Hampshire County Council

Westholme Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 24, 25 and 26 November 2014 and was unannounced.

Westholme Care Home provides nursing and personal care for up to 67 people, including those who are living with dementia. It also provides reablement treatment for up to six people. Reablment is a way of helping people to remain independent, by giving them the opportunity to relearn or regain some of the skills for daily living that may have been lost as a result of illness, accident or disability. There were 63 people using the service at the time of this inspection.

The service is overseen by a registered manager. 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.

People were complimentary about the service they received. However, our own observations and the records we looked at did not always match the positive descriptions people and relatives had given us.

Summary of findings

Although people told us they felt safe, we found medicines were not always stored, given to people and disposed of in line with good practice. Suitable guidelines were not in place for the administration of pain relief medicines for people.

There were enough staff to meet people's needs and the registered manager used regular agency staff who were familiar with the people living in the home. Recruitment to fill vacancies was actively taking place and relatives were involved in recruitment interviews.

People and their families were included in the planning of their care and care plans detailed support required and how risks needed to be safely managed. People were treated with dignity and respect and staff knew the people they were supporting. However, we observed several interactions which were focussed on tasks rather than individual needs.

People told us they had sufficient to eat and drink and they had a choice of meals, snacks and drinks. Family and friends were able to visit and told us they were involved in the service and kept informed appropriately.

Staff were aware of their responsibility to protect people from harm or abuse and knew what action to take if they were concerned. They told us they were confident to use the procedures to raise concerns.

Staff involved relevant health professionals and responded quickly to people's changing health needs. The manager had implemented several approaches to involve people, including relevant professionals in the service and continually seek ideas for improvement. Issues we raised with the manager during the inspection such as some lack of clarity in one of the records were dealt with promptly and followed up with relevant staff.

We identified two areas where the service required improvement. There were a number of missed opportunities for staff to engage and interact with people to enhance the quality of care. There were some inconsistencies with care records putting people at risk of not having their needs responded to appropriately. We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to the management of medicines. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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

Some aspects of this service were not safe. People received their medicines but the service did not consistently follow safe practice around storing them, giving them to people and disposing of them.

Staff were aware of their responsibilities to keep people safe and were confident to use relevant policies and procedures to raise any concerns.

Safe recruitment practices were followed and the registered manager maintained safe levels of staff through the use of permanent and regular agency staff members.

Is the service effective?

Good

The service was effective.

Staff received relevant training to support them to deliver care effectively.

People had access to relevant health care professionals and received appropriate assessments and interventions to maintain their health. Staff had good relationships with professionals and called them for advice or to see a person when necessary.

The staff and management of the service were knowledgable about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Appropriate applications had been made where a person was deprived of their liberty.

People were supported effectively to make sure they had enough to eat and drink.

Is the service caring?

Good

The service was caring. We saw positive, caring relationships between staff and people using the service.

People and their relatives and representatives were involved with the service and their views and opinions regularly sought and acted upon.

People were treated with dignity and respect. Staff were aware of the importance of promoting and maintaining people's privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were not always engaged in activities and staff were often task oriented in their approach to care. There were some inconsistencies with care records putting people at risk of not having their needs responded to appropriately.

People knew how to complain and information was available around the service to support this. The registered manager had a system in place to respond promptly to any complaints received.

Summary of findings

Is the service well-led?

Good

The service was well-led. The registered manager actively promoted good relationships with staff, relatives and other professionals to involve them in the running and culture of the service.

Staff were well supported by the registered manager to undertake their roles and responsibilities. A regular programme of monitoring and quality assurance supported the staff and registered manager to assess the quality of the service and implement improvements.

Westholme Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24, 25 and 26 November 2014 and was unannounced.

The inspection was led by an inspector who was accompanied by a specialist advisor and an expert by experience. A specialist advisor is someone who has experience and knowledge of working with people who are living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had personal experience of caring for someone who lived with dementia.

