Hart Care Limited

Hart Care Nursing & Residential Home

Inspection report

Old Crapstone Road
Yelverton
Devon
PL20 6BT
Tel: 01822 853491
Website: www.hartcarelimited.com

Date of inspection visit: 10 & 13 February & 25 March 2015
Date of publication: 26/06/2015

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection visits took place on 10, 13 February and 25 March 2015. The first two visits were unannounced and the third visit was announced so that arrangements could be made for us to spend inspection time with the registered manager and/or the provider.

Hart Care Nursing and Residential home is registered to provide nursing and personal care to a maximum of 54 people. Most people using the service have multiple health care needs. There were 45 people living at the home on the first day of our inspection; 27 people had nursing care needs.

The home is required to have a registered manager. This is a person registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have

Summary of findings

legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The current manager employed at Hart Care applied to register with the CQC and that registration was completed during the inspection. They are therefore referred to as the registered manager throughout this report.

At the last inspection on 2 September 2014 we found staffing arrangements were not based on the changing needs of people using the service. People were not fully protected from the potential of risks because assessment and quality monitoring of the service was not part of routine practice. Following the last inspection, the provider sent us a comprehensive action plan.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. One person living at the home was subject to a DoLS; some staff were unaware of this application, which could potentially mean they did not support them appropriately. Some staff had a better understanding of the Mental Capacity Act and the Deprivation of Liberties Safeguards than others. Not all staff had received this training. The registered manager understood when an application should be made and how to submit one.

Improvements were needed to ensure that the home was well-run so that environmental safety checks and actions were monitored effectively and the management of complaints were consistent and well-managed.

Recruitment was not managed in a safe way and potentially put people at risk of being cared for staff who not suitable to work in a care setting. The new registered manager and the provider had begun to identify where improvements were needed in staff training, supervisions, and record keeping. They had already started to instigate some new ways of working by the creation of a new role for a senior staff member. They also recognised further training was also needed to support a broader range of training being made available to staff.

Most people living at the home were positive about their care and the support they received from staff. Most people felt there were enough staff on duty to meet their social and care needs. People were satisfied with the quality of the food. The overall view of visitors to the home was that people were supported by caring staff. Staff were positive about the appointment of the new registered manager and told us the provider was approachable.

Staffing arrangements were now based on people's changing needs. Quality monitoring of the service still required further improvement, which was also identified during our last inspection in 2014. We found other breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 linked to the management of complaints and supporting staff through supervision and monitoring staff disciplinary matters.

You can see what action we told the provider to take at the back of the full version of this report.

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?

Requires Improvement 

Some aspects of the service were not safe.

Recruitment practices were not robust so the provider could not demonstrate that staff were suitable to work with vulnerable people.

Environmental safety checks needed to be improved.

The provider was actively trying to recruit more nursing staff. People's opinion on whether staffing levels were adequate at the home was variable. But people told us they felt safe.

Medication was well managed.

Staff knew their responsibilities to safeguard vulnerable people and to report abuse.

Is the service effective?

Requires Improvement 

Some aspects of the service were not effective.

Supervisions, disciplinary issues and inductions were not well managed but the creation of a new role was planned to address this issue.

Generally training was up to date but there were some areas of training that were due to be included to enhance the staff group's knowledge.

Staff understood the importance of offering choice and encouraging people to live as they chose. People were complimentary about the care they received.

Some staff had a better understanding of the Mental Capacity Act and the Deprivation of Liberties Safeguards than others. Not all staff had received this training.

People were generally positive about the quality of the food and the choice provided. People had access to health services.

Is the service caring?

Good 

The service was caring.

The majority of people we spoke with were positive about the way staff treated them and their relationships with them. Staff were kind and caring in the way they described their role and the people they supported.

However, several people living at the home were less positive about some individuals. We followed up these individual concerns with the provider.

Staff treated people with dignity and respect.

People's families were complimentary about the end of life care provided at Hart Care. People received their pain relief according to their needs.

Summary of findings

Is the service responsive?

Requires Improvement

One aspect of the service was not responsive.

Work was needed to improve how complaints were responded to by the management team as the complaints process was not person centred. But people told us their care needs were met.

The service was responsive to people's changing needs.

The registered manager's approach was inclusive and she was committed to responding to people's feedback about the service.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had not yet established an effective quality assurance system to monitor the quality of the service.

