Care Quality Commission

Sheffield Health and Social Care NHS Foundation Trust

Hurlfield View

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?	**Requires improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 04 December 2014 and was unannounced. We last inspected this service in September 2013 and found that it was meeting the requirements of the regulations we inspected at that time.

Hurlfield View is a care home registered to provide accommodation and personal care for up to 16 people living with dementia. At the time of our inspection there were 20 people living there. In September 2014, the service had expanded by creating four extra rooms. However, authorisation from the Care Quality Commission for this change had not been requested and granted at the time of the inspection. Following our inspection, the provider submitted an application which was subsequently approved and the changes were authorised.

There was a registered manager employed at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 provider was not meeting the requirements of the regulation to ensure medicines were managed in a safe way. Guidelines for PRN (as required) medicines were not sufficiently detailed and personalised. The stock taking and auditing process was not robust enough to minimise the risks associated with unsafe management of medicines.

Individual risk assessments were in place for people and staff knew how to report and record allegations of abuse. However, we saw one instance where an allegation made by a person at the service had not been recorded in line with the correct guidance.

We saw times where staff presence was lacking in certain areas, although there were sufficient staff numbers on the premises. This meant that on some occasions people were put at risk of harm by lack of appropriate supervision.

The provider was not meeting the requirements of the regulation to ensure that people consented to their care and treatment in line with relevant legislation. Training had not been provided to staff about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) although they had a general understanding of the Act. Bedrooms were locked when people were not in them. One person told us they would like their own key to their bedroom and did not know why they were unable to have one. The registered manager told us assessments were undertaken on admission about people having capacity to manage a key but these were not documented, nor undertaken in line with the MCA 2005. Therefore they did not evidence that any decision made was in the person's best interest.

Improvements were required to the current quality monitoring arrangements in place as these were not wholly effective. They had not identified all of the areas requiring attention that we found during our inspection such as the lack of staff presence and inconsistency with recording allegations.

Most people we spoke with were positive about the care they received and the staff approach towards them. Our observations showed that staff interaction was predominantly caring although we did see evidence of some negative interaction.

Staff told us they felt supported, had training that equipped them for their roles and received regular supervision. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. People at the service were supported to access healthcare and received assistance with nutrition where required.

Stimulation and activities were lacking on the morning of our visit but people told us about activities they undertook. This included singing, trips out, dominoes and entertainment. In the afternoon of our visit we saw dancing and singing take place for several hours in one of the lounges. The service sought to pro-actively link in with the community by way of a recent 'Adopt a care home' pilot whereby a local school was paired with Hurlfield View with children visiting people at the service and finding out them.

Staff felt supported by management and felt part of a team. They enjoyed working at the service and received feedback about the service via regular team meetings. The registered manager and staff worked pro-actively in partnership with other agencies.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?

Areas of the service were not safe.

People who used the service were being put at risk because medicines were not always being managed consistently and safely.

Although there were enough staff to meet people's needs, we saw occasions where a lack of staff presence put people at risk of harm.

Staff, in the main, knew how to identify and report abuse and individual risk assessments were in place for people to help minimise any risks. An effective recruitment process was in place so that people were assessed as being safe to work at the service.

Requires improvement

Is the service effective?

There were areas of the service that were not effective.

Decisions about people's care were not always made in accordance with the Mental Capacity Act 2005.

Staff received regular supervisions and appraisals and had access to training to equip them with the skills required for their roles. However, staff did not have formal training in MCA and DoLS to fully embed their understanding of this and how this applied in practice.

People were provided with choice at meal times and supported and encouraged with their nutritional needs. People were supported to access healthcare professionals and to maintain good health.

Requires improvement

Is the service caring?

The service was caring.

Observations showed that staff were mainly kind, caring and patient in their interactions with people.

Staff were able to describe people's preferences and offered choice to people whilst providing support.

People were primarily complimentary about the care they or their family member received. People were treated with dignity and respect.

