'welcome to my new home cards'. People were also supported to celebrate their family member's special days and to make cards or gifts to give them. One person told us, "My friends can visit when they like," and another told us, "I can have lunch with my family". Relatives felt involved and told us they could visit at any time and share in their loved ones care. A tea room had been created on the ground floor where people and their relatives could share special occasions together.

Feedback from relatives suggested that a particular strength of the service was the care they too were shown. One relative told us, "I feel welcome, I get a hug at difficult times, they offer me time and a coffee, I would come here if I had to go to a care home". Another relative told us how they had had to go through a number of emotional adjustments when their family member came to live at the home. They told us, "They have looked after both of us, I have been pleased with the intuitive way in which carers and the management have supported me". Another relative told us, "They [the staff] all give so much of themselves".

People were encouraged to remain as independent as possible. For example, people were provided with the information needed to independently use the lift. The code had been reproduced on to four clock faces and made into a decoration by people which was hung next to the lift. This meant that people, had freedom to move around the home without having to wait for staff to assist them. Staff were also able to tell us how they encouraged people to walk short distances rather than use a wheelchair and encouraged them to manage small tasks such as cleaning their own teeth or brushing their own hair. One staff member told us, "One lady needs to be assisted to eat, but we still try and place the spoon in her hand".

People told us they were treated with dignity and respect and when staff spoke with us, they referred to people in a respectful and dignified way. Our observations indicated that care was provided in a discreet manner and staff were able to describe to us how they were mindful of people's privacy and dignity when providing care. For example, one staff member said, "I close the door and do their care in stages so that I can keep them covered for as long as possible, I always explain what I am about to do".

The registered manager understood the importance of people being supported to express their sexuality They had supported the staff team to understand that this was an important part of delivering person centred care and respecting a person's individual rights and choices.

The home had been awarded a 'Six Steps to Success in End of Life Care' accreditation certificate and there were two end of life care leads within the home. The Six Steps programme aims to enhance end of life care through supporting staff to develop their knowledge, skills and confidence in delivering quality end of life care. Implementing this approach within the service had supported staff to focus on meeting people's individual wishes about how they would like their care and environment to be managed in their final days. A health care professional told us, "I think all staff at Hamble Heights have an awareness of end of life care, the registered nurses have had training recently in symptom management….From all that I have witnessed I would say that the nurses at Hamble Heights are able to deliver confident and competent end of life care.

The team have end of life care champions who are keen to deliver high quality care and they have used a traffic light system to identify residents who are entering the end of life phase of their illness". One relative whose loved one had recently passed away at the service told us, "I have witnessed some extraordinary care, they offered to make me a bed and kept me fed, I have extraordinary good memories, had lots of hugs, if I feel down, I turn up here again, this is streets above, the ambience is one of gentleness, compassion and understanding, a hand on your shoulder".

There was also a sense that staff and the management team cared for people following their death. There was a butterfly on the wall near the staff signing in book. If a person had died, their name would be placed here so that staff were aware as soon as they came on duty. The registered manager told us that following people's death, staff came together to say goodbye to the person as they left the home for the last time. There was a memorial wall which displayed pictures of people who had passed away so that they were not forgotten and once a year a memorial service was held in the home remembering each of the people who had died that year.

Good

Is the service responsive?

Our findings

People, their relatives and health and social care professionals told us that staff provided care that was responsive to people's needs. For example, one person told us, "They [staff] treat you like an individual, they know my needs and I appreciate what they do". A second person said, "They [staff] respect me and know me as a person". Our overall impression was that staff knew people well and focussed on their wellbeing and on ensuring that as much as possible people had a good quality of life. Professionals told us the service was focused on providing person centred care, for example, one said, they were, "Impressed by the fact that the residents were known as individuals and their care was tailored to meet their needs". Another said the service provided, "A well-balanced support program for clients according to their care needs".

People's care plans continued to provide a detailed record of their individual needs, preferences and choices. This enabled staff to have a good knowledge and understanding of the people they were supporting and helped to ensure people received care and support which was responsive to their needs. For example, people's care records included a 'Who am I?'. This document provided information about how the person communicated and the things that were important to them. Care plans also, wherever possible, contained a detailed life history which enabled staff to understand the person's life before they came to live at the service. Care plans contained an activities profile which described the person's interests and hobbies. Each person's care plan addressed areas such as their ability to give consent to their care and the assistance they needed with personal care or moving and handling tasks. Care plans recorded the person's wishes in relation to the gender of the care staff that supported them.

Staff used pain assessment tools to help judge the severity and frequency of pain experienced by one person who was not able to consistently express this. The person could at times display behaviour which might challenge and a care plan was in place which described the strategies and interventions staff should follow to support this person. Guidance had been sought from the community mental health team and staff reported that the current management plan was effective. We visited this person; they appeared content and comfortable and expressed no concerns to us.

