Hazeldene House Ltd

Hazeldene House

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

Hazeldene House is a nursing home that was purpose built and opened in 2011. It is registered to provide nursing care, personal care, treatment of disease, disorder or injury, and accommodation for people who require nursing or personal care. It caters for up to 80 persons living with dementia. Accommodation is provided over three floors in spacious care suites that people are able to rent or lease-buy. People purchase care packages according to their needs and wishes and although people are able to choose any other registered domiciliary care providers, 99% of the care is currently provided by an in-house team of registered nurses and care workers who are available 24 hours a day.

There were 77 people living in the home at the time of our inspection, 76 of whom lived with dementia. Not all of the people living in the service were able to express themselves verbally and communicate with us.

This inspection was carried out on 19 and 21 January 2016 by two inspectors and an expert by experience. It was an unannounced inspection.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced. There were sufficient staff on duty to meet people's needs. Staffing levels were calculated and adjusted according to people's changing needs. There were thorough recruitment procedures in place which included the checking of references.

Medicines were stored, administered, recorded and disposed of safely and correctly. Staff were trained in the safe administration of medicines and kept relevant records that were accurate.

People's care suites were respected by staff as being their private quarters and these were personalised to reflect people's individual tastes and personalities.

Staff knew each person well and understood how to meet their support and communication needs. The premises were well maintained and suited people's needs.

Staff had received essential training and were scheduled for refresher courses. New recruits did not work on

their own until they were able to demonstrate the relevant competence. Staff had the opportunity to receive further training specific to the needs of the people they supported. All members of care staff received regular one to one supervision sessions and were scheduled for an annual appraisal. This ensured they were supported to work to the expected standards.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered as per the Mental Capacity Act 2005 requirements. Staff sought and obtained people's consent before they helped them. People's mental capacity was assessed when necessary about particular decisions and meetings were held with appropriate parties to make decisions in people's best interest.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People praised the food they received and they enjoyed their meal times. Staff knew about and provided for people's dietary preferences and restrictions.
Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect. People told us they were very satisfied about how their care and treatment was delivered.
People were involved in their day to day care. People's individual assessments and care plans were reviewed monthly with them or their legal representatives and updated when their needs changed. Relatives were invited to attend reviews that were scheduled.

Clear information about the service, the facilities, and how to complain was provided to people and visitors.

People were able to spend private time in quiet areas when they chose to. People's privacy was respected and people were assisted in a way that respected their dignity.

People were promptly referred to health care professionals when needed. Personal records included people's individual plans of care, life history, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged people to do as much as possible for themselves.

People were involved in the planning of activities that responded to their individual needs. People's feedback was actively sought, encouraged and acted on.

Staff told us they felt valued by the registered manager and the management team. The registered manager was open and transparent in their approach. Emphasis was placed on continuous improvement of the service.

A relatives described the management of the service as "Really efficient." The registered manager kept up to date with any changes in legislation that might affect the service and comprehensive audits were carried out regularly to identify how the service could improve. They acted on the results of these audits and made necessary changes to improve the quality of the service and care.

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 were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs safely.

Safe recruitment procedures were followed in practice. Medicines were administered safely.

The environment was secure and well maintained.

Is the service effective?

Good

The service was effective.

Staff were trained and had a good knowledge of each person and of how to meet their specific support needs.

The registered manager understood when an application for DoLS should be made and how to submit one. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable about the requirements of the legislation.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable food and drink. People were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness, compassion and respect.

Staff promoted people's independence and encouraged them to do as much for themselves as they were able to.

People's privacy and dignity was respected by staff.

People and their legal representatives were consulted about and involved in their care and treatment.

Is the service responsive?

Good

The service was responsive to people's individual needs.

People's care was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when needs changed. The delivery of care was in line with people's care plans.

A daily activities programme that was inclusive, flexible and suitable for people who lived with dementia was implemented by social assistants.

The service sought feedback from people and their representatives about the overall quality of the service. People's views were listened to and acted on.

Is the service well-led?

Good

The service was well-led by the registered manager and the deputy manager who placed people and staff at the heart of the service.

There was an open and positive culture which focussed on people. The registered manager welcomed people and staff's suggestions for improvement and acted on these. Emphasis was placed on continuous improvement of the service.

The staff told us they felt well supported and valued under the registered manager's leadership.

There was a robust system of quality assurance in place that included audits and action plans to address any shortfalls. Action was taken promptly to implement improvements.

Hazeldene 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 and in response to information of concern we had received. This inspection was carried out 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 was carried out on 19 and 21 January 2016 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who took part in the inspection had specific knowledge of caring for older people who live with dementia.

The provider had not received a Provider Information Return (PIR) prior to our 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 gathered the information needed during our inspection, and looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events.

We looked at 15 sets of records which included those related to people's care and medicines. We looked at people's assessments of needs and care plans and observed to check that their care and treatment was delivered consistently with these records. We consulted documentation that related to staff management and six staff recruitment files. We looked at records concerning the monitoring, safety and quality of the service, menus and the activities programme. We sampled the services' policies and procedures.

