Care Quality Commission

Hartley House Limited

Hartley House Care Home

Inspection report

Hartley House
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Cranbrook
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Ratings

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

Overall summary

The inspection visit was carried out on 31 December 2014 and was unannounced. The inspection was brought forwards because of concerns raised to the Care Quality Commission (CQC) from an anonymous source, in regards to people's general care and welfare. We did not find any evidence to support these allegations.

The premises are a modern detached building situated in a residential area of Cranbrook. The service provides general nursing care and accommodation for up to 57 older people, most of whom also have dementia. The accommodation is provided on the ground floor, in four units. Three of these are for older people requiring residential care and who are living with dementia, and the fourth unit is for people requiring residential care. The new premises were opened in December 2013 and included part of the renovated original building and a modern extension. The new lay-out provided accommodation with units that remained connected, so that people could walk to and from any of the units and meet other people. This lay-out reduced the risks of

Summary of findings

social isolation and promoted independence. On the day of the inspection, there were 52 people living in the home. Most rooms were for single use, but three rooms for shared use were being used as single rooms.

The service is run by a registered manager, who was present on the day of the inspection visit. 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 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Many of the people in the home had been assessed as lacking mental capacity to make complex decisions about their care and welfare. There were clear records to show who their representatives were, in order to act on their behalf if complex decisions were needed about their care and treatment. The registered manager had made several applications to the DoLS department to obtain their authorisation for restricting people's liberty when going out of the home, as they had been assessed as unsafe to go out of the building unaccompanied. Other applications were being prepared.

Staff had been trained in safeguarding adults, and discussions with them confirmed that they understood the different types of abuse, and knew the action to take in the event of any suspicion of abuse. Staff were aware of the service's whistle-blowing policy, and were confident they could raise any concerns with the registered manager or provider. Two members of staff told us they "Would not hesitate to report any concern straight away".

The service had suitable arrangements in place to protect people from assessed risks. These included risks of fire; risks of slips and falls; risks with the use of equipment; and risks associated with gaining access to medicines or substances that could be hazardous to people's health. The service had a system in place for monitoring accidents and incidents, which identified their frequency and location, and showed if any patterns were developing. The registered manager took appropriate action to minimise the possibility of further accidents.

The premises provided a clean, welcoming and odour-free environment. All the bedrooms, bathrooms, shower rooms, communal areas, kitchens and toilets that we saw were cleaned to a good standard. Maintenance records showed that day to day checks and repairs were carried out reliably, ensuring that people lived in a safe environment. The maintenance person told us that he "Walked the building" each month with the provider, to discuss on-going repairs, and plan for other repairs and redecoration of different areas. The lay-out and furnishing of the premises were designed with people's safety in mind. The corridors were wide and included hand rails to provide areas that were safe for people to walk in. All flooring was non-slip and under-padded to minimise the risk of harm to people when they were walking about. Call bells and equipment were checked, serviced and repaired as necessary.

There were sufficient numbers of staff on duty to meet people's needs, and include them in social activities of their choice. The registered manager told us she was able to put additional staff on the rotas when needed. The home occasionally used agency staff in times of staff sickness or absence to ensure a full complement of staff was on duty.

The service had robust staff recruitment practices, ensuring that staff were suitable to work with the people living in the home. These included checking prospective employees' references, and carrying out Disclosure and Barring Service (DBS) checks before successful recruitment was confirmed. (DBS checks identify if prospective staff have had a criminal record or have been barred from working with children or vulnerable people). New staff went through rigorous induction programmes and a probationary period before being employed as permanent staff. The probationary period included carrying out all essential training. The service had systems in place to identify when staff were due to attend refresher courses. Additional training subjects were made available for staff. This included dementia training. Staff were supported through individual supervision meetings, regular training, support with formal training qualifications, staff meetings, and yearly appraisals. Only

Summary of findings

senior care staff administered medicines, and they had received appropriate training for this. Medicines' storage and administration was carried out in accordance with the guidelines for safe administration of medicines in care homes.

People's health needs were monitored, and health professionals such as doctors and district nurses were contacted for support and advice as needed. People's care plans provided detailed information about their individual medical needs, as well as their previous family and social history, their preferred lifestyles, and their food likes and dislikes.

