

Westgate Healthcare Limited

# Hampden Hall Care Centre

## Inspection report

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## Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

Hampden Hall Care Centre is a care home with nursing and provides care for older adults, people with dementia and palliative care. There are three floors. In accordance with the current registration, the care home can accommodate up to 120 service users. At the time of our inspection 113 people lived at Hampden Hall Care Centre.

At our last inspection on 5 May and 6 May 2015, the service was rated good .

At this inspection we found the service remained good.

Why the service is rated good:

People were protected from abuse and neglect. We found staff knew about risks to people and how to avoid potential harm. Risks related to people's care were assessed, recorded and mitigated. The management of risks from the building were also considered. We found appropriate numbers of staff were deployed to meet people's needs, although there were a number of vacant posts for care workers. We made a recommendation about staffing deployment. Medicines management was safe, but minor improvements were required. We made a recommendation about medicines management.

Staff training and support was good. Staff had the necessary knowledge, experience and skills to provide appropriate care for people. The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People's nutrition and hydration was closely monitored. Appropriate access to community healthcare professionals was available. A refurbishment programme had commenced to further enhance people's experience of living at the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

We consistently received complimentary feedback about the service. People and others told us staff were kind and caring. People and relatives were able to participate in care planning and reviews and some decisions were made by staff in people's best interests. People's privacy and dignity was respected.

Care plans were thorough, personalised and reviewed regularly. There was a satisfactory complaints system in place which included the ability for people and others to raise concerns. People and relatives told us they had no complaints, but knew the process for alerting staff to any issues.

Management and operation of the service was good. We found staff worked as an effective team to improve care, ensure people were safe and focus on the quality of the service. The service had good working partnerships with external agencies and were honest in their approach. We made a recommendation about statutory notifications for safeguarding allegations.

Further information is in the detailed findings below.

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

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

People's medicines were safely managed, but required minor improvements to practice.

We found satisfactory deployment of staff, with ongoing recruitment to vacant care worker posts.

People were protected from abuse and neglect.

Risks from the building and equipment were adequately managed.

### Is the service effective?

Good ●

The service remains effective.

### Is the service caring?

Good ●

The service remains caring.

### Is the service responsive?

Good ●

The service remains responsive.

### Is the service well-led?

Good ●

The service remains well-led.

# Hampden Hall Care Centre

## 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.

Our inspection took place on 11 September and 13 September 2017 and was unannounced.

Our inspection was completed by one adult social care inspector, a specialist advisor, a medicines 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 care service. Our Expert by Experience was familiar with the care of older adults who live in care homes. Our specialist advisor was a registered nurse with experience in the care of people with dementia.

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.

We reviewed information we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public, local authorities, clinical commissioning groups (CCGs) and the fire inspectorate. We checked records held by Companies House, the Information Commissioner's Office (ICO) and the Food Standards Agency (FSA).

During our inspection we spoke with the provider's operations director, group facilities manager, quality manager and training manager. We spoke with the service's registered manager, clinical manager, five registered nurses and 10 care workers. We also spoke with the service's office manager, chef, the activities coordinator, a housekeeper and the maintenance person.

We spoke with 11 people who used the service and seven relatives. We looked at nine medicines administration records and nine sets of records related to people's individual care needs. This included care

plans, risk assessments and daily monitoring notes. We also looked at five staff personnel files and records associated with the management of the service, including quality audits. We asked the registered manager to send further documents after the inspection and these were included as part of the evidence we used to compile our report.

We looked throughout the service and observed care practices and people's interactions with staff during our inspection.

# Is the service safe?

## Our findings

At our previous inspection on 5 May and 6 May 2015 we rated this key question "requires improvement." This was because medicines were not always recorded correctly. We made a recommendation about medicines management. In addition, some people had to wait for their care to be delivered because there were insufficient numbers of staff at some times of the day and although staff knew how to protect people from abuse, not all staff knew how to support people who had behaviours that challenged. We have checked this at our inspection and found that the service took steps to improve. The service's management of people's medicines still requires some improvement. We consider the service has made satisfactory changes to ensure people's care is safe. Our rating for this key question has therefore changed to "good".

