London Residential Healthcare Limited

Solent Grange Nursing Home

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

This inspection took place on 3 and 7 October 2016 and was unannounced. Solent Grange Nursing Home provides accommodation and personal care for up to 89 adults, including people with dementia and physical disabilities, who require nursing care. There were 30 people living at the home when we visited.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Individual risks to people and risks relating to the environment were not always managed effectively. Most staff understood how to keep people safe in an emergency. The registered manager addressed these issues, but time is needed for them to be fully implemented and sustained in practice.

People, visitors and external health and social care professionals were positive about the service people received. People were happy with activities provided. People were positive about meals and the support they received to ensure they had a nutritious diet. People were supported and encouraged to be as independent as possible and their dignity was promoted.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. Reviews of care involving people were conducted regularly. People had access to healthcare services and were referred to doctors and specialists when needed. People received medicines as prescribed. At the end of their life, people received appropriate care to have a comfortable, dignified and pain free death.

People felt safe and staff knew how to identify, prevent and report abuse. Legislation designed to protect people's legal rights was followed correctly. Staff offered people choices and respected their decisions. People and visitors views about the service were sought in a formal and informal day to day way and were acted on.

There were enough staff to meet people's needs. The recruitment process helped ensure staff were suitable for their role. Staff received appropriate training and were supported in their work.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care. Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

Quality assurance systems were in place using formal audits and through regular contact by the provider and registered manager with people, relatives and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people and risks relating to the environment were not always managed effectively. The registered manager addressed these issues, but time is needed for them to be fully implemented and sustained in practice. However, most staff understood how to keep people safe in an emergency.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. People received their medicines as prescribed.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff followed legislation designed to protect people's rights and freedoms. People received the personal and nursing care they required and were supported to access other healthcare services when needed.

People received a varied and nutritious diet and they were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

Overall the environment was appropriate and well maintained although the registered manager was seeking to improve some areas to make them more suitable for the people living there.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to build friendships.

People and their relatives were positive about the way staff treated them. People were treated with respect. Dignity and independence were promoted and people were involved with planning how their care needs would be met.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

Is the service responsive?

Good

The service was responsive.

People were happy with activities provided which were organised individually or in a group. Outings were also available.

People received personalised care and support. Staff demonstrated a good awareness of people's individual needs and responded effectively when their needs changed.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the care they required.

The registered manager sought and acted on feedback from people. There was a complaints policy in place and people knew how to raise concerns.

Is the service well-led?

Good

The service was well-led.

People and their relatives felt the home was well organised. Staff understood their roles, were motivated, worked well as a team and felt valued by the registered manager.

The service had an open and transparent culture.

A suitable quality assurance process was in place, including formal audits and informal monitoring of the service.

Solent Grange Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 3 and 7 October 2016 and was completed by two inspectors and a specialist advisor in the care of older people. The inspection was unannounced.

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

We spoke with six people living at the home, three relatives and one health care professional. We also spoke with the provider's operations manager, the registered manager, the deputy manager, three nursing and six care staff members, and ancillary staff including the administrator, maintenance staff and the chef.

We looked at care plans and associated records for 11 people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records. We observed care and support being delivered in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The home was last inspected in September 2015, when we did not identify any breaches of regulations.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "Safe, yes, the staff are always around when I need them". A visitor told us when they were unable to visit they were confident their relative was safe and they would be contacted if there were any concerns. Without exception all the people and visitors we spoke with were sure they or their relatives were safe at Solent Grange Nursing Home.

However, not all nursing staff were aware of where some items of medical emergency equipment were stored which may have resulted in a delay in people receiving emergency treatment. The registered manager was aware where this was located and took action to ensure all nursing staff could find all necessary equipment when required.

Most staff were aware of the action to take in the event of a fire, although one staff member did not know how to open an external fire door. We brought this to the attention of the deputy manager who took immediate steps to reinforce the fire procedures to staff. Weekly checks of the fire safety equipment were conducted, together with regular fire drills. The provider had taken appropriate action to address all significant deficiencies identified by a recent fire safety risk assessment, which had made the fire safety arrangements more robust.