People said that the food was "Very good" and that they had plenty of choice. If they did not feel like having the items on the menus, they could ask for something different and this would always be given to them if the cook had the necessary ingredients in stock. Some people needed assistance with eating and drinking, and staff took time to help them and did not rush them. Staff showed kindness to people, and displayed thoughtful and caring attitudes. People were asked for their verbal consent before any procedures were carried out (for example, dressings by the district nurse); and were able to go where they wanted and do what they wanted to. The home provided person-centred care, ensuring that people were able to get up and go to bed when they wished; and to have a lie-down during the day if they wanted to. People's privacy and dignity were respected. Records were well maintained and kept up to date, and were stored so as to protect people's confidentiality.

People and their relatives told us that if they had any concerns they would talk to the senior staff on duty, or the manager. They were confident that if they raised any concerns that these would be dealt with appropriately. The registered manager had a daily visible presence in the home. People, relatives and staff said that she was approachable and listened to any concerns or comments. The manager carried out on-going daily, weekly and monthly checks to monitor the home's progress and to address any issues.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were trained to understand and apply safeguarding and whistle-blowing procedures, and how to protect people from abuse.

The service had environmental risk assessments in place, and individual risk assessments for each person living in the home. Accidents and incidents were monitored to identify any specific risks, and how to minimise these. Equipment checks were carried out reliably. The premises provided a safe and comfortable environment.

Staffing numbers were maintained at a satisfactory level to provide for people's safety and welfare. Staff recruitment procedures were thorough, and provided checks to ensure that staff were suitable for their job roles. Medicines management and administration were carried out safely.

Is the service effective?

Good

The service was effective. Staff received on-going training and were supported with studying for formal qualifications. They had sufficient knowledge of people's dementia needs to assist them effectively.

The registered manager and senior staff had a working knowledge of how to apply the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, ensuring that people were able to take day to day decisions in line with their level of capacity.

Staff were knowledgeable about people's health needs and ensured these were met. The service provided people with a suitable variety of food and drink to enable them to have a nutritious diet. Staff assisted people with eating and drinking as needed.

Is the service caring?

Good

The service was caring. Staff had friendly and caring attitudes, and showed kindness and patience towards people living in the home.

People were given information in formats that they could understand, and staff did not rush people when communicating with them.

Staff maintained people's privacy and dignity, and promoted their independence.

Is the service responsive?

Good

The service was responsive. People were encouraged to take part in their care planning and making decisions about their lifestyles. Their next of kin or representatives were included in decision-making when this was applicable.

People's care plans reflected their individual needs and identified their preferred hobbies and social activities. Staff respected people's individuality, and supported them in carrying out the activities that they liked.

The staff and registered manager listened to people's concerns or complaints, and took appropriate action to deal with these.

Summary of findings

Is the service well-led?

Good

The service was well-led. The registered manager took day to day control of the home, and had a visible presence. People and their relatives said that she was approachable and helpful.

The provider worked with the registered manager and staff to develop the service and to ensure that people were safe and happy living in the home. The management were building increased links with the local community. There were reliable systems in place to monitor the home's progress, including meetings with staff and relatives; questionnaires; and auditing processes.

Records were stored so as to protect people's confidentiality. They were suitably detailed, up to date, and correctly signed and dated.

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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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 31 December 2014 and was unannounced. The inspection was carried out by four inspectors. Two inspectors commenced the inspection at 07.00, and they were joined by two other inspectors at 09.00, who each stayed for part of the day. The visit had been brought forwards due to concerns raised from an anonymous source. No evidence was found to substantiate any of the allegations that had been made.

Because the inspection had been brought forwards, the provider had not been asked to complete a Provider Information Return, which is a form that is usually requested before inspections, and which asks the provider to give some key information about the service; what the service does well; and improvements they plan to make. However, before the inspection we looked at previous inspection reports, and information which providers are required to send into CQC to notify us of specific incidents, serious accidents and deaths in the home. These notifications were in line with those expected from this size of care home. We contacted three Social Services staff to obtain their feedback prior to our visit.

We viewed all communal areas of the home, and some of the bedrooms with people's permission. We talked with 17 people living in the home, from each of the four units. Some people were in their own rooms, and some in lounge or dining areas. People living with dementia were not all able to communicate with us about their experiences of living in the home. We therefore used the Short Observational Framework for Inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We also talked with eight relatives and friends who were visiting people; a visiting health professional; the registered manager, and one of the owners; and with 14 staff from different job roles. These included team leaders and care staff, the chef, domestic staff, the administrator, and maintenance staff.

We observed staff carrying out their duties, such as helping people with reduced mobility to move from one area to another; assisting people to eat and drink; and explaining processes to people before carrying out care. We assessed how people's care needs were being met by reading people's care plans and talking with the same people or their relatives.

