Mrs J I Mirjah

Halwill Manor Nursing Home

Inspection report

Halwill
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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

The inspection visits took place on 14 and 17 April 2015 and were unannounced. The home was last inspected on 14 October 2013 and was meeting all the required standards we checked at that time.

Halwill Manor Nursing Home provides personal and nursing care to a maximum of 25 people. Most live with the condition of dementia. There were 25 people using the service at the time of the inspection.

The home has 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.

Medicine management was not robust. Although medicine management had been reviewed a discrepancy was found in the number of tablets recorded to what was actually in stock. Staff were also putting medicines into pots and carrying them on a tray and so increasing the potential for mistakes. Some medicines had been

Summary of findings

recorded into the home, not needed, but were still in stock over three months later. Changes to people's medicine records had not been dated or signed which increased the risk of medicine errors.

Staff numbers and deployment met people's needs in a safe way and were under regular review, taking into account people's needs and staff opinion.

People were protected by the arrangement for prevention of abuse. This included staff training, robust recruitment and an openness to notify external agencies of any concern.

The home environment and equipment was well maintained and kept in a safe state. Improvements to the environment were planned and in progress.

There was a strong emphasis on staff training. Staff were encouraged and supported to undertake qualifications in care and they benefitted from a broad range of training opportunities. Staff received supervision and support to succeed in their role.

The provider had acted in accordance the Mental Capacity Act (2005) and Deprivation of Liberty safeguards to promote decision making and protect people's rights.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). People at the home were not being deprived of their liberty unlawfully.

People received a diet which promoted their health and welfare. Dietary concerns were identified and action taken as necessary. There was on-going nutritional assessment and management.

One staff member said, "People are loved here not just cared for." People, their families and health care professionals reported staff to be kind, friendly and caring. Staff understood how to engage with people as individuals and in a person centred way. People's dignity and privacy were promoted.

End of life care was provided in accordance with people's wishes and with regard to their dignity and comfort.

People's needs were assessed and their care was planned with them or with people who knew them best on their behalf. People's hygiene and personal care needs were well met and their health was promoted. Staff could describe people's needs and how to meet them, in detail.

People said they had no reason to complain but felt any complaint would be dealt with effectively.

The service was well led by a registered manager and provider working together to manage any risks and looking at how to continually improving the service.

We found one breach of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back 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

The service was not always safe.

Medicine records were not always correct or clear. Medicines were not disposed of within a reasonable timescale. Some medicines were not administered in a safe way. Medicine storage was being brought into line with the legislation required for that storage.

People were protected from abuse and harm through safeguarding arrangements and risk management.

Staffing numbers and skill mix met people's needs in a safe way.

Staff recruitment was robust and protected people from staff who might not be safe to work in a care home environment.

The premises and equipment were kept in a safe state for people's use and environment checks promoted people's safety.

Is the service effective?

Good

The service was effective.

The service gave staff training a high priority and staff received supervision and support in their role.

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

People's dietary needs were being met and they received a nutritious diet and regular fluids.

Is the service caring?

Good

The service was caring.

Staff showed sensitivity to people's individual needs and views, which were promoted through discussion, listening and observation.

People were treated with kindness, dignity and respect. Their privacy was upheld.

People's end of life needs was discussed with them and their dignity and comfort were promoted.

Is the service responsive?

Good

The service was responsive.

Staff had a good understanding of people as individuals and they responded to their physical and emotional needs in a person centred way. People had the opportunity to engage in activities of interest and importance to them.

Summary of findings

People's care needs were assessed and planned with them, or their family representative.

The registered manager and provider were available to deal with any concerns or complaints and people felt any concern would be dealt with effectively.

Is the service well-led?

Good

The service was well-led.

People using the service, their families and staff were happy with the way the service was run and had noted improvement.

There were arrangements for hearing people's views, assessing and managing risk and reviewing and improving the quality of the service provided.

The provider and registered manager were meeting their obligations of registration.

Halwill Manor 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.

The inspection visits took place on 14 and 17 April 2015. The visits were unannounced. The inspection team consisted of one inspector.

Before the inspection we looked at 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.

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.

We spoke with four of the 24 people who used the service and one person's family to obtain their views about the service provided in the home. We interviewed six staff, the registered manager, provider and provider representative and met a training professional visiting the home. We looked at records which related to two people's individual care planning. We looked at medicine administration records, the recruitment files for three staff and documents which related to the running of the home such as audit records. We looked at feedback survey results from 2014 and the home's action plan based on those survey results. We spoke with one health care professional with knowledge of the service.