We spoke with 18 people who lived in the service and 12 of their relatives to gather their feedback. Although most people were able to converse with us, others were unable to, or did not wish to communicate. Therefore we also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, the deputy manager, the sales co-ordinator, three activities co-

ordinators (social assistants), three nurses, eight members of care staff, two members of kitchen staff, one housekeeper and a person responsible for the maintenance of the premises. We also spoke with two local case managers who oversaw people's care in the home. We obtained feedback from two GPs who visit the service regularly, and the GP surgery practice manager about their experience of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living in the service. They told us, "I feel safe being here" and, "We are in security here." Relatives told us, "With all the staff around, this is without a doubt the safest place for our relative to be" and, "Safety was the major issue when our relative lived by herself but this is completely resolved now she lives here because help is at hand and we know we can rely on the staff."

Staff who worked in the service had completed safeguarding training and they understood the procedures for reporting any concerns. All of the staff we spoke with were clear about their responsibility to report suspected abuse. There was a detailed safeguarding policy in place in the service that reflected local authority guidance. This included information about how to report concerns and staff knew they should report to the local authority or the police if necessary. The deputy manager had developed summary versions of important policies to help staff understand and retain information about concerns such as safeguarding. Staff were aware of the whistleblowing procedure in the service and staff we spoke with expressed confidence that concerns would be raised. One staff member told us 'People would speak up for sure'.

Processes were in place to ensure that there were sufficient numbers of staff on shift to meet the needs of the people who lived in the service. There was a protocol that was used to review people's needs to ascertain if additional staffing was required. The deputy manager was able to evidence that additional staffing had been put in place recently when it had been identified that a particular person required additional support. Staff confirmed that they would cover additional shifts if required and rotas showed that there were consistent staffing levels throughout the week including weekends. This included auxiliary staff such as housekeepers. Rotas accurately reflected the number of staff it had been identified were needed to support people in the home safely. When people called staff for help, this was responded to within a few minutes. One person told us, "There is always someone about to help you and they come ever so quickly." There was an appropriate number of staff deployed to help people in the lounges and at mealtime.

The premises were secure and well maintained. Visitors to the home were asked to sign in and there were keypads for the doors and lift that were used to maintain security at the home. Records showed that any maintenance issues were addressed in a timely manner. The deputy manager maintained a spreadsheet in order to provide an overview of any outstanding issues. Checks were also made to ensure that equipment was serviced regularly in line with manufacturers' guidance. Contracts were in place for checks on the water supply to prevent Legionella and appropriate pest control contracts were in place. Risk assessments had been developed and reviewed in relation to the premises. For example, there was a detailed fire risk assessment in place for the premises. A risk assessment had been written in regard to the registered manager's friendly dog who often accompanied her on the premises.

There was a detailed cleaning schedule which was followed within the home. We spoke with the head housekeeper and they outlined the procedures they had in place including schedules for deep cleaning. Cleaning products and personal protective equipment were in ample supplies. Staff used the equipment appropriately and wore aprons and gloves when providing personal care. There were two members of staff

who were the designated infection control leads across the day and night shift. Staff had completed training in infection control as part of their essential training. There were suitable laundry facilities in place within the home. Infection control audits were carried out every six months. The last audit in November 2015 had led to procedures about decontamination of equipment to be reviewed and discussed at a management meeting. There were information sheets available for all of the chemicals that were used in the home.

The premises were safe for people because the home, the fittings and equipment were regularly checked and serviced. Each person's environment had been assessed for possible hazards. People's care suites were free of clutter and spacious. A coded entry system ensured that people remained safe inside the service and were accompanied by staff when they needed or wished to leave the building. There was a system in place to identify any repairs needed and action was taken to complete these in a reasonable timescale. An appropriate log of repairs was kept and appropriately monitored.

There were plans in place that detailed how people would be kept safe in case of an emergency. This included a business continuity plan that identified alternative accommodation if it was necessary to evacuate the building. People who lived in the service had personal emergency evacuation plans in place. These were available in an accessible location and had been coloured coded to show the level of support that people required supporting them to evacuate the premises depending on the levels of their mobility. Staff had received fire training and drills were regularly carried out and documented in order to ensure that staff had the skills and training to respond to an emergency. There was appropriate signage about exits and all fire protection equipment was regularly serviced. The two lifts in the premises were regularly maintained and checks of people's portable electrical appliances were carried out to ensure they were safe to use. Equipment that was used by staff to help people move around was checked and serviced annually.

Accidents and incidents were being monitored to identify any areas of concern and any steps that could be taken to prevent accidents from reoccurring. Accident reports included information about any injuries sustained and body maps were completed when appropriate. Staff confirmed that they were informed about accidents and incidents at handovers. One staff member told us 'The nurse will complete the accident form and we will be told about it at handover and discuss any measures in place'. Audits of accidents such as falls were carried out to identify any triggers or patterns.

Risk assessments were centred on the needs of the individual. These were reviewed by nurses and senior care workers every month or as soon as an incident had been identified and/or when people's needs had changed. They were updated appropriately. Staff were aware of the risks that related to each person. Each person who had been identified at risk of falls had been provided with a sensory mat to alert staff when they got out of bed so they could be helped if needed. A person who experienced hallucinations such as objects in front of them had been assessed as being at risk of falls and staff provided extra support when they walked. Another person had been assessed as being at risk of displaying behaviour that may challenge others. Their risk assessment recommended certain strategies to distract the person if necessary. The staff we spoke with were knowledgeable about these control measures and applied them in practice. We saw that staff helped people to move around safely and that people had the equipment they needed within easy reach.