During the inspection visit, we reviewed a variety of documents. These included: nine people's care plans and related documents such as food and fluid charts; six staff recruitment files; staff training records; staffing rotas; staff handover records; maintenance records such as fire safety and maintenance repairs; environmental and health and safety records; complaints file; auditing records including audits for medicines management, unit audits and kitchen audit; staff meeting minutes; menus; activities plans; minutes for residents and relatives' meetings; and quality assurance questionnaire responses for people living in the home, relatives and staff, from November 2014.

The previous inspection was carried out on 08 October 2014 and there were no breaches with the regulations.

Good

Is the service safe?

Our findings

People told us they felt safe in the home, and their relatives told us they thought they were safe. One person we spoke with told us, "This is a good place because I don't have to worry about anything". Two relatives of a person who lived in the service said, "Our Mum is safe here, she is in good hands" and, "We know our mother feels secure because the staff step in whenever she has a problem". We observed people's interactions with members of staff. Two members of staff were assisting people with mobilising where they wished to go and talked with them to explain how they were supporting them. One person was displaying signs of anxiety and expressed the wish to go back to their bedroom. The staff member accompanying them said, "Don't you worry, come with me and I will see you safely back to where you want to go".

Staff had been trained in safeguarding adults. We spoke with five members of staff who demonstrated their awareness of the procedures to follow if they had any concerns about people's safety. They told us how they would be able to recognise signs of abuse and how they would refer incidents to the local authority if they had any concerns. Training records confirmed that training in safeguarding adults was carried out yearly and was kept up to date. Two staff were unable to recall the full procedures, but both were scheduled for a refresher course. The service's policy about safeguarding adults had been reviewed and updated in December 2014 to reflect the local authority's guidelines. All the staff we talked with were knowledgeable about the service's whistle blowing policy. Two staff members told us, "We all know we have a duty to report any bad practice that could put people at risk, if we witness anything wrong"; and "I would not hesitate to report any concern straight away".

The provider ensured that the safety and cleanliness of the premises was maintained. People lived in a clean, welcoming and odour-free environment. All the bedrooms, bathrooms, shower rooms, communal areas, kitchens and toilets that we saw were cleaned to a good standard. We observed housekeeping staff cleaning surfaces and vacuuming throughout the day. Two relatives said, "The place is always spotless and they are always cleaning"; and, "The bedrooms are always tidied up, the rubbish is emptied and the bedding is changed as soon as it is needed".

The lay-out and furnishing of the premises were designed to keep people safe. The corridors were wide and included hand rails to provide areas that were safe for people to walk in. All flooring was non-slip and under-padded to minimise the risk of harm to people when they were walking about. The glass door panes between the units included patterns of frosted glass to ensure people were aware of their presence. The premises benefited from exposure to natural light enhanced by large windows and skylights. Internal doors opened on to a courtyard that included raised flower beds and garden furniture where people from all units could meet and relax. There were quiet areas in each unit which had been fitted with carpeting. These included comfortable sofas for people and their visitors to spend time in privacy or if confidential matters were being discussed.

We spoke with the maintenance staff who told us, "Every month I walk with the owner through the building and we plan repairs in the home." There were records of on-going repairs which showed that maintenance needs were quickly followed up with the appropriate action. The entrance doors were secured with a code entry system. Some doors were equipped with high sliding bolts to prevent access by people. These doors led to rooms where confidential records, medicines and substances hazardous to health were stored. The registered manager told us, "The doors between the units remain open so that people can walk freely between the units". (This was except for the residential unit, which had a code entry system to protect people going in, as there were three steps down after the entrance door). Window restrictors were in place to promote people's safety when going to the windows. The lift, gas appliances, laundry appliances and people's portable electrical appliances were regularly checked and serviced. Call bells and equipment such as hoists, adjustable baths and wheelchairs were checked, serviced and repaired as necessary.

The maintenance person tested the fire alarm system every week, and carried out monthly fire drills that included checking that the fire doors were functioning correctly. The staff's response to fire drills was monitored to ensure all staff were prepared in case of emergencies. Fire protection equipment and apparatus were checked and serviced by external contractors every year. A list of people who lived in the service and their individual mobility needs was kept in a confidential folder by the front door, in case of emergency evacuation. Each person living in the home had individual

Good

Is the service safe?

risk assessments based on their own personal care and treatment, which included a Personal Evacuation Emergency Plan (PEEP) in the event of fire or other emergency. There was a 'grab bag' ready that included the details of people's contacts and their medicines. The service carried out yearly fire assessments for the premises which identified the fire hazards and people at risk; and evaluated how risks could be reduced or removed. There were clear fire evacuation signs throughout the premises and the service had an emergency plan which had been reviewed in March 2013. The plan included measures to be taken in events such as power and electrical failure, water and gas leakage, and evacuation.

