Hartwood Care Limited

Hartwood House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 15 and 16 February 2016.

Hartwood House is a care home with nursing. It is arranged over three floors and consists of a new purpose built wing attached to an older existing property which has also been completely refurbished. The home can accommodate up to 50 people but at the time of our inspection there were 36 people living at the home. The Emery Down nursing unit is on the lower ground floor and provides care for up to 10 people who have nursing needs. The Limewood unit on the ground floor provides care for up to 20 people who require residential care. The people living on this floor are more independent and may need support with some daily living tasks such as personal care or support with their medicines management. The Minstead unit is on the first floor and can provide care for up to 20 people who are living with dementia. A registered nurse is based on the Emery Down Unit and is available to provide some emergency clinical advice or support to the other two floors which are staffed by senior care workers and care workers.

The home had 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 and associated Regulations about how the service is run.

There was reliance upon staff working extra shifts and on bank and agency staff to maintain safe staffing levels. This meant that people did not always receive care from a stable and consistent staff team.

Some aspects of how medicines were managed within the service required improvement. Staff had not always followed guidance in relation to how the administration of PRN or as required medicines was recorded. Accurate records had not always been maintained about the medicines people were prescribed. We have made a recommendation about this.

Appropriate recruitment checks took place before staff started working at the home although we did note that in two of the records viewed, staff had not provided a full employment history. This information was provided following the inspection.

People's records contained appropriate risk assessments which covered a range of areas. Care workers said that the risk assessments told them what they needed to know about each person and how to deliver their care safely.

The provider had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service.

People told us they felt safe living at Hartwood House. Staff had a good understanding of the signs of abuse

and neglect and they were aware of what to do if they suspected abuse was taking place.

Staff acted in accordance with the principles of the Mental Capacity Act 2005. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

Care plans contained information about people's dietary needs and risks associated with these. People told us they enjoyed the food provided.

The home worked effectively with a number of health care professionals to ensure that people received co-ordinated care, treatment and support including memory nurses supporting those living with dementia and physiotherapists and community dentists.

People were treated with dignity and respect and staff were kind and caring in their interactions with people and people and their relatives were involved in making decisions and planning care.

People and their relatives told us that the permanent staff had a good understanding of their needs and of their preferences in terms of how their care was provided. Records were written in a manner that helped to make sure people received care that was centred on them as an individual, although they did not always reflect the care provided.

People knew how to make a complaint and information about the complaints procedure was displayed within the home and included in the service user guide.

Systems were in place to see feedback from people who used the service, their relatives and staff. This helped to ensure the manager maintained an oversight of day to day issues within the home. Quality audits were being used effectively to drive improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Improvements were needed to how some aspects of people's medicines were managed.

There was reliance upon staff working extra shifts and on bank and agency staff to maintain safe staffing levels. This meant that people did not always receive care from a stable and consistent staff team.

Staff had a good understanding of personal and environmental risk and signs of abuse and neglect. They were aware of what to do if they suspected abuse was taking place.

Is the service effective?

Good

The service was effective.

Staff acted in accordance with the principles of the Mental Capacity Act 2005. Applications for Deprivation of Liberty Safeguards had been appropriately submitted.

Support for staff was achieved through the delivery of a training programme, individual supervision sessions, an annual appraisal and team meetings. This helped to ensure their continuing professional development.

Care plans contained information about people's dietary needs and risks associated with these. People told us they enjoyed the food provided

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff were kind and caring in their interactions with people.

People and their relatives were involved in making decisions and planning care.

Is the service responsive?

Good

The service was responsive.

Staff had a good understanding of people's needs and of their preferences in terms of how their care was provided. Records were written in a manner that helped to make sure people received care that was centred on them as an individual.

Staff recognised and responded to changes in people's health care needs.

People knew how to make a complaint and information about the complaints procedure was displayed within the home and included in the service user guide. Complaints were fully investigated and action was taken to address the concern.

Is the service well-led?

Good

The service was well led.

The home had a registered manager in place.

Quality audits were being used effectively to drive improvements.

Hartwood House were continuing to develop their links with the local community to enable people to continue to engage in community life

Hartwood House

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 15 and 16 February 2016 and was unannounced.

