Park Homes (UK) Limited

Hazel Bank Care Home

Inspection report

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Date of inspection visit:
07 November 2017

Date of publication:
22 December 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Hazel Bank Care Home on 7 November 2017 and our visit was unannounced. At the last inspection in March 2015 we rated the home as good overall.

Hazel Bank provides accommodation, personal and/or nursing care to up to 39 people who may be living with dementia or other mental health issues. At the time of our inspection there were 33 people living at the service.

A registered manager was in post who was planning to step down and deregister with the Care Quality Commission (CQC). An acting manager had recently been employed who was planning to register with the Care Quality Commission. 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.

Safeguarding processes were in place. Staff had been trained in recognising and reporting signs of abuse. Accidents and incidents were appropriately reported and investigated with actions taken to protect people. Assessments were in place to mitigate risk to people and these were updated to reflect changing need.

Medicines were managed safely. People received medicines appropriately from staff trained in the safe administration of medicines.

The service was clean and mostly well maintained. Staff had access to equipment designed to prevent the spread of infection such as gloves, aprons, hand sanitising gels and wipes. The provider took immediate actions to address concerns we raised with heating and hot water on the top floor.

Staff were recruited safely and had received appropriate training to offer safe and effective care and support. Safe numbers of staff were deployed at the service and staff were able to spend quality time with people. Staff received regular supervision and appraisal and felt supported by the management team.

The service was compliant with the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Best interest decisions were evident in people's care records. People were consulted about their choices/preferences and their consent sought prior to care and support tasks. People and/or their relatives were involved in the planning of their care. Care records were individualised, up to date and relevant to people's needs. People's end of life wishes were documented and advanced care planning in place where appropriate.

People received a varied and nutritious diet. People at nutritional risk had their weight and food/fluid intake monitored. However, better documentation was required to reflect people were receiving sufficient fluid intake.

We saw good evidence of staff providing compassionate and caring care. People's privacy and dignity was respected. People with specific needs such as sensory loss or cultural requirements were supported to ensure they were involved with the day to day life of the service. Information about people was displayed in their bedrooms as a quick guide for staff. This helped staff understand people's likes, dislikes and care needs.

An activities programme was on offer, according to people's wishes which included regular activities within the home and trips out.

People's health care needs were met through good communication with the multi-disciplinary team such as GPs, district nurses, opticians, community matron and dentists. The service used video links to aid further access to a telemedicine service which meant some people required less visits to hospitals.

A robust complaints procedure was in place. Minor concerns were also documented and investigated with actions taken as a result. people told us they were happy with the service and were able to approach the management team if they had any concerns.

A range of quality assurance tools were in place to monitor and drive improvements to the service. People's opinion of the service was sought through regular meetings, surveys and informal discussion. The provider and management team were a visible presence within the service and led by example.

Staff were well motivated and morale at the service was good. Staff felt supported by the management team and their opinions were sought through annual questionnaires and regular staff meetings, during which updates, concerns and feedback was shared.

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.

Medicines were managed safely and administered by staff trained in the safe administration of medicines.

People felt safe living at Hazel Bank. Staff knew how to recognise and report signs of abuse.

Sufficient staff were deployed to keep people safe. No concerns were expressed during our inspection.

Is the service effective?

Requires Improvement

The service was not always effective.

People received a varied and nutritious diet. Better documentation of people's fluid input charts was required to confirm people were receiving enough to drink.

Staff had received training in order to equip them for the role.

The service was compliant with the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

Staff knew people's likes, dislikes and care needs and good relationships had been developed with people living at the service. We saw kind and compassionate interactions between staff and people.

People told us they felt comfortable in the presence of staff and this was confirmed during our observations.

People's independence was encouraged and their dignity respected.

Is the service responsive?

Good

The service was responsive.

Care records were person centred and reflected people's up to date care and support needs. Additional information boards in people's bedrooms gave 'at a glance' overviews of the person.

A range of activities were in place according to people's choices and preferences.

Complaints were taken seriously, investigated and actions taken as a result.

Is the service well-led?

Good

The service was well led.

