Barchester Healthcare Homes Limited

# Hurstwood ViewHurstwood View

## Inspection Report

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# Summary of findings

## Overall summary

Hurstwood View is a care home which provides personal care, nursing care and care and support for people living with dementia for up to 55 people. At the time of our visit there were 37 people living at the home.

The service had good systems in place to keep people safe. There were clear systems in place around protecting people from abuse. There was an up to date safeguarding vulnerable people policy in place. The policies gave guidance to staff on what abuse was, and how to report it.

Assessments of the risk to people from a number of foreseeable hazards had been developed and reviewed to minimise the risk of people coming to harm.

We found that the systems to protect people who could not make decisions for themselves were not consistently followed. We saw some good examples where choices had been made for people in their best interests. However we saw two examples where decisions had been made but no formal recording of the best interest decision process had been documented. This meant that there was no record of who had been involved in the decision, or when that decision should be reviewed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Consent to Care and Treatment.

People that used the service and their family members that we spoke with all agreed that the people were supported by kind and caring staff. All of the people were very happy with the standard of care provided by the service. They also told us that the care met their individual needs. A person who used the service told us, "I've nothing to complain about. I have lots of visitors and the District Nurse visits regularly." A relative told us, "I have been involved in all of the assessments and subsequent reviews with my family member."

The staff we spoke with were able to talk in depth about the people, their likes, dislikes and interests. The details we saw in the care plans highlighted people's personal preferences so that staff would know what people wanted from the service. Staff knew people's religious, personal and social needs and preferences from reading their care plans. When we spoke to people and then looked at the records, we saw that their preferences had been recorded.

The service had a registered manager in place and they provided good leadership and support to the staff. They were involved in the day to day monitoring of the standards of care and support that were provided to the people that lived there. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider. The registered manager was not in the home for most of our visit, but we did meet with them at the end of the day. The service ran smoothly in their absence. Staff understood their roles and responsibilities and people received a good standard of care.

We reviewed a selection of records such as care plans, risk assessments, supervision records and medication administration records during this visit. We saw that these were all up to date and completed fully.

The provider completed regular audits of its practices and records to ensure the required standards were met. People who used the service and staff had the opportunity to feedback about what they thought of the service. The registered manager ensured appropriate action was taken if a need to improve was highlighted.

# Summary of findings

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

We always ask the following five questions of services.

**Are services safe?**

People who used the service and two relatives told us they felt safe with the staff. The staff we spoke with were able to give us examples of how they protected people's dignity and treated them with respect.

The service had clear policies in place to protect people from bullying, harassment and abuse. Staff had a clear understanding of what to do if safeguarding concerns were identified. Information was displayed for staff and others about what to do if they suspected abuse had taken place.

Staff had an understanding of the Mental Capacity Act 2005, and what they were required to do if someone lacked the capacity to understand a decision that needed to be made about their life. However we found that some decisions had been made for people without recording who had been involved in the process and when a review of that decision was due to take place.

Detailed risk assessments were in place to ensure people were safe within the home and when they received care and support.

We saw that when the service employed new staff they followed safe recruitment practices. They had checked that staff were suitable to do the job and that they had no record of crimes that could affect their suitability to work with vulnerable adults. Before a person moved into the home their staff support levels had been assessed. We saw from daily support notes, and from what people told us that there were enough staff to meet the needs of the people that lived here.

**Are services effective?**

People had up to date care plans which recorded information that was important to them. People who used the service and their relatives told us that they had been involved in the planning and review of care.

We saw that staff understood people's health needs and acted quickly when those needs changed. Where necessary further support, such as increased staffing, had been put into place to ensure the person's changing needs could be met.

Where people were not able to speak up for themselves family and healthcare professionals had been consulted.

# Summary of findings

Staff  received support from the registered manager. We saw that regular meetings had taken place between individual staff members and their line manager, as well as team meetings.

There was a comprehensive training plan in place for each staff member. We saw that staff had received training to enable them to meet the individual needs of people that they supported.

**Are services caring?**

People we spoke with were very positive about the care and support they received. People told us they felt their individual needs were met and understood by staff. The also told us that staff took time to talk with them and get to know them.

The service had clear policies and guidance for staff on treating people with dignity and respect. Staff were able to give us examples about how they did this.

People who used the service told us that they felt they were listened to. People were encouraged to give feedback about the service in a number of ways. There were house meetings where people had the opportunity to talk through issues they may have had, and we saw that the service responded to the feedback they received.

**Are services responsive to people's needs?**

People we spoke with all said they were happy and felt they were involved in decisions around their or their relatives care.

People's health was monitored and when a change was noticed this was discussed, and appropriate action was taken to support the person and help them get well.

People told us that they knew how to make a complaint if they were unhappy with the service.

