Methodist Homes

Hartcliffe Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 28 & 29 March 2017. At our last inspection in November 2014, we found one breach of the regulations with regard to consent to care. Overall the service was rated as good. At this inspection we found insufficient actions had been taken to address the breach. We found a further breach of the regulations and have rated the service as requires improvement. You will see the actions we told the provider to take at the back of the full version of this report.

The inspection was unannounced. Hartcliffe Nursing Home provides nursing and personal care for up to 66 people. At the time of our inspection there were 62 people living in the home.

There was a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, the registered manager was leaving the care home during the week of our inspection. The provider had arranged for a registered manager from one of their other care homes to provide interim management cover, until a new manager was appointed.

People told us they felt safe in the home. They were cared for by staff that had been trained and understood their responsibilities with regard to keeping people safe from avoidable harm and abuse. Risk assessments were completed and risk management plans were in place. Overall, peoples' medicines were safely managed.

Consent to care was not always sought in line with legal requirements and there was insufficient recording of best interest decisions made on behalf of people.

People's healthcare needs were not always met. When changes to care, such as frequency of positional changes had been identified and recorded, these were not always implemented. Staff had access to, and obtained support and guidance from, external health care professionals. People received the support they needed with eating and drinking.

Staff received training relevant to their roles. Staff confirmed they received supervision and were able to develop themselves through additional training.

Staff demonstrated a kind and caring approach and they treated people with dignity and respect. Staff knew people well and were able to tell us about people's likes, dislikes and preferred routines which were reflected in their care records.

There was a wide range of activities that people could participate in and people were enjoying group activities on the days of our inspection. A team of volunteers provided additional support.

People, staff and relatives told us the home was well-managed. People and relatives told us the registered manager was readily accessible and available to them. Staff told us they were well-supported and described the home as a good place to work.

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 safe. However, we found areas where improvements were needed.

Overall, medicines were safely managed. There were shortfalls and an area for improvement was identified and actioned during the inspection visit.

Staff had been trained and recognised their role in safeguarding people from harm and abuse.

Accidents and incidents were reported and actions taken to reduce risks of recurrence.

People told us there were sufficient staff to provide the care they needed. Care staff reported they were able to provide the care people needed but that care was often rushed.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not meeting the requirements of the Mental Capacity Act 2005 and consent was not always sought in line with legal requirements.

People were referred to and had access to healthcare professionals. When changes to people's needs were identified and recorded, these were not always implemented.

Staff received appropriate training to carry out their roles. Staff felt supported and their performance was monitored on a regular basis.

People were appropriately supported and encouraged to eat and drink a balanced diet that met their individual needs and preferences.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were kind, caring and respectful and we saw people being treated with compassion and dignity.

Staff provided care in accordance with people's individual wishes preferences and choices.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised. People and their relatives were involved in planning and reviewing their care plans.

People had opportunities to participate in social activities and events.

A complaints procedure was in place and this was easily accessible.

Is the service well-led?

Requires Improvement

The service was not always well- led.

Systems were in place for monitoring quality and safety. Action plans were implemented and monitored for progress. However, the audits had not identified the shortfalls we found.

People and staff spoke positively about the registered manager, and told us the home was well-managed. People had the opportunity to provide feedback and this was acted upon.

The registered manager was aware of their responsibilities with regard to notifications and information they were required to send to the Commission.

Hartcliffe Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a comprehensive inspection of Hartcliffe Nursing Home on 28 and 29 March 2017. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors.

Before carrying out the inspection we reviewed the information we held about the care home. We reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with 14 people who lived at the home and four visitors. We observed the way staff interacted and engaged with people. We spoke with the registered manager, a senior manager, the hospitality manager, a visiting health professional and 14 staff that included registered nurses, care staff, community coordinator, chaplain, housekeeping and maintenance staff. We observed how equipment, such as call bells, pressure relieving equipment, bed rails and hoists were being used in the home.

We looked at seven people's care records. We looked at medicine records, staff recruitment files, staff training records, audits and action plans, and other records relating to the monitoring and management of the care home. Following the inspection, the registered manager sent us further information that we had requested.

Requires Improvement

Is the service safe?

