# St. Vincent Care Homes Limited

# St Vincent House - Gosport

## Inspection report

St Vincent House
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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

St Vincent House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This comprehensive inspection was unannounced and took place on 16 and 18 July 2018. St Vincent House provides personal care and accommodation for older people including older people living with dementia. The home is registered to accommodate up to 34 people. At the time of the inspection there were 29 people living at the home.

The home provides accommodation over three floors. There was a choice of communal areas where people could socialise or sit quietly. People's bedrooms were arranged over all three floors. Some bedrooms had en-suite facilities and there were communal bathrooms.

The last comprehensive inspection of this home was in February 2017 when it received an overall rating of requires improvement. At that time, we found the provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to assessing risks to people, the amount of staff available to support people, mental capacity assessments, person centred care plans, quality assurance systems and record keeping. We made five requirements and the provider wrote to us detailing the action they planned to take. During this inspection we found that improvements had been made and the provider was no longer in breach of regulations.

There was a registered manager in post at the service. 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 and associated Regulations about how the service is run.

Potential risks to people were assessed and action taken to minimise them. Risk assessments were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

Environmental risk assessments had been completed. The provider had a contingency plan to deal with foreseeable emergencies. Staff knew what to do in the event of a fire and had been trained to administer first aid.

Where accidents, incidents, and near misses had occurred there was an effective system in place to analyse what had happened so that appropriate action was taken to mitigate any risks or prevent reoccurrence.

There were quality assurance systems in place based on a range of audits. Action plans identified ongoing improvements, with a clear process for planned work to be completed.

There was enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

People felt the staff were kind and caring. They knew how to complain and any complaints made were addressed. There was a range of activities and entertainment which people could choose to take part in.

The home was clean and there were systems in place to protect people from the risk of infection. Plans were in place to redecorate some bedrooms to make them easier to keep clean

Recruitment checks had been completed before staff commenced work to help ensure staff were suitable for their role.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training. Healthcare professionals, such as nurses, chiropodists, opticians and GPs were involved in people's care when necessary.

There were effective systems and processes to protect people at risk of abuse. Staff understood their safeguarding responsibilities.

Staff received training and supervision to equip them for their role. Where people had specific health needs, additional training was provided, so that staff could meet their needs.

People's nutritional and hydration needs were monitored and met. People had been consulted about when the main meal was provided and there was a good choice of food for people.

Staff knew people well and had developed positive relationships with them. Staff sought consent from people before providing care and followed legislation designed to protect people's rights.

People's needs were assessed and staff were aware of people's individual needs and preferences. People and their representatives were involved in planning their care as much as they were able and wished to be. People's end of life wishes were explored with them and recorded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Staff recruitment processes were robust to help ensure suitable staff were employed. Sufficient staff were employed to meet people's current needs.

The service had responded positively to issues that had arisen and made improvements to reduce risks to people.

Appropriate systems and processes were in place to protect people at risk of abuse.

People's medicines were managed safely on their behalf.

Procedures were in place to protect people from the risk of infection.

### Is the service effective?

Good

The service was effective.

People's consent was sought prior to care being given and staff followed legislation designed to protect people's rights.

Staff completed a thorough induction and training programme. Training for staff was updated regularly and specialist training was provided to meet people's specific needs.

Staff received ongoing support and development through supervisions and appraisal.

People's needs were assessed and their care was planned with them and their families, where appropriate.

People's health and nutritional needs were met.

### Is the service caring?

Good

The service was caring.

People felt staff were kind and caring and that they were listened

to.

Staff were relaxed and friendly and appeared to know people well. They were patient and built positive relationships, treating people with dignity and respect

People's individual diverse needs were identified and met by staff.

## Is the service responsive?

Good

The service was responsive.

Staff were able to recognise changes in people as they occurred and responded promptly.

People's care plans were person centred and staff had the information they needed to support them as individuals.

People knew how to complain if they needed to and complaints had been responded to and addressed.

Technology was used to positively promote people's independence.

## Is the service well-led?

Good

The service was well led.

The registered manager had effective systems in place to monitor the service and sought to continually improve it.

There were comprehensive quality assurance processes in place which monitored quality and safety. These were effective in ensuring that shortfalls in the service were identified and addressed.

The quality of people's care records was monitored effectively.

Staff felt involved and listened to and described a positive supportive team culture.

The service had an open and transparent culture, visitors were welcomed and the registered manager notified CQC of all significant events.

