Hardwick Dene Ltd

Hardwick Dene

Inspection report

Hardwick Lane
Buckden
St Neots
Cambridgeshire
PE19 5UN

Tel: 01480811322

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 5 December 2017 and was unannounced. At the last comprehensive inspection on 15 November 2016 we rated the service as requires improvement. This was because we found two breaches of the Health and Social Care Act (Regulated Activities) 2014. The breaches were:

•□People who used the services were not protected against the risks associated with unsafe management of their medication.
•□The provider failed to maintain accurate and complete records in respect of each person's care and treatment.

We carried out a focussed inspection on 24 May 2017 and found that the provider had made enough improvement for them to no longer be in breach of the regulations. However the service remained rated as requires improvement.

At this inspection on 5 December 2017 we found the service had made further improvements and is now rated good.

Hardwick Dene is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Hardwick Dene accommodates 50 people in one adapted building. At the time of our unannounced inspection there were 39 older people and people living with dementia living at the service.

The Care Quality Commission (CQC) records showed that the service had a registered manager. However, they were not in post during this inspection. They had left the service and needed to cancel their registration. There was an acting manager in place to carry out the day-to-day running of this service. They had started their application with the CQC to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Staff were knowledgeable about how to report poor care practice and suspicions of harm. Information and guidance about how to report concerns, together with relevant contact telephone numbers was displayed

as a prompt to staff, people who used the service, and their visitors to refer to. Pre-employment checks were in place to make sure that new staff were considered suitable to work with the people they were supporting.

People were assisted to take their medication as prescribed.

Processes were in place and followed to make sure that infection control was promoted and the risk of cross contamination was reduced as far as practicable.

The service had adaptations in place to help people with limited mobility such as handrails, sloping floors instead of steps, a stair lift and a passenger lift.

Staff were available to support people's individual needs in a caring, patient and respectful manner. People's privacy and dignity was maintained and promoted by the staff supporting them.

People and their relatives were given the opportunity to be involved in the setting up and review of their individual support and care plans. Staff encouraged people to take part in activities and trips out into the local community. People's friends and family were encouraged by staff to visit the service and were made to feel welcome.

People were supported by staff and external health care professionals, when required, at the end of their life to have a comfortable and dignified death.

People had individualised care and support plans in place which recorded their needs. These plans informed staff on how a person would like care and support to be given, in line with external health care professional input. Individual risks to people were identified and assessed by staff. Plans were put into place to minimise these risks as far as practicable to enable people to live as independent and safe a life as possible.

People's health and nutritional needs were met. People were assisted to access a range of external health care professionals and were supported to maintain their health and well-being.

Staff were trained to provide effective care which met people's individual needs. The standard of staff members' work performance was reviewed by the manager through supervisions, spot checks and appraisals.

Compliments about the care provided were received and complaints were investigated and action taken to make any necessary improvements. However, complaints records did not demonstrate that the manager always followed the provider's policy around how all complainants should receive a formal acknowledgement of their complaint and a formal response following the investigation.

The manager sought feedback about the quality of the service provided from people, their relatives, and staff. There was an on-going quality monitoring process in place to identify areas of improvement required within the service. Where improvements had been identified, actions were taken to make the required improvement. Learning from incidents took place to reduce the risk, as far as practically possible, of recurrence.

Records showed that the CQC was informed of incidents that the provider was legally obliged to notify us of.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Systems were in place to protect people from harm or poor care.

Risks to people were assessed and monitored to make sure that people remained safe.

There was a sufficient number of staff to meet people's assessed needs and recruitment checks were in place to make sure staff were of good character.

Processes were in place to ensure that people's medication was safely managed by staff.

Is the service effective?

Good

The service was effective.

People's needs and choices were assessed and staff supported people in line with legislation and evidence-based guidance. Consent to care and support was sought in line with legislation. People were not unlawfully restricted.

Staff were supported with training, supervisions, competency / spot checks and appraisals to make sure they were delivering effective care.

Guidance was followed to make sure that people were hydrated and supported with a healthy and nutritional diet.

Staff worked within and across organisations to deliver effective care and support. People were assisted to have access to external healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect when assisted by staff and were supported to be involved in making decisions

about their care and support needs.

