Care Quality Commission

Hartwood Care Limited

Hartwood House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 2 and 6 January 2015 and was unannounced.

Hartwood House opened in June 2013. The home is arranged over three floors and consists of a new purpose built wing attached to an older existing property which has also been completely refurbished. The home can accommodate up to 50 people but at the time of our inspection there were 33 people living at the home. The Emery Down nursing unit is on the lower ground floor and provides care for up to 10 people many of whom have complex nursing needs. The Limewood unit on the ground floor provides care for up to 20 people who require residential care. The people living on this floor are more independent and may need support with some daily living tasks such as personal care or support with their medicines management. The Minstead unit is on the first floor and can provide care for up to 20 people who are living with dementia. Some of the people living on this floor could at times display behaviour which challenged and also had some complex physical health needs. A registered nurse is based on the Emery Down Unit and is available to provide some emergency clinical advice or support to the other two floors which are staffed by senior care workers and care workers.

The home had not had a registered manager since June 2014. A registered manager is a person who has

Summary of findings

registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A new manager was appointed in July 2014. They have made an application to be appointed the registered manager.

Staffing levels required improvement. People told us that they had to wait for support and assistance. Target staffing levels were not always met and staff struggled to meet people's needs in a timely manner.

Mental capacity assessments were not being undertaken with due regard to the MCA 2005. When a person lacked capacity to make decisions about their care, we were not always able to see that appropriate best interests consultations had been undertaken.

People's records did not always contain enough information about their needs to ensure that staff were able to deliver responsive care.

Some risk assessments needed to be updated to include more detailed and specific guidance to support staff to manage risks in a safe and effective manner.

Staff had not completed all of the training relevant to their role. Staff had also not received supervision in line with the frequency determined by the provider.

People's nutritional needs were met, but improvements were required to ensure people had choice of suitable foods which encouraged their enjoyment of mealtimes and which were in keeping with their known preferences or their dietary requirements.

People said they had no concerns about the leadership of the home. However some staff told us they were not happy about aspects of their role and that morale amongst the staff team was low. The manager was aware that further work was needed to improve staff morale and to develop their confidence in her as their leader.

People told us they felt safe living at Hartwood House. Staff had received training in safeguarding vulnerable adults and had a good understanding of the signs of abuse and neglect. They were aware of what to do if they suspected abuse was taking place. The organisation had appropriate policies and procedures. This ensured that staff had clear guidance about what they must do if they suspected a person was being abused.

People were protected against the risks associated with medicines. The provider had appropriate arrangements in place to manage people's medicines safely.

Whilst a number of quality assurance systems were in place, this were not yet being fully effective and driving improvements.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place.

The home worked effectively with a number of health care professionals to ensure that people received co-ordinated care, treatment and support including memory nurses supporting those living with dementia and physiotherapists and community dentists.

People spoke positively about the care provided by the staff as did their relatives. One person described the staff as "Caring, kind and respectful….I never get one who is unkind". A relative said, "I can't fault them, they are so kind and caring, brilliant".

People knew how to make a complaint and information about the complaints procedure was displayed within the home and included in the service user guide.

Systems were in place to see feedback from people who used the service, their relatives and staff. This helped to ensure the manager maintained an oversight of day to day issues within the home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not always safe

Staffing levels required improvement to ensure people's needs were met in a timely and consistent manner. Target staffing levels were not always met.

Some risk assessments needed updating to ensure they contained detailed and specific guidance to support staff to care for people in a safe and effective manner.

Staff had a good understanding of the signs of abuse and neglect. They were aware of what to do if they suspected abuse was taking place.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to safely manage medicines.

Is the service effective?

Requires Improvement 

The service was not always effective

Mental capacity assessments were not being undertaken with due regard to the MCA 2005. When a person lacked capacity to make decisions about their care, we were not always able to see that appropriate best interests consultations had been undertaken.

Whilst staff told us they felt well supported by the management team. Further improvements were needed to ensure staff received all of the training relevant to their role and regular supervision.

People's nutritional needs were met, but improvements were required to ensure people had choice of suitable foods which encouraged their enjoyment of mealtimes and which were in keeping with their known preferences or their dietary requirements.

The home maintained effective working relationships with health care professionals which helped to ensure people received co-ordinated care, treatment and support.

Is the service caring?

Good 

The service was caring.

Staff were kind and caring in their interactions with people. They were cheerful and attentive and used touch or gave hugs to reassure people when they were agitated.

People were treated with dignity and respect and were supported to be as independent as possible.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's records did not always contain enough information about their needs to ensure that staff were able to deliver responsive care. People's needs were not always being regularly reviewed.

People knew how to make a complaint and information about the complaints procedure was displayed within the home and included in the service user guide. Complaints were fully investigated and action was taken to address the concern.

Is the service well-led?