On the first day, the inspection team consisted of two inspectors, a specialist nurse advisor in the care of frail older people living with dementia, 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 service. Our expert had experience of supporting people living with dementia and of using health and social care services. On the second day, the inspection team consisted of two inspectors.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. The provider was asked to complete a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

We spoke with 14 people who used the service and four relatives. We also spoke with the registered manager, the home admissions Manager, two registered nurses, six care workers and an activities co-ordinator. We spoke with the chef and a member of the housekeeping staff and one agency worker. We reviewed the care records of six people in detail and the records of four staff. We also reviewed the Medicines Administration Record (MAR) for 22 people and the Topical Medicine Administration Records (TMAR) for five people. Other records relating the management of the service such as training records, audits and policies and procedures were also viewed.

The last full inspection of this service was in January 2015 when we found that improvements were needed

in relation to how people's care records were maintained, the staffing arrangements and to how the Mental Capacity Act (MCA) 2005 was being implemented. We carried out a focussed inspection in August 2015 and found that improvements had been made in these areas, but found a new breach of the legal requirements as the Care Quality Commission (CQC) had not been informed of two potential safeguarding alerts. At this inspection we found that the service was now meeting this Regulation and had submitted relevant notifications appropriately.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Hartwood House. One person said "Yes I do, you are safe, you'd only have to complain and they'd put it right". Another person told us, "I feel safe here".

When we inspected in August 2015, we found that the registered manager had not notified the Care Quality Commission (CQC) or the local authority about two potential safeguarding incidents. This was a breach of the Regulations and we made a requirement that this must be rectified. At this inspection we found improvements had been made. Records showed that where appropriate the CQC and the local authority had been informed about safeguarding incidents. Notifying the CQC of incidents which may affect the safety and welfare of people who use the service is important as it enables us to check that the registered manager has appropriately dealt with the matter.

We looked at how medicines were ordered, stored, administered and recorded. The home had three controlled drugs (CD) cupboards. These are prescription medicines controlled under the Misuse of Drugs Act 1971, and which require special storage, recording and administration procedures. We undertook a balance check of the controlled drugs held in two of the CD cupboards against the register and these agreed. Other medicines were stored securely within locked medicines rooms or medicines cupboards within each person's room. The temperature of the fridges and rooms used for storing medicines were now being monitored daily, however, we noted that on Emery Down Unit, the temperature for the medicines room was often reading as being slightly in excess of recommended ranges. Storing medicines within recommended temperatures is important as this ensures that they are safe to use and remain effective. We were informed that this matter had been referred to the maintenance team.

Staff administered medicines only when they had the necessary skills and had been assessed as competent. The registered manager told us that the competency assessments were reviewed annually. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. People told us they received their medicines on time and when they needed them. Where people were prescribed 'if required' or PRN medicines, we found that protocols were in place which provided guidance for staff on when these should be given. We did note that on five occasions a person had been given a PRN medicine but staff had not recorded on the back of the MAR the reason why the medicine had been administered. This was not in line with the provider's policy. We also noted that one person was prescribed a PRN medicine which was in stock, but not recorded on their MAR as a current medicine. It was also not listed on the person's most recent prescription. We were concerned that staff could not be confident that this remained a current medicine for this person. A staff member told us that the medicine was still current but had 'dropped off' the MAR as it was not regularly used.

We recommend that the provider reviews its systems and processes to ensure these support staff to maintain accurate and up to date records in relation to people's medicines as recommended by the National Institute for Health and Care Excellence (NICE).

Staff applied topical medicines; they signed topical medicines administration records (TMARS) to confirm this. We reviewed three people's TMAR on the Limewood unit and noted that each one contained some gaps. We could not therefore be confident therefore that people were always receiving their topical medicines as prescribed.

Arrangements were in place to ensure that unwanted medicines were disposed of safely and the service had agreed a list of homely remedies with the GP practice. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds.

We received mixed feedback from people and staff about whether there were always sufficient numbers of staff deployed to meet their needs. One person told "Sometimes, I wait a long time, it depends how busy they are." Another person told us, "When they are short of staff, morning coffee and afternoon teas have to go by the board". This person also expressed concern to us about the high number of agency used. However, other people told us that there was usually "Plenty" of staff and that the staffing levels allowed them to make choices about how and when their care was provided. A relative told us, "There is always someone around".

