Barchester Healthcare Homes Limited

Hurstwood View

Inspection report

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Ratings

Overall rating for this service	Good

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

Hurstwood View is registered to provide residential and nursing care for up to 55 older people. Accommodation was provided over two floors. People required a range of help and support in relation to their nursing, dementia and care needs. The home is purpose built with large communal areas and a large reception area at the main reception where people and visitors could sit and have drinks and snacks throughout the day. There is a passenger lift to assist people to access all areas of the building. The ground floor (Ashdown Walk) provided nursing care for people. Whilst the upper floor (Deer View Walk) provided care and support for people with dementia.

There were 48 people living at the home at the time of the inspection.

This was an unannounced inspection which took place on 12 and 13 April 2016.

Hurstwood View did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous registered manager had recently left and de-registered. Interim management cover had been put in place and support was being provided by the operations and regional manager. A new manager had been recruited and was due to start work the week following the inspection. The regional manager told us that the newly appointed manager would be registering with CQC as soon as they had completed their initial induction and training.

The operations and regional manager were in day to day charge of the home, supported by the deputy manager, registered nurses and senior care staff. People and staff spoke highly of the management of the home. Staff told us that they felt supported and knew that there was always someone available to help them when needed. We received positive feedback regarding the nursing and care staff from relatives, visitors and people living at Hurstwood View.

Care delivery was supported by clear up to date care documentation which was personalised and regularly reviewed. Staff felt that training provided was effective and ensured they were able to provide the best care for people. Care plans and risk assessments had been completed to ensure people received appropriate care. These had been written using information sought from the person or their relatives/ next of kin if appropriate. This meant information was person centred and reflected people's personal choices and preferences.

Medicine documentation and relevant policies were in place. These followed best practice guidelines to ensure people received their medicines safely. Regular auditing, checks and staff competencies were carried out to ensure high standards were maintained.

There were clear organisational systems in place to assess the quality of the service. Maintenance for example water, electric and gas had taken place. All equipment and services to the building had been checked and maintained regularly. Fire evacuation plans and procedure information was in place in event of an emergency evacuation.

There was a programme of supervision and appraisals taking place for staff. Staffing levels were reviewed regularly with on-going recruitment to reduce the high level of agency staff currently required. Staff received training which they felt was effective and supported them in providing safe care for people. Robust recruitment checks were completed before staff began work.

People's mental health and capacity were assessed and reviewed with pertinent information in care files to inform staff of people's individual needs.

People were encouraged to remain as independent as possible and supported to participate in daily activities. Staff demonstrated a clear understanding on how to recognise and report abuse and treated people with respect and dignity. People were given choices and involved in day to day decisions about how they spent their time. People were asked for their consent before care was provided and had their privacy and dignity respected.

People's nutritional needs were monitored and reviewed. People had a choice of meals provided and staff knew people's likes and dislikes. People gave positive feedback about the food and visitors told us they had eaten with their relative and found the food to be of a very high standard.

Referrals were made appropriately to outside agencies when required. For example GP visits, community nurses and speech and language therapists (SALT). Notifications had been completed to inform CQC and other outside organisations when events occurred.

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 had a good understanding about how to recognise and report safeguarding concerns.

Medicines policies and procedures were in place to ensure people received their medicines safely.

Environmental and individual risks were identified and managed to help ensure people remained safe.

Dependency assessments were completed to identify safe staffing levels. Recruitment was on-going. Agency staff were in regular use; however the same agency staff were used when possible to provide continuity.

Is the service effective?

Good

The service was effective.

Staff felt supported them and they had training they needed to meet the needs of people living at the service.

Staff had a good understanding of Mental Capacity Assessments (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to eat and drink. Meal choices were provided and people were encouraged to maintain a balanced diet. People's weights were monitored.

People were supported to have access to healthcare services and maintain good health.

Is the service caring?

Good

The service was caring.

People were involved in day to day decisions and given support when needed.

Staff knew people well and displayed kindness and compassion

when providing care.

Staff treated people with patience and dignity.

Is the service responsive?

Good

The service was responsive.

Documentation was personalised, up to date and included specific information about people's backgrounds, important people and events.

People's choices and the involvement of relatives and significant others was clearly included in care files.

Clear information was in place for staff. Care plans had been written for peoples identified care needs. Care plans and risk assessments were regularly reviewed and updated.