Staff promoted and maintained people's privacy and dignity at all times.

People's visitors to the service were made to feel welcome by staff.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and staff used this information to deliver personalised care to people that met their needs.

Activities were in place for people to take part in, but people felt that there could be more in place to help with stimulation.

People's concerns and complaints were listened to and acted upon to reduce the risk of recurrence and improve the standard of care provided at the service.

Is the service well-led?

Good

The service was well-led.

There was no registered manager in place. A manager was in post running the service day-to-day with support from the operations manager.

Staff were clear about the high standard of care and support they were expected to deliver. Quality monitoring was in place to oversee this and make any necessary improvements.

The manager was making the necessary improvements to make sure that people and their relatives felt involved in the service.

Hardwick Dene

Detailed findings

Background to this inspection

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

This inspection took place on 5 December 2017 and was unannounced.

The inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their main area of expertise is 'family carers of people with dementia'.

Before the inspection we looked at all the information we held about the service. This included the provider information return (PIR) which was submitted to the Care Quality Commission on 17 November 2017. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We also looked at information we held about the service and the provider. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Before the inspection we asked for information from a fire safety officer; representatives of a local authority commissioning team and safeguarding team; two doctor surgeries; social workers; a dietician; the local authority supervisory body and Health watch. This helped us with planning this inspection.

During the inspection we spoke with 10 people who used the service and four of their relatives. We also spoke with the operations manager; the acting manager; the deputy manager; a senior care worker; four care workers; a domestic worker; the activities co-ordinator and a cook. We spoke with two visiting district nurses and a community nurse.

We observed staff who were supporting people to help us understand the experience of people who could not talk with us. We looked at four people's care records and records in relation to the management of the

service; management of staff; management of utilities; and the management of people's medicines. We also looked at compliments and complaints received; staff training records; and three staff recruitment files. After the inspection, on the 6 December 2017, the manager sent us information about the management of a person with a deemed risk who was under the dietician and a copy of letters to relatives inviting them to attend their family members' care reviews.

Good

Is the service safe?

Our findings

People and their relatives told us that they or their family member felt safe because of the care and support they received from staff at the service. One person said, "I do feel safe here. I have a friend here that makes me feel safe. I just mix in with everybody." Another person told us, "Safe? Oh quite safe here. Generally it's the staff. They are very kind, courteous and very dedicated to helping people." A third person said, "I have been here three or four years I think. I do feel safe; it's the staff that make me feel safe. I can have a laugh and joke with them."

Staff had received training on how to safeguard people from avoidable harm and poor care. They confirmed that they would be confident to whistle-blow. (This is a process where staff can report any poor standards of care if they ever became aware of this). Staff explained to us how they would identify and report concerns in line with their training. This included reporting poor care and/or suspicions of harm both internally to management and to external agencies, such as the CQC. A staff member said, "I have had safeguarding training and I would report any concerns to my line manager. I would monitor that it has been acted on. I wouldn't let it go; I would act upon any concerns." Information and guidance about how to report concerns, together with relevant contact telephone numbers were displayed in communal areas for staff, people who used the service, and their visitors to refer to if needed. One person, when asked if they could speak to staff if they were worried or felt unsafe, told us "Oh yes, you can speak to [staff] about anything." This meant that there were processes in place to reduce the risk of poor care practice.

People's care and support plans were stored securely and contained enough information for staff to deliver safe care. People's risks had been identified when they first used the service and as staff got to know them and their individual needs. These risks were assessed to provide prompts and guidance for staff to support people and reduce the risk of harm. Risks included, people's communication skills; being at risk of isolation; prescribed medication; individual health conditions; poor skin integrity; being at risk of falls; and mobility risks. In general, the majority of people and their relatives were unable to tell us how they had been involved in the management of their/their family member's care records, risk assessments, and review of these. After the inspection we were sent copies of letters that had previously been sent out to people's next of kin inviting them to be involved in their family members' care review. One relative said, "I have never seen a care plan, neither my sister or I have been invited to a meeting with [family member] in the two weeks she has been here. I don't think there is one [care plan]." On speaking with the manager she confirmed that everyone living at the service had a care record in place. Another relative confirmed to us, "There has been family input into this throughout [family members care record]. Staff discussed [family members] risks with the family. Risks such as urinary tract infections, moving and handling and I felt fully involved." We spoke with the operations manager and acting manager who said that they would make the necessary improvements so that people's families felt involved.