We saw where complaints, accidents or incidents had happened the service had completed a detailed investigation, and action had been taken to reduce the risk of the issue happening again.

**Are services well-led?**

We saw that the service promoted a positive culture that was based on meeting the needs of the individuals that lived there. The staff we spoke with had a clear understanding of why they were there, the values of the organisation and what their roles and responsibilities were.

Where investigations had been required, for example in response to accidents, incidents, complaints or safeguarding alerts, the staff had completed a detailed investigation.

# Summary of findings

The provider completed a number of checks to ensure they were providing a good quality service. They carried out regular audits and checks on the service to speak with people and staff, and check that records had been completed correctly. Where issues had been identified, action plans had been generated. These were monitored at follow up visits to ensure they had been completed and that the service was improving.

# Summary of findings

## What people who use the service and those that matter to them say

Not everyone who lived at the home was able to communicate with us verbally due to their complex health needs. We spoke with nine people who lived at the home who were able to express their views. All of them were very happy with the standard of care and support they received. One person told us “Staff are kind here.” Another person told us “Staff understand my needs and listen to what I want.”

We spoke with two relatives who were visiting on the day of our inspection. One told us “My family member receives excellent care here. The staff are very respectful and caring.” Another family member told us “The care is fantastic. The staff are all lovely. We are welcome anytime.”

During our observations staff were relaxed and unhurried. We saw many positive interactions where staff were patient and cheerful with people. They took time to talk with people about the things that interested them as well as around their health needs.

# Hurstwood View

**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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1. We visited Hurstwood View on 30 April 2014.

Before our inspection we had reviewed the information we held about the service. At our last inspection in November 2013 we had identified a minor concern with how the service completed and managed records. We looked to see if they had made improvements and found that they had.

The inspection was carried out by two inspectors.

Over the course of the day we spent time talking with people that lived there and watched their interactions with staff and each other. We also spoke with visiting relatives. We looked at the records held by the service, care plans and other relevant documentation to support our findings.

On the day of the inspection we spoke with nine staff members, which included the registered manager.

At our last inspection in November 2013 we highlighted a minor concern with regards to record keeping. We reviewed a selection of records such as care plans, risk assessments, supervision records and medication administration records during this visit.

# Are services safe?

## Our findings

We asked people if they felt staff treated them with dignity and respect. All the people we spoke with said they were happy that staff did. One person told us, "The staff are very respectful and caring." Another person told us, "Staff are kind here; I would soon tell them if they weren't."

Staff treated people with respect. For example we saw that when music was playing in a communal area staff asked the residents if they were happy with the music that was being played. Everyone said they were happy with the music. During our lunchtime observations we saw that before someone was given an apron the staff member discussed with them whether they would like to wear it or not. These were a few of the many examples that we saw over the course of the day where staff treated people with dignity and respect.

The service had a number of policies in place to ensure staff had guidance about how to respect people's rights and keep them safe from harm. The service had a privacy and dignity policy in place, as well as an equality and diversity policy. These were discussed with staff during the induction process. The policies gave clear guidance to staff on the standards that were required and gave examples which included, 'Always treat individuals with sensitivity and respect." This was followed by examples such as, "Always knock before entering an individual's accommodation and avoid the use of patronising or insulating language." During our observations we saw staff knock on people's doors before they entered, and they called people by their preferred names. This showed us that they had understood the organisation's policy, and people were treated with respect.

The service had clear systems in place around protecting people from abuse. There was an up to date safeguarding vulnerable people policy in place. The policies gave guidance to staff on what abuse was, and how to report it. They also covered whistle blowing. This is where staff would contact an outside agency to inform them of concerns within the organisation. The service also had a copy of the local authority safeguarding procedures. This ensured that the service had information on how to report suspicions of abuse to the lead agency. We saw that where safeguarding issues had been identified, this had been reported to the proper authorities. This showed us that where abuse had been suspected the staff and service had responded in an appropriate manner to keep people safe.

Staff we spoke with had a good understanding of their responsibilities around safeguarding people from abuse. They were able to tell us the signs they had to look out for and who they had to report to. What they told us matched the information seen in the policy. This showed us that they had read and understood the policy.

Other examples of polices seen included confidentiality, challenging behaviour and restraint. Staff told us, "We do not use restraint here; this is a corporate policy that covers all of the service that Barchester manage." The policies covered topics such as equality and diversity, the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS). This ensured that information was available for staff to know how to support someone so that they were protected from discrimination and their human rights were protected.

Staff kept records of accidents and incidents. These contained detailed information about what had happened, and the action that had been taken as a result. We looked at a sample of reports and saw they had been investigated and appropriate action had been taken to minimise the risk of them happening again. These were also discussed at health and safety meetings. We saw samples of senior manager meeting minutes which showed us that the accidents had been reviewed and the outcomes and actions required had been recorded. This showed us that people were kept safe as the service learnt from its mistakes and took action to minimise the risk of them happening again.

