Hatchmoor Nursing Home Limited

# Hatchmoor Nursing Home

**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 |

## Overall summary

The inspection visits took place on 5 and 7 January 2015 and were unannounced.

Hatchmoor Nursing Home is registered to provide accommodation for 64 people who require nursing and personal care. People reside over two floors, split into eight named units. There were 58 people using the service at the time of our inspection.

At the last inspection on 6 and 8 August 2014, we asked the provider to take action to make improvements toward more robust recruitment, ensure care plans included considerations of the Mental Capacity Act (2005) and Deprivation of Liberty (DoLS) Safeguards and to ensure records were complete. We found at this inspection those improvements had been made.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

# Summary of findings

People were supported and cared for by sufficient staff to ensure their individual needs were met with patience and humanity. The staffing arrangements were flexible and where additional staff were required this was provided. Staff training needs were well met and staff were supported and supervised in the work they did. Recruitment was robust and so protected people from staff who might be unsuitable to work with them.

Staff understood how to protect people from abuse and the home had acted to protect people where they believed abuse or harm might have occurred. Examples included staff reporting poor practice and the registered provider reporting possible abuse from a source external to the home. Each person had risks to their wellbeing assessed and steps were taken to mitigate any known risk, such as falls or skin damage from pressure.

The home was a safe environment as maintenance of the premises and servicing of equipment was well managed. Medicines were managed in a safe way and in accordance with people's individual needs, for example, taking time to encourage a person to take their prescribed medicines.

People's care and treatment needs were met. One person said, "That is amazing. That is the first time I've seen (my father) walking that well for years. That's real care." Toward achieving this, the home had good links with local health and social care agencies, such as a local hospice. Nursing staff were able to identify and have training needs met so they could maintain high standards of clinical practice.

People were fully involved in decisions about their care and the staff understood legal requirements to make sure people's rights were protected.

There were many ways in which people's views were sought and the home was responsive to their requests, such as menu and activity choices. A person said, "Everyone gets to give an opinion." There was a very broad programme of 'Core Activities':creative, cultural, esteem, emotional and intellectual, based on an individual's personal history; their strengths and preferences.

People had a nutritious and balanced diet available to them. Where they had specific dietary needs or preferences these were met where possible. Concerns about people's dietary intake were responded to appropriately.

People were cared for with kindness, patience and respect. People's preferences were known and provided for. There were many examples of staff knowing when to provide reassurance and taking time to ensure they felt cared for and valued. People's dignity was promoted: people, their families and staff had been involved in a dignity project.

The home was well led. The goals and objectives of the home were well met. There was a strong ethos of caring and respect for people and staff. Systems used to monitor the service, the approach to staff training, and local health care connections, ensured high standards were maintained and people's wellbeing was promoted. It was a relaxed, friendly and welcoming place.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was safe.

Good

The home had systems to protect people from abuse and staff protected the people in their care. The registered provider put the wellbeing and rights of people using the service as the priority.

There were sufficient numbers of skilled and experienced staff to ensure people's individual needs were met. Robust recruitment practice reduced the possibility of staff being unsuitable to work at the home.

Medicines were handled in a safe way which promoted people's health and welfare. The home was well maintained.

**Is the service effective?**
The service was effective.

Good

People's care and treatment needs were met by staff that were trained, supervised and supported in their role. Best practice was promoted through projects, such as rehabilitation and hospice.

People were fully involved in decisions about their care and the staff understood legal requirements to make sure people's rights were protected.

People were supported to receive a healthy and well balanced diet and dietary concerns were followed up effectively.

**Is the service caring?**
The service was caring.

Good

People felt valued, included and involved in the home through the way they were supported.

The importance of dignity had been explored with people using the service, their families and staff.

Staff were expected to spend quality time with people to ensure their needs were understood and met. It was a happy and relaxed home for the people living there.

**Is the service responsive?**
The service was responsive.

Good

People's views were listened and responded to. Individual preferences and idiosyncrasies were understood and well met. The importance of activities to promote well-being was understood and an integral part of the holistic care provided.