Technology was used to support people to receive timely and safe care and support. We saw that there were call bells in place for people to summon staff when needed. However, we noted that people had mixed opinions about how technology within the service was used by staff. One person confirmed to us that, "I don't wait long if I use my [call bell], I rarely use it, [staff] come fairly quickly." Another person said, "I press

my bell and when they [staff] don't come I shout." We also noted that sensory mat technology used to inform staff when a person, assessed to be at a high risk of falls, was up and walking. This showed us that technology was used in the service to support people requiring this assistance.

Records relating to checks on the service's utility systems and building maintenance showed that checks were in place to make sure people were, as far as possible, cared for in a place that was safe to live in, visit and work in. The service had had an inspection by the local fire safety team on 29 September 2016 which was 'broadly compliant, with a measure of compliance being well above average.' People also had emergency evacuation plans in place to assist them to evacuate safely in the event of an emergency such as a fire.

Staffing numbers were established using a dependency tool based on people's care and support needs. People and their relatives had mixed opinions over the number of staff available, particularly at weekends. The manager and staff spoken with separately told us that care staff numbers were the same during the weekend as they were during the week. One person told us, "It's not too bad [to wait for staff to come], but it does vary." However a relative said, "What I can tell you is there are less staff at the weekends because you have to wait a very long time to be let in the front door." Observations during this inspection showed that there was enough staff to meet people's needs. Staff were busy but supported people in an unrushed manner. Although, we did report one incident to the manager, during our visit. We observed that a person had waited too long for support by staff (10 minutes) and that this wait had made the person anxious. The manager told us that they would investigate this incident. This showed us that the manager at the service took the incident we raised with them seriously.

The provider carried out checks on new staff to confirm that they were suitable to work with people and of good character. Staff told us that these checks were in place before they could start work at the service. A staff member said, "I had to wait a while for the [checks] to come in before starting." Checks included proof of identity; reference checks from previous recent employment; criminal records checks from the disclosure and barring service (DBS) and gaps in employment history explained. This demonstrated to us that there were checks in place to make sure that staff were deemed suitable to work with the people they supported.

The majority of people and their relatives had no concerns on how their/their family members' prescribed medication was managed by staff. One relative had raised a concern with the inspection team that their family member's medication may not have been administered that morning. However, we were able to establish that the medication had been given. One person spoken with said, "Yes, I take tablets for [specific health condition], on time, well roughly they are. I don't think they have ever run out of my tablets." Another person told us, "I take loads…I get them every morning when I come down from my breakfast." Staff who administered medication told us and records confirmed, that they received training to do this and that their competency was assessed. Our observations showed that the medication trolley was locked by the senior care worker during the medication round when they were not in attendance. We noted that the senior care worker did not sign to say that the prescribed medication had been given until people were seen swallowing their medication. This was in line with staff training and the service's medication protocol. People had their medication explained to them prior to administration and were encouraged to take it. We saw that this was done in a caring manner that was at the person's preferred pace.

Medication was stored securely, at the correct temperature and disposed of safely. There was adequate information in place for people who required support with their 'as and when needed' medications. Medication administration records (MARs) looked at showed that medication had been administered as prescribed. This meant that the provider had systems in place to ensure that medicines were managed safely.

We saw that the service was visibly clean and free from malodours. Foot operated bins were available in different areas of the service and we saw that soap and hot water was available for staff, people and their visitors to use to wash their hands. A domestic member of staff told us that they had enough personal protective equipment (PPE) and cleaning equipment available. They talked us through how they cleaned different areas of the service using different cloths, and different colour mops and buckets to reduce the risk of cross contamination. The domestic staff member also told us how often they cleaned each area of the service and records we saw confirmed this. They said that their PPE was for single use only. This meant that they changed their PPE each time they went into another person's room and/or another area of the home. This showed us that processes were in place to reduce the risk of infection and cross contamination.