Most of the staff we spoke with expressed concerns to us about the reliance on staff working extra shifts and on bank and agency staff to maintain safe staffing levels. They told us that agency staff needed additional supervision or guidance due to not being as familiar with people's needs as the permanent staff. One staff member said, "There are agency staff every day, you can't get things done, you have to observe them and then you don't have time to do things like get the care plans up to date or do the menus for the next day or sometimes teas and coffees". Another staff member said, "We use a lot of agency, its fine if they have been here before, but you have to spend a lot of time guiding them". Staff were clear that people's key needs were met, but they expressed regret that they did not always have quality time to spend with the people they cared for.

On both days of our inspection we saw there were enough staff to respond appropriately to people's needs. Call bells were generally answered promptly and when one person was taken ill we saw staff responded quickly to ensure they were not injured. The registered manager told us they were confident that the current staffing levels were safe. They explained that they were using a tool to assist in calculating the number of staff needed to support people. We reviewed this and noted that it did not take into account the layout of the building for example, or the amount of support people might require from staff to prevent falls or manage behaviour which might challenge others. We were concerned that without considering these types of needs, the tool would not provide an accurate reflection of the staffing resource required each day. The registered manager told us that recruitment and retention of staff continued to be a challenge but they were committed to ultimately being fully recruited and reducing the use of agency staff. They explained that they were now fully recruited for registered nurses but were still recruiting care staff and this remained a priority for them and the provider so help ensure that people received care from a more stable and consistent staff team.

Staff had received on line training in safeguarding vulnerable adults and those we spoke with had a good understanding of the signs of abuse and neglect. They were aware of what to do if they suspected abuse was taking place. The organisation had appropriate policies and procedures and safeguarding contact numbers were readily available for staff to consult. A staff member told us, "I would report any safeguarding concerns to the manager or a nurse; I don't have any concerns about the residents here". Staff were informed about the provider's whistleblowing policy, but were also aware of other organisations with which they could share concerns about poor practice or abuse. The manager told us safeguarding people from abuse was discussed in supervision as was the organisation's whistle-blowing policy.

Incident and accidents were all monitored by the registered manager and we were able to see that they usually maintained a good record of the actions taken in response to mitigate any risks and prevent reoccurrences. We did find that the records relating to one incident were incomplete. The person's records contained a series of photographs showing bruising to both of their arms and hands. The photographs had not been taken in line with recognised best practice when photographing bruising or unexplained skin damage. For example, there were no measurements on the photographs. There were also no body maps. We were told that the person often rubbed their hands and lower arms and that this caused skin damage, however, when we looked through the person's records, we could find no reference to the bruising or how or when it might have occurred. The records were therefore incomplete. We were aware that the potential cause of the bruising was being investigated as the service had informed the local authority and had also notified the CQC. However, we were concerned that the lack of detailed records relating to this skin damage could impact upon staff and other agencies being able to effectively assess and monitor people's care and to promote learning.

Appropriate recruitment checks took place before staff started working at the home. The registered manager had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. Checks were made to ensure the registered nurses were registered with the body responsible for the regulation of health care professionals. We did note that in two of the records viewed, staff had not provided a full employment history. This information was provided following the inspection.

People's records contained appropriate risk assessments which covered a range of areas. For example, we saw a detailed and comprehensive falls prevention care plan was in place for one person who had been experiencing a series of falls. We were aware that another person was also experiencing regular falls. We saw that staff had put a number of measures in place to try and reduce the risk. For example, the closing mechanism on their ensuite door had been changed as it was thought that some of the falls might be due to the person turning to close the door when leaving the room. We were able to see that the registered manager had taken action to escalate their concerns about this person's risk from falls to the local authority to ensure that all safety measures were in place. Where people were at risk of pressure ulcers, relevant risk assessments had taken place and were reviewed monthly. Screening for the risk of malnutrition was routinely carried out and people's weight was regularly monitored. A care worker told us, "If a person was losing weight, it would be an indicator that the person was nutritionally at risk. We would inform the manager who would contact the GP. We would then put food and fluid charts in place". Care workers said that the risk assessments told them what they needed to know about each person and how to deliver their care safely.