Requires Improvement

The service was not well led.

The home did not have a registered manager in place.

Quality audits were not yet effectively driving improvements.

Further work was needed to improve staff morale and to develop their confidence in the leadership of the home.

Systems were in place to see feedback from people who used the service, their relatives and staff. This helped to ensure the manager maintained an oversight of day to day issues within the home.

Hartwood House

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 2 and 6 January 2015 and was unannounced.

On the first day, the inspection team consisted of two inspectors. On the second day, the lead inspector was joined by a pharmacy inspector, a specialist nurse advisor in the care of frail older people living with dementia, 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 service. Our expert had experience of supporting people living with dementia and of using health and social care services.

The provider had not been asked to complete a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we referred to other information we held about the home to plan the inspection. We reviewed previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

We spoke with nine people who used the service and seven relatives. We also spoke with the manager, deputy manager, a chef, a registered nurse, nine care workers, an activities co-ordinator and a member of the housekeeping staff. We reviewed the care records of 10 people in detail and the records of five staff. We also reviewed the Medicines Administration Record (MAR) for 19 residents, the medicines sections within care plans for nine residents and Topical Medicine Administration Records (TMAR) for one resident. Other records relating the management of the service such as training records and policies and procedures were also viewed.

The last inspection of this service was in April 2014 when no concerns were found in the areas looked at.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Hartwood House. One person said she felt "Absolutely safe" and another person told us they felt safe, and knew who to tell if they didn't. Visitors told us they had no concerns about their relative's safety. One said, I have no concerns about safety, I am absolutely 100% sure of safety".

Whilst people told us they felt safe, through our observations and discussions with people and staff we found aspects of the care provided were not always safe.

Staffing levels required improvement to ensure people were kept safe and to ensure their needs were met in a timely manner. The usual staffing levels during the day on the Minstead unit were one senior care worker and two care workers. The Minstead unit is on the first floor and is for people living with dementia. When we visited, there were nine people living on this unit. Two people needed two staff to manage their care needs. One person, could at times, need three care workers as they could become agitated when receiving care. Other people could display behaviour which challenged, or were at high risk of falls and so needed to be observed every 30 minutes. One person's care plan stated they required six hours of one to one time each day. All of the staff on this unit told us the staffing levels needed to be improved to ensure they were able to effectively respond to the unpredictable needs of some of the people they supported. They also said higher staffing levels were needed to ensure other people received their required one to one care and supervision. One care worker said, "It's not possible to supervise the communal areas all of the time, if we did this, other people would not be able to go to the toilet or have their pads changed". They explained they rarely took a break as they were "Too worried to leave the floor with less staff". Another staff member said, "It can be really unpredictable on this floor…. more staff are needed". They also said it was not possible to always supervise the communal areas.

At 9am one person's call bell had been ringing for three minutes. One member of staff was administering people's medicines and the other staff were attending to other people. The bell continued to ring for a further two minutes. We were aware the person in this room was at high risk of falls and had an alarm mat in place to alert staff if they stood up, so that staff could promptly check they were safe. There were no staff available to respond to this call bell. We found a member of staff and asked that they respond to the call bell. They told us it would 'just be [the person] doing their exercises' although they did go and attend to the call bell. We were concerned there were not enough staff to respond to call bells promptly but also that staff appeared to have made a judgement, without checking, that the call bell was due to the person doing their exercises and not due to the fact they required assistance.

We observed a number of occasions throughout our visit when staff were not present in the communal areas for 5-10 minutes. On one occasion we needed to intervene to prevent one person from trying to sit on another person. A visitor told us there had been times when they felt they could not leave as they were concerned for their relative's safety. This was because no staff were available to supervise the communal areas and ensure that those people who could display behaviour which challenged were not placing themselves or others at risk.

The Emery Down unit provides nursing care for people who may have complex nursing needs. There were nine people on this unit when we visited. This unit had a staffing complement of one registered nurse and two care workers during day shifts. All of the people on this unit required two staff to assist with their personal care and mobility needs. Six of the nine people also required assistance with eating and drinking. We received contradictory views about whether the staffing levels were adequate on this unit. One person told us, "There is not enough staff, I have to wait a long time for staff and there should be more". This person told us the lack of staff meant they were not always able to get up when they wanted to. They told us, "I need to be hoisted and that can be difficult for them". However the other two people we spoke with said the staffing levels were adequate. One person said, "Staff are pretty good and come when needed".

All of the relatives we spoke with on this unit said staffing levels were a concern and impacted upon people having the help they needed at mealtimes, and being able to have baths or showers when they wanted. One relative said, "I'm sure my relative would love a bath, they have not had one since coming here three months ago". Another visitor said, "My relative has only had one shower because this takes two staff and ties them up". Another visitor said staff were often too busy to hoist their relative out of bed into their chair to enable them to spend time in the lounge. Staff

Is the service safe?

confirmed to us that whilst people received essential care such as bed baths and had their hair washed, it was not always possible to offer baths due to both a lack of time and also a lack of equipment.