Our findings

Overall, people received their medicines safely. However, we found a shortfall in the safety of administration of medicines for one person who received their medicines crushed. A pharmacist had not been consulted to confirm the medicines were suitable for crushing and their effectiveness would remain unchanged. This was not in accordance with the provider's policy that stated, 'The pharmacist must be involved in the decision to alter a medicine from it's dispensed format.' After the inspection, the provider confirmed they had taken action and they had obtained pharmacy approval for the use of crushed medicines. They had also been provided with guidance about medicines that could be dispensed in liquid form, to avoid the need for crushing.

Medicines received into the home were checked and the amounts confirmed on the medicine administration record sheets (MARs). Medicines were suitably stored in locked cabinets and cupboards in designated rooms. Arrangements were in place for medicines that required cool storage or additional security. Medicine storage rooms and refrigerator temperatures were recorded on a daily basis to make sure medicines were stored at suitable temperatures. Records were maintained for medicines no longer required.

People received their medicines when they needed them and when they were prescribed. We saw where people were prescribed medicines that were 'time critical' for example, for Parkinson's, these were given at the specific times prescribed.

We observed medicines being given to people and this was safely completed by the registered nurses. Some people were prescribed medicines to be taken when needed, for example, for pain relief. We heard people being asked if they needed these medicines. For example, we heard one person being asked, "Do you need the gel [pain relief] for your knees today?" Protocols were in place to describe the types of pain the medicines were prescribed for. The records confirmed how people expressed and communicated pain and the potential side effects of their medicines. We saw that staff signed the MARs after they had made sure people had taken their medicines.

No one in the home self-administered their medicines although arrangements were in place if people were assessed as safe to do so.

Where people were prescribed non medicated creams, arrangements were in place to confirm the application instructions. Body maps were completed that identified the specific areas of the person's body the creams were to be applied to. Care staff had received training and understood their responsibilities for signing the charts when they applied the prescribed creams.

We saw that most people had call-bells within reach or wore pendants so they could call for help and support when needed. We observed one person who stayed in bed in their room on the first day of our visit. We checked over a period of four hours and the person did not have their call bell to hand during this time. They were provided with care and support from staff at regular intervals. The care records for the person

stated, 'Is able to use call bell system when she needs help. Staff to ensure it is within reach.' The call bell was not made available and within reach until we brought our concern to the attention of the registered manager.

People told us they felt safe in the home and comments included, "I feel safe enough. I prefer to stay in my room most of the time. Staff come when I need," "They usually come if I press the buzzer," and, "The staff are good as gold, and here in two minutes if I ring my bell." A relative told us, "I can always go home and feel Mum is really safe here." Another relative said, "There usually seems to be enough staff, but my relative has had to wait for assistance before. I was told they were short staffed."

The care staff we spoke with told us all told us they provided the personal care people needed, but they felt they needed more staff, especially during the morning shift. Comments included, "Care is often rushed. We always give people the care they need, but don't have the time to sit with them or talk," and "We have a lot of high dependency people and we just don't have enough staff. It would be nice to have time to actually sit and chat with people".

The registered manager used a dependency assessment tool to calculate staffing levels and monitored changes in people's dependency levels. They told us they reviewed this on a regular basis. They told us they believed staffing levels were sufficient for the current numbers and dependency levels of people living in the home. We checked the staff rota's and saw that, on most occasions, the staffing levels were maintained at the levels the registered manager stated were required. Where there had been staff sickness, the rota's showed that other staff had been called in, or had shifts changed.

Risk assessments were completed and risk management plans were in place for risks including moving and handling, falls, skin integrity, nutrition and use of equipment such as bed rails and pressure relieving equipment. Where risks had been identified, the plans detailed the steps staff should follow in order to reduce the risks. For example, when people required the use of moving and handling equipment in order to change position, the details of that equipment was recorded, such as the type of hoist and type and size of sling that was needed.

When people had a medical diagnosis that might increase the risks of ill health, risk assessments and risk management plans had also been completed. For example, one person with diabetes had plans in place to inform staff about the risks of high or low blood sugar levels and the actions they needed to take to safely support the person.

Staff had a good understanding of their responsibilities with regard to safeguarding people from avoidable harm and abuse. They were able to describe how they would recognise abuse, and how they would act on concerns. Staff told us how they would report concerns immediately to senior staff or to the registered manager. Comments from staff included, "I know exactly what I would do, [if abuse was suspected] and there is more detail on the [staff] notice board" and "We've had training for safeguarding and whistleblowing and we sometimes talk at meetings about what we would need to do." All staff were familiar with the term "whistleblowing" and were able to tell us how they would report concerns about poor care.