Requires improvement

Is the service responsive?

The service was responsive.

People's care records contained current information about their individual needs and preferences and the how these were to be met. Staff demonstrated knowledge of people's personalised care requirements.

Good

Summary of findings

Feedback was sought by the registered manager following each person's stay. This was analysed at regular intervals and used to inform how the service ran. There was a complaints procedure in place and we saw that complaints were investigated and responded to.

Activities took place and there were opportunities for people to be stimulated and maintain links with the community. However, there were periods of time where there was a lack of stimulation available for people.

Is the service well-led?

Requires improvement 

There were areas of the service that were not well led.

The provider had not submitted an application to increase bed numbers at the service in line with the requirements set out in the health and social care act 2008.

There was an audit system in place and processes to monitor the quality of the service. However, the quality monitoring had not identified the issues we found during our inspection. .

The service sought to pro-actively link in with the community by way of a recent 'Adopt a care home' pilot where a local school was twinned with and visited the service.

Staff felt supported by management and felt part of a team. They enjoyed working at the service and received feedback. The registered manager and staff worked pro-actively in partnership with other agencies

Hurlfield View

Detailed findings

Background to this inspection

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

The inspection took place on 04 December 2014 and was unannounced. The inspection team consisted of two adult social care inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). 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. Prior to our inspection visit we reviewed the information included in the PIR, together with information we held about the home. We also contacted commissioners of the service, Healthwatch, a social worker and a team manager of a team that worked closely with the service to ask about the care provided at Hurlfield View. We received feedback from two health and social care professionals who had involvement with the service.

During our inspection we used different methods to help us understand the experiences of people living at the service. These methods included both formal and informal observation throughout our inspection. The formal observation we used is called Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke directly with eight people, and with one relative of a person, who lived at the home. We spoke with the registered manager, the deputy manager, two team leaders, one support worker and the cook. We reviewed the care records of three people and a range of other documents, including medication records, staff recruitment and training records and records relating to the management of the home.

Requires improvement

Is the service safe?

Our findings

We saw some areas of unsafe practice when we reviewed the arrangements in place to ensure people received their medicines safely.

We looked at the medication records of four people. Some of these people's medicines were prescribed 'as and when needed,' (prn) medicines. Although some documentation was in place in the form of 'PRN information sheets', we found that there were no clear guidelines to enable staff to identify when to offer these medicines to people and to ensure they were given consistently. For example, in records we saw for certain prescribed drugs, the guidelines provided were minimal and gave directions to 'administer when presenting with agitation' or 'for anxiety'. Where people were prescribed prn pain relief, guidelines were similarly lacking in detail. One prn document stated that pain relief to be given 'when presenting with pain.' In these examples it was not clear in what ways the agitation, anxiety and pain may manifest itself for each person. Nor was it documented what any pain may relate to. This type of information is especially important for people who may not be able to communicate their feelings verbally. We saw guidance which stated that 'one or two' tablets could be given but no information as to what would determine this. The lack of clear protocols meant there was a risk of these medicines not being used in the right way, or as intended by the doctor.

We saw in one Medication Administration Record (MAR) where the amount of a specific prn medicine a person had was not always recorded. This meant it was not possible to establish the dosage they had and risked them having in excess of what was prescribed.

We spoke with the deputy manager and the registered manager about medicine audits. They informed us a sample of four people's medicines stocks were checked each week by team leaders and we saw these for the past five weeks. We saw that where discrepancies had been noted, no investigation had been undertaken and no explanation as to the cause and how this was to be addressed. This issue had also been highlighted in a team meeting from October 2014 where we saw minutes which stated that no action was being taken by relevant staff when medicines issues were identified. In addition to these weekly audits, a monthly audit was completed by the deputy manager but this still failed to address the issues that had been identified each week. We counted a sample of seven medicines and found discrepancies in four of the recorded balances. This evidenced that the current auditing system was not sufficiently robust to ensure safe management of medicines.