# St Vincent House - Gosport

**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 comprehensive inspection took place on 16 and 18 July 2018 and was unannounced. On the first day of the inspection there were two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection there was one inspector.

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

We spoke with nine people living at the home, six visitors and two external healthcare professionals. We looked at care plans and associated records for six people, staff duty records, training records, three staff recruitment files, records of complaints, accident and incident records, policies and procedures and quality assurance records.

We observed care and support being delivered in communal areas of the home. We 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. We spoke with six members of the care staff, the registered manager, the deputy manager and one member of the kitchen staff.

We last inspected the service in February 2017 when five breaches of regulation were identified.

Good

# Is the service safe?

## Our findings

People told us they felt safe. One person said, "I feel safe here as there is always someone to help me if I need it." Another person said, "There is always staff around and I feel safe with them." A third person told us, "I am very happy here, I came here after a series of falls which made me feel worried."

At our previous inspection in February 2017 we identified concerns relating to people's risk assessments and found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had taken action and there was no longer a breach of this regulation. People had clear risk assessments in their care plans, which detailed what the risks were and what staff needed to do to support the person. For example, one person was at risk of increased agitation at times. There was clear guidance for staff about how to support the person to try to resolve their concerns, so that they did not continue to become agitated and display behaviours that could put themselves and others at risk. Risk assessments were regularly reviewed and updated when needed.

We looked at records of accidents and incidents and saw that some people had recently experienced falls. Records showed that the registered manager reviewed all accidents and incidents each month and analysed any potential causes. The registered manager and senior staff worked in partnership with external health professionals to assess and monitor people's health and considered the reasons people for the falls. For example, we saw that one person had recently had an increase in falls. The person's care plan and risk assessment had been updated to show the increased risks and what action staff should take to safely support the person and minimise the risks.

During our inspection we observed that some people used walking aids such as walking frames or sticks when mobilising. In conjunction with this, some people also had a cognitive impairment, which meant that they did not always recognise risks when they were walking independently. We discussed this with the registered manager who told us that they considered the balance of supporting people to maintain their independence against the risks of them falling. They told us that one of the current measures in place for people who were at risk of falling, were sensor beams. These alerted staff when the person started to move, so they could attend to offer support as quickly as possible. People who had been assessed as being at risk of falling, had these in their bedrooms. In addition, we found staff were always present to support people in communal areas.

People were encouraged and supported to take positive risks to maintain their independence. For example, some people with memory loss went out on their own in the community. Those people used a tracking device which they wore when they left the home. This had been agreed with them or their families to be in their best interests so that they could maintain their independence and access activities that they enjoyed. For example, one person attended a group they had gone to for many years prior to moving into the home. This system meant that the person could continue to attend and should they not return when expected, or stopped moving for a prolonged period of time, staff would be alerted.

Where people came to harm, the provider had robust procedures in place to investigate the cause, learn

lessons from the incident and take remedial action to prevent a recurrence. For example, following a significant choking incident, the provider had carried out a comprehensive investigation, along with the registered manger and had reviewed how people were supported when eating and drinking. This helped ensure swallowing assessments were completed promptly, together with referrals to speech and language therapists (SALT) where needed. Staff had received specific training on managing choking risks and when we spoke to staff they were able to tell us which people were assessed as being at risk. In addition, the registered manager had updated people's individual risk assessments to clearly identify choking risks. There was clear information in the kitchen and drink serving area, to inform staff of people's individual requirements. When people were supported to eat on a one-to-one basis, food was served on plates with a discreet red line on to show that the person was at risk of choking. Staff ensured people were sat upright when eating and provided them with modified food and drinks when needed.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. These were held in a 'grab bag', that staff could take should they need to evacuate the building. Staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary.

The registered manager had recently introduced 'flash cards', which staff carried discreetly on them at all times. These were small laminated cards with key information about each person on. For example, they had a photograph of the person, together with their main needs, their communication needs, any health conditions, with signs and symptoms to look out for should the person require medical attention. We spoke to staff about individual people and they demonstrated a good understanding of each person and any risks that they needed to be aware of such as for health conditions or behaviours.

There were suitable systems in place to ensure the safe storage of medicines, the ordering of repeat prescriptions and disposal of unwanted medicines. People received their medicines safely and the staff carried out a daily audit to ensure all medicines had been administered correctly. Medicines administration records (MAR) provide a record of which medicines are prescribed to a person and when they were given and these were completed correctly.