Staff were positive about working at the service and the majority of the people responding to a survey were positive about their experience of living at the home.

Hart Care Nursing & Residential 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.

The inspection visits took place on 10 and 13 February and 25 March 2015. The first two visits were unannounced and the third visit was announced so that arrangements could be made for us to spend inspection time with the registered manager or registered provider. The inspection team consisted of two inspectors, an inspection manager 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.

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 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 comment directly on the care they experienced.

During our visit we spoke with 16 people who used the service, six people's families and friends, 15 staff, five health and social care professionals, the registered manager and the provider. We looked at records which related to seven people's individual care, including risk assessments, and people's medicine records. We checked records relating to training, supervision, complaints, safety checks and quality assurance processes.

Requires Improvement

Is the service safe?

Our findings

The service users' guide stated that recruitment policies and practices will 'protect residents' safety and welfare'. The recruitment practice within the service needed to be improved. Four recruitment files for recently employed staff showed the recruitment processes within the service were not thorough, which could result in unsuitable people being employed by the service.

There was not a consistent approach to ensuring that new staff members were not employed until information from the Disclosure and Barring Scheme had been received and reviewed. These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people. Two files showed DBS checks had been received before staff started work at the home. However, a third staff member had started working at the home in December 2014 but the DBS check had not been applied for until March 2015 and the outcome had not been received by the service. A DBS check for another staff member was not in place until two months after the person had started working at the service.

A staff member told us a fifth person who had contact with people living at the home had not brought in their DBS to discuss the information on it. This was despite an e-mail from the DBS to staff at the home advising this should happen to enable the service to risk assess the person's suitability to be in contact vulnerable people.

Newly recruited staff had produced relevant identification documents and completed application forms. However, requesting references from previous employers to assess potential staff members' suitability was poorly managed. Four staff files showed references had been requested but staff had started work before they had been received by the service. There were gaps in the audit trail for recruitment decisions, which meant it was unclear why some staff had been appointed, or why their previous employer had not been approached for a reference. During our feedback, we were clear that the current recruitment practices at the home need to be improved to help protect people from being cared for by unsuitable staff.

We found evidence of a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

The provider told us there were no current staff disciplinary procedures in process. They gave examples of when staff had been dismissed because of their unreliability. The provider told us some money had gone missing from one person living at the home; they advised safeguarding had been informed but they had not contacted the police, which would have been good practice. The provider advised they had reimbursed the person; they said there had been no further incidents.

The majority of people told us they felt safe at Hart Care. Their comments included "I feel very safe, I have no worries; I'm very comfortable". They also explained how the actions of staff made them feel safe. For example, one person gave the example of feeling safe when staff assisted them using a hoist. Individual people's health risks were assessed and managed. For example, if people were at risk of falling or pressure damage to their skin. But people were not always protected from risks in their environment. For example, we visited one person on the first day of the inspection, who told us they were unhappy. Staff told us the person's mood was low and that they may be confused. The window in their room opened wider than recommended by the Health and Safety Executive (HSE), which had the potential to put them at risk of falling from a high window. We checked other windows in the building and they did have the correct restrictor in place.

We also found three rooms where the water was hotter than recommended by the HSE and potentially put people at risk of scalding. The provider told us that people using the rooms were not at risk of scalding because care staff always used the taps. There was a regular audit of these areas and so it was unclear how these risks had not been previously identified. When we shared our concerns, the provider took action to rectify the risks.

There was the potential that people might not be protected from abuse because not all staff were trained to identify and report abuse. The PIR stated that 25 of the 47 staff working at Hart Care had received training in safeguarding adults in the last 24 months. A maintenance worker, who

Is the service safe?

confirmed they had been employed at the home since April 2013 and entered people's rooms "all the time" as part of their work, said they had not received training in safeguarding adults.

The registered manager understood her responsibilities about safeguarding through our discussions with her about her role. Staff knew how to recognise poor practice and abuse and their responsibility to report concerns. For example, one staff member said "inequality and neglect" would constitute abuse. There was a good understanding that abuse should be reported and a confidence that it would be followed up within the home. For example, another staff member said they would report concerns to the "nurse, manager or the Care Quality Commission (CQC)". Another staff member said they would report concerns to the manager first, then the provider and then CQC. Staff said they knew where to go to find the information about reporting abuse but some staff were not aware that the local authority safeguarding adults' team, or the police, could also be informed of alleged abuse. However, they did know there was an external agency who they could whistle-blow to if they were not reassured by the provider's response.