Accidents and incidents were reported and recorded. There was a full description of the accidents or incidents, actions taken and steps required to minimise the risk of recurrence. The registered manager told us how they reviewed reports to look for trends in the types or frequency of accidents. We looked at the monthly management review for January 2017 and saw that actions had been completed.

Safe recruitment processes were completed. Staff completed an application form prior to employment and

provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service (DBS) check to be completed. The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Where required, the service had ensured that staff were appropriately registered with the correct bodies, for example the Nursing and Midwifery Council.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella checks, electrical and gas safety, lift maintenance and hoist checks had been completed.

People had individual personal emergency evacuation plans (PEEPS) in place that confirmed the support needed if they were to be moved in an emergency situation.

Some areas of the home were not odour free. Staff regularly cleaned throughout the home and recorded their completed work on cleaning schedules. However, some odours persisted in areas on the ground floor. In addition, several areas had damaged and scraped paintwork. We spoke with a senior manager and the registered manager. They agreed with our findings and told us the ground floor of the home was due to be re-carpeted and redecorated and this was due to take place in April 2017.

Requires Improvement

Is the service effective?

Our findings

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.

When we inspected Hartcliffe Nursing Home in November 2014 we found relatives had been asked to sign their consent for the use of bedrails for people who lacked mental capacity. The MCA does not give an automatic right to a next of kin to consent on their relatives behalf. Mental capacity assessments were not specific or in line with legal requirements. This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 because people's rights were not always protected in relation to consent to care. (The above regulation has now been replaced with the Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found people's consent to care was not always sought in line with legal requirements. Mental capacity assessments had been completed, however, these were not all decision specific. We saw that plans had capacity assessments recorded for 'care and treatment.' These had not all been reviewed when people's care and treatment needs changed. This meant peoples' capacity to consent was not reviewed in line with these changes.

In one person's care plan, there were contradictory statements recorded about the person's capacity. The person had signed to consent to the use of bed rails. Their bed rails support plan stated, 'Has no capacity to choose as has limited insight' and 'has limited insight into the risks surrounding her immediate environment due to confusion and history of dementia.' It was therefore difficult to understand how the person was able to make a decision to consent to the use of the bedrails because there was no documentation to support that staff had explained the risks to the person. For another person the consent to use bed rails had been signed by a family member and a member of staff. There was no confirmation that the family member had the authority to make this decision.

Some people used 'tilt' or 'recliner' type chairs. These can be considered a form of restraint when used with people who are unable to consent to their use. None of the plans we looked at for people who used these chairs provided evidence that consent had been sought or that a best interest decision making process had been followed.

The above amounted to a repeated breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, staff were aware of the need to obtain verbal consent from people before providing care and support. Throughout our visit we observed staff asking people "Where would you like to sit?" and "Can I get you anything?" Staff said "People come first. It's their decision, their choices that are important" and "If

someone doesn't have capacity, I still ask first. I knock on people's doors, tell them step by step what I'm doing and why". One person said "The staff always ask me what time I would like to get up or have a wash or a shower. I say when I want it".

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA.

The registered manager had submitted 26 applications for people living at the home and were waiting for assessment or renewal of expired DoLS, by the local authority. One person at the home had a current authorised DoLS in place. The registered manager understood the requirement to notify the Commission when an authorised DoLS was confirmed.

When best interest decisions were made, the provider's documentation contained sections for staff to record the involvement of health professionals or advocates. We saw two examples where a person's relative, external health professionals and care home staff had been involved in best interest decision making. We saw other examples, such as for the use of restrictive equipment as noted above, where the provider's best interest decision making policy had not been fully followed and decisions had been made by staff without consultation with relatives or health professionals.

People did not always receive the healthcare support needed when their condition changed. For example, one person had a pressure ulcer that had deteriorated. The wound plan was detailed and photographs had been taken. The person's care plan had been updated four days before our visit to confirm they needed support to change their position every two hours, instead of every four hours. The positional change charts confirmed the person was still being supported to move every four hours. We spoke with staff who were not aware the person's care plan and treatment had been changed. We brought our findings to the attention of a registered nurse at the time.