People's care plans provided a detailed account of how staff should support them so their care was delivered in a consistent and safe way.

Complaints were fully investigated and used as a way to improve the service where necessary.

**Is the service well-led?**
The service was well led.

Good

# Summary of findings

A strong ethos and culture of respect at the home was led from the top.

Standards were kept under regular review and prompt action taken where any short falls were identified.

Staff had respect for the home's management and enjoyed working at Hatchmoor. There were strong links with local health and social care organisations which helped promote high standards at the home.

# Hatchmoor 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visits took place on 5 and 7 January 2015 and were unannounced. The inspection team consisted of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/ complex needs. We therefore 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.

Before the inspection, the provider completed a 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. Before our inspection, we reviewed the information in the PIR along with information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law. We received information from five people professionally involved with Hatchmoor Nursing Home toward the inspection.

During our visit we spoke to 12 people who used the service, five people's families, nine staff, the registered and deputy managers and the representatives of the provider organisation. We looked at records which related to three people's individual care and three people's medicine records. We looked at three staffing records and policies which related to the running of the home, such as equipment and utilities servicing records and quality monitoring audits.

Good

# Is the service safe?

## Our findings

People were protected from abuse. All staff had received an annual update in the safeguarding of adults. Staff told us they would report any concerns to the nurse on duty, registered manager, deputy manager or provider and that "abuse would not be tolerated". The provider took immediate steps to protect people. For example, immediately suspending staff if they demonstrated a poor attitude to the people in their care. Staff awareness of how to report concerns outside of the home and organisation were varied. However, each staff member was given a handbook which included how to report concerns to other agencies, the local authority and police, and this included contact details for staff use in such an event.

The provider put the wellbeing and rights of people using the service as a priority. For example, action was taken to protect one person who was at risk, although staff at the home were not involved in the risk.

Policies and procedures were in place and followed to protect people from inappropriate restraint. The home's policy on restraint was regularly reviewed and described restraint as a last resort and only with the person's consent or to protect them from otherwise unavoidable risk.

People were protected from risk. For example, staff induction included a 'fire safety induction book' and associated training. Staff wore clothing to protect people and themselves from exposure to any potential infection. Servicing and maintenance of equipment was well organised and up to date. Accidents and incidents were audited. A daily meeting of heads of departments was used to highlight any concerns; examples included a person's reduced mobility and increased risk of falls that morning. Each person had individual risks to their welfare assessed on a regular basis, such as the potential for skin damage from pressure, maintenance of weight, smoking, and moving safely. There was a 'flag' system in place as part of staff recording so that risks were identified and followed up quickly. Identified risk was reduce, for example, through using specialist mattresses to protect people from skin pressure damage where this was a concern. Also, helping a person to light their cigarette as a safety measure in accordance with their care plan.

People's safety was promoted by the numbers and deployment of staff. People agreed there were plenty of staff to meet their needs. Comments included, "There are enough staff to keep us well looked after. Now I feel safe", "I'm well looked after. I ring the bell if I'm worried and someone comes to see if I'm OK" and "If I use the call bell they come straight away." Staff agreed that there were enough staff, saying, "There is enough staff to do well by residents" and "There is enough staff so we can have a chat with the residents." Our observations confirmed there were enough staff on duty to meet people's needs.

The registered provider, registered manager, deputy manager, chef, administrator, activities workers, laundry and cleaning staff all formed part of the team, alongside care and nursing staff to meet people's needs. The staff complement for the ground floor, where 26 people resided, was two nurses and eight care workers. The day of our visit an additional staff member was shadowing an experienced care worker and was additional to the normal staffing numbers. A nurse told us that staffing arrangements depended on the dependency of people using the service. An example was that one person could become agitated and restless and so additional staff would be brought in "to keep an eye." Another nurse said people's dependency levels were monitored and would lead to adjustments in staffing numbers. They said as an "absolute minimum" there were three care workers, for every 16 people using the service. They said there were usually four care staff.