People had their medicines at the prescribed times. One person said, "I rely on the staff to give me all my tablets and they have never forgotten." Medicines were appropriately managed to ensure that people received their medicines as prescribed. Staff followed clear guidance and adhered to the service's medicines policy. The service had recently upgraded their system of recording the administration of medicines to an electronic system. This new system allowed for stock to be managed and monitored appropriately. There was a sufficient supply of medicines in stock to meet the needs of people in the home. Medicines were

stored in clean and well organised cabinets. Treatment rooms were clean and free from clutter. All medicines seen were in date and liquid medicines had been dated when they were opened. Controlled drugs were appropriately stored and checks on stock were made regularly. When appropriate, medicines were destroyed using 'doom kits' when no longer required. The temperatures of the treatment rooms were monitored to ensure that medicines were stored at suitable temperatures in accordance with manufacturers' instructions. Regular audits of medicines records and competency checks were carried out and documented to check that medicines administration records were appropriately completed and to ensure staff maintained best practice. Recent audits and checks had not identified any shortfalls.

The service's medicines policy provided clear guidance concerning how and when medicines would be administered covertly when people may not have the mental capacity to make this decision for themselves. The policy recommended that appropriate medical professionals must be involved in the decision and a best interest assessment must be completed. Mental capacity assessments and meetings with people's families and/or legal representatives and GP had been carried out and documented and decisions had been made in people's best interest in regard to covert administration of medicines.

We reviewed the use of special mattresses for people who were at risk from developing pressure wounds. We saw that their weights were monitored and the settings on the beds were adjusted accordingly. Records showed that people who were being nursed in bed were regularly repositioned to help to prevent pressure wounds. Nurses who were spoken with showed an awareness of the need to consider nutrition when caring for a person with pressure wounds. They worked closely with the local tissue viability nurses to ensure that pressure wounds were managed effectively. The service maintained a suitable supply of dressings to treat pressure wounds. The registered manager told us, "We have a good professional relationship with the tissue viability nurses and we are pre-empting pressure wounds before they have a chance to develop." People had not experienced pressure wounds in the service for the past twelve months.

Appropriate checks had been carried out to ensure that staff recruited to work in the service were suitable and of fit character. References were taken up before staff started working at the home and a full employment history was documented in staff files. Criminal checks were completed through the Disclosure and Barring Service (DBS) and professional registration was checked when nurses started working at the home. Registration was now checked on line and this was monitored by the registered manager. Checks had been carried out to ensure that staff employed by the home had the legal right to work in the United Kingdom.

The service had a disciplinary procedure in place that was followed if necessary to address any concerns about staff performance. Although there were no current concerns about staff performance, the deputy manager was able to provide an account of when the procedure had been used effectively to address concerns in the past. The disciplinary procedure for the service was clear and detailed. For example, it included information about the steps that would be taken in case of concerns about performance and also outlined the actions that could be taken if the staff member felt they had been unfairly treated and wished to raise a grievance.

Good

Is the service effective?

Our findings

People said the staff gave them the care they needed. People told us, "The staff understands me", "They speak slowly so I can understand", "I like the food" and, "The food is always very nice." A relative told us, "The staff seem very skilled at managing the residents' moods" and, "The staff are very efficient, they know how to care well for people; they know what works."

Staff knew how to communicate with each person. Staff were bending down so people who were seated could see them at eye level. There was a hearing loop system in the reception area. A care plan for a person who had visual impairment included guidance for staff about how to communicate effectively with them. The staff followed this guidance and ensured they were heard and understood and escorted the person if they needed to be helped with finding their way around. A special daylight lamp was used behind a person for reading and when they were having their meal. Hearing aids were checked by staff each morning when they ensured people were wearing them for the day. The registered manager told us that approximately 60% of the staff were originating from abroad, and that several members of staff had attended evening classes to improve their fluency in English. All the staff we observed and the staff we spoke with were able to make themselves understood by people, were speaking clearly and understood spoken and written English. The registered manager told us that two members of staff were in the process of improving their English and as they could not yet be understood by people they were mentored by other staff and did not work on their own. We observed one of these two members of staff shadowing their colleagues and presenting two dishes to people for them to choose from at mealtime. They achieved a good level of communication and people were served their preferred option. All staff used positive body language and were smiling when conversing with people. One person told us, "There is no problem communicating with the staff, they are all lovely."

There was an effective system of communication between staff. Staff handed over information about people's care to the staff on the next shift twice a day on each of the three floors. These meetings were recorded and information about new admissions, accidents and incidents, referrals to healthcare professionals, people's outings and appointments, medicines reviews, people's changes in mood, behaviour and appetite was shared by staff appropriately. This system ensured effective continuity of care.

New staff had an induction before they started working at the service. Essential training was provided within six weeks and a mentor system ensured new staff were 'buddied' with a more experienced member of staff so that they could shadow, ask questions and observe delivery of care in practice. They read care plans and learned about people's individual care needs and preferences. New recruits worked towards acquiring the 'Care Certificate' that was introduced in April 2015. This care certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Staff were provided with an employee handbook that contained comprehensive information about the code of conduct and standards the provider expected them to maintain.