Before we visited the home we checked the information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

During our visit 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 reviewed a range of care records for nine people, including nursing and personal care assessments, daily health monitoring records and visits by healthcare professionals. We looked at the medication administration records for 25 people. We also reviewed records about how the service was managed, including risk assessments and quality audits.

We spoke with 13 people who live in the home and 11 relatives of people who used the service. We also spoke with the registered manager, two deputy managers, the practice development nurse and eight other members of the nursing and care staff.

We last inspected the service on 24 February 2014 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

We found unsafe practices around the storage, administration and disposal of medicines. In the nursing unit the door to an unattended clinical medicines room on the ground floor was held open by a door guard. The nurse in charge told us "We keep it open because then care staff can come in and out as they need". There were drawers and cupboards with syringes in them. In addition, there was a full to overflowing discarded medicines bin with a top that could not be closed. This meant with the open door there was a risk of people gaining access to the medicines contained in the bin. We asked the nurse in charge about this who said "We have been phoning and phoning for a replacement". The system for ensuring discarded medicines bins were replaced when necessary was not adequate.

Medicine Administration Records (MAR) were organised and up to date on both the residential and nursing units. However, on the nursing unit, we found 21 people had been prescribed analgesic medicines on an 'as necessary' (PRN) basis. There were no PRN medicine care plans or pain assessments in place. This meant when people had been medically prescribed analgesic products, there were no systematic means of assessing when these were required. Staff were therefore unable to accurately monitor when people had pain or when pain was changing in severity and frequency, indicating the person needed more or a different form of pain control. A nurse told us the staff all knew people very well and always asked people if they had pain. In addition they said "We can tell when people have pain as they might grimace and so on".

People with advanced dementia were unable to identify or express pain except through behaviour such as agitation, refusal to get out of bed, loss of appetite and withdrawal. The absence of a systematic assessment placed people at risk of being in pain that was unobserved and untreated.

Two people had been prescribed other PRN medicines but there were no care plans providing guidance for staff about the circumstances under which these should be administered. This meant there was a risk that the person could have received the medicine when it was not indicated or that they would not receive it when it was necessary.

Five people had been prescribed a medicine that was used to help prevent and/or treat osteoporosis. The medicine could irritate and damage the throat and so should be used with caution when given to people with swallowing difficulties. There was no evidence that reference to this was made in people's records so staff would be aware of this risk. Of the five people who had been prescribed the medicine, two had also been prescribed products for swallowing difficulties. Their records did not show their medicines had been medically reviewed in the light of this.

The above evidence was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In the residential unit, people's care plans contained assessments about their support needs in relation to medicines. For example, whether they were able to tell staff if they were in pain or to ask for pain relief.

The policies and procedures in relation to obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines were not consistently applied. The staff training programme included medicines management and a competency test. There were clear systems for organising the ordering and supply of medicines. Medicine rounds on both the nursing and residential areas of the home were conducted in a competent way, during which the member of staff spent time with each person explaining the purpose of the medicine and gaining people's consent. The member of staff was friendly towards people and did not hurry them.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971 these medicines are called controlled drugs or medicines. The process for managing controlled medicines was correct as were the amount of controlled medicines. These were stored appropriately. Staff were required to check medicines at the end of shifts, which ensured there was an on-going review to find any anomalies at an early stage.

There were written policies and procedures in relation to safeguarding people at risk. There was a training programme, which included safeguarding awareness training for all staff and this was followed by regular refresher courses. Staff demonstrated their awareness of what constituted abuse and of the procedures for reporting safeguarding matters. There was also a whistle blowing

Is the service safe?

policy and procedure in place to enable staff to raise alerts about poor practice or allegations of abuse. Staff we spoke with were aware of the procedure and told us they would feel confident to use it if necessary.