Activities were provided for people to allow them to spend time doing things they enjoyed.

A complaints procedure was in place and displayed in the main entrance area for people to access if needed.

Is the service well-led?

Good

The service was well led.

The registered manager had recently left, and a new manager had been recruited and was due to start work at Hurstwood View shortly after the inspection.

Staff and people living at the home were aware of the management changes. People spoke positively about the home and staff.

There was a clear system in place to continually assess and monitor the quality of service provided. Audit information was used to improve and develop the service.

Hurstwood View

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 12 and 13 April 2016 and was unannounced. The inspection was carried out by two inspectors.

Before our inspection we reviewed the information we held about the service including the PIR (Provider Information Return) and previous inspection reports. We considered the information which had been shared with us by the local authority and other people, and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with ten people who lived at Hurstwood View. Many were able to tell us about their experiences of living at the home. For those who were not able to talk to us, we carried out observations in communal areas and looked at care documentation to see how they had their care provided.

We pathway tracked four people and looked at a further two care plans to follow up on particular areas of documentation in relation to people's care and nursing needs. Looking at care documentation is an important part of our inspection, as it allows us to capture information about people receiving care. We also looked at daily records, risk assessments and associated daily records, charts and Medicine Administration Records (MAR). We read diary entries and other information completed by staff, policies and procedures, accidents, incidents, quality assurance records, recruitment, meeting minutes, maintenance and emergency plans. Recruitment files were reviewed for four staff and records of staff training, and supervision for all care staff.

We spoke with 11 staff including two registered nurses, five senior and care staff, head chef, maintenance and laundry staff, deputy and operations managers and the regional director. We spoke with four relatives and two visitors to the home.

Good

Is the service safe?

Our findings

People told us they felt safe and well looked after living at Hurstwood View. One told us, "I love it here." Relative told us "I can tell the staff the concerns I have and they take them on board." And, "I leave here knowing he is safe and well looked after."

Systems were in place to help protect people from the risk of harm or abuse. People were kept safe by staff who recognised signs of potential abuse and raised safeguarding concerns with the local authority. A safeguarding policy was available for staff to access if needed and staff had received regular safeguarding training. Staff demonstrated a good knowledge around how to recognise and report safeguarding concerns and told us they could also contact the deputy, operation or regional manager if they needed assistance or support. We were given examples of safeguarding alerts which staff had made themselves and saw that these had been documented in care files One staff member told us, "I would always inform the manager prior to raising the safeguarding so that when social services contact them she is aware of it."

Injuries to people were recorded and photographed as per the policy of the home. Incidents were referred to the local authority safeguarding body when appropriate. Incident reports were completed and the acting manager recorded details of these onto the clinical database. Copies of the form were then kept in the persons file for any action plan to be completed and relevant risk assessments and care plans updated. Staff confirmed that if they noticed any unexplained bruising or injuries to people, they completed a chart called a body map and took photographs to show where on the body they had occurred. The deputy manager said the person would be added to the GP list for a check-up and the GP's advice would be followed. We tracked an incident recorded in a person's care plan to the incident form which had been recorded on the clinical database and saw that this had been responded to appropriately. Risk management with monitoring and review systems were put in place to protect the person's wellbeing.

People living at Hurstwood View had a range of care and nursing needs and assessments had taken place to identify these. For example, pressure support cushions and mattresses were in place for people at risk of pressure area damage. And mobility and lifting aids were used to support people who required assistance with walking or to move safely. Risks to individuals were identified and well managed. There were individual risk assessments in place which supported people to stay safe, whilst encouraging them to be as independent as possible. Such as, washing, dressing, eating, drinking and going out. Other risk assessments included falls, moving and handling, nutrition, choking, safe use of bedrails and any other individual risks identified during the initial assessment or subsequent regular reviews of care.

Staff told us they thought that staffing levels were appropriate to meet peoples care and nursing needs. The deputy manager confirmed the use of bank and agency staff to fill the current staff vacancies which included covering shifts at night as well as during the day. A dependency tool was used to calculate the number of staff required to meet people's needs. Care plans and risk assessments showed the number of staff required to assist people safely. For example when providing personal care or helping people to mobilise. The deputy manager told us the current staffing levels were for one registered nurse (RN) on duty during the day and at night covering Ashdown Walk the nursing floor, supported by four care staff. Deer View Walk was care led

and not nursing. This was staffed by four care staff led by a senior carer. Six out of seven night shifts were currently being covered by the use of agency RNs, but recruitment was on-going. The deputy manager said that they always had a permanent member of staff working with agency staff and that they try to use regular agency staff for continuity of care. One relative we spoke to was worried that the number of new and agency staff may impact on the care provided but had not experienced any concerns at that time.