Staff had appropriate training and experience to support people with their individual needs. Staff were provided with essential training, and were scheduled for refresher courses. There was a monitoring system that indicated all essential training was up to date or that refresher courses were scheduled to take place.

Staff were reminded when they needed to renew their training. The staff we spoke with were positive about the range of training courses and informal opportunities they had for learning that were available to them. Two members of staff told us, "The training is very good, we have face to face training for manual handling, first aid and fire awareness, or E'learning for anything else, and we get tested on our knowledge all the time" and, "Every day we are learning".

The registered manager had set up a system that ensured staff knowledge was maintained. Twice a week during handover, five topics relevant to care and treatment were discussed and questions were asked by nurses and the manager to test what the staff had retained from their training and from these discussions. A nurse told us, "This is called 'Awareness for staff' and it is very interesting, it can be about mental capacity, dehydration, respect and dignity, anything that relates to what we have learned". Staff had the opportunity to receive further training specific to the needs of the people they supported. For example in dementia care awareness, behaviours that challenge, end of life care, diabetes care and Parkinson's disease. The registered manager had ensured that face to face training complemented online training. For example, tutors were scheduled in March and April 2016 to deliver courses on behaviours that challenge, infection control, and diet and nutrition. This ensured staff had the knowledge and skills they needed to care for people effectively.

Staff were supported to study and gain qualifications for a diploma in health and social care. The registered manager told us, "We promote from within and staff are encouraged to progress within this organisation." Most of the care staff either had gained a diploma while in employment or were scheduled to enrol in a study programme. One member of staff had declined the opportunity and this had been respected. An English teacher was scheduled to support two new members of staff who were not ready to undertake academic studies in English. Nurses were supported to attend additional study days relating to specialist topics such as catheter care, end of life care and phlebotomy. The service had joined the Federated Scheme at the local hospice to access training and qualifications for staff via a Qualifications and Credit Framework (QCF) that provided flexible routes to full qualifications, and four care workers were scheduled to take part in the scheme. This meant that staff were able to develop their skills and knowledge.

The registered manager and deputy manager monitored staff skills and competence regularly to make sure they were using their training in practice and were working to the expected standards. This included observations of how staff cared for people and how they safely used the equipment to help people move. The registered manager came out of hours to observe staff unannounced and check that good practice was maintained. An annual appraisal of staff performance was scheduled for all staff to ensure expected standards of practice were maintained. This ensured that staff were appropriately supported and clear about how to care effectively for people.

Staff were supported to carry out their role effectively. They had access to one to one supervision meetings every six to eight weeks and told us they found this support helpful in their day to day work. The registered manager supervised nurses every month. As the registered manager did not have a nursing background, they consulted a manager from a sister service who was a senior nurse when in doubt about any clinical matters that arose during supervision. One staff member told us 'It helps us improve and do our jobs better'. Another staff member told us 'We can discuss anything and get the guidance we need if in doubt." Staff told us they felt valued by the service and by the management team. There was a 'Carer of the year award' in place and at the last award, three members of staff had been awarded with a sum of money, a stay in hotel and a trophy.

There were members of staff who had received advance training and had taken the lead in specific areas of care. They offered guidance and were a point of reference to other staff. For example, one nurse was the

lead in medicines, two nurses were the leads in infection control, and another nurse was the lead in end of life care and mental capacity. The registered manager was a dementia care champion and the deputy manager took the lead in behaviours that challenge.

Staff consistently sought and obtained people's consent before they helped them and no restraint was used in the service. One relative told us, "They are always so respectful and they always ask if it is OK for them to do this or that before they do anything." When people declined, for example when they did not wish to get up or go to bed, or when they declined to eat a particular dish, their wishes were respected. Staff told us, "We always respect their wishes, and often we ask again a few minutes later, maybe in a different way, to see if they still feel the same."

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We discussed the requirements of the Mental Capacity Act (MCA) 2005 and DoLS with the registered manager and they demonstrated a good understanding of the processes to follow. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest, and for people who were unable to come and go as they pleased unaccompanied. The registered manager had considered the least restrictive options for each individual. Staff were trained in the principles of the MCA and the DoLS and the five main principles of the MCA were applied in practice. For example person's mental capacity had been assessed regarding receiving their medicines covertly to determine if they could consent to this. When people had been assessed as not having the mental capacity to make specific decisions, a recorded meeting had taken place with parties such as their legal representatives, GPs and local authority case manager to decide the way forward in people's best interest.

Mental capacity assessments were carried out to ascertain whether people could give their informed consent to their relatives having access to their care plans and personal data. Meetings with their legal representatives had been held or were scheduled to take place, to confirm whether this access could be facilitated in people's best interest. This ensured people's rights to make their own decisions were respected and promoted when applicable.

A senior environmental health officer had inspected the service in November 2015 and had awarded a five star rating in Food Hygiene standards to the service. Cooked breakfasts were offered as an alternative to continental breakfast. We saw several people had their breakfast late in the morning as they preferred. We observed lunch being served in the dining areas and in people's bedrooms. The meal was freshly cooked, hot, well balanced and in sufficient amounts. Condiments were available. A variety of drinks were available for people to choose from. Food was kept hot at the required temperature within a maximum of two hours and this was monitored in the kitchen before the food was dispatched in dedicated trolleys. People were asked where they preferred to sit and were shown two dishes when they were not able to make up their mind from the menu. One person had requested an omelette instead and this had been provided. Equipment such as plate guards was provided to help people eat independently when necessary. People

were supported by staff with eating and drinking when they needed encouragement.