The registered manager had a system in place for monitoring accidents and incidents, which showed the frequency and type of accidents. These were reviewed each month so as to identify if there were any patterns in behaviour, and if action could be taken to minimise the assessed risks. The service included equipment such as pressure mat alarms to help reduce falls. These alerted staff if people at risk were getting out of bed unaided, so that staff could quickly attend to them.

The home had sufficient numbers of care and ancillary staff to provide support to people, to maintain the premises, and to provide a range of social activities. The day shifts usually included ten care staff and two team leaders in the morning across the four units; and eight care staff and one team leader in the afternoon and evenings. The night shift was from 8pm to 8 am, and included, at a minimum, one team leader and three care staff throughout the night; and a 'twilight' care staff during the busy hours from 5pm to 11pm. Staff said that there were increased numbers of people who needed two staff to assist them. However, the registered manager kept this under review and assessed the staffing numbers in relation to the dependency needs of people living in the home. She employed additional numbers of staff when needed.

The service had reliable recruitment procedures in place. Staff recruitment files confirmed that required checks were carried out before staff commenced employment, to assess their suitability for their roles. These included Disclosure and Barring Service (DBS) checks, and checking people's proof of identity. (DBS checks identify if prospective staff have had a criminal record or have been barred from working with children or vulnerable people). Any gaps in employment history were explored, and two written references were obtained. Staff were required to show proof of any previous training qualifications. The registered manager maintained records of people's interviews. The application form requested that applicants provide a history for the last ten years of their employment. However, it is a requirement that applicants provide a full employment history (that is, from the time of leaving full time education). We discussed this with the registered manager, who arranged for the application form to be altered immediately, and she showed us a copy of the new form with the correct request for applicants to provide a full employment history.

Medicines' management followed safe practices and had clear procedures. Medicines' trolleys were stored in two separate locked areas, and their contents were neatly maintained and in good order. Other locked storage cupboards were provided, and internal medicines were correctly stored separately from external medicines. Bottles of medicines and eye drops were dated on opening, which showed that staff understood that these had a limited shelf life. A drugs fridge was used to store items which needed to be stored at lower temperatures. The fridge temperature was checked and recorded daily. However, the room temperatures were not being recorded, and we discussed the importance of ensuring that other medicines were consistently stored at the required temperature below 25 degrees Centigrade. A team leader took immediate action to address this, as thermometers for checking room storage were available. Controlled drugs (CDs) were stored in a separate CD cupboard and were accurately recorded in a CD register. These were only administered by two team leaders, who had received additional medicines' training. Only senior care staff were permitted to administer medicines, and had competency checks as well as medicines' training before they commenced this.

Most medicines were administered using a monitored dosage system whereby each person's medicines had been dispensed separately for each dose, by the pharmacist. The team leader recorded each dose administered in a medicines administration record (MAR chart) for each person. The MAR charts included a photograph of each person to confirm their identity, and highlighted any allergies. The MAR charts contained clear directions, and had been accurately completed to show when medicines had been given.

Good

Is the service effective?

Our findings

Staff were positive about the support they received. They told us that the registered manager was approachable and always available. One staff member told us "The manager and senior staff are always coming around checking we are ok", and that they supported the staff team by taking part in care tasks. Staff enjoyed working in the home, and made comments such as "The manager is brilliant, very approachable and understanding".

Staff told us that they had been given initial training when they started work at the home, and were given regular training updates. Their training commenced with an induction course and a 12 week probationary period. Staff who had not previously worked in care carried out the nationally recognised Skills for Care 'Common Induction Standards'. (These are the standards that staff working in adult social care need to meet before they can safely work unsupervised). The training records showed that essential training had been carried out for all staff, and included subjects such as health and safety, infection control, safeguarding adults, fire safety, first aid and moving and handling. One of the staff told us "We are well trained and the manager does spot checks to make sure we are up to scratch".