People's opinion on whether staffing levels were adequate at the home was variable. Comments ranged from "(My family member) is always attended too quickly. No staffing issues" and "They answer the call bells in reasonable time" to "We are very under staffed" and "I don't think the staff have time to stand and chat." Staff told us it would be good to have more time to sit and talk to people. In their opinion, this approach was hampered if staff went off sick at short notice.

Staff told us there were enough staff to meet people's individual needs and said the staff team was more stable. They explained how changes to staffing levels in one unit had helped ensure people's care needs were met. Staffing levels had been reviewed. The registered manager said dependency levels for people using the service had been "looked at and adjusted." People received care that was unrushed and which met their needs. For example, a health care professional told us they had requested one person be assisted to walk twice a day and we saw the person receiving this support.

The provider used an electronic system to organise staff rotas and the registered manager was able to request extra staff as required. The rota was checked daily and we were told extra staff were arranged if there was staff sickness or absence, which the records confirmed. The registered manager used a dependency tool, which she reviewed each month to see if the staffing levels needed to increase. The provider spoke in detail about their actions to recruit more nurses but had not yet been able to recruit to their preferred levels. In the meantime, agency nursing staff were arranged but sometimes this was not possible when nursing staff rang in sick at short notice. On these occasions, the registered manager had to work on the floor, which could impact on her time to complete her management responsibilities.

Actions had been taken to try and resolve this issue. These included the provider block booking agency nurses. A senior care worker was due to start working three days a week to oversee the training system and the supervision of care staff. Two senior care staff were given the role of co-ordinating shifts, whilst the nurse on duty provided all 'nursing care'. The senior care assistant also administered the medicines to those people receiving personal care, which meant nursing staff could focus on delivering nursing care. District nurses were also responsible for the provision of nursing care to some people.

We checked the rotas for a four week period and saw most shifts were staffed at the levels described to us. For example, there was one nurse working on each shift and nine care staff allocated to work each day. After the inspection visit, we discussed the rotas with the provider. The majority of days showed there were nine care staff working on most days, unless staff had rung in sick at short notice. The provider told us they planned to increase the numbers to ten care staff during the day and four care staff at night, to work alongside nursing staff. There was a hospitality person who provided a service between 9 - 2.30pm, and usually three cleaners during the week and two cleaners at the weekend. This meant care staff could concentrate on caring for people rather than being distracted by other domestic tasks.

People received their medicines in a safe way; staff administering medicines wore a red tabard to indicate that they should not be disturbed during this task. Appropriate arrangements were in place in relation to obtaining medicine. The home used a monitored dosage system on a monthly cycle and the registered manager checked the medicines into the home so they could account for the medicines received. These records were dated and signed

Requires Improvement

Is the service safe?

by staff providing accountability and an audit trail of medication was managed. Medicines were disposed of appropriately. The home had appropriate arrangement to dispose of unused medicines. Records were kept of medicines returned to the pharmacy or disposed of at the home.

The home used 'just in case' boxes containing medicines which might be required for people receiving end of life care to control symptoms causing concern or distress. A care worker said the registered manager was always available, for example, should a person require pain control and the registered manager administered pain relief during our visit. Five nurses were employed at the home and administered medicines. The PIR stated that only one staff had received training in the safe handling of medicines in the last 24 months which raised the potential for mistakes. However, records showed that further training was booked and this potential risk would be addressed.

Medicines were kept safely in separate locked cupboards; medicines were stored in locked trolleys within the cupboards. There was also appropriate storage for medicines needing cold storage and for medicines which required specialist storage, called controlled drugs. Appropriate arrangements were in place in relation to the recording of medicines. The medicine administration records included information which protected people, such as any allergies recorded. It was also clear when a medicine was to be administered and in what dose. We found there were no unexplained gaps within the medicine records, codes were used where a medicine was not taken and variable doses were recorded for accuracy. Body maps were used for clarity for the application of creams and ointments.

Requires Improvement

Is the service effective?

Our findings

Staff files showed that supervision was not provided on a regular basis. Staff told us that their aim was to ensure it took place six times a year. We chose four staff members' files to check how their training and supervision was managed. One file was not available. The three remaining files showed supervision was not happening on a regular basis and annual appraisals were not in place. For example, one staff member started work in January 2013 but there were only three supervision sessions recorded since this date. On all three staff files there were issues relating to staff performance, which were not recorded as having been effectively addressed. Annual appraisals did not happen on a regular basis. The provider confirmed that the creation of a new post that was due to start the following week would result in new arrangements to manage formal supervision and subsequent training issues.