People told us the food was plentiful and that they were able to have second helpings if they wished. There was a choice of two main dishes and two desserts at mealtimes. Some relatives had commented on a nutrition survey that the food appeared bland at times. We noted that the food was not presented in a way to stimulate people's appetite and that brown gravy covered a dish in ample amount. This may present a difficulty for people living with dementia as they may be unable to differentiate food items. We spoke to the registered manager who was aware of this and who had plans to review presentation with the head chef when they returned from leave. On the second day of our inspection, more attention was paid to food presentation and the dishes looked colourful and appetising. The chef and kitchen assistant referred to clear documentation about people's allergies, dietary restrictions and preferences. This information was updated daily and located in the kitchen.

People were weighed monthly and fluctuations of weight were noted and acted on. For example, if people lost a specified amount of weight within a timeframe, they were weighed weekly, provided with a fortified diet, and were referred to the G.P., dietician or a speech and language therapist when necessary. People were provided with a fortified diet and nutritional supplements such as milkshakes due to weight loss and their weight was closely monitored and discussed at staff handovers. They had been checked for possible infection. With this monitoring system in place people could be confident that their needs to maintain a healthy weight were addressed effectively.

Home-made cakes and scones, biscuits, jelly, fresh fruit and milky drinks were served three times in between meals throughout the day. People were encouraged to have hot or cold drinks throughout the day and staff checked regularly whether people may like a cup of tea. The chef sent cereals, bread milk and jam to each of the three kitchenettes situated in each lounge. A member of staff told us, "That way we can always offer additional toast or a mini breakfast in between meals if people are peckish." Two people were offered toast and marmalade when they declined the cakes from the trolleys. Two relatives told us, "There is definitely no shortage of food, the food is always coming in" and, "Our father has put on weight since he had come to live here because food is always available and kindly offered; the cakes are particularly delicious." This meant that people's nutritional needs were effectively met.

People's wellbeing was promoted by regular visits from healthcare professionals. People were able to retain their own GP, and people who preferred to register with the local GP surgery were helped to do so. A chiropodist visited every six weeks to provide treatment for people who wished it. An optician visited people upon request. People were offered routine vaccination against influenza. People had been referred to healthcare professionals when necessary. For example, to a tissue viability nurse, and speech and language therapist and a community psychiatric nurse. When people became unwell, records about their health needs were updated and information was promptly communicated to staff so effective follow up was carried out. This ensured that staff responded effectively when people's health needs changed.

The premises had been designed to meet the needs of the people who lived at the service. The care suites were spacious and light and people were able to furnish them and personalise them as they pleased. Corridors within the home were wide with hand rails that allowed for people to move around freely. Doors were painted different colours to help aid orientation for people with dementia. Some people had their photographs on their care suites doors. There were specially adapted sensory bathrooms that were available within the home if people wished to access them. There was a range of communal areas available for people to access and they were able to spend time with friends and family in private if they wished. A hairdressing salon that was welcoming was well attended and manned by a hairdresser who had received training in caring for people living with dementia. There was a family area available near the lobby where

there were toys available for visiting children.

Good

Is the service caring?

Our findings

People told us they were satisfied with how the staff cared for them. They said, "I love it here, the staff are so kind", "They [the staff] are happy so I am happy too", "We all get on very well the care workers are very good" and, "They [the staff] are so lovely." Relatives told us, "The care people receive here is excellent", "I cannot fault my relative's care" and, "The staff are very good with my wife, very caring and you never hear them say no to anything." A GP who visits the service regularly commented, "I would be happy for a member of our family to be resident at Hazeldene House."

We spent time in the communal areas and observed how people and staff interacted. Most of the people living in the service chose to spend time with others in the lounge and there was a homely feel to the service. Staff spent time to sit and chat with people in the lounges and they listened to people and responded in a compassionate manner. Staff also checked discreetly on people when they preferred to remain in their bedrooms and offered them options about attending activities or having a hot drink. One care worker spent time with a person who wanted to be escorted while they walked in the corridors and sat with them in one of seating areas to have a chat and ensure they were not anxious. All staff were observed to attend to people's needs while respecting their pace and individual ways to communicate. A person had slid off their chair and three members of staff responded to the situation with efficiency and kindness. The person was offered plenty of explanations about how they were about to intervene and use equipment to relocate them safely where they wanted to be. The staff approach was kind, patient and respectful. Staff took care to turn an alarm sensor off by the side of a person's bed before a relative came to visit so they would not be interrupted. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully by their preferred names. Staff told us they valued the people who lived in the service. They told us, "They are like my grandparents – I care for them like my grandmother", "It is important to do a good job and, "It's a homely home with lovely people, we're like a family'".

All staff knocked on people's care suites, announced themselves and did not go in unless people invited them in. Care plans included instructions for staff to follow when helping people with their personal needs. People were assisted discreetly with their personal care needs in a way that respected their dignity. A person told us, "They treat us with respect, and when they help me have a bath they are ever so discreet." A care worker went to fetch a blanket to preserve a person's dignity in the lounge when their legs became exposed while they were sleeping. The importance of preserving people's dignity had been discussed at 'awareness for staff' meetings. Staff were careful to speak about people respectfully and maintained people's confidentiality by not speaking about people in front of others. People's records were kept securely to maintain confidentiality and each member of staff had their own password to access people's records.