Additionally, it was difficult to check whether medicines had been administered as the Medication Administration Records (MARs) did not reliably record stocks of medicines delivered and medicines 'carried forward.' One area of feedback from an external professional involved with the home was, "On occasions [staff] don't notice when they are running low of medication for clients that we jointly work with and may phone us on the day saying they will need a further prescription. This makes it difficult at times to source if a doctor isn't available."

Our findings evidenced a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans we looked at contained personalised risk assessments with actions identified as to how staff were to manage and reduce any risks. Where people could display behaviour that may challenge, information about how this was exhibited and the responses required of staff to try to minimise occurrences of this happening were documented.

Staff received training in safeguarding vulnerable adults and were able to describe different types of abuse. They stated they would document any incidents accordingly and report to their senior or the registered manager. We saw incidents had been recorded and passed to the registered manager who collated and reviewed these on a monthly basis for any trends. It was documented on each form where incidents of abuse had been discussed with the local authority safeguarding team and referrals had been made where required. These incidents had also been notified to the CQC in line with the requirements for statutory notifications as stipulated in the health and social care act 2008.

However, in one care plan we looked at we saw in the person's daily notes that they had made a disclosure previously that another person at the service had hit them and their face was hurting. No injuries were observed, the staff member had sought advice from the local dementia rapid response team and a behaviour chart was put in

Requires improvement

Is the service safe?

place for the person who the allegation was made against. Although this was documented in the person's notes, no incident form had been completed and no referral had been made to the local authority safeguarding team. The registered manager confirmed to us that all disclosures should be documented and logged as an incident. This showed there was a lack of clarity amongst some staff as to what should be logged as an incident which we fedback to the registered manager who ensured she would reinforce this to staff.

The registered manager told us that there was a low staff turnover at the service with most staff having been employed there for several years She informed us of the staffing levels in place for the home and confirmed there were no current vacancies.

During our inspection, although there were several care workers on duty, we did see some instances where there was a lack of staff presence. For example on one occasion we witnessed one person at the service raising their voice to another person. We had earlier seen negative verbal interactions between these same people. At the time in question, we noted the person raising their voice attempt to grab out at the person. No staff were present and when we went into a staff room to attempt to seek assistance, we noted several care staff all located there at the same time. This meant that there was a lack of supervision elsewhere at the service during this period. The staff then left the room and a care worker diffused the situation between the two people.

In addition to this, we saw some significant periods of time where there was a lack of staff presence. The service had two lounges which were each located along a long corridor. In the afternoon we spent some time in one lounge where three people were seated and three more people were walking along the corridor outside of the lounge. For a period of 30 minutes, no staff came into the lounge to check on people and ensure they were safe and well. Although we did not observe anyone come to harm, we had concerns that the deployment of staff was not as effective as it could be to maintain people's safety. We passed on details of our observations to the registered manager who informed us they would review the monitoring and assessing of staffing arrangements to ensure the welfare of people.

We looked at the recruitment files of three members of care staff and confirmed that each had relevant documentation in place. This included an employment contract, previous employment references and a satisfactory DBS (Disclosure and Barring Service) check prior to being able to commence employment. The Disclosure and Barring Service helps employers make safer recruitment decisions. This demonstrated that processes were in place to ensure that staff were assessed as being suitable to work at the service.

Requires improvement

Is the service effective?

Our findings

The MCA (Mental Capacity Act 2005) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and in place so that where someone is deprived of their liberty they are not subject to excessive restrictions.

Discussions with the registered manager demonstrated that she was aware of the criteria in place to necessitate DoLS referrals. She said one issue was that due to the short term nature of the service and the processing time for applications, it was not always possible to have authorisations in place prior to a person moving on from the service. She was aware of her obligations for making referrals and followed the procedures in place.