People had a personal emergency evacuation plan which detailed the assistance they would require for safe evacuation of the home. Fire alarm and fire equipment tests were taking place regularly. Monthly checks were undertaken of the safety of aspects of the environment such as the window restrictors, wheelchairs, bed rails and moving and handling slings and hoists. The lift was serviced on a quarterly basis. Regular checks were undertaken of the water system to ensure the effective control of legionella. Annual checks were undertaken of the safety of electrical items. The provider also had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service.

Good

Is the service effective?

Our findings

Overall people were positive about the staff and the care they received. One person said, "We're very well looked after here and well fed". Another person said, "The staff are very helpful, they are excellent". A visitor told us that they felt their relative was "Well looked after…I can't fault it or complain about here, [the person's] room is kept clean and they are kept clean". A healthcare professional told us, "Staff appear to be knowledgeable and are informed about people's needs and support plans…they contact health services appropriately and for vast majority of their staff and in particular the nursing staff I have confidence in their assessment and management of [people]".

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. Where required mental capacity assessments had been carried out in line with the MCA 2005 which were decision specific. Where people did not have capacity to make specific decisions about their care but had a relative with legal responsibility for making decisions on their behalf, we saw that the staff had consulted them when developing care plans or in response to new concerns about the person's welfare.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom or choices, these have been agreed by the relevant bodies as being required to protect the person from harm. The manager demonstrated an understanding of the safeguards and relevant applications had been submitted and were waiting to be assessed by the local authority.

New staff received an induction which involved shadowing more experienced staff and learning about the needs of the people using the service and the policies and procedures of the home. A member of staff who had been recently employed by the service confirmed they had been given opportunities to shadow staff and had completed a range of essential training. They told us the induction had prepared them for their role and helped them to feel confident.

The training programme was delivered through a mixture of on-line and face to face courses and included subjects such as moving and handling, fire training, emergency first aid, infection control, food hygiene, the MCA 2005 and DoLS, equality and diversity and safeguarding people from harm. Staff completed two half day sessions in caring for people living with dementia. We reviewed a training matrix and noted that some staff were not fully up to date with some of their training. For example, nine staff did not have current moving and handling training. We spoke with the registered manager about this. They advised that they were confident that staff remained competent with moving and handling and that training had been booked for the week following our inspection. We were assured that where other training was out of date, arrangements had been made to deliver this training this within the next month. Most of the staff we spoke with felt that the training provided was adequate and helped them to perform their role effectively. They had recently received new training in care planning which staff had found useful but perhaps too short. A

number of staff told us they would value a longer and more detailed training session around care planning. Support for staff was achieved through individual supervision sessions, an annual appraisal and team meetings. Staff said that supervision meetings were now taking place more regularly and along with their appraisals were useful in measuring their own development and additional training needs.

Most people told us they enjoyed the food provided. One person told us the food was "Not bad, there are two choices every day and one for the diabetics, its very good considering they are cooking for so many". Another person told us they thought the food was "Very Good". We saw that breakfasts were also tailored to suit people's individuals needs with cereals or a cooked breakfast being offered. At lunch, meals were taken in a hot trolley to each floor. People had the choice whether to eat in the dining room or in their own room. The chef told us that menu choices were chosen the night before, but if the person changed their mind they could choose something from the alternative menu. They explained, "Sometimes, they see what someone else has ordered and say 'I fancy that', we're quite happy to give them alternatives if that's what they want". The lunch menu on the day of our inspection was three courses with soup for starter and rice pudding for dessert. We saw that when people asked for an alternative this was provided. For example, one person asked for an omelette which was made freshly for them. People told us that staff were informed about the foods they liked or disliked. One person said, "I don't like mushy peas so they give me garden peas". Drinks, fresh fruit and snacks were readily available throughout the day. Visitors to the home were able to assist their relative and join them for a meal if they wished.

Care plans contained information about people's dietary needs and risks associated with these. Where people required a modified diet this was recorded and staff appeared to have a good knowledge of this. For example, one person's care plan stated that they required prompting to encourage them to eat and drink well. We observed that staff sat close to them and encouraged them to eat. When the person coughed staff responded kindly and appropriately. They reassured the person and were patient with them. This was in line with the guidance in the person's care plan. Kitchen staff also had detailed information about people's specialist diets including those that required diabetic meals, had any food allergies or needed soft or pureed food. They were also aware of people's likes and dislikes. The chef told us how one person liked a cooked breakfast, whilst another liked to have kippers.