We looked at the ordering, storage and disposal of medicines. The ordering of people's medicines from the community pharmacy was efficient and there was a robust process in place for ordering of any new medications started by the GP. Daily temperature monitoring of the medicines fridges were carried out and the results archived on a monthly basis. We found controlled drugs (those subject to stringent storage and recording) on all nursing floors were locked away and the keys kept by the appropriate staff. The controlled drugs registers across the nursing floors were kept in good condition with satisfactory records kept. The ground floor medicines room was neat and clean. The first floor room was dirty and required better organisation of the cupboards. On the second floor, appropriate pharmaceutical waste bins were not used for returned and unused medicines in the medicines room, and we saw items for destruction were put into a blue box near the sink. We found some basic errors in the storage of a small number of medicines. These included one oral antibiotic that was stored in the fridge instead of at room temperature and one bottle of eye drops from April 2017 were still being used. We pointed this out to relevant staff and they took appropriate action.

We observed medicines management practices by staff on all three floors of the service. We saw each medicines administration folder had a specimen list of staff signatures who are able to administer medication, but this was outdated as signatures of staff who no longer work at the service were still on the document. On the ground floor, the morning medicines round was completed by 10.30 a.m. We observed the morning medicines round on the first floor with the unit manager, who was a registered nurse. We found the 8 a.m. medicines round took place until 11.10 a.m. In one case, this meant a person's diabetes medicine, due at 8 a.m. with their breakfast, was administered two hours late. On the second floor, we observed the registered nurse during the morning medicines round and this was still ongoing until 11 a.m. We found the 8 a.m. medicines round took a long time as the registered nurse administered to each person and sat with those who required help to take them. The registered nurse was also disturbed on a number of occasions during the medicines round. One person was fed using a tube into their stomach and we saw the feeding charts had accurate records. However, the fluid charts for the person were not accurate.

Care home staff can give medicines to people without their knowledge (covert administration), and this method was used for a number of people across the service. On the first day of our inspection, we were unable to locate 15 people's records for covert administration of medicines. We asked staff, who were unable to find them at the time. On the second day of our inspection, we saw people's covert medicines

records were within the medicines administrations folder. We found these records were current and the registered manager advised they were previously located within a different folder.

Two out of three floors did not have the current version of the national medicines handbook. We pointed this out to the registered manager. They told us they would take action to remedy this with the community pharmacy. When we checked on the second day of our inspection, the registered manager told us that new versions of the medicines handbooks would be obtained. Staff that administered medicines could access the relevant guidance from computers located at the staff station on each floor. We saw the service had a medicines management audit carried out by the pharmacy provider on 3 August 2017 which reflected that the medicines management was satisfactory.

We recommend that the service reviews the medicines management processes and uses national best practice guidance.

At our prior inspection, we found insufficient staff were deployed. At the time of this inspection, there were 84 staff. The registered manager told us there were approximately 20 full-time vacancies for care workers. We saw agency care workers were being used to cover the service's vacant posts during recruitment. There were no registered nurse vacancies. Registered nurse agency workers were not used at the location for some time.

People and relatives commented that they generally felt enough staff were deployed. They said, "Always somebody available. Ample staff in the minutes I ask for help. But if you want 24-hour attention, you're not going to get it", "Yes, always someone around", "Sometimes they could do with more staff. But it's better now", "The number of staff varies. On shift changes, it can be a bit short; they will take longer to get to you. But you get used to it. There's somebody on all night", "Yes, I think there is enough staff", "Staffing is always an issue. They are aware and fill the gaps. There are always people around" and "There is always staff around. I don't think that is an issue."

We examined how the service calculated the number of staff to deploy for people's care. We saw each person had a needs assessment completed, which was updated at least monthly. This provided a reasonable determination of the number of care hours per day the person required. The information about each person's care needs was obtained by the registered manager each week and used in a tool to calculate the staffing levels. The number of staff per shift per floor was determined from the care hours calculator. Vacancies for staff and the number of agency staff hours were reported weekly to the provider.

Our inspection team observations of the service found sufficient staff were deployed. We noted that although sometimes staff were busy, and there were periods where people had to wait for staff, these were reasonable and people were not neglected. We observed how promptly staff answered people's call bells. In all cases, we found the call bells were attended to within five minutes, with just one exception during lunch time when a person waited longer. Eight people received one-to-one care. These were people who were assessed as a high risk of injuring themselves or with behaviours that challenged. Six people received 24 hours of one-to-one care, and two people received 12 hours per day. We observed whether these people received their care in line with their needs and funded hours. We found that the eight people were not left unattended by the care workers and people had the support they needed.