Care staff had all received training in dementia care, and this training had been booked for all ancillary staff to attend in the next few weeks. This was in recognition that all staff came into contact with people living with dementia, and therefore needed training in how to communicate effectively with them. The registered manager was a qualified trainer, having previously carried out training in Health and Social Care, and dementia, at a college. She delivered some of the training for staff with face to face training. Other training was provided through on-line training, using a total of 19 training subjects, from which staff could choose the subjects most relevant to their job roles. Staff completed a workbook and a test at the end of each course, and had the opportunity to discuss their training together and with the registered manager. All of the care staff had carried out formal training in National Vocational Qualifications (NVQ) or Diplomas to levels 2 or 3 in Health and Social Care, or were in the process of completing this. (NVQs are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability to carry out their job to the required standard).

Staff were able to provide us with examples of how their training had informed their practice. For example, staff were aware of correct moving and handling procedures due to the training they had undertaken. We saw this demonstrated in practice when staff supported people who needed the use of a hoist to move from one place to another. Senior staff who had the responsibility for administering medicines told us they had been trained and that their competency to carry out this part of their role had been assessed. They had been observed administering medicines to ensure that they were following appropriate procedures for the safe administration of medicines.

Staff told us that they had individual supervision with the registered manager every 12 weeks, and records confirmed this. The meetings provided each staff member with the opportunity to discuss their own practice, any concerns, and specific training needs. One of the staff said "Supervision is good, it is planned, but we can have informal ones as extras whenever we need". The registered manager worked alongside staff throughout the week, which enabled her to keep up to date with how staff were progressing in their different roles. She also started work early in the day so that she could meet with night staff. All staff had a yearly appraisal, which identified good practice as well as training needs.

Staff confirmed they had completed training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS), and were able to talk about how they would support people who lacked mental capacity. The registered manager had applied to the DoLS department to obtain authorisation for depriving people of their liberty when going out of the home on their own, as they had been assessed as unsafe to go out of the building unaccompanied. Other applications were being prepared.

Some people lacked full mental capacity to make complex decisions about their care, but were able to make day to day choices such as the clothes they wanted to wear or menu choices. Staff promoted people's independence, but had arrangements in place for supporting people if complex decisions were needed in regards to their care and treatment. Records showed that people's next of kin or representatives and health or social care professionals

were consulted when decisions needed to be taken on behalf of people and in their best interests. The manager knew how to apply for advocacy services for anyone who lacked someone to represent them.

Staff obtained people's verbal consent before they carried out any practical care and asked people where they wanted to go and what they wanted to do, ensuring that they were able to choose. Written consent was obtained from people or their representatives for different aspects of care, such as access and input to their care plan; discussing their medical needs with their GP and other health professionals; and consent to photographs for their identity. Staff had been trained to care for people who might display behaviour that was challenging for other people, and there were clear guidelines in people's care plans to show how to distract people or reassure them. The staff did not use any restraint practices.

People said that the food was good and they looked forward to it. The menus showed a variety of options for each meal, and people were asked about their menu choices on the previous day. Alternative items were prepared if requested. One person told us "I can always ask for anything I want and they will give it to me." We saw this in practice as one person asked for a cooked breakfast, and the staff made scrambled eggs and bacon for her. The staff asked other people in the same dining area if they would also like some. One asked for hot porridge, and two others had toast. Staff told us that the food was good and met the needs of the people who lived at the home. One staff member said "The food's really good and there's always a choice". At lunch time we saw that food was served hot and people appeared to be enjoying their meals.

The chef was knowledgeable about the nutritional needs for older people, and was aware of their different dietary needs, likes, dislikes and any allergies. For example, two people were allergic to onions and we saw that catering staff prepared their meals separately to account for this. The chef explained the different steps taken to meet the needs of people who needed fortified diets due to concerns about their low weight; and people who needed low fat diets or diabetic diets.

Staff confirmed that food and drinks were readily available for people day and night. During the inspection we saw that people were provided with drinks and snacks throughout the day and were regularly asked if they would like a hot or cold drink. We saw that one person was being encouraged to have extra drinks to maintain their hydration levels as they were unwell. Staff were aware that this person needed more support than usual due to their poor health. One person's nutritional risk assessment had identified a risk of weight loss as they showed little interest in food. Measures had been put in place to increase the frequency of weighing them, monitoring their food and fluid intake, encouraging them to eat, and providing individual staff support during meals.