A range of quality assurance processes were in place to ensure service quality and improvement.

Staff told us they were supported by the management team who were a visible presence in the home.

People and relatives said the service was well led and they were able to approach the management team with any concerns.

Hazel Bank Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 November 2011 and was unannounced.

The inspection team consisted of two adult social care inspectors 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. The expert-by-experience used on this occasion had experience in elderly care.

Prior to our inspection we reviewed the information we held about the service. This included reviewing notifications received from the provider and contacting the local authority commissioning and safeguarding teams. As part of the inspection planning, we ask the service to complete a Provider Information Return (PIR). This gives some key information about the service, what the service does well and improvements they plan to make. This had been completed in a timely manner. We took the information within the PIR into consideration when planning our inspection.

We used a number of methods during our inspection to help us understand the experiences of people who used the services. We spoke with nine people who used the service, four relatives, four care and senior care staff, the activities co-ordinator, the cook, the registered manager who was the nurse on duty during our inspection, the acting manager, and the provider. We observed care and support in the communal areas of the home. We looked at elements of five people's care records, medication records and other records which related to the management of the service such as training records, quality assurance processes and policies and procedures.

Good

Is the service safe?

Our findings

People we spoke with and their relatives told us they felt happy and safe living at Hazel Bank. Comments from people included, "I feel safe, there are always plenty people knocking about and they are there if you need anything at all", "I feel very safe here in bed, there are lots of staff and I've got a nice room" and, "I feel very safe here because all the staff looking after us here know us so well." A relative told us, "I think [relative] is well looked after and everyone is so nice, I really can't fault anything here at all." Another relative commented, "[Relative] is safe here, the staff are friendly and there is always enough of them."

We found people were supported by staff who understood what may constitute abuse and knew how to protect them from avoidable harm. For example, staff told us they had attended training and were able to explain their responsibilities with regard to keeping people safe. They were also aware they could report allegations of abuse externally to the Local Authority or the Care Quality Commission (CQC). We saw appropriate safeguarding events had been reported and investigated with actions taken as a result. Safeguarding and whistle blowing policies were in place and staff were aware of these. We looked at the accident and untoward incident records. We found all accidents and incidents had been recorded correctly and there was evidence to show the service had looked for themes and trends and had carried out a 'lessons learnt' exercise.

We saw the registered manager held money in safekeeping for a number of people who used the service and transaction sheets were in place showing income, expenditure and a balance. We saw people's money was held separately in a locked safe and periodic audits were carried out by head office staff. We crossed referenced the money held for three people with the transaction sheets and no discrepancies were found or concerns identified.

Assessments were in place in people's care records to mitigate risks to their safety. For example, we saw a risk assessment had been completed for a resident who was confined to bed and did not have a call bell within reach. We saw in the assessment and staff told us the person had previously wrapped it around their neck, so this had been removed for their safety. Staff we spoke with were aware of this and we saw frequent checks were made by staff to ensure the person's safety and well-being. Risk assessments were also in place for the use of bed rails and people's moving and handling and skin integrity concerns. Where concerns had been identified, we saw equipment in place and used correctly, such as pressure relieving mattresses. We saw tools were in place to assess people's nutritional risk. Where people were assessed at risk, actions were taken such as referring to the GP or community matron and weight monitoring and food diaries put in place.

Personal emergency evacuation plans (PEEPS) were in place and these were up to date and relevant. We saw the fire alarm was tested weekly and a monthly fire drill took place, with a number of staff allocated as fire marshals.

We saw the service employed sufficient numbers of staff to keep people safe. We looked at the rotas for the last month which confirmed this. We saw four or five care staff were deployed during the day as well as a nurse and a member of the management team, with three care staff and a nurse deployed at night time. A

dependency tool was in place which was regularly reviewed by the management team according to people's needs. The provider told us they over recruited staff and had extra staff on duty due to the lay out of the building and the needs of people living at the home. During our inspection we saw staff were visible in communal areas, sitting, talking and spending quality time with people. People did not have to wait for assistance if required.