The service had a more flexible approach to staff deployment. A position of care practitioner was developed since our last inspection. These positions were filled by senior care workers, and were specially-trained and permitted to administer people's medicines. Registered nurses maintained accountability for the care practitioner administering people's medicines. The care practitioner role had eased the pressure of always



having a registered nurse on every floor at all times. Registered nurses were always present on all shifts, but the care practitioner could be a shift leader on a particular floor. We saw the care practitioners received appropriate support from the registered nurses. The clinical manager (a registered nurse) was supernumerary, but able to step in to cover any shortfalls of staff. On one day we saw the clinical manager commence work on a floor because a staff member left unexpectedly.

We were concerned about the high number of care worker vacancies, and examined this in detail. The registered manager explained that the one-to-one care that eight people received comprised a lot of the care worker hours and accordingly, the full-time equivalent posts. They also explained that eight new care workers were offered roles but had not commenced at the time of our inspection. We considered the service used appropriate steps to attract new staff to work at Hampden Hall Care Centre. We looked at the various methods that were used, which were wide-ranging, and determined that every effort was being made to fill the vacant posts. This included overseas recruitment, and supporting new workers with accommodation. Advance block booking of agency workers was used with one agency, and another two agencies were used when shifts were vacant at short notice. The block-booked agency staff helped with the continuity of people's care because they were familiar with the service and those who lived there. We looked at staff rotas and could not find any evidence that allocated planned shifts were not filled.

We recommend that the service continues to build a permanent, stable workforce using appropriate recruitment methods.

At our last inspection, we found some staff could not provide safe care to people with behaviours that challenged. We observed people's behaviours, in particular those who demonstrated extreme verbal or physical effects related to their dementia. We saw staff were kind and patient, and understood people's behaviours well. Staff used appropriate strategies to distract people and encouraged their social stimulation. In the planned refurbishment of the service, we saw how additional places would be built to enable people to reminisce about the past. This included the development of a post office, sweet shop and bus stop.

Staff were able to give detailed information about what abuse was and how to respond appropriately. For example, one member of staff said they would, "Report and record it, tell the senior who reports to the manager who [liaises with] the local authority safeguarding." Another staff member told us whistleblowing was, "If you suspect your colleague is doing something wrong, you must report it to your supervisor, your manager, the safeguarding team or CQC." One member of staff gave an example of what they would do if they found someone had fallen to the floor. They said they would "Call for help, shout for help, and stay by the person's side. You have to stay calm and reassure the person." Staff were knowledgeable about how to report concerns or abuse under safeguarding or whistleblowing. In the service's training matrix we saw staff had attended training about how to protect people from abuse or neglect.

Staff that were offered employment at Hampden Hall Care Centre were subject to robust recruitment procedures. We examined five personnel files of the newest staff that commenced employment. We found all of the necessary checks were on record. This included verification of staff identity, criminal record checks from the Disclosure and Barring Service (DBS), checks of conduct in prior employment and the right to work in the UK. Staff were interviewed by the management team and selected based on their relevant knowledge, skills and experience. Registered nurses' registration with the Nursing and Midwifery Council was also verified. The office manager had an excellent system in place to ensure which ensured only fit and proper persons were employed.

People told us Hampden Hall Care Centre was safe. Comments included, "Yes, I feel safe, yes, yes. Care

attention, can't fault it. Comfortable temperature, winter and summer", "I feel safe with the other residents", "Yes of course I do", "Oh yes, definitely safe. People (staff) here all night", "Completely safe. In good hands", "I'm very safe. I'm not afraid of anyone" and "I feel safe. I don't think I'll fall over." Relatives also told us people were safe. They said, "Yes, I'm satisfied. She (my relative) feels safe", "Yes, yes, quite safe. We feel comfortable with them (our relatives) being here", "Oh yes, very good" and "Oh yes, much better than [elsewhere]."