The service had clear policies around the MCA and the DoLS. The policies covered topics such as supporting individuals to make their own choices; unwise decisions; best interests' decisions; refusing care or treatment; and assessing lack of capacity.

The guidance around the MCA detailed the actions that staff would need to take if they felt someone lacked capacity to make a particular decision around their lives. For example it stated 'Where information suggests the

person might not be unable to make some decisions at some times, the service will carry out an assessment of that persons mental capacity, or if somebody was deprived of their liberty.'

The policy stated that staff would seek an urgent or standard assessment around best interest's decisions and apply to the relevant supervisory body using the appropriate forms. The guidance also mentioned the use of advocacy services. These policies also linked to the best practice guidance given by the Department of Health. This ensured that staff had access to the most up to date information on how to support and protect someone who lacked capacity to make a decision for themselves.

Staff had an understanding of the Mental Capacity Act 2005, and what they were required to do if someone lacked the capacity to understand a decision that needed to be made about their life. They told us about best interest meetings that had taken place, and mental capacity assessments that had been completed. The staff we spoke with had a good knowledge of the advocate system, and knew where information for staff and people in the home was regarding obtaining lay advocates, and Independent Mental Health Advocates (IMCA).

When we looked at a sample of care files to see if assessments around a person's capacity to understand decisions had been recorded. We saw examples where mental capacity assessments had been completed around people's finances. These included input from the person, their family, social services and a solicitor. We also saw that the service was in the process of making arrangements for a mental capacity assessment for one resident due to a change in their mental health. However, we also we saw an example where a comment had been made in the assessment form that the person 'lacked capacity around medication, going out, and choices of food.' We could not see any documented capacity assessments or records of best interest's decisions having been undertaken. The assistant manager said that, "These were usually done using a risk assessment."

We saw another example where a person had recently been taken into the home. The assistant manager told us that this had been an emergency placement. We looked at the pre assessment that had been completed by the service before the person moved in. In the mental capacity section a comment had been made that the person 'does not have mental capacity.' When we pointed this out to the staff they said that they understood that mental capacity was about making a particular decision at a particular time, and should not be a blanket statement that a person lacks capacity. They went on to say, "It should have been recorded that the person lacked capacity at the time to decide to move into the home." The staff member described the people that had been involved in this emergency placement, including a social worker, family member, and a health care professional from the accident and emergency unit at the hospital. However no recorded best interests decision had been made, nor had a review date for this best interest's decision been set. We found that some files had a record of mental capacity assessments having been completed and others did not. This meant the system for ensuring the requirements of the Mental Capacity Act 2005 where followed where not consistently being applied by the service. The organisations policy and the legal requirement were for clear documentation to be recorded where decisions had been made in someone's best interests. The staff we spoke with said these had not been done for these examples. This meant the service had not completely met the requirements of Regulation 18 (Consent to Care and Treatment) of the Health and Social Care Act 2008.

We saw that the home used keypad entry to give access to certain areas of the building and to get out of the front door. The majority of pads we saw had the code to open the door printed by the pad. This would enable people who could read or understand numbers to move freely about the building. We asked what the purpose of the keypads was. We were told that, "They are to protect people that may not have the capacity to understand road safety, or where they are if they go outside on their own." During our observations we saw where two people who lived in the upstairs unit (Deer View Walk) had to request staff assistance to support them to be able to access the garden downstairs. We also saw a person standing by the lift, but they were unable to use it themselves, so were not able to move freely around the entire home without staff assistance.

We asked staff if they had completed any Deprivation of Liberty Safeguard (DoLS) applications for the people who lived at Hurstwood View. They replied, "We don't have any DoLS applications at the moment, but we have raised the issue with the DoLS assessment officer yesterday due to the new guidance on DoLS that have just been issued." This showed us that the staff were aware of the recent guidance

# Are services safe?

and understood that they would need to take action to ensure they were meeting the requirements of the law. We saw copies of emails that had been sent to the local DoLS authority. This demonstrated that the service had started this process.

We looked to see if people's freedom was supported and respected. One person told us, "I am able to walk around without using my walking frame if I want, staff respect my decision."

The service had a policy in place around autonomy and choice. This gave guidance to staff on how to ensure people had the right to freedom and choice over how they wished to live their lives. It covered topics such as enabling people to live with as much independence as possible, giving people choice and respecting people's rights to make their own decisions.