People's medicines were well managed on their behalf because they were given the medicines they needed at the time they were required. A senior nurse was in charge of ordering medicines from a local pharmacy and the home used a monitored dosage system. There were three medicines stations within the home, one on the ground floor and two on the first floor. Medicines were checked into the home, signed for when given and records kept of any medicines disposed of. Medicines were stored securely. This included those requiring refrigeration and specialist storage, known as controlled drugs. Staff administered medicines with care and at people's own pace. For example, one person was reluctant to take the medicines prescribed for them. The nurse returned to the person several times until they were happy to take it.

Medicine administration records (MAR) included specimen signatures for the identification of staff administering medicines, and any known allergies of the person receiving the medicines. This improved medicine safety. Other aspects of safe administration included information for

Good

# Is the service safe?

staff on when to administer “as required” medicines, so their use was consistent, and two staff checking any telephone message to instruct staff that a medicine required changing.

Medicines use was audited. This had led to an addition to the home’s policies on medicines use. We were told there were separate audits for medicines administration records (MAR) and the medicines themselves, between one to four times a month.

There were robust recruitment and selection processes in place. Staff files included completed application forms. Interviews had been undertaken and pre-employment checks were done. These included references from previous employers, health screening and Disclosure and Barring Service (DBS) checks completed. These checks identified if prospective staff had a criminal record or were barred from working with children or people at risk.

Good

# Is the service effective?

## Our findings

People received effective care from skilled and knowledgeable staff. People's comments included, "I couldn't say a bad word about anyone who works here, carers, nurses, cleaners, they all know they job" and "I'm well looked after."

People's care and treatment were provided by a trained and competent staff. A new member of staff said staff seemed to know what was expected of them and knew their job. A member of nursing staff confirmed their induction lasted until they felt comfortable adding, "Induction takes as long as it takes." A second nurse told us, "Training is very good. (The management) are very good at organising it." Training was organised so that mandatory training needs were highlighted and it could be identified if a training update was needed. The PIR and training records indicated that training needs were met. These included: malnutrition care and assistance with eating, dementia care, emergency aid awareness and moving and handling.

Staff said they received the supervision they required. However, the PIR stated 87 of the 115 staff had a named person that provided them with regular supervision (one to one sessions between staff and management) and 46 of the 115 staff had received an appraisal of their work in the last 24 months. The registered manager said that supervision arrangements were under review. For example, different department heads would be providing supervision. They added that if a staff was developing well priority was given to the appraisal of other staff who were needing more support.

Staff demonstrated an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Where people did not have the capacity to make particular decisions about their care and support, due to their health condition, there was evidence of a good understanding by staff of mental capacity and promoting people's decision making. For example, one person had received support from an Independent Mental Capacity Advocate, (IMCA) so they could move from the home in a safe and managed way. Records showed how people's capacity to make a decision had been assessed. For example, recording whether the individual could understand the decision to be made.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The home understood how to protect people's liberty. The home had made 30 applications to deprive people of their liberty following a Supreme Court judgement on19 March 2014 which had widened and clarified the definition of deprivation of liberty. Those applications had not yet been assessed by the local authority and in the meantime the staff continued to make decisions in people's best interest. This included the use of coded doors to restrict the areas within the home in which people could move without staff support. One other DoLS application, where the person was at an increased risk, had been authorised and was being managed in accordance with that authorisation.

Staff knew people using the service and their individual needs very well. For example, care workers knew people's individual food preferences and preferred routines. Nursing staff demonstrated a good understanding of people's health care needs. A daily meeting of head of departments and units was held where the registered manager received an update on each person's care. The information included people's physical, emotional and social wellbeing, such as pain levels, diet, how much help people required and whether a GP or other health care professional was required.