There were appropriate guidelines in place for when staff should administer 'as and when required' (PRN) medicines. These are medicines that people may require if they had a headache, pain, or to manage behaviour that could put themselves or others at risk. We saw that the PRN care plan for one person had recently been updated. This was well written, detailing the requirements for staff to use distraction and to support the person with verbal de-escalation techniques, prior to administering PRN medicines. Medicines that required extra control by law, were stored securely and audited each time they were administered.

The provider had policies relating to safeguarding and whistleblowing. Safeguarding concerns were reported to the local authority and to CQC. Records showed that the registered manager had worked with the local safeguarding team to undertake investigations and had taken appropriate action when needed. Staff demonstrated an understanding of safeguarding procedures and what they would do to keep people safe. Staff completed body maps of any bruises found to people. These were brought to the attention of senior staff who investigated the cause and the registered manager reviewed these each month.

At our previous comprehensive inspection in February 2017 we identified concerns about the number of staff available to support people and found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found there was no longer a breach of this regulation. There were sufficient staff to meet people's needs and keep them safe.

Staffing levels were based on the needs of the people using the service and the registered manager also provided additional support at key times when needed. For example, we saw the registered manger assisting staff during meal times on both days of the inspection, as this was known to be a busier time of the day. The provider had an expectation that the registered manager would inform them if they required additional staff to meet a person's needs and the registered manger confirmed that this arrangement worked well.

There was a duty roster system in place which detailed the planned cover for the home which showed that there were enough staff available as required by people. Short term staff absences were managed by existing staff doing overtime or by using agency staff, although the registered manager told us that they tried to ensure consistency by using staff that people knew. We observed staff supporting people throughout the inspection and they were able to meet people's needs and keep them safe.

The staffing levels in the home provided an opportunity for staff to interact with people; staff supported people in a relaxed and unhurried manner. For example, we saw staff taking time to speak to people and asking if they needed anything. One staff member said, "Morning [person's name] are you okay this morning, do you need me to get you anything?" On the first day of the inspection we saw that a person had spilt their drink. The staff who were present noticed straight away and took action to clean up the spill, reassure the person and make sure they were safe.

The provider had a robust recruitment procedure in place. Potential new staff completed an application form and underwent an interview before being offered employment at the home. Appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff confirmed this process was followed before they started working at the home.

Environmental risks were managed effectively and cleanliness was maintained throughout the home. There were systems in place to protect people from the risk of infection. All staff had attended infection control training and had access to personal protective equipment (PPE), which we saw they wore when needed. People's laundry items were managed safely and staff told us how they processed soiled linen, using special red bags that could be put straight into the washing machine. Within the laundry, there was a clear system to help prevent cross contamination between dirty linen entering the laundry and clean linen leaving it. Although some bedrooms were in need of redecoration, these did not pose an infection risk and plans were in place to complete this work.

Equipment used at the home, such as hoists, were maintained and serviced within required timescales. The provider ensured that risks related to the building and the environment were managed effectively. The provider's health and safety lead undertook weekly visits to the home. Audits of the environment were carried out regularly and any issues that were identified were recorded on an action plan. However, we observed an area of carpet on the upstairs landing that was a little loose and could cause a tripping hazard. We discussed this with the provider's representative and saw from their records that they had already identified this and a risk assessment had been completed. This introduced measures to support people who were walking in that area until the carpet could be replaced. This was scheduled to happen in the near future and we advised that this would be carried out as soon as possible. Records showed that gas and electrical appliances were serviced routinely and temperature checks of all hot water outlets were also completed, to prevent the outbreak of legionella.

Good

# Is the service effective?

## Our findings

People and their families told us they felt the service was effective and living there was a positive experience. A person told us, "The staff are lovely and the food is good and I don't have to do anything." A relative told us, "It's comforting to know my [relative's name] is well cared for. The home phone me immediately to inform me of anything I need to know; that gives me confidence."

At our previous comprehensive inspection in February 2017 we identified concerns relating to the assessment of people's capacity and found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found that the provider had taken action and there was no longer a breach of this regulation. 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.