Requires improvement

Is the service safe?

Our findings

People received their medicines as prescribed and as needed for their comfort. For example, a nurse administering medicines asked a person if they needed any pain relief.

Medicines were stored in locked cupboards in a locked room. However, medicines requiring specialist storage were not stored according to the legislation specific for them. The registered manager was already aware of this and had already taken steps to provide the correct storage. There was a medicines fridge available for medicines requiring lower temperature storage, such as insulin, with daily temperature checks to ensure it was within the correct range for the medicines in use.

Medicines were checked into the home as part of their audit of use. However, medicines were stored which had been received into the home in December 2014 after the person's death and they had not yet been returned or disposed of.

Medicines were not always secure when being administered. For example, some medicines were put into named pots and put onto a small open tray when taken to people on the first floor, rather than administered as dispensed from the pharmacy.

Medicine records management increased risk of mistakes. For example, the drugs register did not tally with the number of medicines in stock. The provider established that this was a recording error from the point of recording the medicine into the home. Also, an amount of insulin had been crossed out and changed repeatedly over many months. The registered manager found the record of when the amount of insulin had been changed but the change was not included in the person's care plan. Neither did the care plan include sufficient information for nursing staff, for example, the normal range expected for that person from blood tests, which might affect the medicine dosage they required. Other recording changes had been made which were not signed or dated.

Areas of good practice in medicines management at the home included: staff specimen signatures, people's current photographs, a record of any variable dose and it was clear at what time a medicine was to be administered. Following a visit from the supplying pharmacy other good practice measures were being introduced, including body maps for people who received their medicines through skin patches.

A nurse confirmed there was medicine training for nurses administering medicines.

We found that the registered person had not protected people against the risk of unsafe medicine management. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager demonstrated a clear understanding of their safeguarding role and responsibilities. They understood the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis. For example, the registered manager had informed the local authority and health professionals, ensuring people's safety, when two people using the service had an altercation.

The safeguarding policy set out the steps which should be followed to safeguard vulnerable adults, such as working in partnership with the local authority. Safeguarding was also addressed as part of staff induction, staff training, each staff supervision and meeting, one of which we attended. People and their families said the home was safe. One person said they felt safe and "there is never any violence or anything." Another person said the home felt safe.

Risks to individual people were identified and the necessary risk assessment reviews and actions to reduce risk were carried out to keep people safe. For example, risks from abuse, choking, mental well-being, leaving the home without support, pressure damage and moving safely were all addressed. For one person there was clear information relating to what triggered their distress and how staff could prevent and manage that distress, thus protecting the person and other people at the home. We observed that staff followed the care plan information.

People's needs were being met by the numbers and deployment of staff. People said there was enough staff to meet people's needs in a safe way. One person's family said, "There are always staff around."

Staffing was discussed at a staff meeting with the registered manager and provider's representative during our visit. The staff said they had no concerns about staffing levels. Staff

Requires improvement

Is the service safe?

opinion of the staffing levels and skill mix were listened to and taken into account. For example, how many care workers would be best for the morning shift, additional time made available for staff to read care plans and meet their role as key workers and time available for the newly appointed clinical lead to fulfil their role. Staffing included: the registered manager and clinical lead, nursing and care workers, two administrators, a training officer, activities worker, two maintenance staff, housekeeping, catering and cleaning staff.

There were robust recruitment and selection processes in place. Recruitment files of recently recruited staff included completed application forms and interview records. In addition, pre-employment checks were completed, which included references from previous employers, health screening and Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work with people using the service. A recently recruited staff member confirmed they had not been allowed to work with people until their recruitment checks were completed.

Maintenance staff worked to keep the home environment in a safe state. No environmental concerns were identified during the visits. A book was available for staff to record any maintenance work required and the registered manager reminded staff about its use during the staff meeting. Equipment was serviced at regular intervals and maintained in a safe condition for use. External companies were employed to ensure safety, for example, from the risk of Legionella and for fire safety.

Good

Is the service effective?

Our findings

People received effective care, promoting their health and wellbeing. People's and their family's comments about staff ability included, "Couldn't wish for better" and "Good." The home's survey feedback forms included comments such as, "All staff are approachable, friendly and knowledgeable." We observed a high standard of personal care was delivered for people's dignity and hygiene needs.