Records showed that there was monthly monitoring of any falls people may have had, and any accident and/or incidents that had occurred. Any actions to be taken as a result of learning from these events were documented. Actions included a referral being made by staff for a person to the GP and then the external falls prevention team. Due to concerns received since the last comprehensive inspection around moving and handling, staff confirmed to us that since then they had been asked to undertake further training. A staff member said, "We have all had an update recently in moving and handling. The deputy [manager] is the moving and handling trainer. He also does observations of staff moving and handling [as additional checks]." Although we noted that these checks were not always documented. The manager confirmed to us that these checks would be recorded in supervision notes going forward. Our observations showed that apart from one incident, people were moved safely and with support from the staff member assisting them. We spoke with the manager about an incident we observed, during this inspection and were reassured that the staff member would be spoken with and asked to attend moving and handling training scheduled for the next day. This showed us that the manager of the service took this concern raised with them seriously and would make the necessary improvements.

Good

Is the service effective?

Our findings

External health and social care professionals visited the service. They told us that they worked with staff to achieve effective outcomes where possible for people. They also said that their advice was used by staff to promote people's well-being and on-going care, without discrimination and in line with legislation and guidance. A visiting health professional told us, "The staff are working really hard and there has been a big turnaround…since the new manager. Things have improved...staff are now requesting [specialist] equipment …they have followed advice. Pressure care [for poor skin integrity] is well maintained in the home. We work well together and we enjoy coming here now." Another external health professional raised concerns that staff may not have been following their guidance re nutrition. We were able to establish through records sent to us by the manager on the 6 December 2017, that since October 2017, staff had been following the guidance given.

To promote and maintain people's independence we saw that staff encouraged and supported people to use appropriately assessed equipment to assist with their mobility requirements. When staff assisted people with their mobility, this was done (apart from one incident) in an unhurried, respectful and kind manner. Staff explained what they were about to do and waited for the person's permission before undertaking the task. Throughout the support, staff reassured people to help lessen any worries the person may have had.

Staff described the training they had undertaken to ensure that they had the right skills, experience and knowledge to provide the individual care and support people needed. Records looked at confirmed this. Training included, safeguarding adults; moving and handling; medication administration; mental capacity act 2005 (MCA) and deprivation of liberty safeguards (DoLS); infection control; and food hygiene. Records also showed that staff, when new to the service, were expected to read the provider's equality and diversity policy and then sign to say that they understood the principles of this. We also noted a human rights act poster on display on a communal notice board for staff, people using the service and their visitors to refer to if needed. This showed us that staff were given regular training and refresher training and prompts to help them provide effective care and support without discrimination and in line with legislation.

Staff were supported with supervisions, competency/ spot checks on their standard of care provision and appraisals undertaken by the manager and deputy manager. Staff said that when new to the service they had had an induction period. This included training and shadowing a more experienced member of staff until they were deemed competent and confident by the manager to provide care.

People's individual dietary needs were supported and catered for. This included people on a softer food consistency due to being at risk of choking or a high calorie diet due to being at risk of weight loss. The cook said that currently no one at the service had a special diet due to cultural or religious needs. However, they confirmed that they could adapt the menus to meet people's cultural or religious needs.

People were supported by staff with their meals and drinks when needed. People, who required additional support from staff to maintain their independence, were assisted and encouraged in a kind, patient, and respectful manner. For people with short term memory loss, we saw that their independence was assisted

by staff when helping them choose their meals. People were shown the two meal choices on the menu plated up so they could remember what they had ordered previously or choose again with this visual prompt. We observed that snacks and drinks were available to people throughout the day to promote people's hydration and nutritional needs.

People had positive opinions about the quality of the food provided. One person told us, "Food is very good, I enjoy the food. They let me have two spoons of honey in my tea instead of sugar. We do get a choice of a main meal and if you don't like it they will make you an omelette [other options]. Sometimes they forget to put the choice on the board but [staff] tell you anyway. Whatever you don't like they will change it." Another person said, "I think the food is excellent, it is very good indeed, very well cooked. I haven't had a bad meal since I came. We have nice puddings, not elaborate but well cooked."