Although staff we spoke with were able to provide an understanding of the MCA and how this applied to their role, they had not received any formal training in the Act. The provider information return completed by the registered manager confirmed that staff had not received training in the MCA and DoLS and said this would be implemented in the future. A clear understanding of the MCA is important for care staff to ensure they are working in accordance with key legislation and in people's best interests.

We saw that people's bedroom doors were locked when they were not in them and the registered manager confirmed this to be standard practice. One person at the service told us, "They [staff] won't let me have a key for my room. I could use one but they won't give it to me, don't know why." A relative we spoke with said they had never seen their family member in their room. They said, "I think [my family member] could handle a key." We saw another person in the lounge after their breakfast who wanted to go to their room found it locked. We asked a care worker to open the room for them which was done immediately and the person was supported to their room. The care worker said the person could have accessed their room any time by asking a staff member. However, some people due to the nature of their conditions may not have been able to convey this request verbally.

The registered manager told us that a decision about people having keys was discussed with the person and any family members or representatives. The service user guide stated that people could have their own key if they wished to and had capacity to use them. However no consent forms, or capacity assessments where people lacked capacity, were completed for this specific decision. Additionally, the pro forma capacity assessment document in place for staff to use contained guidance about in what circumstances this should be completed. One of the examples given on the form was; 'restriction of liberty including physical restraint, locked doors, telephone use, sedative medication'. As no capacity assessments and best interest meetings (where required) had been undertaken, it could not be shown that the practice of locking people's doors, was in the best interests of each person using the service. It also demonstrated that the principles of the MCA were not being followed.

We looked at a capacity assessment which was in place for a person relating to the decision to spend a period of respite at the service. We noted that the information provided was quite generalised and it was not clear on what information the decision was based. For example, on the question which asked what steps had been taken to assist the person in making the decision, the response was 'information from rapid response and family'. It did not give clarity about what 'information' was being used in this case or what the family input consisted of. In the section which asked about 'consideration of person's wishes' the response was '[Name] seems accepting of being at Hurlfield' without any further explanation or background to the person's past wishes or views which could influence the decision . As such, it could not be clearly evidenced from the assessment that this was in the person's best interests.

Our findings evidenced 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.

We asked people their views of the food at the service. The majority of people were positive and comments included, "Quite good food. I don't have the same breakfast every day, you get a choice of meals" and "Dinner wasn't bad, it tastes good." A relative we spoke with told us their family member had cultural requirements which meant they were not able to eat certain foods. They said that staff ensured these requirements were adhered to.

Requires improvement

Is the service effective?

We spoke with the cook who showed us a four week menu plan that was currently in place. He told us the menus were seasonal and regularly changed throughout the year. Discussions about what to include were held with the registered manager to look at what had and had not been popular with people. Where people were known to be staying for a longer time, he would meet with people to try to accommodate their individual preferences. The cook received a 'special diet sheet' every week that contained details of any special requirements such as whether a person needed a gluten free diet or pureed food and any allergies they may have. The service was also able to accommodate cultural requirements with regards to food, for example by catering for halal or kosher meal requirements. Fresh fruit was available to people on a daily basis and snacks and drinks were offered to people throughout the day.

We observed lunchtime service and saw that most people ate in the dining room. The atmosphere was calm and relaxed. Tables were set neatly with placemats, condiments and cutlery. People were asked where they would like to sit and assisted into their preferred place. People were offered the choice of a hot drink or juice. People were offered meals by being shown a choice of the cooked meals available and deciding at that time. Meals looked appetising and nutritious with a vegetarian option available. All people we observed ate independently but staff were present throughout to offer encouragement and support for people.

The manager confirmed that each person was assessed for risk of malnutrition by using a MUST (Malnutrition Universal Screening Tool) assessment to identify whether any interventions were required. People were weighed regularly, at least weekly, so that any changes in weight could be quickly identified. Staff we spoke with were knowledgeable about people's dietary needs.