There was evidence to show the registered manager had prepared for the new care certificate which replaced the current Common Induction Standards, which came into effect on the 1 April 2015. A care worker said they were assigned a senior staff member to shadow for their first week and they read policies and procedures, and knew who to go to for support and other information. They said, "everyone has been very helpful." Four staff were being inducted during the inspection.

The home had employed a training officer who was ensuring suitable training was available and undertaken by staff. This included training in safe moving for non-care staff and assisting people to move safely for care staff, emergency first aid, food safety, infection control, fire safety and the safeguarding of adults. Specific training was also arranged "bespoke to the home", for example, language disorders, such as putting words together to make meanings, relevant to the people using the service who were living with dementia.

Staff were encouraged to undertake qualifications in care; the assessor visited during the inspection. They said the registered manager was "extremely supportive" and had offered additional support to staff that needed it to achieve the qualifications. There was also a visit from the local authority training support team. Staff training needs were being met, as demonstrated through the home's training matrix. Nurse training updates were available and included a scheduled neurological conference on 30 April 2015.

Staff received regular supervision in line with their role and felt supported by the registered manager.

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. One person's family told us their family member was protected through Lasting Power of Attorney arrangements. End of life care decisions were in place, such as whether the person wanted active intervention in the event of collapse, and GPs had discussed this with people. Where people shared rooms this was with their consent or considered in their best interest; the reason for the decision was recorded as part of the care planning.

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. Records showed how people's capacity to make a decision had been assessed. For example, recording whether the person could understand the decision which needed 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 had made 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 a coded main door and gated stairway. No DoLS applications had been authorised at the time of this inspection.

People received the food and fluids they required and their dietary needs were monitored. People described the food as "Quite adequate. There is some variety and they do their best" and "The food is nice." People's nutritional needs were part of their initial assessment and on-going review. Care plans included food preferences and dislikes and the person's preferences and needs at mealtimes called 'My mealtime support plan.' This included where the person preferred to eat and what help they required. Some people needed staff to feed them whilst others needed gentle prompting, which we observed being given.

The four week menus were based mostly on a meat and vegetables dish for the lunch time meal – fish on Fridays.

Good

Is the service effective?

Individual preferences were taken into account, for example, one person liked spiced foods. The supper menu was more varied, for example, tuna pasta; jacket potato and cauliflower cheese.

Information about people's dietary needs and preferences was clearly recorded in a colour coded system - red meant more care was required. One person's record stated, 'Loves anything chocolate'. People's diet was then adjusted accordingly, for example, softer foods or a higher calorific diet. Staff reported any concerns about the amount of diet a person had taken and people's weight was monitored.

People received regular drinks throughout the visits and one person confirmed drinks and food were available at any time.

People told us the arrangements for meeting their health care needs included visits from local GP's, chiropody/ podiatry, dental care, eye care and regular visits from the hairdresser. People were supported to attend medical appointments.

Good

Is the service caring?

Our findings

People and their families praised the caring attitude of staff at Halwill Manor. One staff member said, “People are loved here not just cared for.”

Staff engagement with people was respectful and friendly. Staff spoke quietly, care was at a relaxed pace; staff made eye to eye contact and provided information, guidance and reassurance. For example, one person could not remember where they had left something and a staff member showed them in a casual and empowering manner. One person spent the majority of time walking and regularly arrived in the registered manager’s office. They were greeted each time and made to feel welcome. The person left the office when they were ready to leave. Another person brought the mail in to the office. Some people spent time in the shared staff/resident kitchen. One staff, helping a person to eat their lunch said, “The ice cream is going to be cold” before they put the spoon to their mouth.

People were treated with dignity; people were addressed by their name and personal care was delivered in private in the single occupancy and shared rooms. People were supported to present well-dressed. Where people used clothes protectors at meal times we were told this was only with their agreement and for a short time. Some people had chosen not to wear a clothes protector.

There were regular smiles and gentle contacts. A ‘Dignity champion’ was in place and there was a plan to reward staff for good practice in this. Information was kept confidential. Records were kept in a locked office and staff were careful not to discuss the needs of any person in front of another person.

People were consulted throughout the day, for example, asked what they wanted to do and where they wanted to sit. They were given explanations when staff requested anything from them, such as moving to the dining room for lunch. One person, new to the home, talked through their care needs with the registered manager for their care plan. Some information was displayed which provided information, such as planned activities. There were monthly meetings for people using the service and their family.