People's preferences and choice to make unwise decisions had also been assessed and recorded. We saw from records that one person, when they moved into the home, had arrived with a walking frame, but had chosen to walk around the home unaided. We saw that this person was able to walk around the home without the use of their walking frame. The same person had also recorded in their file that they liked their bedroom door locked at night. It was recorded that a discussion took place about the impact this could have on the person, such as if they were unwell at night staff may not be able to get into the room quickly. There was a risk assessment in place that supported the person's right to have their door locked, and gave instructions that had been agreed with the person to minimise the risk. The agreed actions included for staff to have a master key, and to look through the letter box at night, rather than opening the door, to check they were all right. This showed that the person's preferences had been taken into account so that they were kept safe without restricting their freedom and rights to privacy.

We saw that there was a system in place to identify and minimise risk and protect people from harm. Each person's care file had a number of risk assessments completed. The assessments detailed what the activity was and the associated risk. They also covered who could be harmed and guidance for staff to take. The risk assessments seen included risks around the home; use and maintenance of bedrails; allergies; choking; falls and fire. We also saw that the service reviewed the risks and completed additional assessments when required. For example there was building work taking place at the time of our visit and we saw that the service had completed an assessment around the use of contractors. This showed us that risks to people were identified and managed in a safe way.

The service also obtained information from outside agencies to ensure the risks to people were minimised. We saw copies of medical device alerts displayed on noticeboards. These were notices that gave information to staff on important events, such as equipment and medication recalls from manufacturers. We saw that the service had taken action where required and followed the guidance given in the alerts.

We looked at how the service managed its staffing arrangements to make sure people were kept safe. The assistant manager explained that support needs were discussed during the initial assessment with the person before they moved into the home. The provider, Barchester Healthcare Homes Ltd, had standard staffing ratio for number of residents. The assistant manager told us that the actual number of staff was based on the number of people that lived there plus five. This would ensure there were enough staff to meet people's needs. We looked at the staffing rotas and saw that the staffing levels for day and night shifts matched with the provider's staffing ratio. We also saw that where staff shortages had been identified for the coming week (e.g. to cover sickness) there was a plan in place to ensure there were enough staff to meet people's needs.

Where a person's needs had changed, for example when they came out of hospital, we saw that staff levels had been increased to support that person. When their needs had reduced (as their health had improved) the staff support had been reduced to its original level. This showed us that the service provided sufficient staff to meet people's needs.

During our observations we saw that when people required assistance with their mobility, for example getting out of bed or out of a chair, two staff were on hand to assist them. Staff were available to talk to people and support them with meals and personal care. Staff appeared unhurried and relaxed. When call bells sounded they were answered quickly by staff. These were all indications that there were enough staff available to meet the needs of the people that lived there.

# Are services safe?

We looked at how the service employed new staff to see if they followed safe recruitment practices. We looked at five staff files.

The files detailed peoples' work experience, qualifications and the reason why the person had left their previous employment. The files also recorded people's employment history. We saw that there were no gaps recorded in the files we looked at. Staff responsible for recruitment were aware of the need to check for gaps in employment history.

We saw that checks had been carried out to ensure that people were who they said they were. We saw copies of passports and other photographic identification, as well as documents that confirmed home addresses. Contact details for references were recorded in the files. We saw that written references had been obtained and were stored in the files. This showed the provider had checked that people were of good character.

There was a record in the files that staff had an up to date enhanced criminal record check carried out. This meant the provider had checked that people had no record of crimes that could affect their suitability to work with vulnerable adults.

# Are services effective?

(for example, treatment is effective)

## Our findings

People and their relatives told us they had been involved in the planning and review of people's care. A person who used the service said, "My son is involved in my care plan." A relative told us, "I was involved in all of the initial assessments, and the subsequent reviews." Another relative said, "I am involved in all decisions about my family members care."

Before a person moved into Hurstwood View detailed assessments were completed by the registered manager, or other senior staff member. We saw that people's preferences and views on what they wanted from the service had been recorded. From records we looked at we saw that the people who used the service and those important to them, such as relatives, had been involved in this assessment. The assessments seen were comprehensive and contained a good level of detail around the persons support needs. This meant the service had a clear understanding of each person's individual needs before they moved in.

We saw that people had up to date care plans which recorded information that was important to them. This included detailed information about their health and support needs. The care files we saw recorded who had been involved in the assessment, for example the person, or a relative. The plans covered a number of areas of a person's support needs. For example health and wellbeing; eating and drinking; likes and dislikes; bathing and dressing; mobility; communication; social contact and activities; and hopes and concerns for the future.

One person we spoke with told us about their spiritual beliefs and specific support requirements (for example how they liked support for personal care). We saw that the care plan recorded the information in exactly the way the person had told us. The person told us that staff did support them in the way they wanted. This showed us that staff had listened to the person's views and recorded them so that all staff would know that individuals need and choices. It also showed us that that person had been involved in the development of their care plan.