## Is the service effective?

### Our findings

All of the staff we spoke with confirmed that they had regular support from the service to help them develop their knowledge and skills in nursing and personal care. One of the care assistants said, "This (training) is usually discussed with our manager when having supervision (meetings)." We found staff had regular opportunities for training and skill development and we saw during our visit, training sessions occurred in moving and handling people safely. Another staff member said that they commenced working at the service in July 2017 and were due to have an interim review. They told us this was scheduled and they were prepared for the probation meeting. The staff member went on to tell us that they enjoyed working in the service and that they had to, "Complete the (induction) training before they started."

We asked people and relatives whether staff were knowledgeable and skilled in their respective roles. We received complimentary comments. Feedback included, "Never met a bad one (staff member) yet. Have been kind to me", "No complaints. Never come across a bad carer. Never treated badly. There are times when you wish you were in your own place. But they know what they are doing. Very attentive. Things are done right", "I'm satisfied. The staff are very friendly, right from the receptionist; very welcoming. They all know me in person", "They've lost some good staff. There is now a bit more reliance on agency staff. But they are people who know the system", "The senior care practitioners are brilliant" and "They listen and respond. They keep us well informed, for example, they have called us twice this week as (our loved one) has been a bit poorly."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found mental capacity assessments and best interest decisions were appropriately completed for some people and these records were within care files. DoLS referrals and authorisations were also within the care files. We saw the DoLS documentation identified the reason for the referral, the date of the referral, the date of the authorisation by the relevant local authority and the expiry date of the authorisation. We found the service had evidence for people who had either lasting power of attorneys or enduring power of attorneys. This meant staff knew who could legally consent for the person if they did not have capacity to make a particular decision for themselves.

Staff we spoke with were able to correctly explain the MCA and DoLS principles and requirements to us. The care workers and registered nurses knew how the legislation applied to people's treatment and support. One staff member said, "Everyone has the right to make decisions with regard to their care. However if people lack capacity someone has to make that decision in order that we do not break the law." Another worker told us, "Having locked doors meant that people are not free to move (out of their floor) but this is for their own safety. A mental capacity assessment and best interest decision are completed, if needed." A further staff member said, "The manager would complete the (DoLS) form and send it off to the local authority for an assessment and authorisation."

People told us their health needs were met. They said, "Yes, they look after me. I get my medicine on time. Painkillers come quickly. No problem seeing the doctor. They sorted out my operation" and "It's good. The doctor comes round once a week...You get the right pills at the right time." Relatives also told us people received appropriate access to healthcare professionals. One relative said, "Yes, my dad has nursing needs and they look after him well. I am taking him to a hospital visit this afternoon", "They always get the doctor to see her (family member)" and "He (family member) has good access to health services. He sees the doctor regularly. We also get to speak to the medical staff."

Care records showed input from health and social care professionals including an optician, audiologist, the mental health team, occupational therapists and palliative care nurses. We saw the GP visited the service for a regular session each week. Hampden Hall Care Centre had a good working relationship with the community pharmacist, who visited the service when needed.

We asked people who lived at the service about the food and drinks. They told us, "[There is] always a choice of two, or a third of your own. They know what I like", "Not bad. If I want anything, they'll give it to me", "Absolutely lovely. Perfectly done. Good choice. Enough" and "Lovely food, always plenty of it, nicely cooked and nicely dished up. If you're peckish, you get biscuits. If you didn't like something, they would get you something else. You get a birthday cake on your birthday. Most people have breakfast in their rooms." Relatives we spoke with agreed with the comments we received from people. "The food's been good, I've tasted it", "The food is age-appropriate. Perfect for the generation they're from. Hot, nicely presented", "Yeah, it's really, really nice", "The food's fine, he (my relative) eats it" and "It always looks nice; it is getting him (my relative) to eat that is the problem. Usually he can feed himself. They know his preferences – he always has his chocolate!"

In the care files we reviewed, we saw people's weights were recorded on a monthly basis. If there were concerns by staff of potential weight loss, then people's weights were recorded on a weekly basis to monitor more closely. We found when people received dietary supplements and were being monitored by a dietitian or the GP, there was evidence of good record keeping. Regular evaluations of people's weight loss or weight gain were completed by staff.