All of the people we spoke with said that they felt safe living in the home. Not all people were able to describe their care, so we observed their interactions with staff and spoke with relatives. One person said "I feel safe living here. The carers are very kind. They let me walk about; I need someone with me and they always follow me. I don't mind which carer I get, they are all good. It is the same at weekends as in the week". Another person told us: "I feel very safe living here. I am very independent and I can go to the shops or anywhere. They (staff) just ask me to go with someone in case I fall down. There is always someone available to help. There are plenty of staff". They also told us "I get my medication the same time every day. I know what most of it is for. They do tell me what it is".

People's care records showed risks associated with the provision of care and support had been assessed, such as in relation to mobility and falls, nutrition and weight. All records contained an emergency evacuation plan individualised to each person. Handover sessions between staff leaving and those coming on duty were used to discuss anything that might be affecting the health and wellbeing of people who use the service, as well as what tasks had been done or needed completing. This information was also recorded on a written handover for staff to refer to.

A senior care worker told us they were "Trained to look for reasons behind behaviours people find challenging". They gave examples such as physical health conditions, particular times of day for individuals, and how staff approached them. They added "We don't have people who wander here; we have people who walk with purpose".

In addition to dementia and safeguarding training, senior staff received training in positive risk taking. The senior care worker showed us how they assessed risks to promote people's safety and independence. For example, there was a falls risk assessment in place that supported and did not limit the freedom of a person "Who walks with purpose a lot". There were others for a person who used the lift independently and a person who was supported to go to church. Three people were sitting together and told us they felt safe and happy and were treated kindly. "We use our frames and are able to walk about. We know most of the staff and there always seems to be someone about".

Records of any accidents or incidents were reviewed each month by the registered manager and monitored for any patterns or trends, to reduce the risk of reoccurrence. Emergency fire procedures had been reviewed and changed following an incident. This demonstrated that learning from incidents or investigations took place.

The staff rota was planned and organised in advance to ensure there were sufficient numbers of suitable staff to keep people safe and meet their needs. A dependency assessment tool was used to inform staffing levels. Dependency was assessed in relation to activities of daily living, such as eating, transferring position, moving location, as well as factors such as co-operation, behaviour that may present a risk and immediate interventions that may be required of staff. The registered manager monitored the dependency assessment records to ensure that they were being completed consistently; to check for any patterns or changes and to make sure action was taken where necessary.

On the last day of the inspection, there were two regular care staff and four agency care staff on duty in the residential unit. On the ground floor nursing area, there was an agency nurse in charge and three agency carers. The agency nurse had worked at the home for around two years on a part time agency basis. A senior care worker told us how they had deployed staff across the two residential units to ensure there was one regular care worker with two agency care staff. The senior care worker said some staff had left the service recently, so there was a higher use of agency staff. They said regular staff were asked to swap shifts to maintain a balance of regular staff with agency staff.

On the day of the inspection interviews were being held for residential and nursing care staff. The registered manager told us they had recruited a new nurse and were advertising for another. An agency nurse was regularly employed in the home and was familiar with people and their needs. A new wing had been built and the service was also recruiting staff in advance to meet the needs of the

Requires Improvement

Is the service safe?

planned increase in occupancy. One of the nursing staff said "There are usually enough staff and we eventually get everything done. The only problem is when a member of staff phones in sick at the last moment".

There were appropriate recruitment processes in place. There was a system for ensuring relevant checks had been completed for all staff. This included Disclosure and Barring Service (DBS) checks; confirmation that the staff were not on the list of people barred from working in care services. Records were also on file showing that checks were also undertaken to ensure that nursing staff were correctly registered with the Nursing and Midwifery Council (NMC). All nurses and midwives who practise in the UK must be on the NMC register.

Good

Is the service effective?

Our findings

People said the food was good and there was a choice. Various diets, such as vegetarian, were catered for. A person who was receiving treatment to enable them to return home said "The staff sit and chat with me. They bring me tea but encourage me to make my own tea; I will have to do that when I leave".

A visiting relative told us "When she came in she was not well, her health has improved enormously and she has got a lot stronger". Another visitor told us their relative receiving care "Is happy, eats well and gets good food".