There were not enough staff to serve people their lunch in a timely way. One person sat in the dining room and waited 40 minutes to be served. This was despite the mealtime being supported by two visiting relatives and three members of staff. One member of staff was assisting two people at once with their meal, which lacked dignity. A relative told us, "If some of us did not come in to help with feeding, I don't know how they would manage". A staff member said, "I do think we should have another member of staff here for people's needs like baths, showers and helping at meal times as it can take up to one hour to assist one person to eat. A visiting healthcare professional told us, "Sometimes, they do seem a bit tight on staff. . .they cannot always spare anyone to accompany us when we visit". Later that day staff were again not available to accompany another visiting healthcare professional whilst they examined a person. We spoke with a registered nurse who told us, "I have got too much to do to go with everyone". This indicated there was not consistently enough staff on duty to ensure people received support to manage their daily needs.

Actual staffing levels were sometimes below the target staffing levels. Whilst agency or bank staff were used to cover absences, the management team said sometimes it was not possible to get cover at short notice. We reviewed the rotas for the week of the inspection and the three previous weeks. Whilst the Minstead and Emery Down units were usually staffed to target levels, the Limewood unit was short of one member of staff on 11 mornings between 15 December 2014 and 4 January 2015. The manager told us the home had recently recruited a number of new staff, but still had vacancies for four care workers and one registered nurse. They were committed to being fully recruited and reducing the use of agency staff. They explained judgements about staffing levels were based on the needs of the people living in the home, although they were not able to clearly demonstrate how they carried out an on-going needs analysis or risk assessment as a basis for deciding sufficient staffing levels.

Staffing levels were not organised in in such a way as to ensure staff could always be responsive to people's needs and choices. This is a breach of Regulation 22 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The level of detail varied in some of the risk assessments. Some assessments needed to be more specific about how staff were to manage the identified risk in order to help keep the person safe. For example, one person's moving and handling risk assessment did not provide adequate information about the behavioural constraints which might impact on staff moving the person in a safe way. Screening for the risk of malnutrition and pressure ulcers was being carried out and people's weight was monitored but these were not always being updated each month to monitor changes. We saw three examples where these had not been updated between August and November 2014. This meant changes to people's risk of developing pressure ulcers might not be identified promptly, to enable staff to put appropriate preventative measures in place.

There were good risk assessments undertaken for choking and falls. Some of these had been written clearly and this meant staff had good guidance about how to support people to reduce these risks. For example two people with epilepsy had clear clinical care plans detailing the actions staff should take when the person experienced a seizure.

We received mixed feedback from staff about the effectiveness of the daily handovers. Three staff felt that communication between shifts could be improved to ensure that information about changes or risks to people's health were shared in a timely manner. One night care worker told us they had not been made aware of a new admission to the home. The handover sheet used on the Emery Down unit was out of date and did not reflect people's current needs. Although the regular staff were knowledgeable about people's needs, there was a high use of agency nurses on this unit and there was a risk that the information provided would not be adequate to ensure care was always safe and appropriate.

Improvements were needed to the recruitment procedures to prevent the risk that unsuitable people might be employed to care for people in the home. The provider had accepted Disclosure and Baring (DBS) certificates issued by previous employers on two occasions without carrying out their own checks to ensure these did not reveal any new information of concern about potential new workers. This was not in line with the organisations recruitment policy.

Requires Improvement

Is the service safe?

The provider told us they always assessed the risk of employing somebody with a recently issued DBS but accepted this was not currently clearly evidenced. Records showed people applying for a job completed an application form and had a formal interview as part of their recruitment. The provider had obtained references from previous employers. The registration details of nursing staff were checked with the body responsible for the regulation of health care professionals and these checks were repeated on an annual basis.

People's medicines were kept safely. The home had three Controlled Drugs (CD) cupboards. These are prescription medicines controlled under the Misuse of Drugs Act 1971, and which require special storage, recording and administration procedures. We undertook a balance check of the Controlled Drugs held in one of the CD cupboards against the register and these agreed. Other medicines were stored securely within locked medicines rooms or medicines cupboards within each person's room. Arrangements were in place to store medicines within their recommended temperature ranges. The service had three medicines refrigerators in use. Whilst the "current" refrigerators temperatures were monitored; these temperatures were recorded as if they were the "maximum" temperature. One refrigerator had been outside the recommended temperature range and appropriate actions had been taken.