During the care planning process, the registered manager and senior staff had assessed people's capacity to make specific decisions, such as using bed rails, receiving medicines, and support with personal care. Where the assessment concluded that the person lacked capacity to make certain decisions, staff acted in people's best interests by making decisions on their behalf and providing appropriate care. These were recorded and showed that the registered manager had consulted with others involved in the person's life when making these decisions. However, decisions about people using shared bedrooms had not been recorded in the same format as other best interest decisions. We discussed this with the registered manager and were confident that they understood and had followed MCA guidelines. They told us that they would ensure that the appropriate records were updated to reflect best interest decisions about shared rooms.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (2005). The procedures for this in care homes are called the Deprivation of Liberty Safeguards. The registered manager had applied for authorisations under the safeguards for people where necessary and these were reviewed when required. Some DoLS applications had been authorised and others were awaiting assessment by the local authority. When we spoke with staff, they could identify which people were subject to a DoLS authorisation. This information was in people's care records and was also provided to staff through the key information on the flash cards that staff had about each person. Although the front door to the home was locked, those people who were not subject to a DoLS were able to leave the building whenever they requested.

Staff were knowledgeable about how to protect people's human rights. Staff described how they sought verbal consent from people before providing care and support. They said they always asked the person before providing support and we saw that people were offered choice throughout the inspection. For example, we saw one person had spilt a drink on their clothing. The staff knew that the person would be more comfortable if they changed clothing but when they asked, the person declined. Staff respected this

whilst recognising that the person may not fully understand why they were being offered a change of clothes. The staff gave the person a few minutes to process the information and then offered again, and the person then agreed to the support. In addition, we saw that staff asked people every time they were administering medicines, explaining what it was and seeking permission to give it.

People had choice about what they wanted to eat and drink. The home had a chef who accommodated people's individual needs, including those who were gluten intolerant, diabetic or for those who required nutritional supplements to address weight loss. The main meal was served in the early evening. A lighter meal such as soup or sandwiches was served at lunchtime. The time that the main meal was served had been changed following consultation with the people living at the home. They had requested not to have a large meal at lunchtime, with the exception of Sundays, where a traditional roast meal was usually served. People told us that they enjoyed the food and their specific requirements were met such as for a soft or pureed diet. One person told us, "I've been here a while and I like it, the food is good, there's a choice and there's plenty." Another person said, "The food is better than I got at home." We observed the ambience during the lunchtime meal on both days of the inspection was quiet and relaxed. The staff were attentive to people's needs and were obviously aware of the people who had difficulties in eating or required some prompting to eat their food.

Staff received appropriate training to enable them to carry out their roles. The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as fire safety, medicines training, moving and handling and safeguarding adults. Staff also had access to other training focused on the specific needs of people using the service, such as, dementia awareness, Parkinson's disease, end of life care, falls awareness and catheter care. One staff member told us, "I do lots of training and feel very supported." They added, "If a person has a specific need or develops an illness, we are supported to do some additional training so that we can make sure we can support them properly." Another staff member told us, "The registered manager is very good at making sure we get training opportunities and are kept up to date on all the things we need to know."

New staff received an induction into their role, which consisted of the provider's training as described above. Prior to supporting people on their own, new staff worked alongside more experienced staff and were supported to understand the history of the home. They were given detailed information about the people they would support and completed an information sheet which described the principles of effective team working. Staff confirmed that they felt supported to carry out their role and learn the skills they needed.

Staff were supported to undertake a vocational qualification in care such as the Care Certificate. The Care Certificate is a recognised set of standards that identifies the knowledge, skills and behaviours expected of staff working in health and social care. Staff demonstrated an understanding of the training they had received and how to apply it. For example, they told us about people's specific needs and were able to explain what signs and symptoms they needed to be aware of, in case there was a deterioration in someone's health. One staff member said, "This is the third care job I have had, but this is the best one. The home encourages and supports me to do my vocational qualification." The registered manager and senior staff also carried out competency checks on staff to ensure that their understanding and skills were up to date. We saw that at a recent staff meeting the registered manager had supported staff to complete a quiz about different aspects of the care and support they provided to people. For example, staff were asked to recall the signs and symptoms of someone who may have a urinary tract infection and asked about actions that should be taken in the event of a person choking. This showed that staff were regularly supported with continual learning and development of their skills. Staff told us that the home was a nice place to work and that communication within the team had improved over the last year. One staff member said, "The manager is very knowledgeable and is supportive. They share their knowledge with us and explain things clearly so

that we can understand and learn."

Staff were receiving regular supervision and had a yearly appraisal, which allowed the registered manager and staff to discuss any performance issues or training needs. Supervisions were carried out on a one to one basis or in groups and showed that staff were continually supported to identify new learning and development opportunities.

Prior to people moving into the home, the registered manager carried out an assessment of their needs. This ensured that staff would be able to meet their needs and could provide them with the level of support they required. Details of people's specific needs were recorded within their electronic care record and we saw that these were updated when there had been sudden changes or as people's needs changed over time. If people were admitted to hospital from the home, key information was sent with them, including their health needs and any medicines they were prescribed. This information was held in individual files that could be accessed quickly. When people returned from hospital, senior staff carried out a re-assessment of their needs. This included reviewing any records to ensure changes were updated.