The home made sure that any advanced directives for end of life care were available for staff to follow. For example, donation for research and decisions regarding resuscitation, and other levels of intervention. The registered manager described sitting down with family to discuss any issues and different options, for example, some families chose to stay over at the home. One person wished to have a priest with them and the priest was contacted and that person had their wish. The registered manager said they understood the importance of “last memories” for family members.

People’s end of life care and treatment was planned. ‘Just in case’ medicines were available for relief of pain or anxiety and the registered manager said the North Devon Hospice was available for advice and training.

There were many thank you cards expressing families feelings about the care their loved one had received. These included, “Delighted with the care”; “People truly have the time and have compassion” and “Very peaceful and the care was 1st class.” A GP had written, “Very satisfied with the care at Halwill Manor.”

Good

Is the service responsive?

Our findings

People said the staff responded to their needs, their comments included, “They’ve done everything to keep me happy” and “If you need anything it is here.” One person’s family said, “They pick up any problem quickly.”

Each person had a care file which included any identified risks, the plan of how to provide the care required and monitoring records. They included detailed personal histories and knowledge of the individual including, ‘Things that upset me’; food preferences, previous employment, likes and dislikes. This provided information from which staff members could understand each person and provide their care in a person centred way. For example, staff understood how to support a person sensitively who was lost but who might not respond favourably if told what they had to do, as this upset them.

Staff had a very detailed knowledge of people’s needs and any risks. For example, regarding one person’s vulnerability to pressure damage due to their health condition. The care worker explained how staff checked the person’s feet carefully each day to look for any signs of concern, they creamed the feet to keep them in good condition and a chiropodist visited the person regularly.

People’s families felt welcomed at the home and felt there was good interaction with them. They said they could have a meal with their family member at any time and were always greeted with kindness and offered a cup of tea. This helped people maintain contacts of importance to them. The registered manager was able to describe family who struggled with the change in their loved one and how that family was supported.

People’s social and emotional needs were taken into account. The home employed an activities worker who was new to the role which they said they were developing by “building a knowledge base.” They had qualifications in therapeutic activities and said it was important to “give people a purpose.” They described one person who liked to clean the brass and another who had worked on the raised flower bed. One person was given a book on their farming interests. People were engaged in activities during the visit. For example, one person was playing a board game, which their plan of care said they enjoyed. Where people were unable to engage in group activities the activities worker said, “I make time. Most clients need some one-to-one.”

There were close links with the village community and various people arrived who knew the home, for example, one person delivering flowers for a person’s wedding anniversary celebration. The local vicar visited regularly and one person attended the local church.

People and their families said they felt confident in taking any complaint to the registered manager or provider and any complaint would be dealt with to their satisfaction. Their comments included, “Concerns would be taken to (the registered manager).” People’s rooms contained information about the home including a compliments and complaints policy. There had been no complaints at the home since 2012.

Good

Is the service well-led?

Our findings

People using the service, their families and staff felt the home was well-led. One person's family said, "We couldn't wish for better". Staff members said, "There have been drastic improvements" and "The improvement I have seen is fantastic."

The registered manager started at the home in March 2014. They were considered by staff to be "very available and open". They spent time with people asking questions, providing a friendly smile and encouragement.

Continuous improvement was being led by the registered manager and provider working in partnership. For example, changes in staffing and training arrangements. Staff had a voice and their opinion made a difference. For example, they had added agenda items for a staff meeting and there was discussion during the meeting, led by them, about better ways of working. New initiatives were being progressed, for example, the new posts of training manager and activities coordinator.

The registered manager and/or provider were available to people using the service and their families on a daily basis and were leading the staff team by example.

There was a yearly survey of opinion about the service which had identified areas for improvement based on ratings. The highest area identified for improvement was access to the garden and quiet areas and improved access to the garden had been completed and was in use. Other plans were being progressed, for example upgrading the dining room in line with good practice in dementia care. The provider said funding was now in place for the project to begin and a second maintenance worker had been employed to keep the improvement plans on track.

There were arrangements for monitoring the service. Audits included training records, privacy and dignity, accidents, care documentation and medication. This had led to action plans which were being progressed, including for medicines, although not each of the areas for improvement we found had been identified through the home's audit.

Records were kept confidential and available for staff reference. The way records were used was under review as part of the home's audit arrangements.

The registered manager and provider were meeting their legal obligations in that they were notifying the CQC as required, providing additional information promptly when requested and working in line with their registration.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not benefitting from the proper and safe storage, administration, recording or disposal of medicines.** Regulation 12 (2) (g)