Medicines administration was recorded appropriately. Care plans for people prescribed medicines for challenging behaviour included minimum dose intervals and the maximum number of doses in 24hours. We spoke to one person who was "self-medicating"; they explained how the service had undertaken a risk-assessment and monitored how they took their medicines. However, improvements could be made to ensure there was adequate information about how people preferred to take their medicines, and when, why and who had recommended changes to medicines.

Staff had received on line training in safeguarding vulnerable adults and had a good understanding of the signs of abuse and neglect. They were aware of what to do if they suspected abuse was taking place. The organisation had appropriate policies and procedures. This ensured staff had clear guidance about what they must do if they suspected a person was being abused. Staff were informed about the provider's whistleblowing policy. Staff were clear they could raise any concerns with the manager, but were also aware of other organisations with which they could share concerns about poor practice or abuse. One care worker said, "Safeguarding means to keep people safe from harm….if the senior person did not listen, I would go higher even outside of the organisation". Another worker said, "It is our job to keep people safe, so we should spot things and report them quickly". The manager told us safeguarding people from abuse was discussed in supervision as was the organisation's whistle-blowing policy. The manager and provider had worked effectively with social care professionals in relation to investigating safeguarding concerns. We saw safeguards had been put in place to protect people and others where this was required. For example, one to one care was made available for a person whose behaviour could present a risk to either themselves or others.

The provider had a business continuity plan which set out the alternative arrangements that would be put in place if for example, there was a loss of power or the need for the evacuation of the building. This helped to ensure staff knew what to do to keep people safe in the event of an emergency affecting the premises or essential utilities.

Requires Improvement

Is the service effective?

Our findings

Overall people were positive about the staff and the care they received and they all said they would recommend the home to a friend or family member. One person said, "Yes I would [recommend the home], they would be very well looked after….I have a very much better standard of living here than I did in my own home". A relative told us they had been given a fantastic welcome by the staff when her parent was recently admitted to the home. We saw they had also fed back to the home that they felt their parent had settled so well due to the kindness and good care they received. Another relative told us, "My relative's skin has not broken down and that is good nursing for someone who has been in bed for three months". There were mixed views about whether staff had the necessary skills and knowledge to effectively meet people's needs. Some people told us staff were adequately trained, although two people did express a view that some of their care workers did not always understand their needs.

Mental capacity assessments had not always been carried out in line with the Mental Capacity Act (MCA) 2005. The MCA says that before care or treatment can be carried out, it must be established whether or not they have the capacity to consent to the care. If not any care or treatment decisions must be made in the person's best interests following relevant consultations with professionals, relatives and friends engaged in caring for the person. Some people were unable to consent to aspects of their care and treatment but there was no evidence that mental capacity assessments and best interests consultations had been completed. For example, the records for three people contained a letter from their GP authorising the administration of covert medicines, however there was no evidence that a mental capacity assessment had been completed for this decision. There was also no evidence of a best interest meeting had been held or specialist pharmacist advice sought on how to administer the medicines covertly, whilst retaining the medicines effectiveness. Two people had mental capacity assessments in relation to decisions around their personal care. The outcome of these assessments was that the people lacked capacity; however no best interest consultation had taken place to guide and plan the delivery of care. The provider used a form called 'My Best Interests'. We found this confusing as this form was actually a mental capacity assessment and not a record of a best interest consultation and outcome. One person had an incomplete mental capacity assessment in their records which contained reference to another person.

We saw two examples of fully completed mental capacity assessments and best interest's decisions for one person. The assessments were decision specific. The staff we spoke with had a good understanding of the principles of the MCA. However, the provider had not ensured that each person who lacked capacity to make decisions about their care and treatment had a clear mental capacity assessment and a record of the best interest's consultation which supported staff to act and make decisions on their behalf. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff varied in the amount of training they had received and how up to date this was. The training programme was mainly via on-line courses and included essential training such as moving and handling, fire safety, infection control, food hygiene and safeguarding people from harm. Some staff had completed training in additional subjects such as bowel and catheter care and the use of equipment which helped to control people's pain during their end of life care. Other staff had attended 'Care Giving in Dementia – A Positive Vision' which is a course given by Dr Gemma Jones. Dr Gemma Jones is a Neurophysiologist and nurse working with people with Alzheimer's and their carers. One care worker told us, "The training is brilliant; the dementia training was really good". However another care worker said, "The training does not always come early enough". A relative told us, "The staff down here [Emery Down Unit] are definitely involved in regular training". However when we reviewed the training plan, we found that a high proportion of staff had not yet completed training in nutrition and hydration and the Mental Capacity Act 2005. A person's behaviour risk assessment stated that staff were to receive specialist training in managing behaviour which challenged. None of the staff we spoke to had received this training. Three staff working on the Minstead unit told us they would value training in this area which they felt would help them support people who demonstrated behaviours

Is the service effective?

which challenged. Improvements were needed therefore to ensure staff received all of the essential and relevant training required to carry out their roles and responsibilities effectively.