The service worked with other external organisations to ensure that the best possible quality of service was provided. For example, working with the local authority commissioning team meant that the overall quality of the service was monitored. The local authority older person's team ensured that people received co-ordinated and person-centred care and support when they first started living at the service. Contact with Public Health England ensured that best practice advice would be followed in the event of an outbreak of infection. A representative from the local authority commissioning team told us, prior to the inspection, that following an inspection visit by a member of their team in November 2016, "The provider worked well with us on the action plan produced as a result of monitoring."

People were supported in a timely manner to attend external health care appointments both inside and outside of the service, when required. Visits included; GP visits; district and community nursing; and dieticians. A person said, "If you are not feeling well they will get the doctor out for you, no problem." A relative told us, "If [family member] is not well they soon get him to hospital. He has been in twice already this winter. As soon as anything is wrong they get a GP in, they let his [next of kin] know." A GP told us prior to the inspection, "The staff have always been very friendly and extremely caring when involved in moving a [person using the service] to a quieter area for me to examine them as well as very respectful of their residents. They have continued over this time to try and meet the needs of [people] both medically and socially… I know they have put a lot of work into the large amounts of regulation around medication in [care] homes and I am sure if they are unsure about instructions that they will ring and ask. Our working relationship is good and they know how to get the best care for their patients from our system."

The service was an adapted building that used to be a large family home. Adaptations had been made to the service to enable people to be able to access all areas including the different floors, via a passenger lift, a stair lift and stairs. Sloping floors were also in place, instead of steps, and handrails ran the length of the corridors to aid and assist people with limited mobility. Observations showed that with support from staff people had access to the garden. This was on one level and paved in areas for easy access and people were able to spend time enjoying the countryside views.

The mental capacity act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training in MCA and DoLS. Staff were able to demonstrate their understanding to us. Staff supported people with their decision making by using visual prompts. Applications had been made to the local authority supervisory body for people who had been assessed as lacking mental capacity and needed legal restrictions in place to aid with their safety. These applications were in progress and had not yet been authorised. The deputy manager confirmed that, "Best interest [decision] meetings are now in place regarding MCA and DoLS." This showed that people would not have their freedom restricted in an unlawful manner.

Good

Is the service caring?

Our findings

People using the service and their relatives had positive opinions about the care and support provided by staff. This was confirmed by our observations during the visit. One person said, "[Staff] are kind, very nice and respectful I find." Another person told us, "[Staff] are alright, they speak to you alright." A relative said, "[Staff] do look after [family member] as well as I could."

Staff knew and respected the people they were caring for. Staff were able to demonstrate to us that they knew people's preferences, personal histories and wishes. This knowledge included the promotion, by staff, of people's independence. Records documented what people were able to do for themselves and what staff were to assist with. This was to help staff maintain people's independence. A person said, "I look after myself. I get up; washed and come down for breakfast in the lounge…I don't have any help at the moment." Staff knowledge also included distraction techniques known to work for people who were at risk of becoming anxious. Staff supported people in a reassuring way that helped reduce the fears for the person who was becoming anxious.

People confirmed to us that staff respected their choices and asked permission before supporting them. This was confirmed by our observations. Advocacy information was available on request for people if they needed to be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

People and their relatives were not always able to tell us that they were involved in the setting up, review and agreement of their /their relatives care and support plans. However, records showed that people and/or their named next of kin had signed to say that they were involved in agreeing their/ their family member's care decisions. Following our feedback, they said that they would look at additional or different ways of improving this communication so families would feel that they could be more involved.

People and their relatives had positive comments about staff, and said that communication was good. Records showed that meetings were held for people living at the service to express their views and, where possible, be involved in decisions about the service. Minutes from the meeting held in March 2017, documented that there was a new area in the service where visiting family and friends could make themselves drinks and snacks were also made available. Minutes also showed that there had been positive feedback to the service regarding redecoration and that this had 'improved the look of the home.'

Positive comments were given by people and their relatives when asked if staff promoted and maintained their or their relative's privacy and dignity. One person confirmed to us that staff "were very courteous and respectful when they give me a bath." Another person said, "I do have help with my care. [Staff] knock on the door when they come in and do cover me with towels when they give me a wash."