The registered manager and staff consulted effectively with external healthcare professionals in a timely way. Records showed that people had regular appointments with healthcare professionals, such as chiropodists, speech and language therapists, nurses and doctors. For example, we saw that a district nurse visited the home each day to administer diabetic medicine to some people. The registered manager told us that they had a positive working relationship with medical professionals and asked for advice and support when needed for people. On the first day of the inspection we saw that there was a chiropodist who was providing a service to people who needed it. We were told that the chiropodist visited every five weeks and staff supported people to request this service if needed.

Information about people's needs was shared with staff at the start of each shift. This information was also recorded within the electronic care planning records that the home used and was flagged up for staff to read when they logged into the system.

The environment was supportive of the people living at the home. People told us that there were places for them to sit and meet with family privately. We saw that people's bedrooms had personal items such as pictures and books. One person told us they were able to bring a small amount of furniture with them and this meant their bedroom was a familiar space for them. The lounge areas were spacious for people to move about in and we saw that bathroom and toilet doors were painted yellow. This enabled people living with dementia to easily recognise these facilities and distinguish them from other rooms. In addition, there were pictures on the doors detailing the facilities.

Good

# Is the service caring?

## Our findings

People told us that the staff took time to talk to them and listened to what they wanted. One person said, "I like to chat to everyone, the carers [staff] are very nice to me." Staff told us they enjoyed working at the home and were passionate about caring for people. One member of staff said, "It doesn't feel like a care home, it feels like we are coming into their home and we need to respect that." An external healthcare professional told us, "The staff are very caring and the environment is always welcoming."

People's independence was valued and promoted by staff. Staff took the time to allow people to get up and walk at their own pace and encouraged them. We observed staff speaking to people with kindness and patience and there was an easy friendliness between staff and people living at the home. One person told us, "I like the bustle of the place, it's nice to interact with those that can, it makes it much nicer for me." We saw a staff member walk past a person smiling and blowing a kiss at them. The person smiled and laughed back. Another staff member approached a person and said, "Good morning [person's name] are you okay this morning, did you sleep well?" Another staff member was heard saying to a person, "What's the matter [person's name] are you uncomfortable, would you like me to help you move positions, or would you like to have a lie down on your bed?" The person chose to return to their room for a lie down and the staff member said, "Okay, we will do that now," and supported them to return to their room.

Some people living at the home were living with dementia. We observed positive communication techniques being used with people, which recognised the impact of memory loss on people's communication needs. For example, when staff approached people living with dementia, they introduced themselves each time. One staff said, "Good morning [person's name], I'm [staff member's name], how are you today?" They added, "I've got your medicines here for you. Okay to take them?" Another staff member was heard saying to a person, "Hello [person's name] I'm [staff member's name] are you coming down for lunch, it smells lovely." This method recognised that people living with dementia can have significant short-term memory loss and therefore could feel like the staff are strangers to them. Staff used people's names when talking to them and got down to their eye level to help the person to see them and to enable more positive interaction. One of the registered managers at another home owned by the provider was a specialist in supporting people living with dementia. They recently held a meeting with relatives of people living at St Vincent House to share information about how dementia can affect people and to assist them with understanding the condition and improving communication with their relatives.

The registered manager told us that they had been working with the staff team on communication. Information about each person's communication needs was on the flash cards that staff carried in their pockets at all times. The registered manager had considered how to improve communication and knowledge of people's needs and had introduced the flash cards to assist staff to understand people's needs and communicate more effectively. When speaking to people about what they would like to eat for the following day staff were patient and repeated the choices for those hard of hearing or with limited cognition. We saw that new flash cards were being made available for staff, to provide increased support for people to make choices about their food and drinks. These cards had pictures and photographs of different meals that the home offered, to enable people to visually see the choices they were being offered.

The home had a large display with photographs of each staff member with information about their roles. This helped people and their families know who all the staff were. Families were able to visit their relatives when they wanted to and we saw that visitors were welcomed into the home by the staff. One family member told us, "We come in when we like and there's no problem, the staff are always very welcoming to us." People's records identified who their friends and family were and staff took the time to involve them in their relative's day to day lives. The registered manager told us that people's friends and relatives were always invited to any parties or events they had. For example, the home invited people's friends and families to watch the recent royal wedding together and to attend a summer garden party. There were photographs around the home of these events, which showed a shared involvement in people's lives. A visitor to the home told us, "I like it here, my [relative] was in here, so I know it's good and my friend, who I'm visiting, has nothing but good to tell me about the place."