Food and fluid charts were used to monitor people's dietary intake where this was required. A small number of the charts had some gaps and many were not totalled. Totalling fluid charts helps staff to monitor more effectively how much a person has drank. We also noted that food charts often just showed what meal the person had been given, rather than how much of this they had eaten. People's records showed they were weighed on a regular basis and where they had lost weight, they were referred to relevant professionals such as the GP or dietician. Where people were at risk of choking, they had been referred to a speech and language therapist.

There was an effective working relationship with a number of healthcare professionals to ensure people received co-ordinated care, treatment and support. Visiting healthcare professionals including memory nurses, supporting those living with dementia, GP's, speech and language therapists and other rehabilitation staff such as occupational therapists, dentists and opticians. People told us they were supported to see their doctor when required. We saw that staff maintained a 'GP Book' which recorded which people had been referred to the doctor, the reason for this and the outcome of the health review. This helped to ensure that people were supported to maintain good health.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the staff and said they treated people with dignity and respect. One person said, "It's lovely, I love it, I've no complaints". Another said, "None of the staff dislike me, there is nobody I dislike". Another person said when asked if all the staff were kind and caring said, "Oh yes its very good here". A relative told us, "All the staff are kind and caring and very chatty". A healthcare professional told us, "I have always found the service and staff treat the residents with dignity and respect and they have shown a kindness and caring nature to the residents they care for".

Our observations indicated that staff interacted with people in a kind and compassionate manner and we saw a number of warm and friendly exchanges between staff and people. Staff made eye contact with people when speaking with them and chatted positively whilst completing care tasks. The atmosphere in the communal areas was good natured and calm.

Throughout the inspection we heard people expressing their views and wishes. We saw staff asking people whether they could assist them, what they would like to eat and drink and whether they would like to join in activities. Staff were seen to respect people's decisions and choices. People were supported to be as independent as possible. Staff asked people before providing support and told us they only assisted when it was clear that the person could not manage a task independently. One staff member said, "I always ask before I provide care to people….on this floor people can all indicate if they give consent, even if its by nodding their head….if a resident refuses care, we go back later, most people are co-operative with their care as long as you explain it clearly to them". A person told us, "They let me do what I want; I have quite a lot of freedom".

We looked to see how people and their relatives were involved and engaged in their on-going care planning. Some of the people we spoke with told us they had been involved in drafting their care plan and making decisions about how their care should be provided. One person told us their care plan was "A great big thick book". Although another said, "I need help with washing and dressing but I don't know if I have a care plan". However, overall we saw evidence that suggested that people had been involved in planning their care. For example, we saw that one person who was new to the service had written a detailed history of their own life. A number of other people had life histories drafted by their relatives. Relatives told us they felt involved in their loved ones care and had been asked to share information about what was important to their loved one. One relative said, "Yes I'm involved, they involve in everything, they show me what they are going to do… if I'm not coming in, they phone me if something's not right, for example if they fall, I can't fault it or complain about here".

On the Emery Down Unit we saw that people's records included a 'Dementia Care Needs Plan'. These were written in detail and were individualised in a sensitive manner. There was information about the behaviours people might present with and how staff should best respond to these. For example, two people exhibited repetitive behaviour which meant they asked staff the same question on a regular basis. Each care plan was individualised and provided staff with guidance about how they should respond patiently to reduce the person's anxiety through calmness and distraction. We observed staff following this guidance frequently

during our visit to which people responded positively.
On the Minstead Unit, we were able to see that staff were continuing to work hard to improve the level of detail and person centred information contained within people's care plans. We did note that overall, people's end of life care plans were basic and primarily focused on the person's wishes in relation to the period after their death and would benefit from containing more information about how the person might want their physical, psychological, cultural and spiritual needs to be met in their final days which is acknowledged best practice.

People were treated people with dignity and respect. Staff were polite and courteous. We saw doors were kept closed when people were receiving personal care. We saw staff entered people's rooms, by knocking on their doors and calling out who they were. Staff were able to give us many examples of how they were mindful of people's privacy and dignity to help ensure they remained as comfortable as possible when receiving personal care. The home had recently celebrated Dignity Action Day by planting a Dignity tree. Dignity Action Day is an initiative supported by the National Dignity Council and aims to promote awareness of the need for Dignity in care. People's confidentiality was respected; we saw conversations about people's care were held discreetly and care records were stored securely.