Visitors were encouraged and made welcome at the service. A relative said, "I like the fact that I can come at any time, I trust the [staff] here to look after [family member]." Staff made people's visitors feel welcome and chatted to them to update them about their family members' care and well-being.

Good

Is the service responsive?

Our findings

Care and support plans documented people's daily living needs, care and support and health needs that had been assessed prior to them moving into the service. This record was in place to make sure that staff could meet the person's individual requirements. From this information care and support plans and risk assessments were developed in conjunction with the person and/or their relative or legal representative or advocate. These documents acted as prompts for staff on how each person wished to be supported, including their likes and dislikes, interests and personal preferences. Reviews of these records were then carried out to make sure that these were up-to-date and reflected people's current requirements. People told us of the communication they had with staff about their wishes and how these were respected wherever possible. One person told us, "You can ask [staff] to come back if they come [to assist you] too early in the morning. They generally follow what you request."

During our visit we saw both individual activities and a group activity taking place. However, during the morning of our visit activities seemed very limited for people. We noted that this had been an area identified as requiring some improvement during a recent operations manager audit of the service. We were aware that people were able to use the memory and sensory rooms if they chose to do so and we saw that these rooms were used, on occasion, during our visit. One person confirmed to us, "I have been in the memory room for the first time today looking at old photos."

A visiting local choir singing Christmas carols was in attendance in the afternoon. This was very well attended by people and staff. However, people and their relatives had mixed opinions about daily activities and external trips out of the service. One person said, "I read quite a lot. We don't go out anywhere, no. Sometimes the [religious service] come in here. [External entertainers] do come in from time to time but otherwise we sit here watching TV." Another person told us, "Somebody comes in singing you know. Somebody else does exercises once a month…You can only watch so much TV…It would be better if we had a bit more to do in the afternoon." A third person said, "Anything going I will do it. [There has] been one or two things for me to join in within the three weeks I have been here. Sort of a sing along. I would prefer more exercises, we just sit here, it's not very good for me. The exercise people only come once a month." The activities co-ordinator told us of the external entertainers they had at the service and in addition to this, how they supported people on trips out of the service. They described boat trips taking place, visits to local garden centres and supporting people on individual shopping trips. However, people's feedback was they wished for more stimulation and activities at the service. We fed this back to the operations manager and manager and they told us that they would look at building upon and expanding the activities available to people.

The manager told us that to ensure that more people with sensory impairments were able to access information about the service they intended to expand the use of easy read and large type posters throughout the service. They confirmed to us that the local weekly newspaper was already available to people in an audio format and that visual prompts were used by staff to aid people with their choices. Our observations showed that pictorial prompts were currently being used for menus and dementia signage was in place to help people living with dementia more easily identify communal rooms such as bathrooms,

toilets and communal areas. This meant that improvements were being made to help more people feel more involved with the service and have information more accessible to them.

We saw that the service received compliments from relatives of people who had used the service. Compliments were used to identify to staff what worked well. Records showed that the service had received two complaints since the last comprehensive inspection. We saw that these complaints had been investigated and any action taken to try to reduce the risk of recurrence fed back to the complainant. However, the manager had not always followed the provider policy by formally acknowledging and responding to a complaint received in writing. The manager told us that this would be improved with immediate effect.

People and their relatives told us that they knew how to make a complaint but had not needed to do so. They confirmed to us that they felt that any complaints raised with the management of the service would be listened to, investigated and resolved where possible. One person said, "No complaints. No, this is generally a good place. From time to time things go wrong but [staff] soon sort it out." Another person told us, "I've never made [a complaint] but I imagine you speak to a [staff member]. That is what I do if I have a grumble and it is sorted out."