We observed staff treated people with respect and were mindful of their privacy and dignity. Staff knocked before entering rooms and ensured doors were closed when delivering personal care. People's care plans reminded staff of the need to respect people. For example, one said, 'Knock before entering room, greet [person's name] and introduce yourself, explain why you are there and offer to assist [person's name] at their own pace.'

Staff knew people well and understood their care needs, their likes and dislikes and personal histories. For example; staff knew which people were living with diabetes and dementia and told us about people's histories before they moved into the home. One staff member told us, "[Person's name] used to work in the Royal Navy so it is really important to them that we know that and can talk about past experiences with them." People were highly complementary about the staff and how they met their needs. One person said, "The staff know I like the same breakfast each day, cornflakes, and that's what I get offered." Another person told us, "I like it nice and quiet, so I like being in this quiet room and can look out the window, the staff know and nobody minds."

People's information was kept and stored in a way which protected their privacy. Care plan records were in an electronic format that staff could access using a unique identification code. Staff updated the care and support provided to people using electronic tablets and these were stored securely when not in use. Other records about people's health and care needs were kept in paper format and were stored in secure areas. Records were disposed of when no longer required in line with legislation.

People and their families were supported to be involved in care planning and families were encouraged to share information about their relatives' needs and past histories. One person's relative visited every day and liked to support their relative to eat their meal. The person required specific support with eating and drinking. With the relative's permission, the registered manager arranged for them to receive training in the home on effectively and safely supporting eating and drinking. This meant that they could continue to be involved in their relative's life every day, but were able to do so with additional knowledge that would provide safe support to their relative.

The registered manager was aware of how to request the services of independent advocates if needed. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They are independent people who spend time getting to know the people they are supporting to help make decisions that they believe the person would want. We were told that advocates had previously been used to support people and the registered manager knew where and when to contact them.

Good

# Is the service responsive?

## Our findings

At the previous comprehensive inspection in February 2017, we identified that people were not always being cared for in a person-centred way, which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found action had been taken and there was no longer a breach of this regulation.

People's care plans contained information about their preferences, their past history and their likes and dislikes. Care plan records were person centred and captured the individual information about each person. For example, care plans detailed people's specific care needs, the food they enjoyed and who was important to them. One care plan said, '[Person's name] finds it difficult to undo buttons and to lift their arms up independently. Therefore, they require full assistance when getting dressed and undressed.' Another person's care plan said, '[Person's name] has no specific time that they like to go to bed. They will take themselves to bed when they are ready.' Records were stored on an electronic system but were regularly reviewed and updated to reflect people's changing needs.

People's needs were assessed and documented in their records. People were involved in creating their care plans and in reviews to update them. Families were kept informed of changes and were involved in the developing and reviewing of people's care plans, where permission was given or where people had been assessed as lacking capacity to make certain decisions. One family member told us, "Yes, I do get input into their care plan, they ring me up if anything changes and keep me informed." Information about managing people's physical health conditions was detailed in their care plans and key information about their health needs was also on the flash cards that staff carried with them. Reviews of people's care records were completed each month, with a more holistic review being carried out annually. Reviews involved and considered input from external healthcare professionals, when relevant. An external healthcare professional told us, "I always find the registered manager and staff well prepared for reviews and very knowledgeable about the people who live in the home." People and their families were encouraged to be involved. The registered manager told us that families were not always available, so they discussed their relative's care with them when they visited or telephoned the home. These conversations were recorded in people's care plan records and formed part of the review.

At the last comprehensive inspection in February 2017, staff were seen to be task orientated, with a culture of completing tasks, as opposed to providing individualised care. At this inspection we saw that staff knew people's individual needs well and offered choices throughout the day. Although people's care plans indicated set days for having a bath or their bedding changed, staff told us that people can choose to bathe on any day they chose. They could also have their bedding changed when they wanted or needed it. We were consistently told by staff that this information in people's care plans was used for prompts, so that staff could remember to offer people these options at least twice a week. We spoke to two people and looked in their care records and saw that they had received support to bath or shower at different times during the week and this did not follow the set times stated in their care plan.