We saw where people had access to other health professionals in order maintain a good standard of health. Some people at the service, due to the nature of their conditions could display behaviour that may challenge others. Two external professionals who worked with the service spoke positively about staff's ability to manage this. One professional whose service worked closely with Hurlfield View said, "Staff there on the whole try really hard to meet that people's needs and will often do this in conjunction with support from our team." Another professional said, "The service has been extremely effective in managing people with very complex and challenging needs, this is a testament to the wealth of experience the staff have."

Staff had training in a number of areas which included health and safety, safeguarding, infection control, first aid and dementia. Staff we spoke with told us about the various training courses they completed and said they could access further training via their manager if they requested this. One staff member told us about some specific training they had requested and subsequently received. They said about the training, "If it's out there then we get it."

Staff told us they felt supported by management and said they had regular supervisions and annual appraisals. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually. It identifies strengths and weaknesses and sets objectives for the staff member to work towards. Staff told us that they had no concerns in seeking any support they required between supervisions and would not have to wait for a formal session. One staff member described their colleagues and management as "very supportive."

Requires improvement

Is the service caring?

Our findings

Most comments from people living at the service were positive about the staff and their approach. Some of these included, "I love it. Some very nice people in here [staff]. They do things for you," "The staff? They're perfect, very good. They'll do anything they can to help me. They're looking after me very well," "They're alright here" and "I get on with them all ok." The relative we spoke with was positive, telling us, "Polite and professional staff. Have a lot of patience with my [family member]. They're fantastic. I just wish she could stay here."

Feedback from the two external professionals both supported the viewpoint that the service was caring. One comment was "I can categorically say that the service has a very caring approach to their work." Another was, "They seem to encourage carers to be involved in the persons stay where appropriate and keep in touch with carers by phone to update them on changes in their loved ones care."

Our observations on the day showed that staff were predominantly caring and kind in their interactions. At lunchtime, we observed one person was upset whilst sat at a dinner table. A staff member immediately identified this and went to sit with the person to ask what the problem was and to offer reassurance. The care worker asked the person if they wanted them to stay and at the person's request, they did so. They noticed the person continued to get upset so assisted them into a lounge area where they felt they would be calmer. A short time later we saw the care worker still in the lounge with the person who was no longer as visibly upset. Throughout the interaction the staff member was patient, discreet and offered physical reassurance such as putting an arm around the person and sitting down next to them to engage with the person their level.

However, we later witnessed a negative interaction. During the afternoon we saw a person was visibly upset in a lounge. No staff were present to support the person and when a staff member did enter, they gave the person who was crying a glass of water and left without establishing the cause of the person's upset or offering any reassurance.

One person living at the home told us that their experiences with some staff were not so good, commenting "They treat us like children but some aren't so bad." The person went on to say some staff sometimes made commands such as "you wait there" in an unfriendly manner they did not appreciate being addressed in. We encouraged the person to speak to the registered manager or a member of staff they felt comfortable with should this happen again in future. We also fed back the person's experiences to the registered manager.

People said they chose when they wanted to get up, go to bed and what they wanted to eat and do. We saw people being offered choices throughout the day, for example what people wanted to eat, where they wanted to sit and whether they wanted to listen to music or have the television on. We noted one instance where drinks and biscuits were being offered to people in the morning. Two people we were talking with were handed their biscuits by a staff member from a tub containing a variety without being asked which ones they would like or how many. When we asked the people if they liked these biscuits, one of them told us, "She's a nice girl [the staff member] but it's not the thing to do". They acknowledged that they should be asked what they wanted and given the choice themselves.

People told us that their privacy was maintained and staff were respectful. One person said, "They knock before coming in. They make the bed up nicely." People appeared well groomed and presentable and one person told us how they made sure they were dressed smartly in a suit each day which they prided themselves upon.