People's health and wellbeing were promoted. One family said how the help and encouragement given to their father had given him the confidence to walk with a walking frame when he had previously been unable to do so. They said, "That is amazing. That is the first time I've seen him walking that well for years. That's real care." People's health was monitored and promoted through regular health checks, such as nursing observations, clinical tests, foot, dental and eye tests. People's dietary intake was monitored and concerns responded to. People had access as required to their GP.

Good

# Is the service effective?

People's dietary needs were met and they had menu choices available to them. The menu was decided by the chef in conjunction with information from the points of view meetings held with residents. One person confirmed there was a choice of food and another said they were asked about all aspects of the care, including the food they received. We were told the chef visited two particular people each day because they were particular about their food, to find what they wanted to eat that day. Those choices had included "cheesy mash". People used the lunch time meal as a social occasion and we saw they ate the food provided; staff asked them if they were happy with the food. One person said, "The chocolate pudding is very nice." The menu was varied, for example, the supper menu offered curried parsnip soup and cheesy leek and mushroom bake. There were potato, rice and pasta based meals for variety. The chef told us they received no external training about specialist diets but the home had information relating to diabetic, vegetarian and gluten free diets for reference. Where people needed assistance to eat this was given; the staff were unrushed and took their time. People were often offered drinks throughout our visits and the activities organisation told us a drinks trolley was used to take wine, sherry or beer around with "little cheese snacks, bread sticks and little treats" a couple of times a week.

Where fluid intake or diet were a concern these were monitored through discussion at the daily meeting of heads of departments and nursing staff, fluid and food charts and regular weight checks. Speech and language therapy was organised where there was a risk from choking and a specialist diet might be required. Dietetic advice was sought and followed. The PIR stated, 'Staffing levels are maintained throughout the day to ensure enough staff to spend time assisting residents with diet and fluids. Regular snacks and drinks are offered throughout the day and meals given to residents in the environment they wish in a form that is appropriate to their needs. Staff are encouraged to have drinks with the residents when able. Supplements are given where prescribed and meals may have food high in calories added. The chef of the day will visit a number of residents to discuss meals and choices'.

The home was designed specifically as a nursing home and that design increased the effectiveness of the care provided. For people with memory loss or diminished eye sight there were adaptations to the building to help them find their way around. For example, each of the corridors was painted a different bright colour and there were large signs directing people to communal spaces, such as toilets and lounge areas. There was a variety of spaces available for people to relax or spend time in activities and rooms required for the running of the home did not impact on the homeliness of the environment.

Good

# Is the service caring?

## Our findings

People spoke of the staff kindness with comments including, “The staff are lovely”, “(The staff) are so kind”, “They’re all friendly here” and “It’s a happy place.”

People were valued as individuals. Once people were admitted staff from the activities team spent time getting to know them and recording their views about what they wanted from the home. There were also ‘Points of View’ meetings where people were asked by the provider: “Please give your opinion on anything within the home, good or bad.” People had expressed their views about many things, including: staff uniforms; which part of the home staff were deployed in; answering call bells and “the correct making of beds”. A newsletter welcomed everyone to 2015 and provided people with information. This included the money raised for a local community initiative, the Torrington Cavaliers, and activities arranged for the coming weeks. Every person admitted to the home received a questionnaire asking them how well they had settled. One person could not settle and so they were supported to leave the home.

People’s dignity was promoted. Staff training included Dignity/Respect/Person Centred Care and there had been an event where people using the service, their family and staff had got together to discuss what dignity meant to them. From this they produced a ‘dignity tree’ which we saw contained people’s thoughts about dignity. People were supported to maintain their dignity through their individuality; choice of clothing, how they spent their time and how they wanted their needs to be met. For example, one person spent the day dressed in an outdoor jacket and cap and chatted to people as they passed by.

The PIR stated that specific induction training was provided as staff must 'care' for people with dignity, respect and with choices where possible. A new staff member told us, “I have been told that I should put the client’s needs above everything else”. Other staff members said, “We get to know the residents on our floor and they know us; it’s more like a family atmosphere” and “It’s a nice family atmosphere.”