The staff encouraged people to do as much as possible for themselves. Staff checked that people were appropriately dressed and all people were well presented with comfortable clothing and footwear. People washed, dressed and undressed themselves when they were able to do so. People followed their preferred routine, for example some people chose to have a late breakfast, or stay up late. Staff presented options to people so they could make informed decisions, such as what they liked to eat, to wear or to do, to promote people's independence. People had access to the lounge kitchenettes to make themselves snacks and hot

drinks if they wished and if it has been assessed this was safe for them to do so. A person who was eating their food too quickly had been referred to a speech and language therapist and a smaller spoon was introduced so the issue would be resolved in a way that meant they could continue to eat independently. People left the premises accompanied by their relatives to eat out, to attend appointments, go shopping or meet friends.

Attention was paid to equality and diversity. A person kept a shrine in their care suite and staff helped replenish fruit that was placed daily on the shrine. People's spiritual needs were met with the provision of religious services held in the service for people who were of Catholic and Church of England faith. The registered manager told us they would help any person who wished to attend other services should they wish to. A person was accompanied by staff to attend a church coffee morning.

Clear information about the service and its facilities was provided to people and their relatives. There was a residents' handbook that outlined clearly the terms and conditions of residence. The complaint procedure was on display should people or their relatives wish to complain. A wide range of informative leaflets were available to people and visitors that included, 'Alzheimer's and memory loss', 'Improving lives through dementia research', Parkinson's information and support', and 'Health Watch: Speak out'. Boards were displayed that showed photographs and names of each member of staff who worked in the service. All staff wore named badges. Individual activities were displayed on an information board in a bright pictorial format to help people understand what was on offer. People were provided with pictorial information to explain DoLS. Although menus were not in a pictorial form, the social assistants had started to take photographs of dishes in preparation for a pictorial menu. In the meantime, people were shown the dishes to assist their choosing. The minutes of recent residents' meetings were displayed so people and their relatives could be informed about what had been discussed if they had been unable to attend the meetings. There was a website about the service and sister services that was informative, well maintained and user-friendly.

People were involved in their day to day care as much as they were able to and when they wished to be. People's care plans and risk assessments were reviewed monthly to ensure they remained appropriate to meet people's needs and requirements. Relatives were invited to participate in the reviews with people's consent or when they held legal power in regard to their welfare. A relative told us, "It is marvellous to be able to get online and see the latest update in the care plans and also have a say, especially when you live far away."

People or their legal representatives were consulted about how they wished the service to manage their care and treatment when they approached the end of their lives. When people had expressed their wishes regarding resuscitation, these were appropriately recorded. The staff knew how to care for people at the end of their lives and were supported by a local hospice palliative team with whom they had developed an effective professional relationship. Pain relieving plans were written and implemented in collaboration with the hospice palliative team. A relative told us, "I only have praise for the way they helped my mother when she passed away." The service's policy on end of life care followed specific guidance developed by Skills for Care based on the National End of Life Care Programme 2012, SCIE briefing on End of Life care for people with dementia living in a care home 2012, the DoH End of Life Care Strategy 2008 and the DoH guidance on Advanced Care Planning 2007. As practice was underpinned by appropriate models of care, people could be confident that best practice would be maintained for their end of life care.

Good

Is the service responsive?

Our findings

People were satisfied about how staff responded to their individual needs. Two people told us, "I do what I want", "It is lovely that we have our own hairdresser", "There is always something to do so I never get bored" and, "They [the staff] know what I like". Relatives told us, "The entertainment makes my wife happy; They [the staff] move her from floor to floor if she wants to join another activity."

People were encouraged to personalise their care suites as they wished and bring their own articles of furniture apart from beds that could be adjusted and lowered to the floor to minimise their risk of falls. The lounges included several armchairs that people had brought with them. The registered manager confirmed that people were able to choose to receive care and treatment from other external services. This information was clearly provided in resident handbooks, and in tenancy agreements. The sales co-ordinator further explained this option to people and their legal representatives before they entered a contract with the service. Two people had chosen to retain their private care workers to complement their care package. The sales co-ordinator told us, "Usually people prefer to use our care force for convenience, or may wish to retain their private care workers just for a transition period, however the choice is theirs."

People's needs had been assessed before they moved into the home in respect to their day-time and night-time care and to check whether the service could accommodate these needs. An initial assessment of people's individual needs was written within 24 hours after people had come into the service. This addressed people's choices and decisions over their care and lifestyle, and their needs in relation to their communication, mobility, skin integrity, nutrition, health and medicines.

Individualised care plans about each aspect of people's care were developed further within a month, as staff became more acquainted with people, their particular needs and their choices. Staff sat with people and their representatives when persons had difficulties with communication, to discuss what they liked, disliked, and to note their preferences about routine, hobbies, activities and food. A booklet called 'My Life Story' was completed for each person and included people's accounts of significant events and persons in their life, their history and their past professional activities. This helped staff understand people's perspectives.