Staff were allocated at the start of each shift and knew their roles and responsibilities. This included who they provided care and support to and further tasks including daily mattress checks, helping with activities, afternoon tea and cakes for people and when they should take their breaks.

People told us that if they used their call bells these were responded to promptly. Staff were able to tell us about people and care was seen to be provided in an unhurried manner. Staff told us that they were very busy at points throughout the day but that they all helped and supported each other.

Hurstwood View had appointed maintenance employees. There were robust systems in place to ensure the safety and maintenance of equipment and services to the building. All maintenance and equipment checks had taken place with certificates available to confirm this. Staff told us all maintenance needs were addressed promptly. There was a book to record minor issue, this was read and signed by the maintenance employee once completed. A full list of emergency contact numbers were on display in offices for serious issues. For example gas, electricity and lift maintenance contractors.

People's care and health needs had been considered in relation to their safe evacuation in the event of an emergency. Fire alarm and emergency checks had taken place regularly to ensure people's continued safety. Evacuation plans and equipment were in place with plans of the building, fire safety and evacuation information. An external fire professional carried out annual checks and risk assessments for the building. There was regular training for both day and night staff and evacuation equipment was located around the building to aid evacuation.

The provider had a thorough recruitment system in place. We looked at staff recruitment files; these included the staff file of a newly employed staff member. All files showed relevant checks which had been completed before staff began work. For example, disclosure and barring service (DBS) checks, a DBS check is completed before staff began work to help employers make safer recruitment decisions and prevent unsuitable staff from working within the care environment. Application forms included information on past employment and relevant references had been sought before staff were able to start employment.

Staff had access to relevant and up to date information and policies, including whistleblowing and safeguarding. These were corporate policies and we were told these were updated by the provider and the home would be notified of any updates, these would then be printed off and made available for staff. Policies were reviewed and updated when changes took place; this included the addition of new policies to incorporate recent changes to regulation. Staff told us they knew where policies were stored and that they were asked to read them when changes occurred to ensure they were aware of correct working procedures.

Systems were in place to ensure people received their medicines safely. Policies and procedures were in place to support the safe administration and management of medicines. On Ashdown Walk medicines were given by the RN and on Deer View Walk medicines were given by appropriately trained care staff who had completed medicine training.

Medicines were managed safely. Staff signatures were recorded on medicines administration records (MAR) and the tablets remaining matched the records of the administered medication. There were photographs on

all MAR charts to help staff identify the correct person when giving medicines. We found that although documented on MAR charts a recording system was not in place for PRN or 'as required' medications. This is important to ensure people are given their medicines in a safe and consistent manner regardless of who is administering it. On being made aware of this a record sheet was put in place on both Deer View and Ashdown Walk to record PRN medication.

We observed medicines being administered and saw that this was done following best practice procedures. People who self-administered medicine had risk assessments in place to support this. These were reviewed monthly or more frequently if there were any changes to people's health.
Medicines and topical creams were stored and disposed of appropriately. Medicines were labelled, dated on opening and stored in locked cupboards in people's bedrooms. Medicine fridge and bed room temperatures were monitored regularly to ensure they remained within appropriate levels. Medicines were ordered regularly and when no longer needed were disposed of appropriately.

Incidents and accidents were reported and the operations and regional manager had oversight of any incidents/ accidents or falls that had occurred. All incidents were logged and sent to the head office. A review was completed and these were analysed to look for any trends. For example, one person who was at risk of falling if they tried to stand unsupported had a special alarm in place that would signal and alert staff that this person needed support if they stood up. Management and staff understood the importance of learning from incidents to facilitate continued improvement within the service. For example if someone had a fall, then this would trigger a review and risk assessments and care plans would be updated if needed to ensure peoples safety was supported and to prevent further incidents if possible.

Good

Is the service effective?