People were encouraged and supported to be independent and staff were able to tell us the backgrounds and preferences of people they supported. There was a visitor's room at the service which could be used for privacy and for discussions between people and their loved ones. This also contained information about various services available including advocacy services that people could use. An advocate is a person who speaks up on behalf of a person.

Good

Is the service responsive?

Our findings

People's care records were stored on Insight, the provider's electronic recording system. We were reliant upon staff to access and find information within Insight. All care staff had access to the system and recorded information directly onto it.

Care plans were person centred and detailed people's preferences and information that was important to them outside of their care needs. For example, we saw people's life histories recorded with specific information pertinent to them such as how they liked to be addressed, political beliefs, favourite past times, holidays and preferred clothing. This meant staff had information about how to engage with and support a person in accordance with their preferences and needs.

A relative we spoke with told us how staff accommodated their family member's needs in response to her preferences. They said their family member could "get defensive and stubborn" which could lead to her refusing medication. They said as their family member had favourite members of staff, these staff would administer medication in these circumstances. Their family member would be accepting of this which resulted in her receiving the medicines she needed. The relative also told us, "Every time I come she has different hair styles and different nail polish on which she likes". They said this showed that staff were not simply replicating the same support but were acting upon their family member's changing preferences. The relative also said that despite their family member needing support with their continence, they had never attended and seen their relative in need of attention with this, saying "she's always clean and nice."

An external professional spoke about how the service was able to accommodate people's needs. They told us, "The environment is much improved and offers greater space and several en suite rooms for clients that have a higher level of need."

Staff we spoke with were able to talk about people's care and support needs. They told us relatives were encouraged to be involved and were an important source of information about people's preferences and needs. This was especially important due to the nature of the service which meant people staying there changed on a frequent basis. Staff were allocated a certain number of people to support each time they came on shift which meant this helped to provide continuity of care by staff familiar with people's needs.

The service did not employ an activities co-ordinator. The registered manager told us they were hoping to make improvements in this area by restructuring one of the current care roles into an activities co-ordinator type position early next year.

We asked people how they liked to spend their time. Some people told us, "I like to watch TV. Sometimes play dominos, there's about six of us that like to play in here" and "I like to watch TV and talk to my friends.". Another person told us they had been having a sing song earlier that day and this was something they frequently enjoyed. A relative we spoke with told us their family member had told them in the past about "growing things outside in the garden area." Another person told us they spent time in the garden area when the weather was better. They said, "I put a chair outside when it's nice."

A care worker we spoke with told us how they encouraged people to take part in things they liked to do. For example they told us about one person who liked to go around dusting, some people liked to assist with laundry and some liked to help set the tables and dry pots. They said some people liked to spend time in their rooms, but that they would try to spend time with people to sit and chat and reminisce. Some people occasionally went out for trips in the minibus which was arranged by the day centre attached to the home. One such trip took place on the day of our inspection where several people went out in the afternoon for a drive to a local park.

During our observations we saw there was less stimulation available for people in the morning. One person in their room told us, "I'm bored, there's 'nowt' to do. I've been for a walk round but that's about it.". They told us the TV was too small for them to see and we saw the TVs in people's rooms were small which could make it difficult for people to watch them. A relative we spoke with said about the service, "The only downside is there's not always that much to do." In the afternoon we saw more interaction and stimulation for people. Two people sat in the dining room and played dominos with a care worker. One lounge was particularly lively with a care worker putting a DVD on of a person's favourite songs. The person said "I like that", immediately

Good

Is the service responsive?

got up, took off their shoes and started singing along and dancing in the middle of the lounge. This went on for several hours and other people in the lounge were observed to be smiling, laughing and singing along too.

There was a copy of the complaints procedure in reception and the registered manager told us each person was provided with a service user guide which contained the complaint's procedure. We saw a copy of this in one person's room when invited in by the person at our request to speak with them.