New staff received an induction which involved shadowing more experienced staff and learning about the needs of the people using the service and the policies and procedures of the home. A member of staff who had been recently employed by the service confirmed they had been given opportunities to shadow staff and had completed a range of essential training. They said, "I was well supported through induction". Records showed the induction of new staff was in line with Skills for Care Common Induction Standards (CIS). These are the standards people working in adult social care should aim to achieve within their first 12 weeks of employment. They help to demonstrate that the care worker understands how to provide good quality care and support. We did note that some new staff were not always completing their induction programme within the timescales determined by the service.

Staff were not always receiving supervision in line with the frequency determined by the service. Staff had not received an annual appraisal. Supervision and appraisals are important tools which help to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. Records suggested 12 out of 37 staff, three of whom were night staff, had received less than two supervisions in 2014, whereas the organisation's policy states there should be a minimum of one every eight weeks. The manager and deputy manager told us supervision sessions were a mixture of one to one meetings and practice based observations. They said they had been working hard to ensure a more robust programme of supervision was established and we were able to see some recent improvements in the frequency of supervision for some staff. Where staff had received supervisions, or observation of their practice, we saw the records of these were detailed and feedback on performance had been given in a supportive and constructive manner. However, further improvements were needed to ensure the supervision arrangements within the home operated in line with the provider's policy and were an effective tool in the on-going development of staff.

Feedback from people about the food was mixed. Two people told us they did not always enjoy the food which could lack fresh vegetables, was sometimes overcooked and contained too much salt. Others said the food was improving. A relative said, "The quality has improved, it used to be pasta every night with a bit of tuna in it, on the whole it was poor quality and not nutritious. That has improved and its five star now". This relative did comment that there was not always fresh fruit available and so they had to bring this in.

People were not always supported to have a choice of suitable foods which encouraged their enjoyment of mealtimes and which was in keeping with their known preferences or their dietary requirements. For example, we observed a dairy free alternative to milk was no longer being provided for one person who was lactose intolerant. Staff were unclear about why this was the case. Another person who had enjoyed porridge for breakfast each morning was no longer receiving this. Their relative advised that this just seemed to stop, they were not sure why, but were clear that this had been because of an expressed preference by the person. People on the Limewood unit were offered wine with their lunch. This was not offered on the Minstead unit. Soup was sent up for supper on the Minstead unit, but this was not offered to anyone. There was fruit available on the Minstead unit but this was not fresh. Some people required pureed meals due to swallowing problems or because this was how they preferred to take their meals. It was not clear to us that these people were provided with a choice about their pureed meal. Staff were not aware of what the pureed meal was and so were not able to share this with people when supporting them to eat. We spoke with the chef. They advised that each evening, information about people's breakfast choices were collated by staff and sent down to the kitchen. They explained this information was no longer being provided by the Minstead unit. They said it was the responsibility of staff to visit the kitchen to get fresh fruit. Staff told us there was no time to do this alongside their other duties. At our request fresh fruit was brought up to the unit and the manager told us she would arrange for soya milk to be ordered.

Food and fluid charts were used to monitor people's dietary intake where this was required, however improvements were needed to ensure these were accurate and did not contain gaps or omissions. On the Minstead unit, two people's charts contained gaps. For example, one person had not breakfast or tea recorded on the 29 December 2014 and on the 27 December, no food at all was recorded, just 700mls of fluids. Another person's records

Is the service effective?

suggested that on the 29 December they had just eaten supper and 300mls of fluids. Staff told us this was a recording error and stated that food and fluids were offered on a regular basis which was confirmed by our observations during the inspection. None of the charts contained information about the target fluid levels each person required and on the Emery Down unit, whilst target levels were recorded, these were the same for each person. People require different amounts of fluid intake depending upon their individual needs and so these should be personalised and specific to each person.

Staff were aware of people's allergies and the chef explained that where a person had an allergy to a particular food, that item was not used in preparing any food throughout the home. Staff were able to describe people's dietary needs and how they would identify a person was at risk of poor nutrition. The home used a range of good practice tools to assess any nutritional risks to people. People's records showed they were weighed on a regular basis and where they had lost weight, they were referred to relevant professionals such as the GP or dietician. Where people were at risk of choking, they had been referred to a speech and language therapist.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom or choices, these have been agreed by the relevant bodies as being required to protect the person from harm. The deputy manager had a good understanding of the safeguards and was aware of a recent supreme court judgement which had widened and clarified the definition of a DoLS. A number of applications for a DoLS had been submitted by the home, although improvements could be made to ensure that all staff were aware of which people were subject to a DoLS so that they could ensure the safeguards were effective.