Staff knowledge and skills were supported through supervision meetings and individual performance plans, which provided an on-going appraisal of their work and development needs. There was a comprehensive induction, training and development programme and a system for monitoring staff attendance on courses. Staff told us the training they received was good, relevant to their work and helped them to understand and meet people's needs.

The induction for new care staff lasted four weeks and was based on the Skills for Care common induction standards, which are the standards people working in adult social care should meet before they can safely work unsupervised. In addition to essential training to carry out their roles safely, care staff attended dementia awareness training and were encouraged to undertake diplomas in health and social care.

We spoke with the Practice Development Nurse (PDN), who had responsibility for implementing a competency framework for the clinical development of nurses working in the home. The PDN was working to maintain nurses' clinical skills and support them in on-going professional development, monitoring and supporting this in practice.

The manager understood when a Deprivation of Liberty Safeguards (DoLS) application should be made and how to submit one. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Following a Supreme Court judgement which clarified what deprivation of liberty is, the management had reviewed people in light of this and submitted more applications to the local authority.

We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. We saw the manager kept records of applications submitted and those that had been authorised.

The provider's audit monitored the completion of appropriate documentation of people's wishes in respect of Do Not Attempt Cardio-Pulminary Rescusitation (DNACPR).

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests. Decisions about mental capacity were made as part of a multi-disciplinary team where these involved major decisions about aspects of care and treatment.

Where decisions about everyday living where made for people by staff, mental capacity assessments were also recorded in the relevant sections of people's support plans. Some of these assessments completed by care staff were not always clear about the support that had been given to the person to maximise their participation in the process. The manager and PDN discussed this with us and formulated a way to make this information more explicit in the support plans.

Staff received training in the fundamental principles of the Mental Capacity Act 2005. Managers received more in depth training, including DoLS, which they cascaded down to staff. A senior care worker was aware that timing was important and support to enable people to participate in making choices, however small and "Giving people their power back".

People were supported effectively to make sure they had enough to eat and drink. There was a thirty minute gap between lunches being served in the nursing and residential units. This enabled care staff to be freed up to support people in other areas if needed. The rota was arranged so that all staff, including ancillary staff, provided assistance at meal times.

In one dining area, there were seven people and four staff. The radio was playing softly in the background and the atmosphere was calm. Three people required support to eat their meals. Staff assisted them in a caring and respectful manner, giving manageable portions of food at

Good

Is the service effective?

each person's own pace. The care staff spoke with the people they were supporting and gave them their undivided attention. Each person ate all of their meal. This was reflected in other dining areas throughout the home.

Records contained clear guidance for staff about how they should meet people's eating and drinking needs. This included personal support such as "Always tell me what you are doing and allow me to swallow all the food in my mouth". When people had swallowing difficulties they were referred to the Speech and Language Therapist (SALT). The SALT guidance was included in full in people's care plans so that staff had clear professional guidelines to follow.

One of the nursing staff told us "If someone is not eating we will keep the food warm and offer it to them later. If they are coughing or having trouble swallowing we will call in the SALT team. We have plenty of time to support the people who are cared for in bed. It is all managed very well. There is a list with the trolley and when meals are handed out it is ticked off the list. Everyone gets fed, no one gets missed".

People were weighed monthly and Malnutrition Universal Screening Tool (MUST) records were kept up to date. People identified as being at risk of malnutrition and dehydration had food and fluid monitoring charts in their rooms which were completed.

Records showed people's healthcare needs were monitored and staff took appropriate action when necessary. This included supporting people to access healthcare services. During the inspection staff had raised their concerns about the wellbeing of two people and called their respective GP's, who visited their patient's the same day. There were also regular weekly GP visits when people's on-going health care was discussed. Flu vaccinations for people had been arranged via GP surgeries and the Community Nurse. This showed the service co-operated with external health and social care professionals to promote and support people's health and welfare.