We found evidence of a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

During the inspection, we were told the induction process should be completed within six weeks of starting employment. The provider notified us after the inspection that the induction period for new staff was 13 weeks not six weeks. The provider told us a new post had been created to monitor new staff members' inductions. He explained this was in recognition that a more robust approach was needed to ensure staff had completed their inductions. For example, we checked the induction file for a staff member who had started working at the home four weeks prior to our inspection. There were a number of gaps where areas of learning had not been signed off and the dates of the recording indicated that the induction process was not being monitored effectively. We asked to see other people's induction files but none were available and there was no overview of how inductions were being managed and monitored.

Despite improvements being needed to how inductions were overseen by the management team, staff said they were happy with the staff induction process. One said there had been "Loads of improvement." Staff told us they received an induction pack including procedures, a job description and were given a tour of the home. The formal induction included moving people safely. The first week was spent shadowing senior staff. Staff said that new staff were now staying longer. Senior staff were clear that staff were not expected to complete tasks if they had not completed their training. Staff told us they felt supported by the senior staff; a senior care worker explained how they provided supervision to new members of staff. Staff said they could go to a senior, the registered manager or the provider for anything they needed. People living at the home told us staff knew how to care for them.

Staff told us they had received training in 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. The PIR stated that only one staff had received MCA and DoLS training; three staff members' files showed they had not attended training in this area of care.

Discussions with some staff showed they needed further support to how the MCA and DoLS impacted on the way they supported people. However, discussions with other staff showed a greater understanding. For example, a care worker explained that "we have to assess how they can make their own decisions, what we think they can't do…, it's about not taking away their decision. If someone wants to go on the moor, but I felt they were unsafe, I'd get someone to go with them''. People living at the home told us "They do ask my consent if needed''. Another person said "All staff ask my consent, they're brilliant."

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 had one authorisation to deprive a person of their liberty. The person's social worker said, "(The registered manager) has been great regarding my lady and has attended all the relevant meetings etc." However, improvements were needed to ensure all care staff knew this authorisation was in place so they knew how to support the person appropriately.

The registered manager understood how to protect people's liberty. For example, one person confirmed that they had agreed to the use of bed rails. Staff understood

Is the service effective?

the importance of offering choice and encouraging people to live as they chose. For example, one person chose how to manage their medicines and buy preferred foods and each person had the opportunity to make menu choices. One care worker said that if a person wanted to make a decision which was a risk to them they would ensure the registered manager was informed. Another person had wanted to come off a pureed diet, and the staff had arranged for the Speech and Language Therapist to come and discuss this with them.

We requested the training information for four staff. One file was not available. The remaining files showed staff were up to date on training relating to safeguarding, moving and handling, infection control and food hygiene. Staff were positive about their training, with comments including, "pretty good" and "all up to date". One person had not received a fire training update; they explained why this had happened and a new date was arranged during our inspection. Despite many people living at the home having a diagnosis of dementia, the previous training arrangements had not addressed this area of care. The provider showed us information from an external trainer, which showed that this gap in the training programme would shortly be addressed. A number of staff had signed up for this course. He recognised this was a training need that should be developed to enhance staff knowledge and benefit people living at the home.

The registered manager understood her responsibilities to ensure people's capacity to consent was considered. For example, one person, although receiving end of life care, had the capacity to make decisions relating to their care and was therefore consulted about decisions relating to their care. Records showed that the registered manager was ensuring people's capacity to make certain decisions, at a certain time, was assessed. Reviews included who had been involved and if this did not include the person receiving the service the reason was recorded. For example, the person was "too distressed". Risk assessments included people's mental capacity, although some review dates had recently been missed.

Most people were positive about the food. Their comments included: "The food is very good. There is a choice and fresh drinks are available"; "Superb fish and chips"; "Food is alright"; "I always ask and get a small portion of food as I don't like large meals", although one person said "The food is not good so I have salads most days." Menus were planned by the cook who also did the ordering. They said they were experienced but not trained in menu planning. Two choices of main meal were offered, which included rice and pasta dishes and fish. Residents' meetings were considered an opportunity to give feedback about the menus. One person said the menu had become repetitive "again" and during the inspection food was discussed at a residents' meeting and suggestions were made for improvements, which the registered manager said they would action.