Checks of the safety of the environment included the temperature of the hot water outlets in people's rooms. However, we found these were not being completed or recorded accurately. The staff member conducting them told us they only tested a sample of outlets, but recorded that all outlets had been tested as they presumed they would be the same, which was not the case. We raised this with the registered manager, who took immediate action to help ensure the checks were conducted properly in future. Action had been taken since the last inspection to remove a potential source of legionella from the hot water system. Arrangements were in place to check that gas and electric systems were safe and maintained in good condition. Equipment such as hoists and lifts were serviced regularly to help ensure they were in good working order and safe to use.

There were appropriate arrangements in place for obtaining, recording, storing, administering and disposing of prescribed medicines. We checked stocks of some medicines. Although we found a discrepancy in the stock levels for two people, this indicated that people had received the correct medicine but that the incorrect person's box may have been used. When informed, the registered manager took the necessary action to minimise the risk of reoccurrence by reminding nursing staff that they must use the correct box for each person. People told us they could receive 'as required' medicine such as for pain relief when needed. There were also effective processes for the ordering of stock and checking stock into the home to ensure the medicines available for people were correct. We saw these procedures used when a person was admitted to the home. Nursing staff checked that there were adequate supplies and took appropriate action when they identified a need for some additional medicine.

We spoke with one registered nurse about their knowledge of medicines and found this was up to date and comprehensive. They told us they had received training in medicines management and administration as

part of their induction to the home. We observed nursing staff administering medicines to people in a patient manner, and informing people what the medicine was for. They did not hurry the medicines rounds and Medicines Administration Records (MAR) were up to date and complete. The registered manager had recently introduced a new medicines administration round at 07.00am for medicines that needed to be given before food. This meant people would receive these in a safe way as directed by the manufacture.

There was a procedure in place for the covert administration of medicines when this was necessary. Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. The procedure in place protected people's legal rights and ensured that all relevant people including GP's, dispensing pharmacists and relatives were involved in the decision to administer medicines covertly. The provider used 'as and when necessary' (prn) protocols for pain relieving medicines, and a recognised pain assessment tool was in use for when people were not able to state they were in pain. Additional individual indicators of pain were also included in care plans. For other 'as required' medicines such as laxatives, guidelines for administration were also available. There were suitable systems to ensure other prescribed medicines such as nutritional supplements and topical creams were provided to people.

The provider used a form to support staff to assess the risks posed by bedrails. However, the form did not require staff to consider the possibility or history of the person trying to climb over the bed rails. Staff told us one person had a history of putting their legs over their bed rails, and although they had not tried to climb out of bed they had installed soft mats beneath the person's bed to protect them if they fell. They told us this was "not ideal" and said a safer option was to use a bed that could be lowered to the floor, but none was available. We raised this concern with the registered manager. They took immediate steps to amend the provider's risk assessment form and explore more appropriate options to manage the risk posed to this person.

In other cases, where individual risks to people were identified, action was taken to reduce the risk. These included the risks to people of falls, choking, poor nutrition and skin damage. People told us staff assisted them to change their position and records confirmed this was undertaken on a regular basis which would reduce the risk of pressure injury. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Pressure relief mattresses were set appropriately and there was a system in place to check these weekly. Moving and handling assessments clearly set out the way staff should support each person to move and correlated to other information in the person's care plan. Staff had been trained to support people to move safely and we observed equipment, such as hoists, being used in accordance with best practice guidance. Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets to reduce the risk. Risk assessments, with specific actions to reduce the risk where possible, were relevant to the individual person and had been regularly reviewed. All staff members were provided daily with a comprehensive handover sheet which detailed the management of people's individual risks. This helped ensure staff had quick and easy access to this information when required.