Where people were not able to speak up for themselves family and healthcare professionals had been consulted. The staff we spoke with were aware of advocacy services that could be used if a person had no family. Contact information for lay advocates and Independent Mental Health Advocates was available and staff were able to tell us where this information was stored. Posters were also on display around the home, so that people that used the service and relatives could see the services that were available.

People told us that regular residents' meetings took place and that they had their own committee. We saw examples of the meeting minutes. These showed that personal preferences and choices about the support people received were discussed. For example issues around laundry and outings had been recorded, as had a request for changing the staffing arrangements during breakfast. The service had taken on board these suggestions and made changes.

Staff were able to describe how they met people's individual needs or preferences. We saw an example where a staff member had to contact the local emergency services due to a fall. They were able to give the emergency services information about the person, for example their preferred name.

We saw that health care professionals had regularly visited the service. The local GP visited twice a week and district nurses were called to attend when necessary. The staffing arrangements meant that there were two Registered General Nurse (RGN) members of staff permanently on duty on the nursing floor of the home. This meant that if people's health care needs changed they had access to appropriate medical support.

The staff we spoke with were able to describe how they would react if someone's health or support needs changed. For example they would record in a 'GP book' to alert the visiting GP about people with changing health needs. They also talked about the GP making referrals for people to be seen by a Speech and Language Therapist (SALT). We saw documented examples where this had happened. We also saw examples where staff had made referrals to the Occupational Therapist and the Falls Team. These health changes had been recorded in the care plans. This showed us that staff understood people's health and support needs and ensured referrals to other service were made where a change was noticed.

We saw examples of staff meeting minutes. We could see that people's health had been discussed and changes identified. For example weight gains and losses, and

# Are services effective?

## (for example, treatment is effective)

reports from GP's. They also looked at falls and reviewed the assessments that were in place. Information was recorded in people's care plans about when appointments had taken place, or were due. Relatives also confirmed that their family member's health was regularly monitored and checked.

The staff we spoke with felt that they had received good training. They talked about the induction training they had been through, followed by a week shadowing experienced staff. They also told us they received regular training updates. This gave them the skills they needed to be able to support the people that lived here.

There was an induction programme in place which gave the staff the skills to meet the needs of the people who used the service. We spoke with the assistant manager and the trainer. They explained that all staff completed an induction when they joined the service. This lasted 12 weeks. We saw that there was a training schedule that detailed all the training that staff had completed and when a refresher, or new training, was due. The induction training covered areas such as medication, person centred care and how to manage behaviour that challenged others.

We saw that staff had on-going one to one meetings with a senior member of staff every two months. These were used to discuss issues the staff member may have had and to talk about any training they may want. This ensured that staff had effective support over the year. The staff files we looked at confirmed that these meetings and appraisals had taken place.

# Are services caring?

## Our findings

People were very positive about the service. A relative told us, “My family member receives excellent care here. The staff are very respectful and caring.” Another family member told us, “The care is fantastic. The staff are all lovely. We are welcome anytime.”

We observed that during lunch people were supported to eat where assistance was needed. Over the course of the day we saw people were supported with personal care needs when required, and medicines were given at the times specified in care plans. All the people we spoke with said their needs were met by staff. One person told us, “Staff know my beliefs, and that I have a diet based on those beliefs.”

Staff we spoke with knew about the people they supported. They were able to talk in depth about people, their likes, dislikes and interests. The details we saw in the care plans highlighted peoples personal preferences, so that staff would know what people wanted from the service. Staff knew people’s religious, personal and social needs and preferences from reading the care plans. When we spoke to people about their preferences and then looked at the records, we saw that these preferences had been recorded.

During our observations over the course of the day we saw that people’s mood was generally lively and there was lots of chatter between residents, and with staff. For example over lunch people were happy and animated and seen laughing with the staff.

People who lived with the dementia were based on the first floor. The area had a number of decorations and pictures in place that reflected the time period when the people that lived there had been young adults. Film posters from the 1950’s and 60’s were on display, as well as other items from that era. These were all good prompts for people’s memory and made good conversation pieces for people to reminisce. We also saw that the doors to people’s rooms had a memory box attached. These contained old photos of the occupants or items that had a memory jogging effect for them. This enabled a person to recognise their room, and it also gave staff a visual clue to the person and their history.

The care plans we looked at covered the person’s life history, their preferences, places that were important to them, where they were born and raised, relationships, family and key memories they had. Staff told us they felt the care plans were detailed enough so that they could provide good quality care and know the person as an individual. Staff were seen to refer to people by their preferred name, and show an interest in them and what they were doing. When we reviewed the care files we noted that they contained a good level of detail about the person and their support needs. For example one gave clear instructions to staff on how best to communicate with that individual. They also contained information about what people were able to do for themselves and what they may need help with.