During lunch there was a lot of friendly banter. Relationships between people using the service and staff were strong. For example, one nurse sat with five people to have a chat with them after lunch. Staff regularly interacted with people in a compassionate way. For example, one rubbed the person’s arm and said, “Shall I pop you back into bed for a while”. A second talked to a person about her new haircut and asked if they were thirsty. People were encouraged to engage in conversation and express their views. Staff had, and took, the time to have meaningful conversations with people.

There was a strong, visible person centred culture. For example, a nurse told us how one person only liked particular staff to provide his personal care because they “had a rapport with him.” She said “he wants to keep his identity” and they respected that. Staff understood people’s idiosyncrasies. One person liked to sit in the office with staff and we saw them there several times. Another time they had walked to a different area of the home and staff ensured they were included in the conversation they had walked in to. A third person needed constant attention to keep them calm. We saw different staff interact with them with patience and kindness each time until the person had what they required and relaxed.

People’s privacy was upheld. One person took a phone call from their family on the home’s mobile phone in the privacy of their room. All care and treatment was provided in private and when we spoke with staff they were very careful not to mention individual people within earshot of other people using the service.

People could be confident they would receive end of life care which promoted their dignity. Staff had received training in ‘Loss, grief and bereavement’. The PIR stated that some nursing and care staff attended an outreach training programme provided by the North Devon Hospice. The programme involved communication, care in the last days of life, emotional impact of life-limiting illness and symptom control. The registered manager told us that de-brief sessions were used for staff following a death so they could look at improving their care and support. The PIR described the community Hospice Team supporting the staff to give excellent care. Nursing staff talked of different training provided which was specific to their end of life care. The PIR stated: ‘We work closely with the Palliative Care Specialist Nurses in the community when we have people at the end of their lives. This can be for guidance with symptoms etc. for us or for them to help support the resident and families as appropriate. The management team also attend multi-disciplinary Gold Standards Framework meetings at the local health centres to promote communication and continuity.

Good

# Is the service caring?

One person's family said, "My mum died in here. They couldn't have been kinder. They phoned us if anything changed in her condition. Absolutely fantastic."

Good

# Is the service responsive?

## Our findings

People's individual needs were responded to. People's comments included, "Nothing's too much trouble" and "Nothing they won't do to keep us happy." Comments from many of the residents and family members indicated how personal the care was. For example, we were told people could request certain help from care workers and they were confident their needs would be met. One person told us, ''We are treated as individuals. We have choices to join in the activities or have time to ourselves. Tuesdays and Thursdays are my quiet days; I like to stay in my room and read. We can choose where we want to have our meals, when we have showers; just like being in your own home."

People's views were routinely sought so staff could be responsive to their individual needs. This included reviews of people's care plans, feedback questionnaires and resident's points of view meetings. One person told us, "We are asked our point of view, about all aspects of our care here. About the food, the cleaning, the care. Any suggestions about anything. You can't get fairer than that. If any residents can't get to the meeting they bring the question form into their rooms. Everyone gets to give an opinion." We also saw people's opinion was sought and choices offered as part of normal daily staff practice when supporting people.

People's lives were enhanced because an activities coordinator and activities workers were integral to the staff team and the daily life at Hatchmoor. The coordinator told us, "Everyone is asked whether they would like to join in with activities. We document who is asked and who takes advantage of the social activities. They have a choice but if a person keeps on refusing then I try to give them individual one to one sessions. We also have local volunteers who help to keep people involved." We saw how one person found comfort from a baby doll which was provided for them to embrace.

The activities workers said that when people were admitted they tried to find their 'life skills' and therefore activities which suited them. Diverse needs were taken into account. A 'life biography' was taken for each person and included: 'Where about have you lived during your life', What do you like to do to relax' and 'Are there any resources that you would like to be available to use in the lounge that are not currently available?'