People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, staff encouraged people to mobilise using their walking frames; they remained close by, in case the person needed additional support, but allowed them to travel at their own speed and retain their independence. One person had limited vision, so staff gave them verbal instructions to help them negotiate their walking frame around furniture; this was done in a patient, supportive way.

There were appropriate policies in place to protect people from abuse. One staff member told us, "Everyone is at risk of abuse. If I had any concerns I would inform the manager. I would expect her to take action, but if she didn't act I would go to [the local safeguarding authority]." All staff were confident the registered

manager would take the necessary action if they raised any concerns and knew how to contact the local safeguarding team if required. Information about when and how to contact the local safeguarding authority was displayed on the notice board at the nurses' station and staff were aware it was there. The registered manager was aware of the action they should take if they had any concerns or concerns were passed to them. They followed local safeguarding processes and had reported and responded appropriately to allegations or concerns of abuse.

There were sufficient staff to meet people's needs. Call bells were answered promptly and staff were available to support people in communal areas of the home at all times. Staffing levels were determined by the registered manager on the basis of people's needs. They ensured at least one nurse was always on duty, supported by sufficient care staff and ancillary staff. The registered manager told us, "We take a team approach. For example, housekeepers are trained to [support people to eat] so can help out when needed." Care staff said they had enough time to meet people's needs. We observed they had time to sit and talk with people and did not rush them when supporting them in communal areas. Absence and sickness was covered by permanent staff working additional hours when needed to help ensure people were cared for by a consistent team of staff.

Following an increase in the number of people who could be accommodated, the registered manager had developed a plan to increase occupancy by two additional people per week. They were clear that this could only happen once there were sufficient staff in place, so were actively recruiting to increase the staffing numbers. The registered manager told us, "We have to be able to meet [people's] needs and won't take anyone unless the right staffing is in place."

The process used to recruit staff was safe and helped ensure staff were suitable for their role. The provider carried out relevant pre-employment checks to make sure staff were of good character with the necessary skills and experience needed to support people effectively. Staff confirmed this process was followed before they started working at the home.

There were plans in place to deal with foreseeable emergencies. An emergency file had been prepared containing contact details for staff and management out of hours, together with personal evacuation plans for people. These included details of the support people would need if they had to be evacuated.

Good

Is the service effective?

Our findings

People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found the provider was following the necessary requirements and DoLS applications had been made with the relevant local authority where necessary. The registered manager was aware of specific conditions which had been added to some DoLS authorisations. These were no longer applicable to one person and action was being taken to amend these. DoLS are approved for a set period of time and the registered manager should reapply for a new assessment shortly before the existing DoLS runs out. The registered manager had been unaware of this and one person's DoLS had expired in August 2016. They took immediate action to reapply for the DoLS for this person.

People's ability to make specific decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Some people living at Solent Grange Nursing Home had a cognitive impairment and were not able to give valid consent to certain decisions. This included the delivery of personal care, the administration of medicines, the use of bedrails and the use of pressure relief mattresses. Staff therefore made these decisions on behalf of people in consultation with family members and health care professionals as required by the MCA.

Staff understood the Mental Capacity Act (2005) and their responsibilities within this. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to act in the person's 'best interests'. Care plans contained information about the specific decisions people required staff to support them to make. Care plans also contained information as to who had the legal right to make other decisions on behalf of the person. When in place, we were told copies of the legal documents confirming this were held.

People's nutrition and hydration needs were met by staff who had time to support them to eat, when necessary. One person told us "I always get a choice of meals". They added that the food was "very good". Another person said, "The food is very good and the chefs gets things in for me, like spinach and broccoli. Last night they got me [a type of cheese biscuit] which I really enjoyed." The chef stated they would sometimes go to a supermarket on their way home if a person requested a specific food item. Records showed people were provided with food when they wanted it. Staff told us they could provide people with food and drinks at any time this was requested or required.