Concern for people’s wellbeing was demonstrated by referrals that had been made to the GP or other health professionals. We saw the registered manager had been kept updated on people’s condition. We saw that when a person had a fall staff responded quickly and were kind and compassionate to the person. While one staff member went to call the emergency services other staff stayed with the person and comforted them.

People were given the privacy they needed. Staff knocked on doors and waited for a response before they entered. People’s modesty was protected when personal care was given as doors where shut. Staff also told us that they would close curtains in people’s rooms when they supported them, so that people could not see in when they were getting dressed. We saw that the doors to people’s rooms were closed when staff where supporting them.

The service had a privacy and dignity policy in place. This had been reviewed within the last year. Records showed that this was discussed with staff during their induction. The policy gave guidance to staff on standards they were expected to meet. For example ‘always treat individuals with sensitivity and respect.’ Other guidance given was ‘Avoid the use of patronising or insulting language.’ Over the course of the day we saw that staff acted in accordance with this guidance, constantly treating people with respect.

The staff we spoke with understood their responsibilities and respected people’s confidentiality. They signed a confidentiality clause as part of their contract and were aware of the provider’s confidentiality policy. Care plans and other confidential information about people were kept in lockable cupboards with the door to the room locked shut when staff were not there. This ensured that people

# Are services caring?

such as visitors and other residents could not gain access to people's private information without staff being present. This meant that people could be confident that their personal details were protected.

People were able to lock the door to their rooms if they wished. We saw an example in the care records where a person had requested that they keep their door locked at night. The service had agreed to this and put a plan in place so that staff could check on the person during the night without entering their room. We spoke to the person and they were happy with the arrangement that had been made.

The service had a clear set of values in place. The values statement was on display in the staff room so all staff could see it. Staff were able to describe the values of the organisation when we asked. This meant that staff were aware of the standard of care that was required, and the vision and goals of the organisation.

We saw that people had equipment and choices provided to enable them to be as independent as possible. For example cups with two handles were used by people so they could drink without staff support. When the breakfast was served people had the choice of getting it themselves, and a choice of where they wanted to eat it. For example we saw a number of people make up a plate of food for themselves and then went to have their breakfast in their bedroom, while others chose to have staff bring it to the dining table for them.

People told us they were encouraged to give feedback and the manager and staff always listened to what they said. One person told us, "I would feel happy to talk to the manager about any concerns." A relative told us, "At first we were concerned that there weren't many outings, we said something, and it's much better now." Another relative said, "Health care here is excellent. We call it a care hotel, not a care home."

People were encouraged to give feedback about the service in a number of ways. There were house meetings where people had the opportunity to talk through issues they may have. It was also an opportunity for the manager to inform people of any issues, for example building work that was planned. During care reviews we saw that the person who received the support and family members had been involved. They had the opportunity to feedback their thoughts on the care provided. The care plan reviews had a section to record if the person was happy with the care that had been provided. The examples we saw were all positive.

We spoke with the activities co-ordinator who explained how after each new activity people were asked to give feedback about if they enjoyed it and wanted to do it again. We saw an example where bingo had not been on the activities list, as it was felt by staff to be too institutional. However, people had requested during these feedback sessions, so regular bingo now took place. We also saw feedback had been received about the number of outings, and how a plan had been put into place to increase them. This showed us that there were a number of opportunities for people to give feedback to the service, and that when they did, the service responded.

We asked the registered manager about how people were given the opportunity to give feedback about the service they had received. They explained that in addition to the day to day opportunities mentioned above, an annual survey was also completed. They also encouraged family members to leave feedback on review websites. We reviewed the feedback on these websites and saw that it was very positive, for example care and support was recorded as 'excellent' on all the entries we saw.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

People and relatives we spoke with all said they were happy and felt they were involved in decisions around their or their relatives care. One person told us, "Staff understand my needs and listen to what I want." A relative told us, "We are always kept informed about what is happening with our family member."

People had been involved in the planning and delivery of their care. Staff we spoke with explained that when reviews of peoples care were carried out the person and their family were involved. This was confirmed by people and relatives we spoke with. This was also seen when we reviewed the care files as we saw that people had signed care plans and review records.

We saw that information was given to people in a number of ways. There were notice boards around the home which explained what services were on offer. These ranged from activities that were available to the days that health care professionals visited, or when religious and cultural events took place. Information about issues that could affect people were also available. For example building work was taking place. We saw that signs were up which explained what the work was for, and how it was progressing. This kept people who used the service and visitors updated about important information that they may be interested in.