Good

Is the service responsive?

Our findings

People and their relatives told us that the permanent staff had a good understanding of their needs and of their preferences in terms of how their care was provided. One person said, "They [the staff] know me well". Another person said, "They [the staff] know what I need, I can talk to them if I want to". A relative told us, "I am made very welcome on my weekly visits, the nurses always stop for a chat and update me, the staff seem to know [my relative] well". A number of compliments were received about the service which also praised the responsiveness of staff to people's individual needs. For example, one relative had written how staff knew 'each resident personally which is very reassuring'. Another relative had written 'The staff understand Mum's needs and ensure a happy, comfortable and safe environment'. A third relative had commented that their loved one was 'being looked after very well' with staff being 'flexible and willing to work to their specific needs'.

People were assessed prior to their admission to ensure that the service would be able to meet their needs. From this, staff developed a more detailed care plan which helped to ensure they were able to deliver personalised and responsive care. People and their relatives were asked to provide information about their lives before coming to Hartwood House and about their likes and dislikes. This helped staff to deliver person centred care.

Records were written in a manner that helped to make sure people received care that was centred on them as an individual. We looked at the records of three people who lived on the Emery Down Unit. All three included a high standard of relevant and personalised information. For example, one person was living with a life changing condition. The person's care plan provided extensive information about the person's abilities and how staff could support the person to maintain as much independence as possible even in small ways. A second person had a nutrition plan which included detailed information about how they were to be supported with their artificial feeding regime. The plan was very person centred and comprehensive and provided detailed guidance for staff.

Handover meetings were conducted daily during which staff shared information about any new risks or concerns about a person's health. People now had keyworkers who were responsible for ensuring that their care plans remained up to date. Reviews were completed monthly and a written summary showed any changes made, so updates were easily shared between staff. Three monthly reviews of care plans were undertaken with the person and their relatives. A staff member told us how they had recently been involved in a review with a person and their daughter. They had reviewed the care plan in depth which they felt had enabled them to have a better insight into the person's life before coming to the service and the things that were most important to them. These measures helped to ensure that people's care plans remained relevant and continued to meet their individual needs.

People and their relatives felt that staff recognised and responded to changes in their health care needs. One visitor told us that staff had picked up quickly that their relative needs had changed, they said, "They recognise issues and respond". We saw that one person had been noted to have lost a concerning amount of weight. They had promptly been referred to the GP and had been commenced on nutritional

supplements. A review of the GP book on each floor showed that people were being referred for a medical review due to sounding chesty or having the signs of a urine infection. This helped to ensure that when necessary people had access to prompt care and treatment to meet their individual needs.

The service employed two activity coordinators who provided a total of 58 hours of both group and one to one activities for people living at the home including during some weekends. A schedule of activities was advertised and included walks in the garden, movement to music, nails and hand massage and baking club. During the inspection only one of the activities staff was available, but we saw that they spent time engaging people in jigsaw puzzles and colouring. On the second day of our inspection, a pianist visited the home and this was well attended by people who appeared to greatly enjoy the visit. People were mostly positive about the activities. One person said, "The usually have at least two [external activities] a week, we've had animals in that you can hold…we've had a pianist and a singer and also a puppet show". A small number of people told us the activities could be more tailored to their particular interests. For example, one person on Minstead Unit told us they 'Hated jigsaws". We observed that once they had finished reading their newspaper in the morning, there was little else available to entertain them. The registered manager told us she had arranged for some people to visit a local wellbeing day centre. One of the people who attended this told us, "Every Monday we go to the [wellbeing centre]…we do quizzes and have lots of fun, its so much fun there". A member of staff told us, "We do one to one and pampering with the ladies". They explained that when people didn't want to engage with the planned activities, it was often a case of "Holding their hands". Another member of staff told us, "The activities are good, they went to the motor museum last week, they really enjoyed it, there is always something going on, although some do like their own company too".