Families told us that they thought the staff knew their relatives well and provided a good standard of care. A

relative told us, "My [relative] has been here since earlier this year, it was tough at first as they didn't settle, but the carers have been great and now they seem very settled." They added, "They have stopped asking to go home and talk about their room as 'their flat', I'm really pleased how the home has handled it all." There was evidence through observation and discussion with staff that they were aware of the individual needs of people. Staff were able to describe people's health needs such as diabetes or dementia and were clear about which people were at risk of choking, or who required support with eating and drinking.

The registered manager demonstrated a clear understanding through the planning and delivery of care about the requirements set out in The Equality Act to consider people's needs on the grounds of their protected equality characteristics. The Equality Act is the legal framework that protects people from discrimination on the grounds of nine protected characteristics including age, sex and disability. At the time of the inspection, the demographic of the home was predominantly white British. However, the registered manager told us that the home had previously supported someone who had specific cultural needs and had adapted the food they provided to meet their needs. The provider had an equality, diversity and inclusion policy which considered people's specific needs and we were assured by the registered manager that these would be met. Staff were observed to treat people on an individual basis. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way that they could understand. It is now the law for the NHS and adult social care services to comply with the AIS. The staff were working with a person centred focus and we observed staff supporting people to understand choices they were offering by taking time to explain things to people. The registered manager showed us small laminated cards that had photographs and pictures of food and drinks people could choose. In addition, they were developing further cards to enable people with a cognitive impairment to be involved in their own care planning and making choices.

At the time of the inspection there was no activities coordinator in post. The home had previously employed an activities coordinator but they had recently left. However, people had access to a range of activities. The registered manager was in the process of recruiting a replacement activities coordinator and in the interim period, the provider had made arrangements for the home to share an activities coordinator with one of their other homes. The registered manager told us that in addition the existing staff team were providing some activities. One staff member told us, "We take people to the local shops to get things they want and to have a look around. Some of the ladies like to get their nails done so we go to a local salon with them or we can do nail care at home." They added, "The other day we took some people out to the seafront for an ice cream, we are always doing things like that." The registered manager told us about other activities that the home provided, which included an activity group to music each week, a trained dog who came in for people to stroke and spend time with, local church singers once a month and a local theatre group who visited four times a year to perform. People had the choice about what they wanted to join in with. One person told us, "I don't tend to mix, I like to read and I go out and about as I please. If there are any activities I probably wouldn't join in." Another person said, "I go out to Gosport to play bingo, so it gives me a bit of freedom."

People and relatives were given information on how to make a complaint should they need to. Complaints were looked into and feedback was given. We spoke to people about how they might complain and they told us that they would report any concerns directly to the registered manager. One person said, "The manager comes around to say hello regularly, I know I could tell them if I had any issues, but I don't have any complaints." Another told us, "I have no complaints at all." The provider also had feedback forms for people and their relatives to complete. These were sent out twice a year and were analysed by the registered manager who spoke to people and their families about any concerns raised. The home also kept a record of any thank you cards or letters they received. Both the positive praise and any concerns were shared with the staff team during meetings.

Staff made appropriate use of technology to support people. For example, a call bell system was used to enable people to seek support from staff when they were in different locations around the home and staff carried portable equipment that meant they could talk to each other and request assistance when required. In addition, where people had been assessed as being at risk of falls, a sensor beam was used. This was an invisible beam that if the person stepped through, would set off an alert on monitors the staff carried. We also saw that tracking devices were available for people who had some memory loss but were still able to go out in the community independently, as described in the Safe section of this report. People had access to the home's internet service. One person had their own computer and accessed the wi-fi to enable them to keep in touch with family.

For those people at end of life or nearing end of life, anticipatory medicines had been prescribed and were securely stored within the home. There were arrangements in place for external health professionals to support people when they were nearing the end of their life and care plans detailed people's preferences and wishes. There was an on-call system to contact external healthcare professionals, which staff were aware of should they feel a person needed urgent assessment or support during the evening or at night.

Good

# Is the service well-led?

## Our findings

At the last comprehensive inspection in February 2017 we found the provider had failed to ensure that quality assurance processes were established and effectively operated. People's care plans were not kept up to date and records were not always accurate. This was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014. At this inspection we found action had been taken and there was no longer a breach of this regulation.

Records were kept up to date and held accurate information. There were enough staff available to ensure that records were updated regularly throughout the day and there was a clear management structure for staff to raise any issues, which were acted upon promptly. The systems in place to monitor and record the care and support needs of people living at the home, were effective in ensuring that people received a good standard of care.