Our findings

People told us they thought the home ran smoothly. Relatives told us "I honestly think she has improved since being here, the three meals a day and being weighed monthly has made a difference." And, "Everyone has been so lovely, we are settled now and they are very well looked after."

People were supported to have access to healthcare services and maintain good health. Referrals had been made to other health professionals when required. This included GPs, community nurses, speech and language therapist (SALT). For example, one person was complaining of pain, a member of care staff had responded to them and told us the person had also been added to the GP's appointment list that day. We followed up on this after the GP had visited and found they had been prescribed treatment and staff had been able to reassure them and they had explained again what the GP had said.

People were supported to eat and drink and to maintain a balanced diet. Audits were completed for weight loss and food and fluid charts were put in place to help improve and maintain healthy weight. We discussed fluid charts with the regional manager. We found that fluid charts although being monitored were not always being totalled at the end of the 24 hour period. However, amounts were being added as they were documented. The regional manager told us staff would be reminded that as well adding up the amount as fluids were given, an overall total was required to ensure monitoring was effective and that any areas of concern where identified.

People's nutrition was monitored and appropriate action taken when required. We spoke to the head chef who told us, "I meet with the nurse on duty once a week for an update on people's weight loss or gain and who needs a fortified diet. For people on weight charts we fortify the food with cheese, cream, milkshakes and smoothies." People's dietary needs were being met by pureed or soft diets being provided where appropriate.
People told us, "I love the food it's very very good." And, "The foods beautiful."

People were able to choose what they wanted from the menu and were supported to make choices by staff who ensured people knew the options and gave information about each dish. People were able to change their mind about their choices which was accommodated by the staff for example deciding to have a starter after originally saying they did not want one. The head chef told us they met with people when they first moved into Hurstwood View to learn about their food preferences and this information was used to plan the quarterly seasonal menus. People were able to access meals at their preferred time without being rushed, for example a sign said breakfast was served from 08.30am. We saw that people who chose to were having breakfast up to 10:30am with poached eggs made to order for one person. People were looking at menus and talking about the menu options, for example, "I'm having the soup, what are you having?" "I'm having that too" "Are you having the pate?"

People received care from staff who had knowledge and skills to look after them. There was a programme which included all essential training for staff, with further training for example National Vocational Qualifications (NVQ) or similar. Staff had received a range of training and this was reflected in their practice.

For example, care staff had recently received report writing training. Staff felt that this had improved the standard of documentation and had reminded them of the importance of clear and accurate information. Staff told us the training they received enabled them to understand people, for example supporting people with dementia. Staff displayed a good working knowledge of dementia and when people became anxious or upset support was provided appropriately. Competency checks took place to ensure staff training had been appropriate before staff worked unsupervised this included giving medicines. During the inspection staff attended a specific training on enteral feeding systems. Staff told us they had found this extremely informative and helped them have a better understanding.

We spoke to RNs on Ashdown and care staff on both floors who told us that they enjoyed working at Hurstwood View and felt supported and appropriately trained to provide care for people.

An induction programme was in place to support all new staff. We saw that these included reflective accounts and new staff were signed off when deemed competent by their mentor or senior staff member. Induction files included learning outcomes, competences and standards of care that are expected from care workers to ensure they are caring, compassionate and provide quality care. We found that induction information had not always been signed off as completed. However, we spoke to staff who confirmed this had been completed and just needed to be documented in the induction folder. Staff felt supported, telling us that changes were discussed and information shared at meetings and handovers. Staff were aware of recent management changes and knew when the newly appointed manager was starting at Hurstwood View. Staff told us feedback was listened to and suggestions taken seriously, this made them feel involved and encouraged to continually improve the service.

Mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS) had been completed for people. These detailed who had capacity to make decisions and who else was involved in decision making for that person. For example next of kin and power of attorney. The operations and regional manager had a good understanding of (MCA) and (DoLS) and what may constitute as a deprivation of liberty. Including restrictions on people leaving the building. DoLS applications had been made and we looked at information for people who had a DoLS in place. Staff also demonstrated an understanding of MCA and its aims to protect people who lack capacity and when this might be required. Capacity decisions had been assessed in relation to specific areas, for example living in a care environment, restricted movements and Do Not Attempt Resuscitation (DNAR). The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests. People's mental health and wellbeing was assessed and reviewed regularly with liaison between the manager and community mental health team if required. Best interest meetings and decisions had been documented to support any decisions made regarding people's safety and welfare.