After lunch one person sat watching their preferred "soap" in private. The television set was directly in front of them at their height in a lounge which was homely and pleasant; they had that important individual time arranged for them. Other people chose to play a letter quiz on a huge board in the specially adapted activities room. There were many library books, memory boxes, old photographs, arts and crafts equipment and equipment for music and films available and in regular use.

The activities staff had produced a 'Core Activities' list in order to address all diversity of needs. Activities were categorised as creative, (for example, flower arranging), cultural, (for example, talks on tradition), esteem needs, (for example, beauty care), emotional needs, (for example, pet visits and befriending) and intellectual needs, such as discussions, computer skills and word games. The core activities list was transferred to a programme of activities, which included: pub quiz, sweet trolley, cooking, Australia day and Burns night. We were told that an activities plan was being produced for each person and saw activities separated into: 'everyday', 'every week' and 'every month/ sometimes'. The programme of activities included week ends.

The registered provider told us there was access to WIFI so people could have face to face conversations with family and friends who could not visit.

Staff used a computerised system for care planning and monitoring. Care plans are a tool used to inform and direct staff about people's health and social care needs. People's care files were presented in a format where information was easy to find and could be printed when required. The electronic pads were available throughout the home, positioned on the walls in each area, and we saw staff input information and refer to them. One staff member, recording the care which they had delivered, showed us how easy it was to check the support a person needed, for example, for moving safely.

The care plans described in depth how the person's needs were to be met, taking into account their diverse needs, beliefs, family connections and how any medical condition they had affected them. For example, one care plan clearly described what contributed to that person's anxieties and aggressions and the measures staff should take to support the person and manage their distress and behaviour. That person later came into the office where we were working, and from the information we had read we knew how to

Good

# Is the service responsive?

respond. A social worker told us "I am really impressed with the records (at Hatchmoor)". Care plans were regularly reviewed and updated to ensure staff had the right information to support people in a consistent and safe way.

People received a copy of the complaints procedure with their contract of admission. The majority of people expressed complete confidence in taking concerns to the home's management. One told us they had complained about a staff member they felt had been a bit rough. They wrote a letter to the registered manager and "the matter was looked into straight away." They were happy with the outcome and felt they had been listened to. Another told us they were not aware of a formal complaints procedure but if they had any worries they would speak to the registered manager and were sure they would be listened to. Another person said they recognised that where a lot of people lived together you were bound to get an odd complaint, adding "the carers are not our servants." They also gave an example of a person played their radio very loud. She said she spoke to the (registered provider) about this and was happy with how it was resolved. Two people's families were involved in complaints about the service. The registered provider had involved other agencies to ensure best practice was being followed and the people's rights were upheld. They had protected the people in their care and supported the families, despite the difficult situation.

Good

# Is the service well-led?

## Our findings

There was a positive culture which was person centred, open, inclusive and empowering. The standards expected were clearly defined through the behaviour of management and senior staff. Staff were clear about their roles and the expectations of the provider. For example, a staff member brought a concern about staff practice to the registered manager immediately it had happened and the registered manager took immediate action, suspending the staff pending investigation.

Information provided from the organisation states that the goals and objectives of the home are: 'To provide each service user with a warm and friendly atmosphere which will provide the opportunity to enhance their quality of life within a comfortable environment giving support and stimulation to help them maximise their potential physical, intellectual, emotional, spiritual and social capacity which are met through the extensive activities programme along with the necessary staffing levels'. The goals and objectives of the home were being met through the importance and time given to meaningful activities, the ability of staff to spend time with people and the respect of the registered provider for the people in his care.

The management expected staff to spend quality time with people and those staff had the time to do so. This included chatting with people after lunch and sharing the office with a person who took comfort in being there. Time was taken to elicit what mattered to people so activities could be based on their strengths and interests; people were at the heart of the service. A new member of staff was clear what was expected of them and felt supported.