We checked the kitchenettes on all three floors and found these were clean and tidy. There was some expired milk in one fridge which staff discarded once we pointed this out. Chemicals were stored in the kitchenettes, but not locked away. When we pointed this out to the registered manager locks were fitted to the cupboards. The main kitchen was clean and tidy, and had the highest food safety score awarded in June 2016. We completed observational audits during lunch time on both days of our inspection. There were good interactions between people and the staff who were serving them. People appeared to enjoy the food being served and choices were offered to all everyone. We saw one staff member demonstrated the meals served on a plate to one person so they could point to the one they preferred. Dining rooms were set in a traditional style and included condiments. This helped people enjoy their dining experience and socialise with the other people sitting around them. Where people required a more peaceful environment for eating and drinking, staff served people in small lounge areas. Staff sat beside people, allowed them to eat slowly and ensured they were satisfied before taking the food and drink away.

We looked at the adaptation, design and decoration of the service. There were large communal dining rooms and lounge areas. We found the provider had planned the building surrounds carefully. Externally, there was a level, paved pathway around most the outside of the service that was suitable for people with limited mobility and those who used wheelchairs. Within a section of the ground floor, there was a courtyard-style garden that people could go to if they preferred not to exit the building. A refurbishment programme had commenced for all three floors. At the time of our inspection, the colours and fabrics of

each floor was displayed for people and others to look at. The registered manager told us they received feedback out the refurbishment and said people and relatives were happy with the planned changes.

## Is the service caring?

### Our findings

We asked people about the staff who cared for them and provided their support. People said, "Staff are very good this morning. Yes, they do what I want", "Yes, they are caring. I feel listened to", "Lovely, lovely", "They tell me what I need to know. They are attentive. They understand me and the things I need", "Yes, very good, very caring. A lovely little dog comes in", "As pleasant under the circumstances as you would want. They are caring and compassionate. They attend to little things, like cutting your nails, when asked. They do everything they can", "They are all very nice", and "They look after me." This showed staff had built positive relationships with the people they cared for.

Relatives also told us staff were caring. One said, "They seem caring and compassionate, but my relatives are not particularly needy." Another relative commented, "They do care for him (family member). They are great to him." Other comments included, "Yes, they are very caring for my mother" and "They are all very friendly. We know a lot of them by name."

We saw within the care folders that there was evidence of involvement by people, relatives and advocates (IMCA s) in the care planning and review process. An IMCA is a impartial person who represents the person when there are no family members to help with important decisions. People told us they did not always want to be involved in care plans and staff confirmed this when we spoke with them. However, we found evidence in care files that relatives and IMCAs were involved in nine people's support package. We noted the reviews varied from three to six months, and were signed by all parties who attended the review meeting.

We asked people if they their preferences were respected. One person said, "My son comes all the time. No problem. It's very easy to visit." Another person told us, "They know that I want to stay in my own room. My family can come and go whenever they want. My daughter was here first thing today." A third person said, "They're (staff) respectful, and treat you with dignity." Other comments included, "My family can visit whenever they want. They bring the dog. There is another dog that comes in. The family came over [overseas] recently, and spent a lot of time here, no problem" and "My daughter can come any time. She comes on Christmas Day."

We observed people's privacy and dignity was maintained. We noted staff knocked on the bedroom doors before entering to ensure people's privacy was maintained. Staff we asked told us that they needed to be sure of the likes and dislikes of the people so they could provide the right care. One member of staff said the best way to do this was to, "Get to know the resident and their families." Another worker told us, "[Getting to know people] takes time and patience. We do have training on dementia. I learned how to deal with difficult situations so I don't make things worse and don't feel frightened."

People's confidential personal records were protected. We saw all office computers used for recording information was password-protected and available only to staff with the appropriate access. Paper records of care were maintained, but where these existed they were locked away so that there was restricted access to staff only. Staff records or documents pertaining to the management of the service were also locked away. In some instances, where there was sensitive information, the records were only accessible by the

registered manager or provider.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 (DPA) requires every organisation that processes personal information to register with the ICO unless they are exempt. This ensured people's confidential personal information was appropriately recorded, handled, destroyed and disclosed according to the legislation.