People said staff always asked for consent before providing any care. Staff described how they would ask for people's permission before giving support, and what they would do if someone declined the support offered. We observed staff speaking to people and involving people in decisions. For example, people were reminded when GP visits were due that day and what activities were taking place. People then made decisions about what they wanted to do, whether they attended activities, returned to their rooms, went out with family or sat in communal areas.

On Deer View we saw that signs and decorations of the communal areas were specifically designed to assist people living with dementia to remain independent and to be able to interact with their environment. Care staff wore t-shirts of different colours. Staff told us that wearing different tops was a topic of conversation for the residents who would tell them if they liked the colour or not. People's doors had their names on them

and a large personalised framed box for each resident that contained photos, objects or for example a sheet of music depending on the person's interests. Rooms were personalised with photos, ornaments and items that were important to people. Bathrooms were decorated with a nautical theme with ornamental accessories. Bathrooms and toilets had pictures on the door to help people know what the rooms were for. Wall decorations in hallways included some made from raised wool so they were tactile for the people to touch.

Good

Is the service caring?

Our findings

People told us that they thought staff were kind and caring. We saw examples where staff responded to people in a supportive and caring manner. This included when people told staff they were in pain, and staff responded promptly. People told us, "They are nice girls. They are very good." And, "I do like it here." Relatives told us they felt people were well looked after and that staff always treated people with kindness and support.

Although the service had been divided in relation to nursing needs and people requiring support with dementia. We saw that throughout the day people were able to access other areas of the building. The main reception/entrance area had a large open area with tea/coffee and cold drinks available. Staff were sitting at tables with people and families and visitors were able to visit and spend time in this area. This gave the area a relaxed informal feel. Visitors told us they enjoyed sitting in this area when they visited as everyone chatted and, "It felt like going out to a coffee shop for a drink." Another told us it made a real difference when they bought young children to visit as there was space and it was so much better than having to sit with someone in their room.

People received care which ensured their dignity was maintained and supported at all times and staff had a good knowledge on how to provide care taking into consideration people's personal preferences. When one person had spilt food down them staff responded calmly and politely and helped the person return to their room to change. People were referred to by the name of their choice. The emphasis of the home was to safely promote and encourage independence as much as possible. People were given choice and staff were aware of people's personal preferences. For example, one person liked to be called a specific term of endearment. This was documented in their care plan and had been discussed with their family. Staff told us by referring to this person in this way, comforted them and they responded positively. Another person liked to wear pyjamas during the day and their family had been asked to provide extra pyjamas to enable them to continue to do this if they chose.

Staff were seen to knock on people's doors and enter when invited. We saw that people had their own private locked medicine cabinets in their wardrobes. This meant people were able to have their medication in the privacy of their own rooms. Senior staff told us that medicine cupboards were put in people's wardrobes, "To take away the clinical feel."

At lunch time we saw that staff sat and spoke with people. Staff assisted people and ensured they were using their mobility aids safely. People were orientated to time by staff so that they knew what was about to happen, for example when lunch was due, or activities about to start. Discussions were heard when staff helped people to the dining room around what was for lunch. Staff constantly spoke to people to ensure they were comfortable, that chairs were close enough to the table and they had everything they needed. People were offered choice about how they spent their time with some choosing to stay in their rooms, or go outside. We saw staff holding people's hands to reassure them and stopping to chat with them to make sure they were alright.

A relative came to visit someone. During the visit they were sharing some information; however the person was struggling to understand this. When the relative left, staff took the time to sit with the person and repeated the conversation until they were reassured they understood what was happening. This visibly calmed the person and they thanked the staff member for explaining things to them.

Relatives and visitors told us that they were felt welcome, encouraged to visit, invited to stay for meals and always offered a hot drink during their visit. We also spoke with other visitors to the service and all feedback received was complementary.

Good

Is the service responsive?

Our findings

People told us that staff responded to their needs, and relatives confirmed that they were kept informed of any changes to people's health. Relatives felt that staff were always happy to chat and had a good understanding of people's individual needs, including how they liked to spend their time, what clothes they liked to wear and their favourite foods.