People received the appropriate amount of support and encouragement to eat and drink. Staff were attentive to people and, whilst promoting independence, noted when people required support. For example, we saw one person being helped by a staff member. The staff member had a fork, as did the person, who was encouraged to use it and was assisted appropriately when they did not. This showed

people were supported to help them overcome their difficulties. Where people required more support this was provided patiently, giving people time to finish one mouthful before they were offered more.

Staff, including kitchen staff, were aware of the specific dietary needs of individual people. For example, the chef was aware of which people required their meals in a softer format or had dietary restrictions such as due to a medical condition. A staff member correctly told us a person required their meals in a softer texture and their drinks thickened to a specific consistency. Meals, including those which had been pureed, were pleasantly presented. Drinks were available throughout the day and staff prompted people to drink. Staff monitored the weight of people and we saw two people were referred to their GPs for advice when they experienced unplanned weight loss. As a result, one person had been prescribed a supplement which they had received. When their weight then stabilised, the supplement was discontinued. Where necessary records of the amount people had eaten or drunk were kept.

One person was receiving their nutritional needs via a tube directly into their stomach as they had been assessed by the Speech and language Therapists (SaLT) as not being able to swallow safely. The person's care plans also contained clear instructions from the dietician as to how the person's nutritional needs should be met, including the amount of fluid they should receive each day. Records showed they were receiving this as recommended and other care relating to the tube was being completed.

People received the personal and nursing care they required. A person confirmed staff assisted them when they were ready to get up and that they were encouraged to be as independent as possible. A visitor told us they were happy with the way their relative's personal care needs were met. Staff recorded the personal care they provided to people including if people had declined care such as a shower or bath. These records showed people were supported to meet their personal and other care needs. Systems were in place for a senior staff member to review records of care monthly to monitor that people were receiving the care they required.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. Nursing and care staff described how they supported people which reflected the information in people's care plans and risk assessments. People were seen regularly by doctors, opticians and chiropodists as required. Solent Grange Nursing Home had equipment suited to the needs of people living there. We saw this included individual equipment where necessary such as hoist slings and slide sheets. We spoke with a visiting healthcare professional who was complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's health care needs were met. A relative confirmed that health professionals were contacted when required. Where necessary staff advocated on behalf of people with health care professionals to ensure they received appropriate care and treatment. The registered manager told us, "We look at any new medicines and what they are for, to understand why we are giving them and what the side effects are. If people can't verbalise, we have to act on their behalf. For example, one person had been discharged from hospital with [a particular] sedative, after they had been receiving [a different sedative]. We monitored it and suggested to the GP that we change back to [the sedative they had been receiving in hospital], which worked much better for them."

We saw other people were supported to return to bed in the afternoon to change their position which would protect any vulnerable areas of skin from damage. They told us they had received wound management training from a specialist tissue viability nurse who they felt able to contact for guidance when necessary. One person had been admitted to Solent Grange Nursing Home with significant skin care needs and wounds. Records showed these were being appropriately managed under the guidance of the NHS tissue viability specialist and that the wounds had improved in the time they had been at the home. A whole person approach had been used which considered not just the specific wound care but also factors which

would promote or hinder healing, such as nutritional intake. Pain relief had also been considered and was being provided in an appropriate way.

People's needs were met by staff who were skilled and suitably trained. Staff were positive about the training they received and said they could ask for any additional training they felt would benefit people. Staff demonstrated an understanding of the training they had received and how to apply it. For example, when supporting people to move, they used appropriate techniques; and they explained how they communicated with people living with dementia by remaining patient, asking simple questions and providing continuous reassurance. A staff member told us, "[One person] only has a little sight, so we use touch and speak clearly in a calm way. They have a set routine and it's important to follow that." Another staff member said, "I did the end of life training and it helped emphasise the need to involve the family and take account of their needs."