Some people used pressure relieving mattresses where they had been assessed as at risk or had pressure ulcers. Some of these mattresses needed to be set according to the person's weight in order to provide the pressure relieving support people needed. We checked five pressure relieving mattresses at random and found that two were incorrectly set. This meant that some people were not receiving the pressure relieving support they needed. We brought this to the attention of a registered nurse and they took immediate action to address this shortfall.

The above was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives spoke positively about the staff that supported them. They told us they were well cared for and that staff met their needs. One person commented, "Can't fault it here, the staff are good as gold, know what I need and what to do."

We looked at the training records and saw training had been completed for topics described as mandatory by the provider. This included health and safety, first aid, moving and handling, food safety, mental capacity and safeguarding. Staff were provided with further training, designed to help them meet the individual needs of the people they were providing personal and nursing care for. This included specific illnesses such as dementia awareness and end of life training. Staff who administered medicines had their competencies checked each year to make sure they remained safe to practice.

Staff completed an induction programme when they started in post. The programme incorporated the Care Certificate, a national training process introduced in April 2015, designed to ensure staff were suitably trained to provide a high standard of care and support. Staff then worked with experienced staff until they were confident to work unsupervised. One member of staff described their induction as,"Really good and thorough."

Staff received individual performance supervisions and annual appraisals. Staff told us they felt supported and told us they received supervisions on a regular basis. They told us this gave them the opportunity to discuss and receive feedback on their performance.

We spoke with people who were positive about the quality and choice of food available. Comments included, "The food is great," "We get a choice and if we don't like it they'll make something else for you" and, "It's very tasty and it's hot." A relative commented, "Our chef here is wonderful."

People chose where they wanted to eat their meals. The dining rooms were laid in advance and we saw meals served to people in the dining rooms and in their bedrooms. We saw that some visitors joined people for their lunch. People were offered choices and 'sample plates' were shown to people to help them decide which meal to choose. People were assisted when needed and when this happened, we saw that staff sat with people, explained what the food was, asked if they were enjoying it and whether they wanted more.

We saw that people were offered a choice of drinks at lunchtime. One person replied to a member of staff after being offered a choice of squash, juice or water, "Not sure if I should have a drink, I think I drink too much." The member of staff replied kindly, "You can never have too much. Here, shall I just leave you a small glass just in case." We later saw the person happily sipping the drink that had been left for them.

Food such as soups, cakes and pies were all homemade and the hospitality manager completed a nutritional balance review of each menu and used an allergen recipe matrix to inform staff and people of the content of meals. This was all displayed on the daily menu. The catering hospitality manager knew people's individual dietary needs, including people with diabetes and textured diets. They were also aware of people who had lost weight and required additional calorific intake.

People's weights were recorded and significant weight loss or gains were noted. The registered manager monitored people's weights each month and we saw advice had been sought from the GP and some people had been prescribed food supplements. One person with a percutaneous endoscopic gastrostomy (PEG) had been reviewed by a dietician who had amended their nutritional feeding regime.

People were referred and had access to other external healthcare professionals. Specialist health care practitioners were accessed when people needed particular support to manage their health needs. For example, we saw where people had been referred to and had appointments with consultants, district nurses, dentists, chiropodists and speech and language therapists.

Good

Is the service caring?

Our findings

All of the people and relatives we spoke with told us that staff were kind, caring and respectful. One person told us, "I really can't fault it here, staff are lovely." A relative said, "I am really happy with the care here. The staff are very nice and I can see that they always speak to the residents when they're helping them. [Name of staff] is absolutely lovely, nothing is too much trouble," and, "My relative is always clean and tidy. Their teeth and nails are always clean too". A visiting health professional commented, "I would say the staff here are caring and compassionate".

We observed positive interactions between staff and people using the service. The atmosphere was calm and friendly and there was lots of laughter. For example, we heard a member of staff say to one person "Don't you look glamorous this morning," and the person replied laughing, "I know, I can't help it." The person looked very smart and when we complimented them on their outfit their visitor said "That'll be [name of staff member]. They always make sure she is co-ordinated".