There was an effective working relationship with a number of healthcare professionals to ensure people received co-ordinated care, treatment and support. Visiting healthcare professionals including memory nurses, supporting those living with dementia, GP's, speech and language therapists and other rehabilitation staff such as occupational therapists and physiotherapists. We spoke with a visiting healthcare professional who told us the home was well organised and people appeared to be well looked after. They said, "The staff follow our instructions and people seem to get good care".

Hartwood House provided a pleasant environment for people to live in. There were a number of sitting rooms, dining areas with kitchenettes and a well-equipped activities room on the Minstead unit. Overall the home was comfortable and homely and appeared to be well maintained and furnished to a high standard. The home was clean throughout and there were no offensive odours. A relative told us, "The housekeeper keeps it spotlessly clean" and another said, "I think the beauty and cleanliness is wonderful".

Good

Is the service caring?

Our findings

People and relatives spoke positively about the staff and said they treated people with dignity and respect. One person said, "The staff are kind and respectful". Another person said, The carers are polite and helpful, they ask before assisting me and knock on the door before entering".

Staff were kind and caring in their interactions with people. For example, we saw one care worker sensitively explain to one person who was living with dementia, why they were living at the care home. They reassured them they would be looked after and would be having a visit from their family later. We saw another care worker comforting a person who was distressed. They bent down, making eye contact with the person, reassuring them before taking them for a walk. Care workers assisted people with eating in a patient manner. One person who was being supported to eat in their room was talking and laughing with their care worker and clearly enjoying the experience. The staff were cheerful and attentive and used touch or gave hugs to reassure people when they were agitated. Staff could describe people's individual likes and dislikes. At lunch-time we saw care workers dancing with people who were really enjoying themselves.

People's relatives and friends were able to visit without restrictions. We observed relatives visiting throughout the day and sharing in aspects of their relative's care and support. A relative said, "I can't fault them [the staff], they are so kind and caring, brilliant. They have warmth and are genuinely fond of my relative". Another relative said, "They always dress mum really nicely, she has perfume on and her beads, she is dressed with dignity". A third relative said, "The main thing is kindness, it's so important and they are kind". We saw that every relative who had responded to the recent satisfaction survey had been complimentary about the kindness of the staff.

Upon admission to the home people were given a service user guide which included a 'Residents Charter' which stated people had the right to be treated with dignity and respect, kindness and to have their privacy and confidentiality respected. Our observation indicated people were treated people with dignity and respect. We saw doors were kept closed when people were receiving personal care. A relative said, "They always close the door and pull the curtains when they caring for my relative". We saw staff entered people's rooms, by knocking on their doors and calling out who they were. We observed that where people had capacity, staff sought their consent before providing care and support.

People were supported to be as independent as possible. Staff told us they only assisted when it was clear that the person could not manage a task independently. We saw evidence that care plans were written in a manner that encouraged staff to promote people's independence, for example, one person's plan said, 'Encourage [the person] to eat and drink independently, but offer support when needed'.

Requires Improvement

Is the service responsive?

Our findings

People's views about how responsive the service was to their needs were mixed. Some people told us staff tried to respond promptly to their needs but this was not always possible due to staffing levels. One person said, The staff do their very best, but it's not good enough, they can't cope at meal times, they need more staff". Another person said, "I can't complain about the staff, but I can complain about the lack of staff. ...carers don't get enough time to spend with you, to get to know you, they can't get out quick enough because everything is piling up behind them".

People did not always have a detailed plan of care which helped to ensure staff were able to deliver personalised and responsive care. This is important as detailed information about people's needs helps staff to provide appropriate interventions and also assists them to recognise changes in people's health. Care plans often did not provide information about the strategies staff could follow to meet people's needs. For example, one person's plan stated staff should try and prevent the person from becoming agitated or distressed by involving them in activities. There was no detail about what activities the person enjoyed and might therefore be most effectively used by staff to de-escalate behaviour. Two people with diabetes had care plans in place but these were not personalised to their specific needs and only considered the protocols or procedures to take should the person's blood glucose levels become too low. There was no guidance about the actions staff should take in response to the person's blood glucose levels being too high.

Continence assessments contained information about what continence product was to be used but lacked personalised information about how staff might promote and preserve as far as possible, the person's independence with continence. Five of the eight records viewed on Emery Down Unit indicated that the person was living with forms of dementia. These people did not have specific dementia care plans. This increased the risk of them not receiving the skilled care they required to manage agitated or aggressive behaviour. For example, it was noted that one person might get aggressive when being hoisted. There was no guidance for staff about best to support the person during moving and handling procedures. Another person was noted to be at risk of becoming confused or aggressive on waking. There was no guidance about what specific behaviours this person might present with or any guidance for staff on how best to support the person and prevent these behaviours occurring. There was no evidence the person's behaviour was being monitored to try and identify specific triggers. We were concerned this could mean the behaviour might become established.