Quality assurance systems had been improved and become embedded in day-to-day systems and management. For example, the registered manager had maintained more effective monitoring and governance of the service. Regular monitoring of key aspects of the service's performance took place and was recorded to identify any necessary actions. The provider carried out detailed and regular audits of the environment. These looked at specific areas of the home and included audits of equipment used, the cleanliness of the home and fire safety.

There were processes in place to enable the provider to monitor accidents, adverse incidents or near misses. These had been used to identify where action was needed and were either resolved immediately or if deemed non-urgent were identified on the provider's on-going action plan. The provider had a business continuity plan which had been adapted to the specific needs of the home. The plan contained clear details regarding the action to be taken in the event of specific incidents, such as a power supply outage or the lift failing.

The provider had a clear vision for the home to provide person centred care and support in an environment which is homely. This approach was reflected in feedback from people and their relatives and the way staff supported people. It was clear that they knew people well and were aware of their specific needs. One member of staff told us, "I love working here, it's like a home from home." A relative told us, "My [relative] was confused when they first moved in and found it disorientating, now they feel like it's always been their home and they are really happy and settled."

Since the last inspection there was a new registered manger in place. 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 and associated Regulations about how the service is run. There was a clear management structure which consisted of the registered manager, a deputy manager and senior care staff who had individual responsibilities. The registered manager had looked at the areas of concern that were raised at the last inspection and had worked to address these with the staff team, by improving

communication and promoting a strong team spirit.

We observed an open and inclusive culture and staff told us the registered manager was open to constructive feedback, which they listened to. Staff told us that they enjoyed working in the home and that the registered manager was supportive. A staff member said, "The manager is brilliant, we have had so many changes in the past and I think we may now be in a period of stability." Another said, "It feels so much better working here now, it's supportive and better run, it's fabulous." A third staff member said, "The manager is really supportive, if you have any problems they are there for you."

The service had notified CQC about all incidents and events required. Providers are required to display the ratings from inspections so that people, relatives and visitors are aware of these. The rating from the previous inspection, undertaken in February 2017, was prominently displayed in the home and there was a link to the CQC's rating on the provider's website.

People and their families also told us that the registered manager was available and supportive. One family member said, "The manager is very nice and professional. We chose a room for our [relative] and the manager held it despite [our relative] being held up longer in hospital."

Staff were open and honest when things went wrong. When accidents or incidents occurred, the registered manger analysed what had happened and what could be changed to reduce the likeliness of an occurrence. All near misses were recorded on accident and incident forms. This meant that even when harm had not occurred, the registered manager could use the information to develop how they supported that person moving forward. People and their families were kept informed and the registered manager worked with them to try to resolve issues when possible.

Team meetings took place regularly and staff were encouraged to feedback and make suggestions for improvements to the service. A specialist nurse in caring for people with mental health needs, recently came to a staff meeting to discuss older people's mental health and to explain why specific types of medicines were used to support people. The registered manager told us that this was received positively by the staff team and they hoped to continue to invite external professionals in so that their skills and knowledge could be shared.

The registered manager received appropriate support from the provider and had a visit each week from one of the provider's representative. The provider arranged regular registered managers' meetings, where managers from all of their homes could meet and share experiences and learning together. The provider's registered managers also conducted peer reviews of each other's homes. This was so that good ideas could be shared amongst the provider's homes and any issues could be discussed constructively with potential resolutions being provided.

People and relatives were involved in planning care and were able to raise concerns or ideas through informal discussion with the staff or the registered manager, through a feedback questionnaire. They also gained feedback by having one to one conversations with people and their families on a regular basis. The home also provided a newsletter for people and their families four times a year, which gave information about things that had happened and future events that were planned.

The registered manager told us that they had good links with other organisations, including the local GP surgeries and community nurses, and could seek advice and support from them if needed. District nurses visited the home every day and we saw that they had a positive working relationship with the staff at the home. One external healthcare professional told us, "If the registered manager has an issue that needs

sorting, they will always contact us at the time to resolve it rapidly and without fuss." We saw that there were links with local community groups. People were supported to access the community independently or with staff and local groups such as singing groups and church groups visited the home on a regular basis.

The provider had a whistle-blowing policy, which provided details of how staff could raise concerns if they felt unable to raise them internally. The staff were aware of the different external organisations they could contact if they felt their concerns would not be listened to. The provider had detailed policies and procedures that were available for staff to read. We were told policies were reviewed yearly or when changes were required. This ensured that staff had access to appropriate and up to date information about how the service should be run. New staff were supported to spend time reading these and discussing any queries they may have.