People's health needs were assessed before they came to live in the home, and included details of their medical history. Daily living assessments were completed for all aspects of people's health and care needs such as their nutrition, continence, mobility, pain levels, mental health and medicines. These were monitored on a monthly basis, or more often if changes in people's needs occurred. Additional charts were used to record positional changes for people with reduced mobility; fluid charts for people at risk of dehydration; and personal care records which showed when people had had a bath or shower. Body maps were used to record bruising, scratches or abrasions on people's bodies both on admission and as a result of knocks, falls or sore areas that had developed.

Risk assessments and care plans were put in place to identify the management for people's specific health needs, such as diabetes, or history of chest or urinary infections. One person's care plan highlighted their need for a diabetic diet, and showed that they needed their blood sugar levels monitoring twice daily. There were clear guidelines in place for people with diabetes, showing staff what action to take if their blood sugar levels became dangerously low or high. According to the blood sugar level, staff were directed to give either food or drink containing sugar; drinks without sugar; contact the GP; or phone for an ambulance.

Assessments were included for people's pain management that included their ability to communicate their needs through their breathing, vocalisation, facial expression, body language and how they responded when staff comforted them. Staff communicated with people according to the instructions in their care plans. For example, a member of staff ensured a person with hearing difficulties could see their mouth clearly and spoke slowly to enable them to lip-read.

People's health records contained a report for each visit from a health care professional, such as doctors, district

Good

Is the service effective?

nurses, dietician, dentist, optician or mental health team. These recorded if any additional tests or treatment were needed, such as blood tests, urine tests, flu injection or wound care. The records showed when these had been carried out. We talked with a district nurse who was visiting to assess a person's pressure areas, and who told us that staff were very reliable in contacting the doctors and district nurses as needed, and were knowledgeable about the people in their care. A relative told us "The manager always keeps us informed when our mum is not well; for example every time they suspect she may have an infection, they call the GP straight away".

Is the service caring?

Our findings

People said that the staff looked after them "Very well" and several laughed when we asked how they felt the staff cared for them, and responded with, "Very good", "Definitely", and "They are lovely." Relatives made very positive comments about the staff, such as, "We could not have hoped for a better place, all our mum's needs are met"; "We are always made to feel welcome and can visit any time at all"; and "Christmas was absolutely fantastic, they went the extra mile and everyone had such a great time". Another family member told us they were very happy that their relative had been admitted to the home, and were very satisfied with the level of care and support provided to them. We overheard staff speaking kindly and respectfully with people, asking them for their preferences around food, and laughing and chatting with them. One relative told us "It's open visiting hours, I've been in during the evenings, and at all times of the day" and said that staff provided good care whenever they visited.

The home had a welcoming atmosphere and included Christmas decorations in the reception area, and six decorated Christmas trees on display in different communal areas. Some people had their bedrooms decorated for Christmas, and bedrooms were personalised with people's own choice of décor, bedding and soft furnishings. People were encouraged to make decisions about their daily lifestyles, and to sit in the lounges, dining areas or their own rooms as they preferred. They were able to get up and go to bed at the times they wanted to. One of the night staff told us, "People only get up if they are awake and want to get up, and they go to bed when they want". Two people told us at 7am, "Yes I have always liked to get up early"; and "Yes, I am an early bird aren't I? I like to get up by 6am". We observed that three people chose to return to their beds after breakfast and their wishes were respected. A person from another unit was reading a newspaper during the morning, and said "I think I will go and have a lie-down before lunch", and staff supported him with this.

Staff were aware of the need to protect people's privacy and ensure their dignity was upheld. They were kind and patient, offered explanations and reassurance to people, and sought their consent before they proceeded with providing their care. They described how they would enter rooms by knocking and checking that a person had acknowledged them before going in. We observed one person being supported to move from their wheelchair to an armchair using a hoist. Staff spoke with the person to explain what was happening and to offer reassurance. Staff also communicated with each other during this process so that the move was carried out smoothly and efficiently. We noticed that staff responded quickly to people's call bells. Some people were unable to use these, and their care plans and daily records showed that staff carried out regular checks for their wellbeing and safety throughout the 24 hours.

We saw that there were positive interactions between staff and people and their relatives. People were addressed politely and staff ensured they were at eye level when speaking to people who were sitting down. People were supported to move at their own pace when being helped to move around the home. One person living with dementia became confused and distressed as they thought they had not been given any breakfast that day. Staff supporting this person did not contradict them but supported them sensitively by acknowledging their distress and reassuring them that lunch was going to be served shortly. This lessened their distress and showed that staff were aware of how to manage this situation in a calm and thoughtful manner. One person was very affected by the recent death of a close friend and staff talked together at their handover about how best to support him through his grief and bereavement. The staff were all sad for him, demonstrating their compassion and sensitivity towards him.