The registered manager reviewed the care plans after the first four weeks to ensure all their needs had been addressed. People had emergency health care plans, which were agreed plans of care should the person become unwell. All care plans were written referring to people's needs with sensitivity. For example, the recommendations for staff when a person had difficulties settling to sleep included, "Quietly check to make sure she is settled and comfortable; if not sleeping well, offer another warm drink and snack, sit and chat to her in the main lounge for about half an hour and then support her gently back to bed". A person who rubbed her heels in bed and who was at risk of skin damage was encouraged to wear specially designed booties and was help to reposition every two hours by staff.

Staff referred to people's care plans several times a day and logged their observations about people's physical and psychological wellbeing. As staff were aware of people's care plans they were mindful of people's likes, dislikes and preferences. For example, they knew when a person enjoyed certain activities,

that they preferred a certain type of music, a bath or a shower, tea or coffee, and particular routines. A person had a particular fondness of dogs and was missing her own dog. This person was provided with daily opportunities to welcome the registered manager's dog on her bed for companionship. With such an approach, people could be confident that staff understood what was important to them and accommodated their wishes whenever possible.

Care plans were reviewed monthly or as soon as people's needs changed and were updated to reflect these changes to provide continuity of their care and support. A person who had difficulties adapting to their new surroundings had been referred to their GP and the local mental health team to check their medicines were appropriate and assess whether they could benefit from the support of a community psychiatric nurse. A person whose relative had died in the service was allowed to remain in their room until such time as they felt ready to move to another service that was more suitable for their needs. Staff were sensitive to the person's bereavement. This indicated that the staff focussed on and responded to people's individual needs in relation to their physical, mental and emotional wellbeing.

Staff placed emphasis on the improvement of people's health. One member of staff told us how satisfied they felt when a person had regained a certain level of mobility. Two relatives told us told us how their relative's health had improved since they had come into the service. One relative said, "After a fantastic two and a half years of care, my wife is better now than when she came in; she is more mobile and alert." A person's behaviour had greatly improved as they were provided with one to one attention from staff; a person who remained in bed for a period of five years had put on weight when they had needed to, and had no pressure area due to staff responding well to their needs.

A range of daily activities that were suitable for people who lived with dementia was available. Three social assistants provided activities in the morning and in the afternoon on each floor during weekdays. This included gentle exercise, art and crafts, motivation classes, light cooking, music, singing and reminiscence. Musicians such as a jazz band and a harpist and entertainers such as a 'singing cowboy' came to perform. People and their relatives were consulted about what they enjoyed doing and were involved in the planning of the activities programme. A person enjoyed knitting and the staff had responded with creating a 'knitting and chatting' club. People had expressed the wish to have 'quiet weekends' and during that time staff supported people with doing puzzles and playing board games if they wished. One to one activities were provided for people who remained in their care suites such as reading, hand massage, and reminiscence sessions. There were 'corners' that were situated at the end of the corridors on each floor and that were used for small group activities or one to one sessions. This provided a different setting where people could focus more on jigsaw puzzles, games or reading. The staff planned to introduce an herb garden and a pet corner where people could tend to guinea pigs and rabbits if they wished.

Some outings had taken place such as boat trips on three occasions to ensure all could take part. However, as this proved to be too long a journey for some people, local outings such as visiting garden centres and family picnics had also been organised. The service held an open day and a summer fete to which the community was invited. An ice cream van had been commissioned, and when people had a birthday they helped staff mixing and baking their birthday cake if they wished.
Relatives were able to visit at any times and people going out with their family was a daily occurrence. This ensured that social isolation was reduced.

Resident and relatives meetings were held quarterly and recorded. The registered manager held an additional meeting in the evening for any relatives who were unable to come during the day. One relative told us, "We are always invited to the meetings." Relatives were invited to contribute to the agenda. People's feedback was sought about every aspect of the service and their suggestions were welcome. At the last

resident meeting, topics such as health and safety, care planning, social activities, menus and re-decoration programme had been discussed. As a result of a previous meeting, a relative handbook was in process or being designed, a chair cushion had been replaced; staff had been reminded to ensure that people washed their hands before meals and a senior carer had been nominated to hold a master key during their shift to facilitate permitted access to the domestic and laundry team. There were two to three 'customer satisfaction' surveys per year that included 37 questions about the quality of care that people received. The results of the last survey carried out in October 2015 showed that relatives were very satisfied and would recommend the service to others.

There was a comments and suggestions box in the reception area and in the staff room. The registered manager checked these weekly. Staff feedback was collected at each one to one supervision sessions and the registered manager was developing a staff survey to further consider staff comments and views.

People were aware of how to make a complaint. The complaint procedure was displayed in evidence in communal areas. Five minor complaints had been lodged since 2013 and had been addressed as per the service's complaint policy and to a satisfactory outcome. A relative told us, "If we had anything to complain about we are confident that staff or the manager would take action straight away."

Good

Is the service well-led?

Our findings

There was an open and positive culture which focussed on people. The registered manager was visible in the service; they walked around the premises each day and communicated effectively with people and staff. People told us, "I like the manager, she is nice" and, "The manager is very good to everyone." Two local authority case managers told us, "The management is very transparent; we are contacted immediately if she has any safeguarding concerns" and, "I've always found the manager to be very helpful; she rings to inform of any issues with any clients I have there. Similarly, when I visited for a review meeting, the manager was very involved with the meeting and gave detailed information; I also found the home environment to be of a good standard with caring staff." A relative told us, "We have every confidence in the manager; she is very caring and efficient." A GP commented, "The doctors in our GP practice have been impressed with the manager of the home and the nursing staff."