During our observations we saw that when staff asked people questions, they were given time to respond, for example when being offered drinks, or choice of meal. Staff did not rush people and waited for a response. They did not make the choice for the person. Over the course of the day we saw numerous examples where staff asked people questions about their preferences and choice. When offered drinks people were asked what drink they would prefer, if they liked it strong or weak, with milk or sugar. People were also reminded that drinks may be hot to reduce the risk of them scalding themselves. It also showed us that hot drinks were served at the correct temperature rather than them being served at a cool temperature 'for safety.'

We looked to see if people received personalised care that was responsive to their needs.

All of the people were very happy with the standard of care provided by the service. They also told us that the care met their individual needs. A person who used the service told us, "I've nothing to complain about. I have lots of visitors and the District Nurse visits regularly." A relative told us, "I have been involved in all of the assessments and subsequent reviews."

We saw from the care plan files we looked at that people's preferences and lifestyle choices had been recorded. For example information around interests, likes and dislikes, and any cultural or religious needs were recorded. Clear information was also recorded and displayed about allergies that people had. This was recorded in the care plans and were displayed on the wall in the staff office on each floor of the home. This would ensure that staff could see at a glance important information about a person.

Regular management meetings were held by staff. These discussed people's health and wellbeing. They identified any changes in a person's health and the actions that may need to be taken to help them. The minutes of these meetings recorded what the issue was and the proposed course of action. We saw that each case was reviewed at the meeting to see if the actions had been effective. They also recorded who had been involved in the discussions around the changes in the care, for example the person, or their family member.

Further examples of how the service had responded to people's needs were seen where referrals had been made to dieticians, occupational therapists and the Speech and Language Therapy team. Care plans recorded where a change in a person's health had happened and the action that had been taken to help them. From the records we looked at we saw that staff had responded quickly to ensure the care provided met people's needs. This showed us that people's needs were regularly reviewed and met.

During our inspection a person fell and injured themselves. We saw that staff responded very quickly and effectively. Staff were immediately available to support the person and keep them comfortable while the emergency services were called. The staff member that telephoned the ambulance was able to give appropriate details about the person to the operator. They were able to quickly access the file for that person as well as give information from their own knowledge of the individual.

We looked at how people's concerns and complaints were responded to. We asked people what they would do if they

# Are services responsive to people's needs?

## (for example, to feedback?)

were unhappy with the service. One person told us, "Staff are kind here; I would soon tell them if they weren't." A staff member told us, "If there are any issues, the manager ensures they are attended to."

The service had a clear complaints policy in place. This detailed how complaints would be dealt with by the organisation. This included the timescales that the organisation would respond by.

The home kept a complaints log. We saw that a clear record was kept of each complaint that had been received. The service had recorded the investigation into the complaints and identified any trends, patterns and contributory factors. From looking at the records we could see that people's complaints had been responded to in good time.

Information about how to make a complaint, or give comments on the service was available in the reception area, and in the service user guide. The relatives we spoke with said that if they needed to make a complaint they would tell the registered manager. They all felt that the registered manager would listen to them and take action.

# Are services well-led?

## Our findings

We looked to see if the service promoted a positive culture that was personalised, open, inclusive and empowering. We asked staff if they felt there was a positive culture within the organisation. One staff member said, "We have a good manager. I always feel listened to." Another said, "If there are any issues, the manager ensures they are attended to." Staff also told us that the manager had an 'open door policy' and that they felt they could approach them at any time with any concerns. They also told us they were able to discuss issues at staff meetings and one to one meetings with their line managers.

We saw that Hurstwood View had a clear values statement. This was displayed on the wall in the staff room and was covered in the staff induction. The staff we spoke with had a clear understanding of why they were there and what their roles and responsibilities were. This showed us that there was information available to staff about how they should work when supporting people to ensure they did this in an open and inclusive way. During our observations, all the staff we saw treated people with kindness and compassion and showed an interest in the people they supported.

Hurstwood View had a whistleblowing policy in place which identified that staff would be protected if they raised concerns. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. It is usually used where the person's line manager or senior management is accused, or they have not taken action to address the employee's concerns. The staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected. They also knew about the service's whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns. The contact details for a whistle blowing helpline were clearly displayed in the reception area. This meant that people could easily see them if they needed to use them.

We saw records of audits and meetings that had taken place which showed that senior management were aware of the culture of the service. For example the staff we spoke with told us that senior staff from the organisation came to visit and talked with the staff. The provider also carried out monthly quality assurance visits of the service. These contained a section where the staff were spoken with. The report was then published so the registered manager of the service and the provider could see the results. This gave the staff the opportunity to raise issues and for the senior managers within the organisation to understand what staff where feeling.

We looked to see if the service learnt from its mistakes, incidents and complaints. Where investigations had been required, for example in response to accidents, incidents or safeguarding alerts, the service had completed a detailed investigation. This included information such as what had caused the issues and the actions that had been taken to resolve them. We saw an example were a concern had led to a safeguarding referral. An investigation was carried out by the registered manager at the request of the safeguarding team. The investigation was detailed, and we saw that appropriate action had been taken by the registered manager. This would mean that there was less chance of people who used the service being affected by this issue again.