The registered manager talked with each person daily to ensure they were comfortable and to obtain their feedback. We saw that people were encouraged to participate in conversations and their views were listened to. Visitors told us, "This is like a home away from home"; and "We are always welcome and can have a cup of tea and cakes and chat with our Mum and the staff, it is such a friendly place".

The staff acted as 'key workers' to people, so that each person had a named member of staff who took time to get to know and understand their needs, preferences and lifestyle. Staff told us, "I am a key worker and I have developed a closer relationship with my allocated resident so I understand her more than my colleagues and can tell them what she wants and what she means". Another staff member said, "Each person is unique and we know each person so well they are like an extended family".

Good

Is the service responsive?

Our findings

People and their relatives told us that the staff discussed their assessments and care planning with them when they moved into the home, and were involved in on-going care reviews if they wished to take part in these. Each person had a personal profile that enabled staff to gain an overview of their background, their likes and dislikes and their usual daily routine. These profiles helped staff to care for them according to their individual preferences. Staff said that this was particularly important for people living with dementia, as they could not always express themselves clearly. The profiles included details such as 'Prefers a bath to a shower'; 'Goes to bed early'; 'Likes a lie-down mid-morning'; 'Likes the curtains closed and a side light at night; sleeps with two pillows'; and 'Has a cup of tea when wakes up'.

The registered manager and senior staff were in the process of putting the care plans into a new format that made it easier to find the information. However, all of the care plans we viewed contained comprehensive details about people's individual care needs, so that staff could follow the directions. Daily living assessments identified the levels of support that people needed, such as requiring help with dressing/undressing, washing/bathing, using the toilet, mobility, eating and drinking, and preferred social activities. Specific details were included about managing people's nail care, visiting the hairdresser, wearing glasses and hearing aids, and their communication skills. An assessment form was used for 'signs of wellbeing' which included signs such as being sensitive to other people's needs and feelings; self-expression; using humour; assertiveness, and showing affection. These assessments built up a picture about each individual person, so that staff could enter into their ideas and their feelings and develop caring relationships with them.

The provider employed two activities co-ordinators, and there was a wide range of activities available. All of the care staff took part in these, so that people were supported every day in carrying out their preferences. These had been discussed and documented when people moved into the home, so that staff were aware of what people liked to do. Staff told us that some people liked to take part in household tasks, such as one person who liked to help by laying the tables and folding laundry. Another person liked taking part in food preparation, and we saw them peeling vegetables.

The activities co-ordinators facilitated activities within the home and the local community. A number of special events had recently been held, and included a 'sax and swing' show, an autumn BBQ, Christmas Fair and a Carol Service. Some people also enjoyed 'Zumba', a type of fun and musical exercise class. Others enjoyed taking part in arts and crafts activities, and some of the art work was on display around the home.

The co-ordinators had started an 'Evergreen Activity Project', with a statement that "The Hartley House Evergreen Project will provide stimulating activities that promote individuality, restore a sense of purpose, identity and control". The staff had a clear vision concerning the role of activities in promoting positive outcomes for people. People were supported to engage with the local community, and enjoyed outings to local cafes, garden centres, and 'pubs'; and had visited a local school for lunch. Sometimes outings were further afield, and in the past year had included a seaside outing to Hastings; and a fish and chip lunch at Dungeness. Local church groups came into the home to carry out church services. People's family and friends were invited to attend events at the home. One family had visited the home on Father's Day and had lunch with their relative. They had sent an e-mail in thanks, stating "We were thoroughly spoilt". Another relative had commented in a quality assurance survey, "We like the outings and the freedom for visitors".

People told us that the registered manager was easy to talk to and there were two team leaders in particular who were "Really good", and "You always feel able to talk with them about anything". People said they felt confident about raising issues and that the registered manager would deal with them. Staff told us that if they received a complaint or expression of concern from anyone this was referred to the team leader or registered manager.

The complaints procedure was on display on a noticeboard in the home, and was discussed with people and their relatives at the time of admission. There had been no formal complaints during the previous year. People's concerns had been documented, showing the action that had been taken to address them. We saw that the registered manager had investigated people's concerns

Good

Is the service responsive?

and had responded to people thoughtfully and appropriately. People's concerns were discussed with the staff where relevant, and used as an opportunity to provide further improvements.

Good

Is the service well-led?