Quality was under regular review through a monthly programme of audit. The audits included medication, care plans and falls. These had led to improvements, such as an addition to the medicines policy. Audits were monitored by the registered provider and so they were actively involved in maintaining standards and supporting the registered manager and staff. The results of the audits undertaken were fed back to staff at meetings for compliment or where practice needed to be addressed. For example, reminding staff how an individual needed their call bell attached so it was easily available to them. This issue had been identified and was being addressed.

People expressed confidence in the home's management. People at the home, their families and staff, expressed respect for the management. The majority were confident complaints would be taken seriously and that individuals would be listened to. Where concerns about practice were raised these were fully investigated. For example, CCTV throughout the corridors provided an 'event log' such as: "11.30am x3 staff in (the person's room), 11.35am x3 staff in (the person's room), 1200 (Family) arrives wearing (coloured) coat, 12.04pm (Family) peers out of door and 12.14pm (Family) walks to medical room." Therefore the registered manager and registered provider were able to establish facts about the visits one person received when this was brought into question. People were pleased to see the registered provider, smiling and making conversation. The registered provider had a good knowledge of the individual people at the home and the staff supporting them.

Staff were positive about working at the home and enthusiastic about their work. Activities staff had researched best practice in their role and were taking improvements forward. For example, introducing the 'Core Needs' programme which ensured people were offered a wide variety of therapeutic activities. One staff member said, "I love working here. Residents are happy; staff get on well." Another told us, "There is an open door policy. I can speak my mind and I feel like I'm being heard." A third said, "It's very much like a family here." There were systems to keep staff well informed, updated and address any practice issues. This included the daily meeting for heads of departments, staff meetings and staff supervision.

Staff were valued and fully supported in their roles. For example, following a death there were de-briefing meetings to support the staff and reflect on the care and treatment given. Staff were very positive about the training and staff support arrangements. There was a rolling programme of training for all staff and any particular training needs highlighted, were sought on their behalf. The registered manager, recently recruited, was supported to undertake the Level 5 Diploma in Leadership for Health and Social Care.

Regular meetings with external professionals helped the home to review the service provided in conjunction with the local services. Physiotherapists, Occupational Therapists and the Clinical Commissioning Group had corporate meetings at Hatchmoor which they described as

Good

# Is the service well-led?

"A valuable community resource". We were told the registered manager and registered provider were "Very, very helpful." The home was involved in the 'Torrington Project' where, following the closure of hospital in-patient beds, the home was providing six week rehabilitation for people prior to them returning home. Two of the home's nurses had taken responsibility for linking with the physiotherapists and occupational therapists and had received specific training from those professionals for the role. Some care workers were specifically assigned to supporting the people receiving the rehabilitation. However, a physiotherapist involved in the scheme said that although the first admission under the scheme had been "highly successful" admissions since had been less successful, they felt because of the different approach required from staff for people requiring rehabilitation. The home also had strong connections with a local hospice team. For example, two staff were part of a pilot for end of life training.

The home demonstrated good management and leadership. Where improvement had been identified there was prompt action, such as improving the robustness of recruitment practice. The registered manager and registered provider met their responsibilities. For example, keeping CQC fully informed, seeking advice as required, protecting people and ensuring people's rights were upheld. For example arranging advocacy for a vulnerable person who wanted to return home. Their discharge to a safe place had been arranged.

Resources were made available as needed for people's safety and comfort. For example, specialist equipment was bought to meet the needs of a clinically obese person from their admission and a hairdressing salon was nearly complete. Staff were assigned specific roles as required.

Managers and staff understood issues relating to the day to day running of the home because of the arrangements to share information. For example, the daily meeting of all nurses and heads of department to ensure information or importance was shared and acted upon. This included dietary information, the need for external health care advice, activities arranged for the day, any maintenance needs or upgrading and arrangements for individuals, such as travel. The care planning and reporting system ensured any concerns were highlighted and these were immediately visible to nursing and management staff. The deputy manager felt the home was well-led and spoke of the "lines of responsibility" at the home. They added that the registered provider was available at any time and "Any staff can go in and see him."