There was a clear system in place to assess, document and review care needs. Care files included personalised care planning and risk assessments. Care documentation had been written with information provided by the person or their next of kin if appropriate. This meant that care plans were person centred and reflected people's needs and preferences. Including people's lives before they moved to Hurstwood View, significant life events and relevant medical history. People's hopes and concerns for the future had been sought, along with cultural, spiritual or social needs which were important to that person. We spoke to relatives and they told us they felt involved in the care arrangements for their relative. We met the relative of someone who had recently moved into Hurstwood View. They spoke highly of the staff and the way they had made them all feel welcome. They also felt that the staff listened to them and had really tried to get to know them all. This had made the whole transition so much easier for people.

Information in care files gave relevant details and signposted the reader to look at other areas of the care plan if this information was relevant. For example mobility equipment needs was linked to moving and handling and this in turn led you to read skin integrity needs. There was clear information in care files to support good communication. For example one person had limited verbal communication. Staff had been provided clear information about asking questions and how the person would answer.

All care documentation and risk assessments were reviewed by management, RNs or senior care staff to ensure information was relevant and up to date. This was incorporated into a 'resident of the day' when all aspects of care were reviewed for the person, this included maintenance, kitchen and care staff. Any changes to people's health or care needs were updated and information shared with staff at handover. All staff told us they read care plans and care documentation regularly and were aware of any relevant information about people. We saw that care documentation clearly showed how the staff had responded to people's needs and how this impacted on people's health. For example, one person had used a special walking aid when they lived at home. Through support and encouragement this person was now able to walk around the home without mobility aids.

GPs visited Hurstwood View each week. We saw that a GP book had been used by staff to detail who needed to be seen and why. Staff were aware that they could add people to the list to be seen by the GP on these days; However, all staff we spoke with were clear when they would contact a GP immediately or emergency services if needed.

There was a lively programme of activity available for people. There was a part-time activities co-ordinator who worked three days a week. They told us that on days that they were not working they tried to organise visiting entertainers and other activities to ensure people had things to do. Care staff told us they also did

activities for people and a second activity person was currently being recruited. Many of the activities took place in the ground floor reception area. This included small farm animals, during the inspection baby lambs were bought in for people to pet. Visiting performers including a story teller and singer and music therapy specifically tailored for reminiscence, both of which were well attended by people living at Hurstwood View, relatives and visitors. People gave positive feedback as they had found these activities interactive and entertaining. A number of daily in house activities were also scheduled and people could attend if they chose. We saw that staff actively encouraged people from all areas of the home to attend and participate. People were reminded throughout the day what activity was due to take place and staff went to assist people who wanted to attend. People told us they had something to do throughout the day if they were not busy doing their own things. We saw that this included games, quizzes, listening to music and trips out. Communal rooms had a variety of items for the people to access including clothing, hats, keyboard, pictures, ornaments, boxes to open and pictures made of raised wool which were very tactile. There was an outdoor terrace on the first floor which had a ping pong table, giant connect four, hula hoops and garden equipment and activities information was displayed on notice boards around the home.

A complaints policy and procedure was in place and displayed in the entrance area. People told us that they would be happy to raise concerns and would speak to staff or management if they needed to. For people who were unable to voice concerns staff told us they took notice if people seemed unhappy or there were changes to their behaviour which might indicate an issue. We looked at complaints received and saw that people's complaints had been acknowledged and responded to. Copies of all letters and emails had been logged to ensure a clear audit trail. We saw that concerns had been raised regarding issues around staffing; the operations and regional manager were able to tell us actions taken to improve this, with on-going recruitment, staff changing from day to night staff to ensure that regular staff were more available. There had also been a few concerns regarding lost clothing, we spoke with the laundry staff who showed us how peoples clothing was name tagged. Named boxes were used for staff to return items to people, however items still occasionally got misplaced. Laundry staff told us, "There has been a real push to locate lost items which had been returned to the wrong persons rooms." We also saw that management had identified this area and were implementing ways to help prevent and improve the laundry process to ensure people's items were returned. When complaints had been concluded this had been recorded. Everyone we spoke with told us they would be happy to raise any concerns if they needed to.

Good

Is the service well-led?