Our findings

People told us that the home was well-led. Comments from staff included, "The manager is brilliant, very approachable and understanding"; "The manager is always receptive and even when she is busy she makes time to listen to us"; and "We couldn't ask for a better manager". Relatives said, "We are very pleased with Hartley House as a care home"; and "The manager is always around and I can raise any concerns". The registered manager led the staff by working alongside them for some time nearly every day. This enabled her to know if staff were happy in their work; if they needed additional training; and if people were being given good quality care. Her philosophy was that "Happy staff make happy residents". She also said, "I love my job, it is a privilege to work with this team, they are dedicated and hard working".

During the inspection we met one of the providers, who showed us the business plan for the coming year. This identified the home's strengths and weaknesses for improvement. The strengths included having an excellent reputation within the local community; and the new facilities and garden landscaping that had been completed. The home held an Investors In People (IIP) award, and the owner said they were hoping to gain a silver award in the future. (IIP is a recognised management framework, which gives accreditation to businesses and services for their commitment to people. It is to 'empower people to be the best they can be' within their organisation). This demonstrated the provider's commitment to developing and encouraging the staff in their different job roles. Weaknesses identified that the home had 33 bedrooms which did not have en-suite facilities; and plans for renovation of two units were in place.

The owner obtained staff views through an annual staff survey. This enabled staff to share their views anonymously if they wished to do so. The results showed that staff had a high level of satisfaction in the workplace. Staff were asked for their views about 'What does the home do best?' and their responses were very positive. Some of these included "Having the residents' best interests at heart"; "Being friendly and giving kind and compassionate care"; and "Staff work as a team and are passionate about their jobs". Staff were also asked for their views about things that they thought could be improved. Staff had all responded positively to agree with the statement, 'Employees and managers work together to get the job done'. Staff were invited to attend general staff meetings for all staff; and meetings for different departments and job roles. These included team leaders' meetings, kitchen staff meetings and domestic staff meetings. This enabled staff to discuss concerns or progress within their different areas of work.

The registered manager sent out a regular newsletter which informed people about forthcoming dates and gave people an overview of how things were going. Quality assurance surveys were given or sent out to people in the home and their relatives. We viewed results from a recent survey which showed an overall score of 8.8 out of a possible score of 10. People's comments included, " Thank you for the newsletter, I think you do a grand job!"; "The home is clean and inviting, the meals are appetising"; "Good communication with relatives and staff"; "Nice friendly staff who are caring to people; and "I know my relative is looked after very well and this gives me peace of mind".

One person had responded in the survey by stating that they thought that the staff should have an increased awareness of dementia care. All of the care staff had been trained in dementia, but the registered manager recognised that ancillary staff had not all received this training. Action had been taken quickly in response to this, and dementia training had been booked for all additional staff to attend. However, the registered manager took this a stage further by raising this as a topic at a family meeting for people and their relatives, and asking if they would also like some training in understanding dementia. Family members thought this was a good idea, and the registered manager was in the process of finding out how many people would like to attend, and to arrange dates. This was an example of forward thinking, and of providing support and information for relatives as well as for staff and people receiving care.

The registered manager was an NHS Dignity Champion and had previously taught dementia care to Health and Social Care centres and colleges up to level 5. She had been in post for a year, and staff felt she had made a significant difference in the running of the home. She was highly regarded by staff, people and their relatives.

The providers were involved in the running of the business, and one of the providers visited the home at least once per week. This enabled him to be aware of any changes, to keep on top of the home's maintenance and development, and to work with the registered manager to oversee the

Good

Is the service well-led?

running of the home, the staffing and people's care delivery. The registered manager said that the providers were supportive in all aspects of the management. Systems were in place to carry out weekly and monthly audits to monitor the home. These included a weekly medicines' audit, weekly audits for each unit, and other audits for kitchen management, maintenance and infection control. Unit audits included spot checks, when the registered manager assessed if people were being cared for in accordance with their care plans; checked that the home was presentable and clean; and looked for any significant hazards. The unit audits were otherwise completed by senior staff, and included checks of each room to see if they were clean and tidy; checked that people had appropriate toiletries; looked to see if their wardrobes were in good order; and checked their call bells were working correctly.

The registered manager was aware of her responsibilities to inform CQC of formal notifications. (These are used to inform inspectors about specific events that take place in the service). Notifications were sent into CQC in a timely manner. The registered manager and administrator provided records promptly for the inspection team to review. Records were well maintained, up to date, appropriately signed and dated, and stored so as to maintain people's confidentiality.