## Is the service responsive?

### Our findings

People and their relatives told us care at Hampden Hall Care Centre was person-centred. They said, "I get up early, but they're always ready, do breakfast when I want it. I get my paper every day and do the word and number puzzles. We can all get our own papers to our rooms", "They (staff) always tell me what's going on", "They keep you up-to-date. I get the things I want, like my own paper every day and my phone in my room", "The senior care practitioners are very geared to the individual: the little things they know...they know what is required and they get to know us as relatives, so I feel really confident talking to them" and "They (staff) involve you in decisions and keep you updated. They try different activities with him (family member), and he likes to chat with the staff."

There was evidence of a pre-admission assessment completed in all people's files we reviewed. We found the pre-admission plans were very comprehensive and contained the necessary information needed to determine a person's support plan. As people's needs were assessed before they lived at the service, care was planned in response to their needs. We saw assessments included general health, medicines, hearing and vision, dietary needs, communication, sleep, continence and mental health. In the care folders we reviewed, we saw each person had a number of ongoing monthly assessments to check whether their needs had changed. These included care dependency, falls risks, malnutrition risks and pressure ulcer risk assessments. Other specialised care plans were also on file. These were areas specific to each person, such as monitoring of their health conditions like diabetes. A person who received artificial feeding via a tube into their stomach had an in-depth care plan which demonstrated regular involvement with the dietitian and speech and language therapist.

The service appropriately used a number of standardised, evidence-based tools to assess people's needs, such as the malnutrition universal screening tool (MUST) and the Waterlow pressure sore risk assessment. Care plans in all instances provided staff with guidance on how to reduce people's risk of harm. This included guidance from health professionals, where this was relevant. For example, risks to people's skin integrity were identified and assessed, suitable pressure-relieving equipment identified and used to reduce risk of developing a pressure ulcer. We also saw guidance for staff on how people should be supported to reposition in their bed or chair. People's wounds were closely monitored and tracked for healing or deterioration and dressed in line with the wound care plan.

We found social activity recommendations along with people's likes and dislikes were in each of the care files we viewed. Where people liked to stay in their room, activities were also provided that they could engage in, for example therapeutic hand massage. We saw activities each person participated in were appropriately documented in care records. We saw people's bedrooms rooms were decorated and furnished according to their wishes and were very individualised. In some cases, people were keen to show us their rooms and we went with them to look at how they liked to live at the service.

Staff demonstrated an understanding about person-centred care. One member of staff said person-centred care was when you, "Put the person in the centre, consider needs, wants, choices." Another member of staff explained that people, "Have different care needs and you give care the way they want it." Another worker



told us, "You have to listen to what is being said. That is the difference between a good experience to a bad experience. You have to let the manager or deputy know as soon as possible (of any issues) and document in the (person's) care file." Another staff member said, "There is a policy and procedure in the home and you have to follow that. You must share any issue with management."

Staff told us that because some people had advanced stages of dementia they were very aware of what could cause a change in behaviours. Three care workers we spoke with told us that if someone was 'off colour' it could identify that the person might be an infection. One of the care staff said that they, "Would report any illness to the nurse" and another said they would, "Report (people being unwell) and if I suspected a urinary tract infection I would test the urine and send a specimen off (to pathology). These two staff explained that they would be aware of potential issues of concern by reading the person's care plan as well.

People we interviewed were satisfied with the care and knew the process for raising concerns. One person said, "If am not happy, I tell them. Most times it is dealt with. It very rarely happens." Another person told us, "I am not the kind of person to moan. It would have to get very bad for me to complaint. I talk to them about the small things and I feel listened to." A third person we met commented, "I would talk to [a member of staff] and she will sort it out. They listen, and after a while things change." Other comments from people were, "If you're worried, you can always ask the nurse in charge. Talk one to one. Initially, I'd speak to my son, through him to management. But I've never had to raise anything", "I don't have any complaints. No worries, no wants" and "I am ok. I don't complain." Relatives also knew how to make a complaint. They said, "If I had a problem I would go to the lead carer", "I have made suggestions, for example about food or parking, and they listen to them, and act on them if they can" and "They'll always listen. The senior staff will always listen and respond."

The service had a satisfactory complaints policy and we looked at the complaints log. We saw the registered manager dealt with all recorded complaints promptly and any outcomes and actions were recorded.

## Is the service well-led?

### Our findings

We found some improvements were required in the recording of medicines incidents, sharing of relevant healthcare alerts with staff and reporting safeguarding allegations to us.