Staff understood the importance of providing an adequate supply of drinks for people. One person's family described how care workers had always tried hard to get their family member to drink and had always assisted her to eat. They said, "She wanted ice cream and she got it." People had drinks available in their rooms and were offered regular drinks throughout the day. Specialist diets were catered for. For example, gluten free and pureed diets. On admission each person had a form completed which described their dietary requirements and people's dietary needs, and any risks, were part of people's assessment, care planning and dietary monitoring.

Records showed that health care professionals were called on a regular basis. For example, one person said ''If you need a doctor they would call, I get my medicines when I need them." People could be admitted for intermediate care for 10 days. This is where someone comes in and is supported back to independence so they can return home. We met a community physiotherapist and an occupational therapist. They said '' The home provides excellent support for our therapy goals. We get good feedback from the home, particularly with people who want to be discharged.'' ''We don't worry about people here, they really encourage people to get back home."

People were complimentary about the care they received. Comments included: "The staff seem very competent"; "The staff are absolutely brilliant" and "I had a care worker yesterday who was a real carer – she was genuine." Care workers felt the standard of care provided was good and they were able to demonstrate a commitment to high standards and the people in their care.

Good

Is the service caring?

Our findings

We spoke with 16 people and six visitors about their opinion on the skills and approach of staff at the home. The majority of people were positive about the way staff treated them and their relationships with them. Asked if the staff were kind and caring one person said, "My care could not be improved." People said the staff spoke to them with respect and were "kind, respectful and friendly." Staff who spoke with us were kind and caring in the way they described their role and the people they supported.

However, several people living at the home were less positive about some individuals. We followed up these individual concerns with the provider. For example "All staff are pretty good but certain ones have attitude". The provider spent time with us considering the less positive comments. He agreed to ensure that he checked with individuals living at the home if they had any issues or concerns they wished to report to him. Feedback from people living at the home was the provider did visit them regularly and was approachable. One person was unhappy with one care worker's approach, but raised this concern directly with the registered manager in our presence.

There were positive comments from people's families about the care provided. They included written and verbal feedback "Thank you both for the careful attention that dad received"; "Absolutely fantastic. I am impressed by the quality of care" and "The girls are kind, very caring and lovely. It doesn't feel institutionalised."

The PIR stated that no staff had received training in dignity, respect or person centred care; the provider showed us that an external trainer had offered training to promote dignity whilst caring for people. Staff had signed up for this training.

However, staff treated people with dignity and respect. Staff stood outside a bedroom door whilst someone was using the commode, so that they could have privacy. One care worker said "We talk people through what they need, try and make them feel at ease, try and be as nice as you can." One staff member said "the best thing about working here – the clients make the place."

Our observations showed that staff interactions with people were positive. For example, one person was very distressed at lunch time and was worrying about her mother. All the staff showed a very respectful, kind and compassionate way of relieving her anxiety. Staff knocked on doors before they entered. One person said '' What's good is the carers; they are a pretty brilliant bunch. They're happy and they always care."

People's privacy was upheld. For example, one person had not wanted a male care worker to attend to them and their wishes were respected. One person's friend confirmed that staff would not discuss the person's illness with them because they understood confidentiality. Personal care was delivered within the privacy of people's rooms. However, one person wanted a key to their room so they could restrict who entered their room, although they confirmed they felt safe at the home.

People's families were very complimentary about the end of life care provided at Hart Care. One told us about the "dignity and compassion" and the "gentle way" care staff provided care. They added, "They are terribly kind to the family at this time." Another person's family said they were pleased, adding "X is always clean, tidy and comfortable. All very caring." The registered manager ensured a 'programme of intensive care' was started when people reached this stage of their life.

People received their pain relief according to their needs. For example, the registered manager left a meeting to administer one person's pain relief at the time required. The registered manager liaised with the person's GP about the most appropriate pain relief for the person. The PIR stated that only one staff had received training in end of life care but a care worker said that their training had recently included this. This linked to information in the minutes from a staff meeting; the registered manager had emphasised to staff they needed to be committed to training in palliative care. One care worker was passionate in this area of work and said "It's the last service you can give people" and they told us they had undertaken training in palliative care.

Requires Improvement

Is the service responsive?