We saw there was a recruitment and selection policy in place which showed all applicants were required to complete a job application form and attend a formal interview as part of the recruitment process. The registered manager told us during recruitment they obtained references and carried out Disclosure and Barring Service (DBS) checks for all staff before they commenced work. These checks identified whether staff had any convictions or cautions which may have prevented them from working in the caring profession. This showed the appropriate checks were carried out to ensure people were suitable to work with vulnerable people.

We looked at three staff employment files and found all the appropriate checks had been made prior to employment. The staff we spoke with told us the recruitment process was thorough and they were not allowed to start work until all relevant checks had been made. They also said they felt well supported by the registered manager and senior management team.

We completed a tour of the premises and inspected a random selection of people's bedrooms, toilets, bathrooms and various communal living spaces. All hot water taps we looked were protected by thermostatic mixer valves to protect people from the risks associated with very hot water. However, the provider needed to ensure the heating and hot water supply on the top floor of the building was consistent since we found this was not always the case during our inspection. We discussed this with the provider who immediately booked a plumber/heating engineer to visit the home the day after our inspection to address this matter. From the provider's immediate actions and our discussions about the service, we had confidence this would be resolved.

We saw fire-fighting equipment was available and emergency lighting was in place. We saw fire escapes were unobstructed. The upstairs windows we looked at had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows.

We found all floor coverings were appropriate to the environment in which they were used were well fitted and as such did not pose a trip hazard. We inspected records of the lift, gas safety, electrical installations and fire detection systems and found all to be correctly inspected by a competent person. We saw all portable electrical equipment had been tested as required.

People who lived at Hazel Bank and relatives told us they were satisfied with the general cleanliness of the service and had no concerns. One relative commented, "It always smells nice and clean. It's better since the carpets have been replaced. The bedrooms are always kept nice, the laundry is fine. It's never been dirty when we've visited."

We saw infection control policies and procedures were in place and all cleaning materials, disinfectants were kept securely and product information relating to the control of substances hazardous to health [COSHH] was available. We saw staff used hand sanitizing gels and offered people sanitizing wipes before and after meals. However, staff were not always double bagging clinical waste prior to disposal. This was discussed with the registered manager who confirmed they would take immediate action to address this matter. From our discussions we had confidence this would be addressed.

We looked at the accident and untoward incident records. We found all accidents and incidents had been recorded correctly and there was evidence to show the service had looked for themes and trends and had carried out a 'lessons learnt' exercise to help improve safety.

Medicines were managed safely. Staff who were responsible for the administration of medicines were trained and had their competency assessed. A medicines policy was in place and we saw a copy of this was kept in the front of the medicines administration records (MARs). People's medicines profiles and medicines risk assessments were also kept in the medicines file. Systems were in place to give time specific medicines appropriately, such as those needing to be given before breakfast. People's medicines were reviewed annually by the GP or as required. A record of this was kept in the medicines room.

Most medicines were administered using dossette systems to minimise the risk of medicines errors. There was a process in place for ordering and disposing of medicines.

We observed the morning medicines round. The nurse administering the medicines on the day of our inspection did so in a calm and patient manner. For example, they sat with people and gently encouraged them to take their medicines, asking their consent and staying with the person until they had taken their medicines. We saw they signed the MAR once this had been completed. One person chose to take their medicine in between spoonfuls of their breakfast cereal. We saw this was documented in the care records and their medicines profile.

Some people were prescribed medicines 'as required'. We saw PRN policies and protocols were in place and detailed individual protocols were in place for each person within the medicines record file. This contained details of why, when and how much of the medicine should be given as well as possible side effects. The nurse administering the medicines on the day of the inspection discretely asked people if they required PRN medicines and noted this accordingly on the MAR.

We saw the medicines room and the medicines fridge were monitored at least daily to ensure the temperature remained within acceptable limits. Additional daily checks were completed to ensure these had been done and that the medicines trolley was secured to the wall when not in use.