We found the incidents and accidents 2017 folder didn't include any records of medication-related incidents or "near misses". A "near miss" is a care event where potential harm could occur to a person but is prevented before it occurs. We explained to the registered manager having no medicines incidents recorded may indicate under-reporting of events on the three floors. We saw that other accidents and incidents, such as those involving falls, staff needlestick injuries and verbal abuse were regularly recorded. Staff mentioned examples of medication incidents that had occurred prior to our inspection. We also checked the provider's policy about medicines incident reporting. The registered manager was receptive of our feedback. They explained that medicines incidents awareness would be completed with staff so they understood when to report an issue formally. The registered manager agreed that the service had not followed the reporting procedure for medicines incidents set out in the provider's policy.

We found recent national safety alerts circulated by the Medicines and Healthcare products Regulatory Agency (MHRA) were not present in the three floors of the service. There was a risk nursing and care staff would not have the information they needed to be aware of other safety failures within England. Staff informed us the alerts were emailed to unit managers who then circulated these via the use of the alerts folders in the treatment rooms. However, when we checked the folders they did not contain updates from several months. We spoke with the registered manager regarding this and they told us they would check why this had not occurred. On the second day of our inspection, the registered manager had ensured the necessary alerts were printed and placed into each floor's treatment room folder. The registered manager also explained that they reviewed the process with relevant staff so it was clear who was accountable for printing and storing the alerts in an ongoing basis.

Prior to our inspection and via our ongoing monitoring process, we found there was under-reporting of previous safeguarding allegations to us. We asked the registered manager about this and they explained the instances of when to report allegations of abuse or neglect to us. Once we spoke with the registered manager, they understood that safeguarding allegations needed reporting to us as soon as they became aware of them .

We recommend that the management team sends safeguarding notifications to us for all allegations of abuse or neglect in line with the regulation.

All of the people and relatives we spoke with were aware of the regular meetings and surveys which were used to convey information and gauge opinion. Some people and relatives told us they did not wish to attend but heard important information from staff instead. Comments included, "They have meetings, not very often, not every month. Nothing important comes up", "No, I have not been to a residents' meeting. I know they happen", "My daughter goes to the relatives' meeting. Things do change as a result of the meetings. But there is nothing they could do to make this place better than it already is", "I've been to a

residents' meeting. Not a lot said, but you can have an exchange of views", "I've not attended, but I know they (meeting minutes) are on the notice board", "I saw the survey results" and "I've not attended because the timing doesn't work for me. But I don't think they need to change the timing of them, I would make them if it was important."

There was a relatives' notice board on the ground floor. It has pictures of staff, dates and times of upcoming meetings, together with a copy of the notes of the last meeting. There was also information on the board about eye examinations, whistleblowing, and preserving people's dignity. A large amount of information was available for people and visitors throughout the service. This ensured that people were well-informed of important dates, events or changes within the large premises.

There was a positive workplace culture at Hampden Hall Care Centre. All staff who we met with were asked if they felt supported by their management team. They all replied that they did. One said, "The team is supportive of one another." A second staff member told us, "I can go to the nurse in charge at any moment in time if there are issue." Two more staff thought the registered manager embraced the collaborative team spirit at the service and that she was the first to instigate activities. For example, the registered manager and other staff "wore pyjamas at work day" for a particular event. Staff also told us the registered manager was, "Always on the floor visiting on a daily basis and she is very approachable."

We found a wide range of audits and checks were used to measure the safety of care and quality of the service people received. The results from the audits were used to drive continuous improvement. A quality calendar was used to determine which areas of the service to check each month. For example in some months infection control was examined, and in other months catering and the management of wounds were checked. We saw these checks were regularly repeated and measured against prior findings. Where improvements or changes were required the registered manager and provider's staff took action to ensure this occurred. The actions were sometimes delegated to other staff members but the management team always ensured they followed up on the outcomes. The provider required performance information data to be submitted daily and weekly to the head office. These were used to compare services and further drive improvements across the provider's small group of services.

The service complied with their conditions of registration and sent us notifications of certain events, as required by the regulations. When serious injuries occurred, the documentation for duty of candour required some improvements to ensure that the service could always display that they had conducted investigations and provided written apologies.