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. This was based on a range of DVDs, followed by knowledge checks. It was then supplemented by face-to-face training, including supporting people to move safely. Most staff had completed dementia awareness training, including eight staff members who had completed a university accredited dementia course. Nurses were supported to undertake study to meet the needs of their registration and training to meet the specific needs of people living at Solent Grange. This included catheterisation, skin viability and syringe driver training.

Arrangements were in place for staff who had not worked in care before to undertake training that followed the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, a high proportion of experienced staff had completed, or were undertaking, vocational qualifications in health and social care. The provider offered a financial incentive for staff to obtain qualifications. The registered manager told us this "Encourages people to get their level three [qualifications] and has had a positive effect."

People were cared for by staff who were appropriately supported in their role. All staff received regular one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Additional supervisions were arranged when staff needed additional support. For example, a group supervision was held to de-brief a serious incident where a person had needed urgent intervention after choking on their food, which had distressed some staff. The registered manager told us, "We needed to make sure everyone was okay and that everything had been done properly, which it had."

Staff who had worked at the home for over a year had also received an annual appraisal, with the registered manager, to assess their performance and identify development objectives. Staff told us these sessions were helpful and spoke positively about the support they received from the registered manager on a day to day basis.

The registered manager was seeking to improve one part of the environment to make it more suitable for the people living there. Action was being taken to identify the way these areas could be upgraded to provide a more homely and supportive environment. In the newer parts of the home the environment was appropriate and well maintained. People were able to bring in items of their own, including furniture, to make their rooms feel homely and familiar. This would help people settle in and feel at home. There was a range of communal and bathing facilities suitably equipped to support people with high care needs. People had access to a safe enclosed garden or courtyard area providing access to fresh air and sunlight if they wanted this.

Good

Is the service caring?

Our findings

People were positive about the way staff treated them saying that all the staff were kind and caring. One person said "They're very good to me". When asked if they thought the staff were caring another person said "Yes". Visitors also felt staff were caring. One said "I've never seen or heard anything that would worry me". Another visitor said "The staff are friendly and I am always made to feel very welcome, offered a drink etc."

We observed staff over the course of our inspection and found they were caring, patient and kind. Staff spoke to people in a respectful but friendly way and people responded in a similar manner. One care staff member apologised to a person who they had left when another person required some immediate support to ensure their safety. We saw staff crouched to people's eye level and spoke in soft warm tones. There was lots of 'in house' joking and frivolity between staff and people and there was a great deal of warmth evident. We observed staff supporting people with their meals in ways that were kind and patient. Staff did not rush people and they spoke with them about their food. This ensured, where people were being supported to eat in their own bedrooms or individually in communal rooms, they enjoyed a social occasion rather than a task being completed. One person was asleep when their lunch arrived. The care staff member attending them roused them very gently and gave them time to come round before offering them their lunch. We were told the person spent a lot of the day asleep so it was necessary to wake them for their meal. We saw that once awake, they seemed happy and ready to eat. One person needed their feet raised on a cushion in the lounge. A care staff member had an engaging conversation with the person, discussing which of their cushions would be best. They decided on one that was still in the person's room and the care staff member went to fetch it for them.

People's dignity was protected during the provision of care. People told us curtains were always drawn and doors shut when any personal care was provided. From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. Care staff told us which people preferred care from staff of a specific gender. They told us this was always met. Care plans identified if people had a preference for the gender of staff providing personal care. Staff described how they promoted dignity and privacy, such as ensuring doors were closed and people were covered as far as possible during personal care. We saw dignity screens were put in place when staff used moving and handling equipment in communal areas.

People received care and support from staff who knew and understood their history, likes, preferences and needs. For example, they knew about a person's preference for green vegetables and that a special order had been placed which was due to be delivered the following day. A care staff member asked a person "Would you like cooked breakfast and then porridge or porridge and then cooked breakfast?" The person was then asked "Ketchup? Where would you like it? Here? Here? Or all over". This demonstrated that staff had a good knowledge of people, their needs, usual routines and preferences.