Staff praised the registered manager for her approach and support. Their comments included, "She helps us if we don't understand. She gives us support every time", "She's a good manager – always helping", "She listens to us and helps to resolve things", "The manager is good with us – I like working in the team", "She is hands-on", "She's excellent" and, "She's available 24/7 – she will come in." They said they could come to her or her deputy at any time for advice or help.

The registered manager felt well supported by the provider who took an active part in the running of the service and who visited the home on a weekly basis. They said, "We communicate well and always strive for improvement together; he is always receptive to new ideas and consistently supportive of what we do in Hazeldene House." Monthly management meetings were held that included the provider, the registered manager, the deputy manager, a finance administrator and administration co-ordinators to discuss the running of the service and set up action plans.

The registered manager and deputy manager carried out unannounced spot checks of staff practice at day and night time to ensure good practice was maintained at all times. As a result, disciplinary action had been taken when a care worker had not adhered to their code of practice.
The registered manager had introduced 'staff awareness sessions' to test the knowledge that staff had acquired during their training to check staff maintained the knowledge to carry out their role effectively.

The registered manager held regular staff meetings and encouraged the staff to be involved with the running of the service. Staff were invited to discuss existing systems and their suggestions were listened to and considered. As a result of a member of staff's suggestion, an 'I-Pad' had been introduced to take photographs of wounds to measure their healing progress.

The registered manager was open and transparent. They consistently notified the Care Quality Commission of any significant events that affected people or the service. They were fully aware of updates in legislation that affected the service and had ensured that a policy on 'duty of candour' had been introduced. They participated in safeguarding meetings concerning people's safety when necessary. They learned from mistakes to improve how the service was run. For example, the full details relevant to legal representatives'

power had not been fully appraised when a people entered the service. This meant that only details of powers in regard to people's finances had been taken and not about their welfare. When the registered manager had realised this shortfall, they had implemented a full survey to determine which type of 'Power of Attorney' relatives had.

The registered manager had 16 years of previous managerial experience. They kept up to date with latest research on dementia care and especially consulted the 'Dementia Care matters' website that provided an evidence based approach to developing dementia care in organisations. The registered manager had formed a 'dementia support group' where people's relatives and friends were given the opportunity to listen or share experiences as families and carers. They had attended several conferences about dementia care and had travelled abroad last year to see how dementia care was delivered in different culture settings. As a result, they had brought new ideas and had implemented a sensory garden and improvements to sensory bathrooms.

People were placed at the heart of the service and the registered manager placed emphasis on continuous improvement in all aspect of their care. The registered manager spoke to us about their philosophy of care for the service. They said, "If I can ensure the care we deliver is as best as it can be then we have achieved our goal; our role is making changes for the better, continue to improve and enable people to live as full a life as possible; our setting promotes family life, it is lovely to see families including great grand-children playing with their toys around their loved ones."

Robust systems were in place to monitor the quality of the service. Comprehensive audits were carried out by the registered manager and by an external quality assurance consultant who was commissioned by the provider. The consultant completed checks and analysis of all aspects of the service on a monthly basis. Audits included accidents and incidents, weighing of people, infection control, completion of documentation, policies reviews and updates, nutrition, recruitment, staff training and end of life care. The consultant wrote monthly management reports that were scrutinised by the provider and the registered manager to identify how the service could improve. Action was taken or scheduled to take place in response to the report's findings. For example, a policy on 'duty of candour' had been introduced; consent had been sought from people and their legal representatives in relation to having movement sensors placed by their beds to alert staff when they were at risk of falls; a re-decoration programme was in progress.

The provider had a business plan with clear objectives and relevant action plan in regard to marketing, quality, building and equipment, staff and about how to improve the experience of people who lived in the service. All planned action had a time frame in which to be achieved. A new system to monitor medicines had been introduced.

The registered manager had a comprehensive yearly management plan that detailed goals to be achieved in respect of staff, people living in the service, internal processes to be completed, premises, and her personal professional development. We compared the action plan from last year to the current one. All actions that had been planned in 2015 had been completed within the estimated time frame and the outcomes were clearly documented. These included the development of an improved policy on end of life care, end of life care plans to include six specific steps, the introduction of staff awareness checks about their knowledge, an outside play area, and a change of pharmacist provider. This indicated that the registered manager was monitoring and tracking the steps that needed to be taken in order to improve the quality of the service.

The registered manager worked in partnership with other organisations to ensure standards of good quality of care were maintained. The registered manager and a senior nurse had joined the local GP practice in a

project to improve patient care by developing better systems. This project focussed on the delivery of quality improvement in the care given to people living with dementia.

The service's policies were appropriate for the type of service and clearly summarised to help staff when they needed to refer to them. They were reviewed on an on-going basis, were up to date with legislation and fully accessible to staff for guidance. All records were well organised, completed, reviewed regularly, updated appropriately and fit for purpose. The service was working towards becoming paperless and held data about people's care in their computerised system that was safely backed-up.