Our findings

There had been a number of changes to management, with the previous registered manager having left, and the deputy manager due to leave a few days after the inspection. The provider had put management plans in place to cover the interim period before a new manager began work at Hurstwood View. Recruitment had been completed and they were due to start work shortly. Staff and people we spoke with were aware of these changes and although people told us the changes were, "A shame for the home." They were aware that measures were in place to provide management cover at all times and everyone we spoke with knew that a new manager was due to start work very soon. Staff meetings had taken place these included care and nursing staff, kitchen and hospitality. Minutes showed that staff had met covering managers and been kept up to date with the impending changes. Relatives told us they had met the operations and regional manager and were quite happy with the systems in place until the new manager started. The regional manager told us, "The new manager will shadow at one of our homes to help them to get to know the service. I will meet with the relatives during the manager's transition period and listen to any concerns and get feedback."

There were organisational systems in place for the ongoing assessment and monitoring of the service. The provider had internal regulations for the auditing process. All information from auditing was imported onto the computer for the organisation to review. Analysis of information was then formulated with time frames given to complete identified actions. These areas of improvement remained open on the system until the regional director was satisfied they had been resolved and the organisational requirements met. The regional director was able to decide if further information was required and this information was recorded on the system.

The regional director showed the auditing tools on the internal clinical database which included audits for tissue viability, accidents/incidents, hospital admissions, safeguarding and deprivation of liberty safeguards. The system generated an email reminder to prompt managers to complete the updates by a specified date each month. The reports identified accidents/incidents that had occurred and those that were being monitored. The regional and operations managers confirmed that all reports were checked and discussed monthly.

The audits also triggered reviews of action plans where events continued to occur. If the action plan was not successful, alternative options to manage the risk were considered. For example, further equipment, training or medication reviews. A fall recorded on the database was tracked back to the person's file where the documentation and actions had been taken in line with the procedure outlined by the regional director. This showed that the system in place identified and responded to incidents and concerns in a clear and responsive way. The management and RNs were clear there may be occasions when the assessments and auditing may identify when it may be more appropriate for people to move to alternative services, for example if they were unable to meet peoples nursing or care needs.

Relatives were able to feedback on the home via the website and any comments were fed back to the management and Head Office so they could be acted upon immediately. We were told, "We have a monthly

review to get feedback from the residents who are able to give it." A new IPad was about to be installed in the main reception area, this was for anyone living at Hurstwood View, visitors or relatives to use to give immediate feedback to the management. We were told that this would be a way of completing feedback both positive and negative before people left the building and would be used to make improvements.

Staff feedback had been listened to, staff had fed back during meetings that they needed someone to be able to assist people in the reception area. The home had just employed a 'hostess' to provide drinks and 'meet and greeat' people when they arrived at the home or sat in the reception area. We were told management would be reviewing this role and were looking at employing a second person.

The provider supported staff to ensure they received appropriate training this included specific training to ensure peoples medical needs were met, for example enteral feeding systems, catheterisation, dementia care and customer care. A member of care staff told us they had recently attended report writing training. TAnd they were able to tell us how this had improved the documentation and their understanding of the importance of accurate documentation

Staff competencies were reviewed including medicine and care provision. The regional director told us, "I also do unannounced spot checks. I visited bank holiday Friday and we also do spot checks out of hours and at weekends." If any concerns were highlighted during these checks these would be responded to appropriately. For example, further training if appropriate, or discussed during supervision meetings. This meant that management were checking that peoples care was appropriate and that staff had the training and competencies to meet people's needs.

Staff could be nominated for awards. The organisation rewarded staff with 'Employee of the Month' and the person's name and photograph were displayed in the reception. Staff told us they thought it was nice that people received some recognition for their hard work.

The organisation and management kept up to date with developments in health care by sourcing information online and reading and reflecting on changes to practice. This included changes in the CQC inspection process. The provider had completed the Provider Information Return (PIR) and had provided us with detailed information about how they continually assessed the service to ensure high standards of care were provided and best practice was maintained.
The PIR included a lot of information around how the service provides people with appropriate care, the goals and values of the service and how the provider planned to continue to take the service forward.

Policies and procedures where available for staff to support practice. There was a whistle blowing policy and staff were aware of their responsibility to report any bad practice. The management had a good understanding around 'duty of candour' and the importance of being open and transparent and involving people when things happened. The operations and regional manager told us that they were always keen to learn from incidents to improve future practice.

Staff were aware of the policies and were aware that these underpinned safe practice. Policies and changes to procedure were discussed at meetings to ensure everyone was aware if changes occurred.

Registration requirements were met and notifications were sent to CQC and other outside agencies when required.