Staff were creative in the ways in which they experimented with their approach to people who were distressed. For example, one staff member told us that when managing agitation there was often a trigger and it was important to find out what this was. They explained that staff had eventually worked out that one person did not respond well to staff wearing glasses and so this had informed how and who provided the person's care. Staff told us that encouraging another person to dance was an effective tool at averting agitation. A relative of another person who could at times display behaviour which might challenge told us staff managed this really well. Wellbeing audits were carried out to assess and monitor the emotional wellbeing of people. Where these highlighted concerns about a person's mood a plan was put in place to try and address this, such as increased visits from the wellbeing / activities team.

Staff told us they could refer to the updated care plans in order to understand people's needs and it was evident the care plans had been read by the staff. This all helped to ensure that staff understood the needs of the people they supported and assisted them to provide responsive care. There was evidence that the

care plans seen had been evaluated on a monthly basis and were generally up to date and reflected people's current needs.

Staff documented visits by t GP's or other healthcare professionals so that a record was maintained of changes to treatment pathways. Relatives told us they were kept fully informed about their family member's wellbeing and there was lots of evidence that family members were promptly told about falls, the outcome of health appointments or for example, weight loss. One relative told us, "The slightest thing they phone me".

Staff provided creative opportunities for people to be engaged in a range of activities that were meaningful to them and met their needs in a person centred way. This was confirmed by the relatives we spoke with, one of whom said, "I have never been anywhere where they do quite so much". The wellbeing team consisted of two full time members of staff who were responsible for leading on activities in the home. They provided a range of both group and one to one activities over seven days a week. A schedule of activities was advertised and included quizzes, movement to music, painting with water colours and clay making. Whilst there were planned activities, this was flexible and a member of the wellbeing team told us that if people wanted to do something different then they would be led by them.

During our visit the wellbeing staff had arranged a Halloween party. They had made a significant effort to make this a special occasion with decorations, themed food and a BBQ. A number of members of staff had come in on their day off to join in the celebrations which included music, dancing and a best witch's hat competition. People and staff were greatly enjoying the occasion together. A fireworks party was also planned and a range of activities for Christmas including an activity advent calendar for every day in December. The service subscribed to the 'Ladder to the Moon' programme. This programme provided themed activity boxes on a monthly basis to support stimulating activities, conversations and reminiscence with people on a group or one to one basis. A member of the wellbeing team told us, "The boxes start up memories you haven't heard of before, it brightens up their day". The activities team had recently won a Ladder to the Moon award for evidence of outstanding activities.

Within the home a range of areas had been created for people to enjoy. These included a sensory room, a library, a reminiscence area which contained a large gramophone and an older style typewriter that people could interact with. There was also a music / karaoke area. The registered manager told us that one person enjoyed coming here to play the guitar. A laundry area had been set up and was regularly used by one person who loved to iron. More recently the service had opened its own pub stocking a variety of wine, spirits and beers. The gardens were stocked with raised beds so that people could get involved in growing vegetables. There were plans to replace some of these wooden beds with beds made up of tyres stacked up, allowing people in wheelchairs to get closer without there being sharp edges. The tyres could then be removed or added to raise the height of the bed based upon a person's individual needs.

Staff recognised the positive effect that pets could have on people. The home had a resident cat who was popular with people. Some birds in cages were placed in communal areas of the home and served as a focal point for discussion; they also provided calming 'chatter' and bird song. A fish tank was already in place, but was soon to be moved to the sensory room. A miniature donkey visited the home and visited people in their rooms. The registered manager had a dog who visited the home and other therapy pets also visited on a regular basis.

People were supported to make craft items which were then sold at the shop located in the home. The craft items were good quality and included jewellery and tie dye bags. People were then able to buy these as gifts for their family and friends. Some of the activities supported people to maintain links with the local

community, for example, some people visited the local pub for lunch. During our inspection people were enjoying a visit from a local nursery school. A mini bus was hired to take people to OOMPH (Our Organisation Makes People Happy) activities. All of the staff got involved in providing activities and enjoyed this. For example, one care worker told us, "It's nice to think, what are we going to get up to today". Relatives told us that staff supported many activities in their own time, with one relative telling us that a staff member had taken their family member and another person out for tea on their day off. Records were maintained of the activities undertaken by each person and these evidenced that people cared for in their rooms were also supported to have one to one interaction with the wellbeing team. A care worker told us, "Activities staff go to people in their rooms and maybe read a book, they may not understand, but there is someone there".

People and relatives told us they were confident they could raise concerns or complaints and that these would be dealt with. For example, one relative said, "I feel confident raising concerns, they have listened and it's been addressed". Records showed that when issues or complaints had been raised, these were investigated promptly and appropriate actions taken to ensure similar complaints did not occur again.

Good

Is the service well-led?

Our findings

People and their relatives told us the service was well led. One relative told us the registered manager was, "Strong" and, "On top of everything". Another said, "[the registered manager is lovely] I get cuddles every time I come, [the deputy manager] is lovely too". A third said, "I think he has done pretty good, he makes everyone feel special". A health care professional told us the registered manager was, "Very passionate about his job. The staff think that he is a really good manager and are happy with his management style….the home has a feeling of being well led….all appeared to be well organised and happy."