Since the last inspection work had been done to create an improved environment that supported people who were living with dementia. One area of the home had recently been redesigned and decorated like a pub. We saw people sat reading the newspaper there or receiving visitors. The manager told us a well attended quiz had taken place in the pub and there were plans to get more of the community involved in events to be held there. There were plans for a 'cinema' and a tea room. Funding had also been granted to build a 'shop' where people could go to purchase items such as toiletries.

We saw examples of personalised signage on people's bedroom doors, which could help them locate their rooms. A senior care worker told us when there were new admissions, staff would put up something they thought the person might like. When they had got to know the person better, the signage was changed to something more suited to the person.

Garden and courtyard areas were available for people to use. The corridors were well lit and had handrails on the walls to promote people's safety and independence. There were signs on the doors of bedrooms, toilets, bathrooms, dining rooms and lounges. Some signs were easier to see than others that were placed over the top of the doors.

Good

Is the service caring?

Our findings

People told us they were treated well. One person said "Staff are very, very kind, always smiling". Another commented "The treatment is excellent here". One person told us "The staff are very friendly. If I want something I just ask. If I press a call bell they come quickly" and "I feel very well cared for". A person's relative told us "It's very caring in that it's a loving care and that's something money can't buy. The care staff are very patient. I can't remember any time when any one was nasty or offish".

Another visitor remarked "The best thing about this home is the care and attention; and the consideration to visitors". Relatives told us they could visit at any time and were always made welcome by staff. One told us "They make you feel like one of the family. You get individualised care here. This place is homely and pleasant and the staff are amazing. The group size works well, everyone gets involved. The cook knows everybody".

Another person's relative said "There's a lot of love here. The staff are very dedicated". They were involved in reviewing their relative's care and the service always phoned if there were any changes in their relative's health or wellbeing. Another visitor told us "This home is top class, I could not ask for any better. If I ever had a reason, I know the staff would fix whatever the problem was because they care, they really care and want things to be right. If I needed to raise anything with the manager I could, she is always around and cares what we think. This is a happy caring place".

Care records all contained a section for information on people's preferences and dislikes and information about what was important to people. The records included evidence that relatives had been involved in meetings to review and plan people's care and support.

A senior care worker told us how they supported people to be involved in making decisions about their care. Staff acting as key workers attended reviews with the person and/or their relatives or representatives if appropriate, to discuss whether the care being offered was suitable to the person. Key working is a system where one member of care staff takes special responsibility for supporting and enabling a person. The aim of this system is to maximise the involvement and help to build relationships between people using the service and staff.

Each person was given a turn at being 'Resident of the Day' and records of this were on file. This was designed to help ensure each aspect of the service was meeting their needs and they were visited on one day by senior staff from the various departments within the home, including the chef, housekeeping, assistant unit manager and their key worker.

People were treated with dignity and respect. Staff knocked on doors before entering and closed the door when giving personal care. Staff made eye contact with people and gently got their attention, holding their hand or stroking their arm and informing them what was going to happen next. The atmosphere in the home was calm and we observed that staff interacted with people and their visitors in a friendly, respectful and caring manner.

A senior care worker told us about the training and learning they had received in relation to moving and repositioning people and the use of continence aids. This involved being lifted in a hoist and wearing continence pads. The member of staff said they felt this helped staff to understand the importance of supporting people in ways that promoted and upheld privacy, dignity and respect.

People's end of life care and treatment reflected relevant research and guidance. The service used advanced care planning processes based on a recognised framework of standards for palliative care, which aims to improve quality of care for people as they near the end of their lives. As part of the accreditation process, an external assessor had recently audited the service. While the full assessment report had not yet been received, the manager and PDN told us the feedback had been positive.

The management had collated a comprehensive file of evidence demonstrating how they were meeting the end of life standards. For example, there had been a reduction in hospital admissions, due to more effective assessment of people's needs when they required moving from residential to nursing care.

Requires Improvement

Is the service responsive?