People were supported to express their views and were involved in making decisions about their care, treatment and support. A person told us they could choose how they spent their day and where they took their meals. They preferred to take their meals in a quiet area of the lounge because they had difficulty

eating, which caused them embarrassment, and said staff always arranged this. At lunch time, a care staff member asked people if they wanted the radio on in the lounge or if they would prefer some peace. The only person who expressed an opinion asked for the radio to be turned off, which it was. Where people required support to make decisions we saw this had occurred. An advocate had been arranged for a person who did not have family members to act for them. They had suggested purchasing a CD player, so the person could listen to a large collection of CD's they had. This had been done and we saw the person using it and enjoying their music. Staff described how they involved people in choices. One said "We ask them, or we will show them a few choices such as clothes".

People's views were also considered about other aspects of the running of the home. For example, there were plans to improve the environment in the older part of the home where people living with dementia were accommodated. The proposal 'Bluebell Unit – The Way Forward' was at the consultation stage. People, visitors and staff were being asked what they would like to see included in the refurbishment. We saw feedback and suggestion forms for anyone to complete. This showed people and visitors were considered as an important part of the development of the home.

Care plans contained information to help staff communicate with people. For example, in one care plan there was information detailing the specific slang words the person used when they wanted to use the toilet. Staff were aware of these and said the person understood them when they used these terms. Another person used a note book for staff to write in as they had hearing loss. Staff were aware of this and one told us the person had complained about their [care staff members] handwriting. This showed that the note book was used by staff and that staff had established a good rapport with the person.

Care was individual and centred on each person and staff had a good awareness of people's needs. People, and when appropriate relatives, were involved in care planning and reviews of care. Care files were reviewed monthly by a senior nurse. This included a discussion with the person or a relative about their care plan and any changes they would like made. We saw people or family members where appropriate had signed care plans and risk assessments to show they were aware of them and had agreed to the planned care. Family members told us they were always kept up to date with any changes to the health of their relatives. Contact with family members was recorded in care records. One visitor said, "We have been kept informed".

Where people had religious or cultural preferences these were known and met. Care plans contained information about people's religious needs and how these should be met. If requested people were individually visited by a religious leader of their choice. The deputy manager was aware of how to contact religious leaders of various faiths should these be required.

Staff followed people's end of life wishes wherever possible. One person had been taken to hospital following an injury. Their health had deteriorated and they expressed a wish to return to Solent Grange to receive end of life care, which staff had arranged. The registered manager told us, "We brought her back and she had a peaceful death with their family. It was great to have been able to do that for her. It's important to get end of life care right."

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. Nursing staff had attended training to enable them to better manager symptoms people may have at the end of their lives. One told us about recent update training they had attended for the use of specific equipment to manage symptoms such as pain. Nurses were aware of how to obtain and administer symptom management medicines should these be required. Senior nursing staff had undertaken additional training to enable them to verify when a person had died. This would mean that there would not be an unnecessary delay in this being confirmed to relatives and procedures being commenced. The registered

manager was aware of who they could contact for additional support if required. Information about people's preferences for their end of life care were included within care files.

Good

Is the service responsive?

Our findings

An activities calendar was displayed on the notice board. These included: newspaper quiz, visits by Pets At Home, flower arranging, weekly church service, cat visits, sing-along, owl visit and pat dog. In addition people could choose to purchase aromatherapy and the hairdresser. The registered manager told us there were also some outings organised with one planned for December to visit a local stately home which would be decorated for a Victorian Christmas. They told us staff had volunteered to support the outing in their own time. One person told us a staff member was going to take them shopping for some new clothing. They were clearly looking forward to this as they told us they did not have anyone able to shop for them and they liked to be able to make their own choices. A person told us care staff had taken them for a walk outside every day that the weather had been suitable. All people and visitors we spoke with felt that the activities provided were suitable and they were happy with these.