Medicines audits were carried out on a weekly and monthly basis by the nurse on duty. We carried out a random stock check of medicines and found no concerns. We checked the controlled drugs (CD) storage and administration system and found this to be robust. A stock check of these medicines was completed at the start of the morning and night shift by a nurse from the day and night staff and a handover sheet completed. The registered manager or acting manager also checked the CD book monthly. Where CDs were administered, we saw two staff checked and signed the CD book after administration.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they had confidence in staff and said staff knew what they were doing, care needs had been assessed and care was delivered in line with people's needs. Comments from people living at the home included, "The staff know me here very well", "There are some difficult people who live here but the staff just know how to deal with them," and, "Yes the staff do know what they are doing. They were very good with me when I had a problem with another resident."

Our review of care records confirmed assessment processes were in place which included people's needs and choices. We observed staff had put information within care plans into practice. The service had information relating to Accessible Information Standards and best practice and was working to achieve these. We saw staff used appropriate aids to communication with people whose first language was not English. For example, staff documented key phrases in some people's own language, used interpreters when required and utilised staff who spoke another person's language to achieve effective outcomes. We saw this had been used effectively to encourage a person who had initially been at nutritional risk to consume a more healthy diet.

Staff told us the training at the service was good and had equipped them with the required skills to provide safe and effective care. A staff member told us, "I'm confident in what I'm doing because of the training." A training matrix was in place. Staff training was planned to ensure all staff were up to date with refresher training and training on specific subjects. These included moving and handling, food hygiene, health and safety, fire training infection control, end of life care, Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS), dementia, nutrition and first aid. We saw a number of staff had been completed or enrolled on levels two and three, National Vocational Qualifications (NVQ) and staff new to care registered to complete the Care Certificate. This is a government recognised qualification, designed to equip staff new to the care industry with the appropriate skills for the role. We saw the service used a blend of face to face and on-line training, with some staff trained as subject trainers in moving and handling, dementia, first aid and MCA/DoLS. We did not see any poor practice during our inspection which showed the training was effective.

We saw staff supervision was planned for the year to take place every two months and these were taking place. Staff told us these were an opportunity to discuss any issues and concerns as well as training opportunities. Staff received annual appraisal to discuss areas such as career development, performance and plan objectives for the year.

We saw the premises was light and brightly decorated. We saw photographs of people living at the service on the walls and homely touches throughout the premises such as themed areas and chairs placed in small groups. Adaptations had been made for people such as clear signage on bathroom and toilet doors and carpets were plainly coloured. We saw people's bedroom doors had a photograph and name of the person to ease identification. People were consulted about the decoration of their bedrooms and we saw these were personalised with ornaments, items of their own furniture and photographs on the wall.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw two standard authorisations had been granted by the supervisory body and a number of other authorisations were still with the supervisory body awaiting a decision. We found the conditions attached to both authorisations had been met. We saw people's care records contained evidence best interest processes had been followed and people and their relatives involved. Some people's relatives had lasting power of attorney (LPA). However, in was unclear whether these relatives had lasting power of attorney for health and welfare as well as finance. This meant staff did not know the level of input or control relatives had over people's care. The acting manager told us they would investigate and ensure the correct paperwork was in place. We saw evidence of people's choices being respected throughout the inspection. We also saw people/relatives were involved in planning their care through information recorded in care records.

Nutritional care plans were in place. Those we looked at gave clear instruction about the consistency of the meal, equipment required, eating position along with the individuals likes and dislikes. This helped ensure staff provided the correct level of care. Where people were prescribed supplements, these were given at a separate time to meals to maximise their benefit. We saw mid-morning and mid-afternoon drinks were offered and there were jugs of water or juice available for individuals to help themselves if they were able.

We saw fluid and/or food charts were put in place if staff felt people were not having sufficient food or drink or had experienced weight loss. However, some people's fluid charts required better completion since we found gaps where drinks had not been documented on the charts. For example, the fluid chart for a person who was nursed in bed documented on 1 November 2017 they had been offered and drank 450mls of fluid between 08:30 and 16:00. There were no other entries on the fluid chart after 16:00. We discussed our concerns with the registered manager who told us they were confident people had sufficient to drink but acknowledged staff were not always completing the charts correctly. They also told us staff were at times recording what people had to drink on the 'contact form' which they completed when they provided care and support to each person. They confirmed that in light of our findings they would review the documentation in place and ensure people's fluid intake was accurately recorded on one chart/form. From our conversation we had confidence this would take place.