Our findings

Overall, people's comments about the service were complimentary. They spoke highly of the care provided and people were referred to external healthcare professionals when necessary. However some comments, along with our own observations and the records we looked at, showed there was a risk that people were not always receiving personalised care that was responsive to all of their needs.

A relative told us "There are too many agency staff, but that's not their fault". They said "I would like to see more activities. The three part-time coordinators are fully occupied". Another relative told us "If there was any issue it is to do with the staff turnover and agency, who take some time to get to know things around here, then they go." Another visitor said "There are not enough activity coordinators. None of them are here for long enough. Each has 18 hours a week". Another person's relative told us they would like to see more interaction between staff and people using the service.

On the nursing unit we saw staff approached people in a friendly way, sitting alongside them and speaking with them. However this contact was often brief and task orientated. The staff smiled at people and spoke with them in respectful ways but terms such as 'love', 'darling', 'sweetie' were commonly used in place of people's names. For a person who is experiencing the confusion associated with cognitive impairment, this can be too generic, especially if a person has a hearing or visual impairment.

People were not always supported to be involved in activities. An activities co-ordinator was sitting at a table with two people who were seated in wheelchairs. The staff member was focusing on making decorative paper chains, while people sat watching them rather than being actively engaged in the activity.

During our observations on the first floor residential unit, we noted that some of the staff interactions with people were also more task oriented than individual. The people living on that floor were more dependent on staff than some of those who lived downstairs, for example in relation to their mobility.

There were a number of missed opportunities for staff to engage and interact with people to enhance the quality of care. We observed three out of four people asleep and the television on with no one watching. A member of staff turned off the television and played a music CD without asking any of the people in the lounge. One person started humming along and said "How lovely, I haven't heard that in a long time". When they spoke to the member of staff telling them it was a lovely piece of music the staff replied "Mmm". Shortly afterwards they turned the music down without asking anyone if that was what they wanted. This was a missed opportunity to engage with people in a meaningful way.

We observed staff approaching a person discreetly about a personal care task and gently waking another person to encourage them to drink. This member of staff addressed everyone by their names. However, we observed other staff concentrating on tasks such as cleaning and giving only short responses to questions from the people in the lounge.

The relatives of a person who lived on the first floor of the residential unit said they were "Happy with the care generally. Staff are very good". They commented that during the building work, their relative had been moved downstairs and had "Livened up", but that had changed when they moved back upstairs. A member of staff told us people were supported to go downstairs to join activities. They said if there was a lot of agency staff on a shift, it could make it difficult to provide the same level of support. They gave an example of not being able to give so many baths with inexperienced agency staff on duty.

Following the inspection the registered manager informed us she had a meeting with staff and had revised the staffing allocations. One member of staff from downstairs would go upstairs at 11:30am to do activities with people. The Assistant Unit Manager would help with lunchtime meals in that area, while activity coordinators supported people in the downstairs lounge. The registered manager was also planning a learning session on the 10 December 2014 with key workers to develop the way they supported people.

During the inspection a group of singers came to the home to entertain people. A game of bingo in the residential unit was also well attended. A person who used the service told us "The activity co-ordinators asked 4 or 5 of us what we would like to do, they wanted ideas". The manager had attended a four day training course about promoting activities, engaging people and staff. The manager told us the activities co-ordinators would also be attending the training.

Requires Improvement

Is the service responsive?

While most of the records we saw were detailed and clearly written, there were some inconsistencies. Continence care plans were not sufficiently detailed to ensure people received the continence support that met their needs. For example, they stated 'I wear continence pads' but there was no frequency of any changes and no times detailed when people should be checked or supported to use the toilet. The PDN showed us a continence assessment folder was maintained, which contained some important individualised information about people that had not been transferred to people's care plans. When we discussed this with the manager and they identified ways in which the information held in the separate folder could be transferred to peoples care plans.

In one person's daily records bruising to one area had been noted over a number of days. We saw from the GP record that they were due to visit with regard to this but it was not clear what immediate action had been taken. We followed this up with the manager and were able to establish that the terminology used in the records was not accurate and the GP was involved from an early stage for a medical complaint. The manager said she would follow up with staff about the accuracy of the record keeping and terms used.