It was one person's birthday and staff had decorated the door of their bedroom with birthday banners. Throughout the day we overheard staff wish the person a happy birthday. When people were sitting in the lounge we saw that staff frequently went and checked that people were comfortable. For example, we saw one staff member sit next to one person and ask how they were. The window was open behind them and they asked the person "Is there a draught on your back? Would you like me to shut the window for you?" The same member of staff then went and spoke to another person and said "That's a pretty top you've got on. Didn't you have that one for Christmas?"

One member of staff said "This job is so rewarding. It's great to be able to go home at night knowing you've done something good" and "Seeing people smile or laugh, it's lovely". Another staff member said "We're like the resident's extended family and it's nice being able to make a difference to people's lives. For example, there's one lady whose face just relaxes when you speak to her".

Staff were able to tell us how they made sure people's privacy and dignity was maintained. Comments from staff included, "Simple things like closing doors, covering people up with towels so they're not embarrassed and making sure they're nice and warm," and "I just think it's common sense and basic respect." All personal care took place behind closed doors. We observed staff knocking before they entered people's rooms.

Relatives visited during both days of our visit. There were no restrictions and they told us they were always made to feel welcome.

On arrival people were given key information about the home, what people should expect from the service, how to make a complaint and key telephone numbers for a range of organisations, including the Care Quality Commission and the local authority. This ensured that key information was communicated to people. In addition, newsletters were produced each month and these provided details of planned events and activities.

The home had received 34 written compliment letters or cards during the last 12 months. We saw extracts from recent letters and cards and read, 'We will always remember the interest you took in [Name of person]; our heartfelt thanks for all the time you spent with her,' and, 'We the family could not have been happier with the care, consideration and dignity that was given to her... the thoughtfulness, caring and understanding that you showed us throughout we will be eternally grateful.'

People and their relatives were supported to express end of life wishes and preferences and these were recorded in final wishes documents in peoples' care plans. A chaplain was available in the home to provide additional support as it was needed.

Good

Is the service responsive?

Our findings

People were assessed by the registered manager before they moved into the home to make sure their individual needs were known. A visitor whose husband had lived in the home until he passed away continued to visit a friend in the home. They told us, "My husband was here and [Name of registered Manager] came to see us at home before he moved in." People and relatives where appropriate, were involved and contributed to their care plans and were invited to six monthly reviews. One relative told us, "The staff have asked me to read my relative's care plan and sign it to say I agree."

The care records we read contained life history documents that provided details about peoples' lives before they moved into Hartcliffe Nursing Home. Care plans were personalised to people's individual likes, dislikes, preferences and needs, and were updated on a monthly basis. For example, one person's care plan stated they needed help to, 'Put on my glasses,' and to, 'Show a choice of clothing. Wears trousers and a top.' The care plan recorded that the person, 'Worried about who is looking after the house.' This meant that staff had access to information to help them provide the care, support and reassurance people needed.

The staff we spoke with understood people's individual needs, preferences, likes and dislikes. They knew what was meant by personalised care and described how they provided this. Comments from staff included, "Person centred care is making sure the care is all about the person's preferences," "It's about doing everything for individuals that they want when they want," "I talk to people and ask them what they would prefer" and, "Making sure residents choose their clothes, make-up if they want to wear it, jewellery, when they want to get up and go to bed and if they want music or the TV on."

A comprehensive activity and engagement programme was in place, and the weekly programme confirmed a wide variety of activities was offered to people. These were organised by a community coordinator and involved the chaplains, a music therapist and a large team of volunteers employed by the home. The range of activities for people to participate in was extensive and varied. For example, a coffee morning took place during our visit. We saw groups of people enjoying the company of others and lively discussions were taking place.

Later in the day, there was a performance of Irish dancing by local school children. The next day people commented that the event had been, "Fabulous, they were so good." The activities plan for the next two weeks included entertainment, crafts, painting, holy communion, singalong with a community choir and a visiting zoo.

When people were unable to or chose not to participate in group activities, one to one interaction was provided if people wanted it. For example, the co-coordinator said "One of the volunteers writes poetry and will sit with people and read them poems," and "I try and match volunteers with people based on their work history or interests so that people have something to talk about". One person told us, I can choose, and I'm asked but don't often go [to planned activities]. I'm usually happy in my room and have visitors come in to see me." Another person commented, "There's always something going on here."