People knew how to make a complaint and information about the complaints police was readily available within the home and in the service user guide. The registered manager told us, "We don't get a lot of complaints we try and sort things out before they become a complaint". Three complaints had been received in the last 12 months. They had each been responded to in line with the provider's complaints policy. All of the people we spoke with told us they had no complaints about the care they received, but they were confident that they could talk with a staff member or the registered manager and that any concerns would be listened to and acted upon.

Good

Is the service well-led?

Our findings

Most of the people we spoke with had no concerns about the leadership of the home. One person said, "Yes I know who the manager is, I see them most days". A relative told us, "It's all very good, very friendly. [The registered manager] is extremely nice. She greets me warmly; I'm very fond of her". Another relative said, "Yes I see the manager around doing things, she seems to know the residents well".

A range of audits were being undertaken to monitor the effectiveness of aspects of the service including care documentation, infection control and medicines management. Where areas requiring improvement were identified, an action plan had been drafted. We reviewed the most recent action plan resulting from an infection control audit and found that the required actions had been completed. The registered manager submitted a weekly report to the provider which looked at risks within the service and how these were being managed. The provider also undertook regular visits to the service and undertook audits which assessed whether the service was safe, effective, caring, responsive and well led. Reports were produced in response to these visits and were used by the registered manager to drive improvements.

The engagement and involvement of people and their relatives was encouraged and their feedback was being used to drive improvements. Meetings with people and their families took place regularly. We saw the minutes of these meetings. They had been well attended and were used as an opportunity for the registered manager to update people about changes or developments within the service and for people to ask questions. For example, at the most recent meeting, we saw that questions had been asked about keyworkers and about having visits from pets.

Staff meetings were held on a regular basis. We saw that these were an opportunity to participate in discussions about how aspects of people's care and support was being managed and their roles and responsibilities. We saw that the meetings were also used to enhance their skills and knowledge. For example, we saw that the registered nurses had met in January 2016 and had used the meeting to explore the procedures for referring to specialist advocates. They had also spent time discussing how best to approach the care needs of one person with complex and multiple healthcare needs.

The registered manager was continuing to work to improve staff morale and the recruitment and retention of staff. The staff survey which had been completed by 48% of staff showed an increase in satisfaction in every area surveyed compared to January 2015, including to the questions, 'I feel part of a team'. Staff comments included, 'The chain of command is friendly from the top to bottom' and 'I like the fact that we have a supportive manager. We are able to talk to our manager and go to her if we have any issues or concerns. I think Hartwood House is a lovely home and everybody that works here aims to provide the best possible care for our residents'. Where staff had noted areas for improvement, these related to the need for more permanent staff. The results of the survey reflected the feedback we received from staff. Some staff told us they were not happy about aspects of their role and that morale amongst the staff team was low. They were frustrated that there continued to be high agency use and poor retention of staff, they felt more needed to be done to improve job satisfaction, One staff member said, "I think we are just not asked what's wrong enough". Others though were very happy in their roles. One staff member said, "The manager has

always been very nice to me, I like working here, it's nice". Another said, "There is a culture of openness and fairness, I have a job description, what I do reflects that, the manager is polite and professional, there is good moral now, I am not aware of the staff team being concerned about anything". A third staff member said, [the registered manager] is supportive, they will help with breakfasts, their first focus is on the residents". We spoke with the manager about the feedback from staff, they acknowledged that there had been some issues with staff morale, particularly on one of the units. They felt this was improving. They were confident that most staff believed them to be working hard, transparent and accessible and that the recruitment and retention of staff was being treated as a priority. They told us that it was important that staff felt valued and that to support this, an employee of the month scheme had been introduced to reward staff. The registered manager explained that this had not been awarded in December but would now be used each month to reward and thank staff for their hard work.

Hartwood House were continuing to develop their links with the local community to enable people to continue to engage in community life. For example, they had recently hosted a Dementia Matters coffee morning and a pamper day for local mums. They had welcomed children from the local primary school to had spent time reading with people.

The provider's philosophy of care was to understand and respect each person's individuality and to provide everything they needed to live a dignified and fulfilling life. Their values of care, comfort and companionship were central to this. The staff survey showed that staff were confident that they understood these values and provided care in a manner which was keeping with the values. Our conversations with people indicated that most felt did feel they received a good quality of care in a comfortable environment and where they had access to the companionship they needed to live a fulfilled life.