Staff were positive about the leadership of the service and felt well supported in their roles. One staff member told us, "[The registered manager] is very good, he goes above and beyond, we have to tell him to go home". Another said the registered manager was, "Very supportive and up and down [the floors in the home] all the time". A third staff member said, "They are the best manager I've had in ten years of care work, if you need something, you get it…I wish I had found this place years ago". Staff told us morale was good and that staff worked well as a team to meet people's needs. Staff meetings were held on a regular basis. Staff told us they felt encouraged to contribute their ideas for developments and that if possible these were listened to and acted upon.

The registered manager and provider were proactive in driving the service forward to improve outcomes for people. There were robust systems in place to monitor and improve quality and safety within the service. For example, the service had a system in place to report, investigate and learn from incidents and accidents. Each month the deputy manager completed an analysis of these to identify any trends or patterns so that remedial action could be taken which might reduce the risk of similar incidents happening again. Each month an analysis was made of the number of clinical incidents that had taken place within the service such as pressure ulcers, the number of people with unplanned weight loss, the number of infections and medicines errors. The information was reviewed from month to month to see if the number of these clinical incidents had increased or decreased so that the service could measure the quality and effectiveness of its clinical care. Daily heads of department and unit manager meetings were held. These reviewed any potential issues, concerns or risks within the service. For example, there was a discussion about people who had been referred to the GP, any staff sickness, complaints, training due and care plan updates required.

A range of audits were undertaken to monitor the effectiveness of aspects of the service including care documentation, falls, infection control, tissue viability, nutrition and medicines management. The provider's head of operations made monthly visits to the home and undertook detailed audits. The audits helped to identify what the service was doing well and the areas it could improve on. Clear action plans were drafted in response. The organisation used a health and safety consultant to undertake a full audit of the home to help identify any risks or concerns in relation to the environment and equipment used for delivering people's care and a different consultant had recently undertaken a detailed audit of all aspects of care delivery. The finding of these audits fed into the services 'home development plan' which clearly set out the areas for improvement, who would be responsible for delivering this and timescales for these to be completed.

The provider sought feedback from people, their relatives and from staff and used this to continually improve the service. 'Residents and relatives meetings' were planned in advance and these gave people and their relatives the opportunity to discuss issues about their day to day care and support, and to suggest improvements they wanted to see within the service. There was also a suggestion box at reception. The provider undertook regular surveys. The most recent surveys were completed in March 2017 and the results were mainly positive. Where areas for improvement had been identified, a 'you said', 'we've done' poster had been produced to show where action was being taken. For example, the quality of the pureed meals had been reviewed and the use of agency staff had been reviewed.

The registered manager demonstrated good knowledge, passion and enthusiasm Their commitment to the service, the people in their care and to the staff team was clear to see. The registered manager had fostered a homely, friendly and person centred culture within the home and they spoke enthusiastically about their vision for the service and areas they wanted to develop. They spoke fondly about the people living at the home and of the staff team that provided people's care. They spent time interacting with people, providing reassurance when this was required. A relative told us, "[The registered manager is lovely, knowledgeable… they always have time for you, you get a big hello and a hug, it lifts your mood, I can't praise him enough, he is wonderful and his dog is too".

The registered manager talked of the importance of caring for the staff team and told us how much they valued their commitment to care for people to the best of their ability. To demonstrate their regard for the staff team, initiatives such as celebrating staff birthdays had been introduced. A 'Wall of Fame' in the home celebrated the achievements of staff in line with the provider's values. A staff member told us, "I do feel valued, the manager is very approachable, he gives me a hug, he always has an open door".

The provider was committed to ensuring that the registered manager continued to develop their own skills and knowledge in order to continue to deliver a high quality service. The registered manager was signing up for a nationally recognised Level 7 qualification in leadership and management in health and social care and leadership coaching was also being made available. The provider's representative visited the service on a regular basis to provide support and guidance. The registered manager had a good understanding of the future challenges facing the service which included managing a smooth transition to electronic care records. Their vision for the service included continuing to develop the wellbeing aspect of the care provided. They had plans to try and source the interior of an old plane for the home and also create a cinema. Plans were also in place to introduce a care practitioner role within the service.

The registered manager was keen to continue to build upon the services links within the local community by holding coffee mornings and supporting isolated people in the community over Christmas. They were also continuing to donate surplus or out of date medical stock to a national charity providing medical aid to rural Africa. Staff embraced and shared the registered manager's vision for providing high quality person centred care and genuinely wanted the very best for people. Staff were aware of, and our observations throughout the inspection indicated that staff put into practice, the providers values which were joyfulness, spontaneity, creativity and being part of a family. This was evidenced by one care worker who told us, "We are joyful and spontaneous; we know our residents… every day is different".