Our findings

Work was needed to improve how complaints were recorded by the management team so they could demonstrate there was an effective system to identify, receive, handling and responding to complaints. We looked at eight separate complaints; one complaint had not previously been shown to the provider. There was not a consistent approach in the way outcomes were recorded and it was not routinely logged what action had been taken to address the complaint. This did not follow the complaint procedure. There was not a clear recognition in the records how the complaint had impacted on the individual and what feedback had been given to the person living at the service. This meant the complaints process was not person centred.

The provider assured us that people's complaints had been responded to verbally but acknowledged that the recording did not provide an appropriate audit trail. During the inspection, a relative raised a concern with a staff member but was not provided with information about how to make a formal complaint. Since the inspection, the provider has advised that action has been taken to address the concern and the family have been contacted and apologised to. Staff had also been made aware of how to respond to complaints.

We found evidence of a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

However, the majority of people said that any complaint they had made was followed up and people had a guide to the service in their room, which included the complaints' procedure. People said "They write any concerns or complaints in a book and they are always dealt with"; "Everything I have complained about has been sorted" and "I would speak to the manager if I had problems, she is very good at dealing with things." A fourth person said "If I had a complaint I would go to the matron, it would get sorted." Recent minutes from a staff meeting showed the registered manager had listened to some people's complaints that they were experiencing disturbed sleep because of night staff checking on them; the outcome was to reduce checks unless people needed more support because of higher care needs. This showed the registered manager was responding to people's concerns.

People told us their care needs were met. For example, "They look after me very well, no complaints…I wouldn't complain about the girls, all very good, All perfectly fine." One person said

"I have a bath twice a week, they let me soak!'' and "I get up when I want to." One person had been transferred from hospital and had become used to a particular new hoist whilst they were there. The provider had purchased one for them to use at the home, which responded to their individual moving and handling needs and recognised they would feel more comfortable with equipment they knew. A person told us they felt safe when staff moved them.

The service was responsive to people's changing needs. One person did not want to eat her meal, which the staff recognised was unusual for them. They made sure they kept encouraging her, and also took various tests to see if there was a health reason as to why they weren't eating. They also called the doctor. This showed they recognised the need to respond to someone's changing needs. One person said ' the registered manager is an amazing person, she never forgets, and she picks up, she can tell when I'm getting a headache''

People told us they had a pendant they could use if they needed to call staff for assistance. People told us the call bells were generally answered in a timely manner but some people felt staff could be rushed. The provider explained how they could monitor the response time to call bells and showed us a call bell history print out, which showed timely responses for the time period we checked. Two health care professionals commented that in their opinion people in rooms closer to the nursing station got a "better quality of care" than people further away, in particular on the top floor of the original building. This included a person receiving end of life care.

The home used a computerised care system to record people's assessment, care plans and monitoring records. Staff frequently used the system to record information, for example, when and what care was provided, people's weight and people's fluid intake. Care plans included risk

Requires Improvement

Is the service responsive?

assessments for moving safely, skin damage and the likelihood of falls. Care records also included some comprehensive, detailed information, such as medical visits and observations for monitoring people's health.

Work was still taking place to expand information regarding people's personal history, which were still in a paper format. These were due to be transferred onto the electronic system. The registered manager told us they were positive about the new system; the provider told us by trialling the system they had been able to influence areas that needed to be developed further to benefit people's care and staff knowledge.

We attended a residents' meeting which was chaired by the registered manager. At the meeting, there were 18 people and three relatives. The registered manager's approach was inclusive and allowed everyone to talk about topics that they thought were important. People commented on the positive changes that had been made since the previous meeting. One topic was the 'predictability' of meals; some people wanted to try some different meals. The registered manager listened to people's discussions and made notes throughout the meeting, which would then be circulated after the meeting. Other comments included: "I have been to one resident's meeting but it did not seem to make a difference" and "We have resident's meetings when the staff have time. They do act on our suggestions."

Two care staff were responsible for activities. These included exercises, entertainers, games, and trips out. In the residents' meeting, the registered manager discussed with people what activities they would like to do over the summer. People suggested having a list of the weekly activities available on notice boards and in their rooms which was agreed. Many people had family who visited regularly. Some people chose to spend time in their rooms, enjoying the views of Dartmoor, the birds coming to the bird feeders and their flowers.

Requires Improvement

Is the service well-led?