Most people we spoke with told us the food was good. Comments included, "The meals are very nice here, they always give us plenty to eat, snacks between meals and we can have a sandwich for our supper if we want", "The food here is good. I always enjoy my cooked breakfast," and, "I love my food here. There is a choice of two hot main courses served with fresh vegetables followed by a desert at lunchtime. Soup and sandwiches are served at teatime with an additional choice such as salad, fishcake and beans or a pork pie. Followed by a dessert, fruit, yogurt or a piece of cake." A relative commented, "[Relative] enjoys [relative's] food here. It always looks nice and so does the baking [relative] does with the activities co-ordinator."

During our lunchtime observation in the dining area there was a pleasant, relaxed, informal, happy

atmosphere as residents and staff were singing away. Staff encouraged independence, involving people with organising the menu display, setting the tables, laying table cloths, folding napkins and placing cutlery on the tables.

Staff were kind, caring and gentle with people and demonstrated they had built a good rapport with them. Protective clothing or napkins were used for those who needed these, helping to preserve their dignity. People were assisted to wipe their hands with antibacterial wipes before and after their meal. People who required assistance were attended to by staff who showed respect and dignity. Staff all wore aprons. We saw the cook spoke with people about their meal experience to find out if the food was to their satisfaction.

People were allowed to make choices as to what they ate. For example, at lunch time we saw staff showed people plates with a choice of beef or pork casserole accompanied by mashed potato, croquette potato, sweet corn, green beans and gravy. When people had finished their main course they were offered a further helping. Thereafter, a dessert of treacle sponge and custard or ice cream was offered. Beverages of tea, coffee and a choice of two flavours of cordial were served. Food was home cooked and freshly prepared. We sampled the meal at lunchtime and found it well prepared, tender and tasty.

We spoke with the cook. They explained how they fortified food with full fat milk, butter and cream, potato flakes and milk powder. They told us staff kept them updated with people's dietary needs and they spoke with people after meals about their satisfaction with the food. We saw they did this on the day of inspection. They showed us a list which they received from staff which included information about which people were prescribed drink thickeners or required soft diets. We saw these were adhered to. The list also detailed a number of people who were diabetic. We saw records that staff monitored these people to ensure their sugar levels remained stable. We saw information from the local diabetic team regarding diabetic guidelines for food and the service was following these guidelines.

Our review of care records showed people were supported with their health care needs. We saw records showed visits from health care professionals including GPs, district nurses, opticians, dentists and chiropodists. People and their relatives commented on how responsive the service was regarding health care needs. Comments included, "They were very good here. They took me to the dentist when I needed to get my teeth sorted", "My [relative] takes me to see my psychiatrist but only because [relative] wants to know how I'm getting on. They would take me from here. They have arranged here for someone to come in to take my blood", "The staff here take me to the dentist and are taking me for my mammogram soon," and, "They got the GP in to see [relative] because [relative] had some blisters on [relative's] legs and needed antibiotics. They phoned me after to let me know. They are very good here at sorting anything out like that". This demonstrated the service worked well with organisations to deliver effective care, support and treatment.

We saw the service had access to the telemedicine system. The registered manager told us they used this frequently for video consultation. They said, "It's brilliant. We can request a GP visit via telemeds if required. We can use it for out-of-hours and end of life advice. For example, we booked a consultation with the Lymphedema clinic through the system." This showed the service made timely referral to health care professionals and reduced the need for hospital visits to limit anxiety and disruption to people living at the service.

Good

Is the service caring?

Our findings

Everyone we spoke with said the staff were kind and caring. People told us staff knew them well and met their individual care needs. Comments from people included, "Those girls are so kind and caring they really are a special breed", "The staff all know me very well here, they know what I like and dislike", "The staff here are marvellous, they really care and look after us all so well" and, "They all know me so well here. If I need any help to shower they take me upstairs and help me when I need help. They also leave me to be private if I want". However, we observed only one staff member wearing a name badge on the day of our inspection. We saw information in people's bedrooms about who was their key worker, although people we spoke with told us they did not know this information.