Hardwick Dene is a residential care home that is not registered to provide nursing care. Staff told us that to support people at the end of their life, they would work with external health care professionals, when it became clear that people's health condition had changed or deteriorated. External health care professionals that staff worked with during this time included doctors and community or district nurses, as well as specialists in particular areas such as dieticians. This was to enable staff to support people to have the most comfortable, dignified and pain free death as possible. A relative told us how staff had made a room available for visiting family to stay in so that they could spend time with their family member during the latter stage of their life. They said, "During the end stage of [family members] life the family practically lived at the home and staff were marvellous…Nothing was too much trouble…district nurses were coming in to support staff and [family member]. The GP was involved around pain medication and medication to calm [family member]. Staff respected the end of life wishes of the family…staff and the GP did everything they could to promote a pain free and dignified death." A doctor told us before the inspection, "I have never had concerns about their management of my most unwell [people living at the home] and their end of life care and attention to people who have been in their care a long time is second to none. They have managed some cases which would perhaps usually have been passed onto nursing home with support from district nurses so that the [person] does not have to go to hospital or a nursing home in the last few days of their life."

Care records documented people's end of life wishes, including a wish to not be resuscitated, cultural and religious wishes and/or funeral arrangements and preferences. This showed us that there were protocols in place for staff at the service to respect and promote people's end of life wishes.

Good

Is the service well-led?

Our findings

The Care Quality Commission (CQC) records showed that there was a registered manager in place. However, the CQC were aware that they were no longer in employment at the service and needed to apply to cancel their registration. There was a manager in place who was overseeing the day-to-day running of the service with support from the operations manager. The manager had applied to the CQC to become the registered manager.

A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was supported on a day-to-day basis by care workers and ancillary staff.

Observations showed that the rating from the last CQC inspection that was carried out on 15 November 2016 was displayed on a communal notice board for people, their visitors and staff to refer to. This rating was also displayed on the provider's website. Records showed that the CQC was informed of incidents that the provider was legally obliged to notify them of. This showed us that the manager was aware of their responsibilities in reporting notifiable events to the CQC when required.

Staff told us that there was a clear expectation, by the manager, for them to deliver high quality care and support. People and their relatives told us that communication was good between staff and themselves. A person said about the manager, "Yes she is very good, very kind and speaks to you, but she is busy." Another person told us, "I know who the stand-in manager is and I would say she is very approachable." A third person said, "The managers are all approachable, especially that deputy [manager]. One in a million that man, one in a million."

Staff made very positive comments about the manager. They said that since the manager became in charge there had been positive changes to the way the service was run and the quality of care provided to people. Staff said that the manager took time to explain the changes required to staff. This was so staff had a clear understanding of why the change had been made and why it was needed. Staff told us that the service continually strived to learn from incidents to reduce the risk of recurrence and improve the quality of the care provided. A staff member told us how they had made a suggestion to make a form easier and clearer to complete. They said, "The culture here is one that listens and supports staff. I'm a new member of staff so it is like coming in [to the service] with fresh eyes. My line manager always asks me for my opinion and between us we have made changes…They have listened to my suggestions."

Management systems and meetings were in place to monitor the quality of the service provided. At these meetings the management team and staff discussed any successes and suggestions made and any learning from the quality monitoring systems in place. Staff told us that supervision meetings were a two way conversation, where any concerns or problems could be discussed.

Organisational/provider quality monitoring audits were also undertaken by the operations manager to

ensure organisational oversight was in place. These audits looked at all areas of the service including; general observations throughout; people's meal time experiences; activities; and whether people's equality and diversity needs were being met. Other quality monitoring at the service included; medication audits; infection control audits; and checks under the questions, is the service safe, effective, caring, responsive and well-led? Areas for improvement were noted and either actioned or on-going, with a deadline the action needed to be completed by documented. Actions included that all window restrictors were to be in place within each room of the service by 22 December 2017.

Meetings were held and questionnaires sent out for people, their visitors/family so they could engage with the service and feedback their views. Records showed that responses were positive and any areas for improvement noted and where possible acted upon. However, documents showed that the last meeting for people at the service was held in March 2017.One person said, "We used to have meetings once a month, we could say what we liked, I'm not sure what is going to happen now." Another person told us, "There are no residents' meetings now."

Staff worked in partnership with key organisations to provide joined-up care. This was to help the manager measure how people's care was delivered against current guidance from national care organisations. The operations manager and manager told us that legislation changes and updated guidance would be sent from the provider and shared with all of the registered managers/managers within the organisation. At organisation meetings held regularly, registered managers /managers would also have the opportunity to share with the other attendees any updates and feedback about legislation and guidance changes and how they could be implemented within each of the services.