There was a clear log of all complaints, compliments, accidents and incidents kept. From looking at the records we saw that these were detailed and we could clearly see at what stage of the response process each one was at. This meant that opportunities to improve the service would not be missed, and staff and senior managers knew what was outstanding and required a response. The complaints procedure was on display in the reception area by the visitor's book. This made it very easy for people to access if they wished to use it.

We saw that feedback from relatives and people that used the service were on display in staff areas. This meant that staff could see both the positive feedback and where they may need to make improvements. This was also discussed at staff meetings. Staff meetings were held at times that enabled staff on day and night shifts to take part. This meant that staff were given information about how the service had, or had not, met the needs of people so that they would know what they were doing well and where they may need to improve. The majority of feedback we saw on display was very positive.

The service had a number of systems in place to review concerns that had been identified and make sure improvements had been made. For example we saw minutes of health and safety meetings where accidents and incidents had been reviewed. A review of the outcomes and

# Are services well-led?

the actions that had been taken were also recorded. From the sample of records we looked at we could see the service had taken appropriate action to improve as a result of these issues.

At our last inspection we highlighted a minor concern with regards to record keeping. We reviewed a selection of records such as care plans, risk assessments, supervision records and medication administration records during this visit. We saw that these were all up to date and completed fully. The service also completed regular audits of its documentation to ensure the required standards were met. These checks were recorded in the monthly quality assurance visit reports. This meant the service had taken suitable action to correct the issues we had raised and had now met the requirements of Regulation 20 (Records) of the Health and Social Care Act 2008.

There was a organisation wide system in place to give a basic staffing level per number of residents. This level could then be adjusted by the manager of the service to ensure people's individual staff support needs could be met. We saw on the weekly staffing rota records that the number of staff on shift matched with the figures calculated by the registered manager. During the day we saw that where people required assistance, for example with eating, or when they had a fall, staff were always available. Staff were seen to be available to people, for example to spend time talking with them, and appeared unhurried. This indicated there were enough staff on shift to meet the needs of the people that lived there. No one we spoke with raised any concerns with the level of staffing at the home.

We looked to see if staff demonstrated good management and leadership. We asked people if they thought the service was well led. One relative told us, "We are always kept informed." We are always welcomed; there is an open door policy for relatives."

The service had a registered manager in place. We asked staff if they thought the service was well led. All responded positively. One staff member said, "We have a good manager. I always feel listened to." Another told us, "If there are any issues, the manager ensures they are attended to." This showed us that people and staff felt the manager provided good leadership.

During the majority of our visit the registered manager was not present. The assistant manager and staff were seen to effectively manage the service in the registered manager's absence. We were able to gain access to all the documentation we needed to see, and staff coped quickly and efficiently when an emergency took place. Staff were also able to give us details of policies and procedures. This showed us that staff understood their roles and responsibilities within the service. The registered manager told us, "I never worry when I am not on site. Everyone has a voice in this home, everyone is valued and valid."

The service had systems in place to drive improvement. The organisation regularly undertook audits on a number of aspects of the service, for example completion of care records, medication records, complaints and health and safety. The results of these audits were reviewed and analysed at various team meetings, such as the heads of department meetings. Minutes of these meetings where on display on noticeboards around the home. Feedback from people that used the service and relatives was also displayed for people to see. This meant that all staff and residents could see the results of the feedback they had given, and that actions had been completed in response to any issues raised.

A monthly quality assurance visit was completed by the provider. This checked how the service was run and identified if there were any areas for improvement. The audit was comprehensive and covered areas such as feedback from people that used the service and staff, visual checks of the environment and a review of records. Each report included a check on the actions that had been made at previous visits. From the reports we looked at we could see this was a good system for checking that the service was providing a good standard of care and had made improvements as required.

The registered manager showed good leadership and management as they carried out their own checks on the care provided to people. They checked on the service provided during the day, and carried out unannounced visits at night. This meant they could see first-hand the levels of care provided to people at all times of the day and night, to ensure it met the required standards.

The service had a robust business continuity plan (BCP). This included information on how to manage situations such as loss of electricity, water, gas, flooding, and national events that may affect the service. The registered manager explained that the majority of staff lived locally, so issues such as poor weather would not have a major impact on

# Are services well-led?

the level of care provided to people. The plan detailed the actions for staff to take to ensure the impact on the care and support provided to people would be minimised should these emergencies arise.

This section is primarily information for the provider

# Compliance actions

## Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to Care and Treatment.<br><br>There were not suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. There was inconsistent recording where best interest's decisions had been made. Regulation 18. |