Our findings

Improvement was required to ensure quality assurance checks provided a stronger audit trail on how the provider reassured himself that systems were running well at the home. A previous action plan submitted to CQC in July 2014 identified a number of areas that needed to improve these included staff recruitment and staff supervision. After our last inspection in October 2014, a compliance action was made to improve the quality assurance systems in the home. The service's PIR identified that improvement was still needed around the quality assurance systems, which was confirmed during this inspection.

There were written monthly audits and these contained notes, such as events that had happened or the employment of new staff. However, these audits did not show that records were being routinely monitored for the quality of their completion or to look for patterns and trends. Recruitment, supervision, yearly appraisals, staff disciplinary issues and the management of complaints needed to be improved but had not been addressed through the service's quality assurance system.

One upper window had not been appropriately restricted and the water temperature in some areas put people at risk of scalding. These issues had not been picked up as part of the quality assurance building checks. The provider assured us during the inspection these issues would be addressed as a priority.

After the inspection visit, we discussed the hot water temperature records, which had been sent to us, with the provider and the registered manager. The temperatures indicated there was a potential risk of people being at risk of scalding. The provider told us some of the records were inaccurate and assured us that this was being followed up with staff. He confirmed a new boiler fitted at the beginning of April 2015 had rectified the issue and agreed to send records to demonstrate the change. He planned to add spot checking hot water temperature to his quality assurance visits.

Previous action plans had identified fire safety being an area for improvement; maintenance staff said they completed fire safety checks and records showed staff were trained in fire safety. The provider sent us certificates to show that other safety checks had been completed for gas equipment and portable electrical equipment.

Since the last inspection in October 2014, many people living at the home had completed a survey about their experience of care. This feedback had still not been collated and therefore people had not been provided with reassurance that their views were valued and could influence the service. However, there were minutes from residents' meetings with the registered manager, which showed she listened and responded to people's suggestions.

In February 2015, the manager was registered with CQC. A social worker told us since the manager had been in post they had "noticed a definite improvement to the overall leadership, communication and joined up work". However, a health care professional said they had difficulty contacting the manager; they said nurses were busy and on one occasion a nurse had not had been available to discuss a patient with them. At the beginning of the inspection, we were not able to spend time with the registered manager as she was covering staff sickness. However, later in the inspection, she was able to spend time with us and explain her role. The provider told us what steps they had taken to address vacancies in the nursing staff team. After the inspection, they advised they were delaying admissions to the home until staffing vacancies were addressed.

Rotas for a four week period showed for two weeks, the registered manager was providing nursing cover for ten shifts and their hours totalled 120 hours in two weeks. The provider told us they recognised the impact on the registered manager when they had to cover a nursing shift as they then struggled to fulfil some of their management duties. The provider informed us of the action they had taken to recruit more nursing staff but that this was currently proving problematic.

We found evidence of a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

One person said, "I have no problem with the management. On the whole it is very good." A second person said "(The registered manager and provider) talk and ask for any ideas or thoughts for the benefit of the home. Overall it is a good home and I would recommend it. A third person said, "(The registered manager) is very good and very fair."

Requires Improvement

Is the service well-led?

Since the last inspection in October 2014, there have been three staff meetings; these included day staff, night staff and nursing staff. The content showed the registered manager was committed to improving the experience of people living at the home.

There was a poor response to a staff survey last year but staff were positive about working at Hart Care and the new leadership. Their comments included "The home is an awful lot better than it was, for example, communication"; "It has changed a lot for the better. The manager is very approachable"; "The manager is really good" and "Yes, really (well-led). (The manager) works along-side us, listens and gets along with the residents – her door is open." The staff spoke very highly of the provider saying he was available at any time and they all had his mobile telephone number.

Staff told us the provider would call them into the office on a regular basis to ask how they were and how things were in their job. A staff member said "He's a really good boss." All the people and staff at the home who spoke with us said they could go to the owner or the manager for anything and that they would always resolve issues. The registered manager said she was supported by the provider '' If I want something I get it''. Staff said "Staff are very close, a big family. It's a really nice place, always something going on."

Notifications had been appropriately sent to CQC, apart from on one occasion when money had gone missing from a person living at the home. A notification is information about important events which the service is required to tell us about by law.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **People who use services were not protected against the risks associated with unsafe recruitment processes.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **People who use services were not protected against the risks associated with a poorly managed complaints system.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People who use services were not protected against the risks associated with a poor quality assurance system.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **People who use services were not protected against the risks associated with poor supervision and appraisal systems. Staff disciplinary issues were poorly managed.**