We also spoke with some people who were cared for in bed. They told us they were happy with the activities. One person told us how they enjoyed watching birds and that staff would place bird food on a bird table positioned outside their bedroom window. Although people and visitors felt there were adequate activities, one external professional thought the home could offer more stimulation to a person living with dementia. One care staff member said they felt the activities were "not always dementia focused" and felt there should be more music, dancing and sensory based activities. The home employed an activities coordinator who organised activities in small groups or individually depending on people's needs and wishes.

Nursing and care staff were able to describe the care and support required by individual people. For example, care staff were able to describe the support people required to meet nutritional needs. One person required a fluid thickener to be added to their drinks to enable them to swallow safely. Staff were aware of this and we saw the thickener being added to the person's drinks. When talking about a person with limited vision, a staff member said, "If they have chocolates, we put them on a white plate so they're easier for them to see and tell them how many there are".

Care plans were well organised and provided comprehensive individualised information for staff, which corresponded to the care people were receiving. Care plans contained information about how people's individual personal care needs should be met and about how people may communicate in a non-verbal way. This included guidance for staff about interpreting what a person's behaviour may mean, such as the need to use the bathroom. This detail ensured that staff were aware of triggers and were able to identify the early signs of people who may require assistance. A process was in place to ensure care plans were reviewed every month by a member of the nursing team. We saw records showing this had occurred along with other amendments to care plans when these had been required.

Staff responded appropriately when people's individual health or personal care needs changed. Action was taken when people had experienced a fall. Their risk assessment was reviewed and action to reduce the risk of further falls was considered. For example, one person had slipped out of their chair and was then cared for in bed until an alternative, more suitable chair had been obtained for the person. If people sustained a head injury during a fall, appropriate observations were conducted for the following 24 hours to monitor the

person's health and vital signs. Care plans contained information for staff about the signs and indicators a person with epilepsy may show prior to a seizure. Likewise there was information about the support a person with diabetes required including guidance for staff as to the signs and symptoms the person may experience if their blood sugar levels were too high or too low.

Staff had information as to how they should respond to medical emergencies. For example, one care plan contained information about the support a person should receive if they had an epileptic seizure. This included the use of a monitoring mat and guidance for staff as to when to call paramedics or administer rescue medicine. Staff were kept up to date about people's needs and any changes to these through a formal handover meeting at the start of each shift. They were also provided with a detailed handover sheet which provided all relevant information for care staff such as how the person should be supported with food and drinks and moving around the home.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the necessary care. Incidents and accidents were recorded. Forms showed that, where necessary, external medical advice was sought and action was taken to monitor the person for any signs of deterioration. Action was taken to reduce the risk of repeat incidents such as through the use of movement alert equipment for people who were at risk of falling. The registered manager reviewed accidents and incidents to identify any patterns. None had been identified, but they described the action they would take if any themes were found.

The provider sought feedback from people, relatives and external professionals through the use of questionnaire surveys. These showed a high level of satisfaction with the service provided. 'Residents meetings' were also used as an opportunity to seek the views of people and family members. For example, people had made suggestions about activities they wished to undertake. Although the residents meetings were not well-attended, the registered manager told us, "Some people are used to them and would miss them if they were stopped."

People knew how to complain or make comments about the service and the complaints procedure was displayed on the notice board in the entrance hall. Relatives and people told us they had not had reason to complain but would contact the registered manager if needed. The complaints records showed that two complaints had been made since the previous inspection and these had been investigated, and responded to, appropriately. The registered manager described how they used complaints to consider whether improvements could be made to the service. For example, a recent complaint related to procedures following a person's death. While these could not have been changed as the correct legal procedures had had to be followed, the registered manager told us they had learned from the experience and were now better informed and able to explain them to family members in more detail.

Good

Is the service well-led?