Relatives were also complimentary about the staff. One relative commented, "Their faces light up when they see the girls and you can just tell they feel confident with the staff."

We saw a folder containing detailed communication records between staff at Hazel Bank, family and friends was available for each resident. This showed the service fostered good lines of communication to ensure the home was as inclusive as possible. We also saw where staff had printed and placed a list of key phrases in the room of a person whose first language was not English to enable staff to communicate better with the person. Information about this was documented in the person's care records. We saw the service had also made use of an interpreter to aid communication with another person.

Staff demonstrated patience and kindness in their interactions with people living at the home. For example, we saw a staff member speaking kindly and compassionately with a person who was becoming distressed. The staff member calmed and comforted the person in a gentle and sensitive manner. Some staff had been nominated as 'dignity champions' and our observations showed people were treated with dignity and respect. For example, we saw staff knocked on people's bedroom doors before entering and asked permission before carrying out care and support. We also saw the person who was administering medicines on the day of our inspection discretely ask people if they required specific medicines so other people could not overhear.

We saw a staff member speaking with a person whose first language was not English in their native language. The staff member's verbal, non-verbal communication and body language towards the person demonstrated consideration and respect. This also meant the person was included in the day to day life at the home. We saw information about how to communicate effectively with the person was included in their care records. This demonstrated the service was responsive to the diverse needs of people living at the service and working within the framework of the Equalities Act 2010. Other protected characteristics are age, disability, gender, marital status, religion and sexual orientation. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

The staff demonstrated good team spirit and camaraderie which created a jovial atmosphere. There was plenty of interaction between staff and people living at the service. Staff spent quality time chatting, laughing and joking with people or gently talking with them, according to their needs and personalities.

We saw staff respected people's preferences and choices and encouraged their independence wherever possible. One person told us, "The staff know me here very well. They let me get up when I like, go to bed when I like. They let me go out for a smoke when I like". We observed a staff member asking this person if they would like to go outside for a cigarette, which they did. Another person told us, "Its just like home from home here; you can get up when you like, go to bed when you like, go on a trip if you like. The staff know what I like and don't like. They know I like to go on the shopping trips to Morrison's, Matalan, The Range and the garden centre." Staff we spoke with clearly knew people well including their likes, dislikes, care and support needs. Another person told us, "I go out with my (relative) once a fortnight to Skipton or White Rose and my (other relative) takes me out every Saturday." We saw staff encouraged people to help around the home. For example, we saw some people encouraged to organise the picture menu and activity lists and others helped to set the tables for meals.

We saw evidence of people and/or relatives involved in the planning of their care. Advocacy information was displayed within the service to help those who lacked capacity and did not have someone to speak on their behalf to access an advocate.

Good

Is the service responsive?

Our findings

The registered manager told us wherever possible either they or a senior staff member visited people prior to their admission to Hazel Bank. During this visit they completed an initial assessment of their needs, and gained an understanding of their background, likes and dislikes. The registered manager told us this information was used to develop a care plan and shared with staff in preparation for the person's arrival. They also told us they encouraged people who were considering using the service and their relatives to have a look around the home and speak with staff and people already living there if possible.

Care records we reviewed contained sufficient information to enable staff to provide appropriate care, treatment and support. They showed what the person could do for themselves and the level of support they needed from staff, which included any particular preferences. We saw care records contained detailed risk assessments relating to activities of daily living such as mobility, eating and drinking, continence and personal care. The risk assessments and care plans had been reviewed at least monthly and where an issue had been identified, action had been taken to address and minimise the risk.

We saw wherever possible people who used the service, their relatives and other healthcare professionals involved in their care and treatment had been involved in the care planning process. For example, one person who did not speak English as their first language and their family had translated some simple every day words in to their native language for staff to use. For another person whose religious beliefs meant they did not eat certain food we saw a discussion had been held with them and their family to ensure their dietary needs were met.