We observed one person, who was identified as being at risk of choking, was coughing. The care worker supporting them said this person often coughed when eating. Their records stated that during the week prior to our inspection, they 'ate and drank poorly due to coughing'. There were also references to the person having increased saliva. Increased saliva and coughing could be indicators of an increased risk of compromised swallowing or of choking. This person's risk assessment had not been updated. One person who was lactose intolerant had an eating and drinking plan which stated they enjoyed milkshakes. This would not be in keeping with a lactose free diet. All of the staff we spoke with were aware this person should not be offered milk, but there was a risk that less experienced staff could offer this person inappropriate foods.

Staff were not routinely using a standardised tool to monitor and assess people's pain when they were unable to identify or express pain themselves. This was the case even when the person had been prescribed 'as required' pain relief. Three people's records showed they could become agitated during personal care, but it was not known if pain contributed to this as pain assessments were not undertaken.

People's end of life care plans were basic and whilst most included information about the person's choice of funeral director, they did not include any other additional information which would help to ensure people received end of life care in the manner of their choosing.

People's records did not always contain enough information about their needs to ensure staff were able to deliver responsive care and meet their needs. This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Toileting slings were not available within the home. Toileting slings are specially designed slings which ensure dignified moving and handling and efficient access to clothing allowing people to still use the toilet even though

Is the service responsive?

they might not be able to stand or weight bear. A member of staff told us, "I have been asking for toileting slings for over a year". They told us there was a person who asked to use the toilet, but that this was not possible without the sling. Slings were also not available for bathing and showering. Suitable equipment was therefore not in place to ensure people were at all times able to receive personalised care in line with their choices and wishes.

The manager told us people's care was reviewed every three months. We found some people's care and support had been reviewed and their care plans updated, but entries in other people's care plans showed that this was the case. For example, one person's last recorded review was in June 2014. Their care plans had not been updated since August 2013. The quarterly reviews were also overdue in another three of the care records we viewed. We saw this had been identified as an area requiring improvement in an audit undertaken by the provider in October 2014 and again in care plan audits undertaken in December 2014. One relative told us, "I can't remember the last time I had a review… its must be over a year ago". Four of the nine relatives who responded to the provider's satisfaction survey stated there should be more opportunities for meetings with key staff to discuss their relatives care. Improvements are therefore needed to ensure there are effective arrangements in place to ensure people and their relatives are involved in making decisions and planning care.

The manager told us a 'resident of the day' system had recently been put in place. This system provided a structured approach for all staff to get to know a particular people and their families and understand what was important to them, their likes and dislikes, their interests and to have meaningful interactions with them. The initiative also provided an opportunity for the persons care and support needs to be fully reviewed along with their relatives. The manager felt this would ensure people's care needs were reviewed on a regular basis. These improvements need to be embedded in practice and sustained in order for this to become an effective tool for reviewing each person's needs.

People told us they were supported to take part in a range of activities which they enjoyed. One person said, "There are lots [of activities], carol singing, a pantomime and knitting…I have gained a lot". We observed people taking part in pamper sessions and an exercise class which they appeared to enjoy. Activities were provided by two designated staff and were also available at weekends. The programme for the week of our inspection included, word and board games, movie afternoons and visits to the local shops. We saw that once or twice a week, the activities staff set time aside to provide one to one interactions for those cared for in their rooms. However we found three examples where people being cared for in their room had a low number of recorded activities. For example, one person's diary had only two entries over a nine-day period. We did not see evidence that the activities programme was tailored to the needs of people living with dementia or that each person was supported to take part in leisure activities that were meaningful to them. NICE guidance quality standards for supporting people to live well with Dementia states, 'It is important that people with dementia can take part in activities during the day that are meaningful to them. This helps to maintain and improve their quality of life'. We spoke with the manager about this. They were aware that the activities programme was an area that could be improved and we could see that plans were being drafted to address this.

People knew how to make a complaint and information about the complaints police was readily available within the home and in the service user guide. One person told us, "I would talk to the manager if I had a complaint". A relative said, "I had quite a few concerns which I have raised with the manager and on the whole my relative is now well cared for, the manager is approachable". There had been three complaints received by the service since September 2014. The manager had responded to each complaint and records showed that each had been investigated and appropriate actions taken to address the concerns. Relatives told us that the manager tried to ensure improvements were made in response to their concerns. Three relatives expressed concerns to us about the lack of a dish washer in the Emery Down Unit. They said, residents, staff and visitors cups just got rinsed during the day and were concerned because staff did not use rubber gloves and the water was not changed regularly. Relatives told us that this was raised with the management team and that arrangements were made to try and address this. Whilst they said this had not yet been fully effective in addressing this issue, they felt that their concerns were being listened to.

Requires Improvement

Is the service well-led?