Each person had an assessment of their needs and a support plan, including risk assessments. The records contained information about people's care needs and progress notes showing how the care and support was delivered. A senior member of care staff spoke in depth with us about the needs of people whose care records we saw, demonstrating their knowledge of the support plans. This included people's current needs in terms of their physical, emotional and mental wellbeing. An 'at a glance' summary record of people's daily needs was given to agency staff. This provided important and personalised information to guide them when supporting people they may not be familiar with.

We observed staff asking people if they wanted to use the toilet and assisting them to do so. A senior care worker told us how they supported people to maintain their independence when going to the toilet. They told us how people were assessed for various types and sizes of continence aids to meet their current needs and how these were ordered.

People were aware of the complaints procedure and felt comfortable to raise any issues they were not happy with. There was information in the reception area about how to raise any concerns anonymously. A system was in place to monitor and respond to any concerns or complaints about the service. The registered manager kept records of complaints, the actions taken in response and the outcomes. This demonstrated that the manager and provider listened to people's experiences and concerns and took action when necessary.

Good

Is the service well-led?

Our findings

People spoke positively about the quality of care and how the home was managed. One person's relative said "I believe this is an excellent home, with a wonderful group of staff". They told us there were monthly meetings with the manager and other staff "Where they talk things through with us". They commented that the home had a "Good manager, she takes on board what people say and she responds". They gave examples of changes to dining arrangements. A suggestion had been made about using pictures to promote choice at mealtimes and a meeting had been held with kitchen staff that morning. They said the manager "Is receptive to change" and "Morale in the staff has improved".

Another person's relative told us about monthly coffee mornings with the manager, to which relatives "Can bring any problems and suggestions". They said they were looking to make the home more homely and the manager took their views seriously. Two people told us they thought the home was well led and another person said "They are all doing well in here, I would recommend this home".

The registered manager was developing an open and inclusive culture by meeting and working with people's relatives, staff and external health and social care professionals. The registered manager told us how the service had improved and developed relationships with external healthcare professionals, in order to share and increase knowledge. For example, workshops on skin and pressure area care and continence care: "We share information and educate relatives and staff about good skin care. I arrange educational workshops for carers and medical staff, it has made health and care professionals close".

Relatives had been involved in dementia workshops and had visited other homes in Hampshire as part of this. They said they felt both staff and relatives learned from this. Another joint initiative had led to relatives becoming involved in making improvements to the garden. Relatives were also involved in interviewing new staff. A relative who was taking part in this told us their opinion was asked for and listened to by the interview panel. They said "I look for staff having the right attitude and here staff have it".

Staff meetings took place where staff could suggest improvements, such as for team working. Staff said they could approach the managers with any issues they wanted to discuss and if they raised a concern it was acted upon. A nurse said "I would be happy to whistle blow, I have never seen anything here that needed it". Another nurse told us "The manager is very positive and fair". One member of staff said they "loved working at the home". They said "This is a fantastic place to work; the manager is very approachable and responsive so that if you need anything they understand. This is a supportive place to work. I look forward to coming here. I feel appreciated and I appreciate the support I get". The provider ran 'Hearing what matters' forums for staff to express their views and opinions about the way services were delivered.

We saw that regular audits of the quality and safety of the service were carried out by the provider's representative and the homes management staff. Action plans were developed and followed to address any issues identified during the audits. Performance management systems were in place and the manager told us how she had implemented these when necessary to ensure working practices delivered high quality care. Although the audit system was comprehensive, issues around the storage of medication had not been picked up clearly. The manager was positive about rectifying the issues found. The manager had started to revise staffing allocations and meet with staff in response to our feedback about the missed opportunities for meaningful engagement with people using the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services were not protected against the risks associated with the unsafe use and management of medicines, because staff did not consistently follow safe practice around storing them, giving them to people and disposing of them.