The staff we spoke with told they were confident the care plans and risk assessments provided accurate and up to date and confirmed they used the care plans as working documents.

We saw information boards displayed in people's bedrooms containing information about the person. Staff we spoke with told us these were very useful as a quick guide and to inform them of people's history, likes and dislikes.

We saw the service was working towards the gold standard framework for end of life care. We saw good information documented in care records about people's end of life wishes and records of advanced decisions where appropriate. We saw the person and their family were involved with the planning and up to date information recorded. For example, one person had recently changed the funeral director they wanted to use to one who was from their country of origin. We saw they had been visited by a priest from their own church who spoke their language as well as a local priest. This showed the service was supporting the person's cultural and religious needs. Anticipatory medicines were in place and the service liaised with the GP and the district nurses to discuss any changes in their condition. Staff had received training in end of life care and the provider told us they were organising further updates.

We looked at how the service was working within the Accessible Information Standard. The provider was aware and had a copy of the Accessible Information Standard and told us they looked to implement this in

everyday care and support. For example, one person was living in the service with a sensory loss. We asked the provider, registered manager and staff about how they met their needs. They told us all staff were aware the person was registered blind with limited sight in one eye and ensured areas were free from clutter to ensure their safety. However, they told us the person had grown very used to the environment at Hazel Bank and was able to move around freely and it was now difficult to tell the person had a sensory loss. We saw this to be the case during our inspection. We saw staff explained things very clearly to the person, spoke to them face to face and at their eye level. We saw they ensured the person had easy access to cutlery and drinks at mealtime. This meant the person was able to lead a meaningful life within the home. We saw a photograph of each person was fixed to their bedroom door to assist them locate their bedroom. The service also used the telemedicine video system to access consultations for some people without them having to attend hospital appointments which could cause unnecessary anxiety or disruption.

We saw the service had a complaints policy in place and information on how to complain was displayed. Complaints concerns were documented, investigated and actions taken. We saw these were analysed to look for trends and lessons learned. We saw five complaints had been documented during the course of 2017 with the complainant contacted about the investigation and outcome. Verbal complaints and concerns were also investigated with outcomes documented. People told us they knew how to complain but did not have any need to. Comments from the recent relatives' survey echoed this with remarks such as, 'If I need to raise a matter I tell staff or management. It is always dealt with'. We saw a comments and suggestions box had been placed in the reception area of the home to encourage people to voice their opinion of the service.

The service employed an activities co-ordinator. We saw they had devised a monthly and weekly activity programme which was displayed in picture format outside the dining room. The home offered a wide range of hobbies and interests for those people who wished to participate. These included painting pictures and furniture, gardening, potting plants, putting up a greenhouse, dominoes, bingo, crafts, sing-a-longs, games, film shows, music workshops, baking, gentle exercise classes, and pamper days. In addition, the activities co-ordinator organised trips out such as a weekly shopping trip, three weekly trips to the local garden centre, meals out and attending a pantomime. Visits to Hazel Bank were made by cubs, scouts, carol singers and musicians which meant people were able to keep contact with the outside community.

We saw a folder on display that held photographs and a diary of events throughout the year. We saw the activities organised for November 2017 were displayed in pictorial format on a notice board within the home. The activities co-ordinator also showed us they kept a record of activities enjoyed or declined by each person living at the home. We saw care plans included information about the social and leisure interest's people had prior to admission.

We observed an exercise activity which nine people participated in and appeared to thoroughly enjoy. We saw this activity enabled them to exercise their arms and legs, have some fun, be stimulated and interact with one another. There was a happy and relaxed atmosphere. The activities co-ordinator demonstrated enthusiasm for their role and had developed a sound rapport with those who participated.