Our findings

Hartwood House had not had a registered manager since June 2014. The current manager had been appointed in July 2014 and their application to become the registered manager was in progress. People said they had no concerns about the leadership of the home. One person said, "The manager and the under manager always say hello and pass the time of day". Another person said, "The manager is wonderful, I can talk to her about anything and if she can't help, she will put me on the right track to find someone who can". A third person said, "Things are improving, young people had been give senior roles which doesn't always work". Relatives told us they felt the management team was making improvements but there were still further improvements that could be made. One visitor told us, "This floor went through a very negative time….this has improved, but staff do feel undervalued and stretched". Minutes of a relatives meeting in December 2014 suggested relatives had a growing confidence in the management team. Comments included, "Overall its tons better than it was before" and "We couldn't be happier". This indicated that people and their relatives felt the leadership team was having a positive impact upon the quality of care.

Some systems were in place to monitor the quality of the service provided to people, however action was not always taken to address any shortfalls. The provider undertook audits of the operational stability and clinical safety of the home. The last such visit took place in October 2014 and identified a number of areas where improvements were needed. The audit stated that all actions 'must be resolved within 48 hours'. During the inspection in January 2015, we found concerns similar to those identified in the provider's audit. These included shortfalls in training and supervision for staff, inconsistent or incomplete care records and lack of involvement of people and their relatives in care planning. The management team had completed some recent care plan and medicines audits. However, there was no evidence to suggest that where actions had been identified that these had been completed. An external report by the provider's community pharmacy had recommended that the room temperatures of the medicine storage rooms be monitored; the service had not implemented this recommendation at the time of the inspection. We could not be assured that the systems for identifying and implementing improvements were effective.

Staff gave us mixed feedback about how well led they felt the home was. Some staff told us they were not happy about aspects of their role and that morale amongst the staff team was low. Comments included, "Concerns fall on deaf ears', "We don't really see them…if I do it's usually when I am being asked to do extra shifts" and "The management are not consistent in what they expect from us". Three staff told us their concerns about staffing levels and not being able to take breaks had not been taken seriously. Other staff said that they felt the management team was supportive and approachable. A care worker said, "I like working here…everyone knows what they should be doing and they do it". Another care worker said the deputy manager was "Excellent and approachable". This was echoed by a second care worker who said, "I can't fault the deputy manager, they will stay on until midnight if there is a problem". We spoke with the manager about the feedback from staff. The manager was aware further work was needed to improve staff morale and to develop their confidence in her as their leader and in the organisation. They acknowledged the biggest challenge was to recruit and then retain staff in order to improve the consistency of care and to develop a strong, unifying culture within the home.

The provider's statement of purpose set out the organisations aims and objectives. These included the 'Provision of a caring, comfortable and happy environment and dedicated person centred care service'. The manager told us the values of the service were 'care, comfort and companionship'. We saw the interviews for new staff, asked them to explain what these values meant to them. The manager said this helped to ensure they employed staff who understood and acted in accordance with these values. Throughout our inspection, staff demonstrated that they worked in a manner that was consistent with these values. One care worker told us, "It's important to try and make time to sit and chat with people; their only interaction should not just be when they need to toilet".

Systems were in place to seek feedback from people who used the service, their relatives and staff. A satisfaction survey was in the process of being undertaken with relatives and we were told an action plan would be prepared to ensure the feedback influenced changes and improvements. Relative meetings were held. All but one of the relatives we spoke with felt these were productive and

Requires Improvement

Is the service well-led?

resulted in positive changes being made. One relative said, “Things get done, but it takes a while”. Another relative said, “We had a meeting and made suggestions, the manager is approachable, things get responded to”.

Staff meetings took place periodically. These meetings were used to share developments with staff and to discuss how the delivery of care could be enhanced. This indicated the management team identified areas where practice could be improved and raised this with staff to ensure the improvements happened. Each day the manager held a short meeting with her senior staff and the heads of departments who updated the manager on any issues relevant to people’s care or the safety of the home. These meetings helped to ensure the manager maintained an oversight of day to day issues within the home.

A record was kept of incidents and accidents within the home. These were reviewed by the manager or the operations director. There was evidence appropriate actions had been taken to reduce the risk of a reoccurrence. For example, following one incident, we saw one to one support had been put in place for a period of time. The manager told us reflective supervision was also used following incidents or accidents to ensure learning was shared with staff.

Hartwood House were developing links with the local community to enable people to continue to engage in community life. The manager explained they were developing links with the local Alzheimer’s Society and had held a stall at the Lyndhurst Picnic in the Park in the summer. This is a fun day designed to bring the whole local community together.

The manager told us she was proud of the care provided by the home and said each day she saw staff delivering brilliant care. She was also proud that the home was making improvements and expressed a commitment to continue to work hard and drive on-going improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not taken appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person did not have 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.**