The coordinator told us they had taken people on trips to Chew Valley Lake, to the museum in Bristol city centre and were planning a trip to a local steam railway. They said "I try to plan trips so that they are person centred. I know one person loves steam trains which is why I'm planning the railway trip". They said some people knitted blankets for a local homeless charity and that people made cards to welcome new people moving into the home. They also told us about a local primary school project called "Proud to be me" where the children visited the home weekly to talk to people about their lives and histories.

A 'fine dining' evening was offered regularly. A number of people were sent formal, written invitations to attend and were encouraged to dress up for the occasion. A member of staff told us, "Some people were discussing how they used to go out to restaurants, so we thought we'd bring the restaurant experience here. They have a three course meal with wine, and they all tell us they really enjoy it".

People and relatives said they knew how to complain. Comments included "I have no complaints, but I know how to," "I'm happy to speak up if I need to," "I'd go straight to the person in charge" and "I did complain once. I was worried [name of person] would fall out of their wheelchair. [Name of Registered Manager] sorted it straight away. We agreed a plan and now we're happy."

A complaints procedure was followed and we saw that complaints received had been responded to in accordance with the provider's policy. The registered manager told us how they reflected on complaints they had received to make sure lessons were learned and improvements made. For example, they told us about one complaint that related to a person's weight loss. They told us they had introduced a more robust system for monitoring and responding to changes in people's weight. We saw a detailed audit that provided detail of actions taken in response to identified weight changes.

Requires Improvement

Is the service well-led?

Our findings

We spoke with the registered manager and a senior manager about the quality assurance systems that checked the quality of the service provided and helped to ensure risks to people's health safety and welfare were monitored. We checked the records and established there was a range of auditing and quality monitoring systems in place. These included monthly checks of care plans, medicines management records, falls, accidents and pressure ulcers. Action and improvement plans were in place where areas for improvement and action had been identified. Whilst we saw that areas had been identified and improvements made, the provider's systems had not identified the shortfalls we found and reported on in the 'safe' and 'effective' domains.

The registered manager and the provider's quality team analysed reports, provided a summary of findings and looked for emerging trends or patterns of behaviour. Actions were agreed. For example, one person who had lost weight had been prescribed supplements, the catering team had been informed and enhanced monitoring of the person's intake and output had commenced.

People told us they considered Hartcliffe Nursing Home was well-managed. We received positive feedback from people and relatives about the management of the home. One person told us, "She [Registered Manager] is so good and she always listens." A relative commented, "We are very happy with the management here and sad that [Name of Registered Manager] is leaving."

People and their relatives had been given the opportunity to provide feedback about the service. The results from the most recent survey completed independently by a market research organisation were awaited. The registered manager told us they had, in response to the previous year's survey, made improvements for people unable to participate in outings. They had introduced the use of an iPad to support people to communicate by Skype with friends and relatives. 'Resident' meetings were also held on a regular basis and minutes were recorded and available.

The provider's values were stated on 'prompt' cards that were given to staff. The values included statements about respect and dignity, being open and fair, becoming 'the best we can be' and nurturing people to promote a fulfilled life. We observed during our visit how these values were embedded into day to day practices in the care home.

Staff spoke positively about the organisation and the management of Hartcliffe Nursing Home. A member of staff told us, "It's a shame that [Name of Registered Manager] is leaving, she's a good manager, but management are all supportive so we'll get the support we need," and another member of staff commented, "I love my job, it's good to work here and we all get on."

Staff told us they had the opportunity to express their views, and that they felt listened to. A range of staff meetings were held to make sure communication was effective throughout the home. These included specific team meetings, such as heads of department, in addition to general meetings where all staff were invited to attend. Minutes of meetings were circulated and we saw from recent meetings held that staff had

been reminded that, 'Calls bells must be in reach,' and, 'breaks/uniforms-complying with policy' had been discussed.

A business continuity plan set out the procedures and strategies to be followed in the event of an incident that caused disruption to normal working. If this incident affected the ability of the care home to give care as usual, maintain adequate safety and the well-being of people and staff, the plan had guidance on the action that should be undertaken. These could be events such as disruption to gas, water or electric supply or failure of equipment within the service.

The registered manager understood their responsibilities with regard to the notifications they were required to send to the Commission.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care was not always delivered in response to people's assessed needs. Equipment was not always used correctly used.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not always protected in line with the Mental Capacity Act 2005. Consent to care was not always obtained in line with legal requirements.

The enforcement action we took:

We issued a warning notice.