People were positive about the activities on offer. One person told us, "There's always something going off here, I love it. I go to bingo on a Monday, baking cakes or buns on a Tuesday and Wednesday another activity. I go to (day centre) on a Thursday where I do a few exercises, read the paper and hear what's going on in the World. Fridays we go to Morrison's from here." Another person commented, "I'm kept occupied here. The activities co-ordinator is good with all of us. (Activities co-ordinator) takes us out every week to Morrison's. We have a cup of tea and a doughnut there. I love it. I do baking, play dominoes. We have a lovely time here at Christmas, people come and sing carols, play music and dance." One person told us, "I

like swimming and playing Scrabble but I don't have a swimming costume and they don't have a Scrabble here."

Good

Is the service well-led?

Our findings

People we spoke with were happy about the way the home was managed and had no concerns. Most people knew who the registered manager was. One person told us, "I get on really well with the manager, she's a really nice lady. We don't have meetings very often but I would go to her if I had a problem." Another person said, "The manager is really good here and if there were any problems I would go to her". This showed the registered manager was a visible presence in the home and people thought them approachable.

Staff told us, "I feel supported by the management team and can approach them. Always see management 'on the floor'. [Registered manager] is really approachable and helpful," and, "Management is very approachable. They always ask how I am. (Provider) is very approachable. I definitely feel supported." Staff told us they worked well together as a team to ensure tasks were completed and people received good care.

We saw the registered manager or delegated staff members such as senior staff or the nurse on duty carried out a range of audits to monitor the quality of the care and facilities provided. These included care plans audits, medication audits, staff training and supervision audits, environmental audits and accidents and incidents audits. We saw if any shortfalls in the service were found an action place was put in place and steps were taken to address the matter. Accidents and incidents were analysed to identify where improvement could be made and action plans generated as appropriate. We saw monthly mealtime observation audits were carried by the registered manager or a designated staff member to monitor people's mealtime experience.

We saw an external consultant had carried out a Health and Safety audit in May 2017 and completed an action plan. We saw the provider had completed all the work highlighted in the action plan.

We saw team leaders completed a daily checklist which covered all areas of people's care and treatment and the day to day management of the service.
The registered manager told us they felt well supported by the provider and we saw the provider or a designated person visited the service at least monthly and completed a 'provider visit' report. We also saw the registered manager carried out three monthly 'out of hours' visits to ensure the evening, night and weekend staff were delivering care and treatment in line with people's agreed care plans.

We found the management team to be open and honest, leading by example and keen to look at ways to improve the service. We saw actions had been taken where identified through internal and external audits and immediate actions had been taken with minor areas of concern we found during our inspection. There were clear lines of responsibility within the management structure and the staff team and staff morale was good. Some staff had been given additional responsibility such as being trainers for key areas of training, fire marshals, dignity champions and leads in various areas of interest such as end of life care and dementia. This demonstrated a culture of staff empowerment.

Our discussions with the provider and management team showed they knew the people living at Hazel Bank

well and we saw they were a visible presence in the home. The provider told us they attended local meetings with other providers to ensure they kept up to date with best practice. They also had introduced a code of conduct for all staff to ensure everyone followed best practice guidelines.

The acting manager told us although residents and relative meetings were organised regularly, these were not well attended. We saw this was the case when we reviewed the meetings held over the last year. However, the home had introduced a communications book to ensure they kept in touch with relatives and family who were unable to attend these to share any updates and information. We saw minutes from the last meeting in October 2017 which discussed areas such as food, rooms, care and welfare. We saw actions taken as a result which were communicated to people. A quality survey was sent out annually to people living at the home and their relatives. We looked at the results from the 2017 survey which had been analysed with action taken. Comments included, 'Staff do a wonderful job; proud of them all', All the staff are welcoming and friendly,' and, 'If I need to raise a matter, I tell staff or management. It is always dealt with.' This showed the service welcomed the input of people and relatives about the running of the home.

We saw quality questionnaires had been sent to healthcare professionals and any comments actioned, such as renovation of the patio area. This showed the service worked in partnership with other agencies to improve the service.

We saw the results of the staff survey showed staff were happy in their role and felt supported. Results had been discussed at staff meetings and at individual supervision. Staff meetings were held regularly and staff told us these provided an opportunity to discuss service issues, improvements and updates.

Everyone we spoke with told us they would recommend Hazel Bank Care Home as a place to live.