Our findings

People, relatives and staff felt Solent Grange Nursing Home was well-led. One person told us "Everything is well organised. [The registered manager] holds the place together." Other people were able to name the registered manager and were confident they would sort out any issues should these occur. One person said the registered manager often came to see them and check they were happy. They added "If I wanted to see her I would use the bell and ask to see her, I know she would come as soon as she could". An NHS health care professional told us the registered manager was open and receptive to their suggestions and followed their guidance.

There was a duty of candour policy in place which required staff to act in an open and transparent way when people were harmed. The registered manager followed this when a person fell and sustained a serious injury and they had notified family members of the incident by telephone. However, they had not sent a letter of apology, detailing the circumstances, as required by the regulations. We discussed this with the registered manager who took immediate action to address this. They also told us they would raise the issue with the provider as their policy did not provide clear guidance about when a letter of apology should be sent.

An appropriate quality assurance system was in place that focused on continuous improvement. This included auditing key aspects of the service, such as care planning, medicines and infection control. Where changes were needed, specific actions were developed and implemented. For example, a spread sheet was used to monitor staff training and we saw training courses had already been scheduled for staff needed to repeat or refresh specific training. The registered manager and a nurse conducted weekly and monthly reviews of all medicines in stock to help ensure they were managed effectively and errors had not occurred. The registered manager was responsive to feedback provided during the inspection and took immediate action to address the safety concerns we identified. The registered manager also conducted unannounced spot checks during the night to monitor whether staff were delivering care to an appropriate standard.

In addition, the Operations Manager conducted monthly reviews of the home. These included observing staff interactions with people and completing a range of audits. When improvements were identified, we saw action plans were developed and monitored through to completion. For example a recent review identified the need for two short-term care plans to be developed and we found these were now in place. Meetings were held regularly with groups of staff, including senior managers, housekeeping, nurses etc. These provided an opportunity for staff to make comments about the service and how it could be improved. They also allowed the registered manager to reinforce the values and vision of the provider and remind staff about best practice guidance.

There was a clear management structure in place and all staff understood their roles. The registered manager told us they had access to advice and support from the provider's operations manager. A new deputy manager had been appointed to provide support to senior staff. We observed positive interactions between the operations manager, the registered manager, staff, people and relatives who appeared comfortable discussing a wide range of issues in an open and informal way. The registered manager told us they undertook some nursing shifts, which they felt helped them understand the pressures felt by staff and

enabled them to directly monitor the quality of care provided. When we identified minor areas which could be improved the registered manager was receptive to these and where necessary took immediate action. This showed they were willing to listen to others opinions and views about the service. Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory work. Checks of CQC records showed all incidents had been notified as required. Providers are also required to make sure people who use services are aware of previous inspections and their findings. A copy of the previous inspection report showing the overall ratings was displayed and available to people or visitors in the entrance area of the home.

Staff spoke positively about the support they received from management. One staff member told us, "Things are more thorough now and if you go to management things are sorted out. They're professional." They added, "[The registered manager] has an open door policy. She is always stressing that 'if you have any problems, come to me'. She is very hands-on; she's always on the floor and visible." Another staff member said, "I'm very happy working here; it's great." A third staff member said "Everything flows, it's good". They added about the registered manager "She's the best one, knows what she is talking about, that's reassuring". The registered manager was open to suggestions from nursing and care staff about how the home could be improved for the benefit of people. For example, they had supported one nurse to introduce a new therapy for people living with dementia which was being embraced on the unit where people were living with dementia. Staff reported positive benefits for some people.

There was a plan in place to develop and grow the service over the next year to achieve full occupancy. The registered manager was aware of the need to do this in a controlled way to maintain the quality of service provided. As part of the process, they were consulting with people, relatives, staff and other professionals to seek their views.

The operations manager told us the provider's vision was to "grow organically and strive for excellence by following the values of the three Cs: Comfort; Care; and Compassion." They said they communicated these values to staff during meetings, supervisions and training sessions. In addition, the values were detailed in the staff handbook. We observed that staff showed a commitment to these values in the way they supported people.