We looked at the complaint's file and found the most recent complaint had been received in October 2014. The registered manager told us this was currently being investigated by the provider's complaints department and the complainant was being kept updated in accordance with the timelines set out in the policy. Prior to this was a complaint made in Sept 2013 and one made in 2009. We found that these had been responded to accordingly. We saw the service had a number of compliments in place from the last year. The relative we spoke with told us they had no complaints at all with the service and would feel comfortable approaching staff about any issues they may have.

The registered manager sought feedback from people and relatives by way of a satisfaction surveys that were sent out following each person's stay. The information was collated at regular intervals to look for strengths and any weaknesses of the service. The registered manager would then use these to inform where improvements could be made.

Requires improvement

Is the service well-led?

Our findings

The registered manager told us that audits were undertaken by relevant staff members, for example the housekeeper was responsible for mattress audits and infection control audits. The deputy manager undertook medicine and care plan audits. The registered manager told us she was responsible for audits sign off and they would be discussed during supervision sessions.

Additionally a quarterly service governance audit was completed by the registered manager. This was comprehensive and covered a number of areas in the service with clear time scales and areas for follow up recorded. However, this audit was not wholly effective as we had identified areas pertaining to staff deployment and staff attitude that required attention. We also found there was inconsistency in staff knowledge as to what needed to be logged as an incident as well as the process for checking medicines not being sufficiently robust. The registered manager told us they would review this audit process. Therefore, although there was a system in place for continuous monitoring of the service, improvements were required to ensure this encompassed and addressed all relevant areas.

At the time of our inspection, due to recent refurbishment and expansion the service could accommodate 20 people and this was the number of people using the service at the time. However, at the time of the inspection, the location was registered to accommodate 16 people. In order to exceed this number, an application to vary the condition of registration was required with authorisation being granted by the CQC. The registered manager advised that she understood the provider had applied for any changes as required and as such had not submitted any application to vary conditions. As one had not been received, we asked the provider to submit an application form which they did so shortly after the inspection. Although this application was subsequently approved, authorising the changes that had been made, there had been a failure to identify that this process should have taken place prior to any adjustments being made.

During our inspection we saw the registered manager knew people at the service and was able to describe their care needs and background. This showed she was familiar with the people who were using the service. We observed her greet people warmly by name, ask how they were doing and offer reassurance to people

Staff we spoke with were positive about the management and said they felt supported. One staff member told us, “I’ve had a lot of support from management. They’ve been lovely, really supportive and they’re very helpful.” Another told us, “I love it here. I like everything, especially the managers, they’re so approachable” and “They’re [managers] not stuck in the office. First thing [deputy manager] does is come round and see how things are.”

A comment from a social worker involved with the service was, “The management team at Hurlfield are very experienced in their field and so in my view the service is very well led.” Feedback from another professional involved with the home mentioned another location of the provider’s closing which meant some staff had to integrate with the team at Hurlfield View. They went on to state, “Considering this change in team dynamics and the unsettling nature of change I feel they [staff] worked hard to help people to adapt and it always felt that there was a clear management structure and a cohesive team feel.”

Staff told us they had regular team meetings and we saw detailed minutes for team meetings that took place on a monthly basis. These covered a range of issues, some of which included governance, complaints and risk. Staff we spoke with told us they received feedback about the service and key information about any changes so they were always kept informed.

Incidents were documented by staff and overseen each month by the registered manager who would look for any themes or trends and take appropriate action. For example, referring people to specialist services such as the falls team if someone had been having repeated falls.

A staff survey was undertaken by the provider each year. However, information was captured at provider level only which meant the registered manager did not receive results which were pertinent to their service so they could identify any issues at a local level. The registered manager and staff felt they had a team whereby people would be comfortable raising issues at any time.

The service was proactive at trying to engage and promote links with the community. The home had recently taken place in an ‘Adopt a care home pilot’ which was a new

Requires improvement

Is the service well-led?

project facilitated by the local council in conjunction with the local university. The purpose of this was to link a local school with Hurlfield View to raise awareness of dementia and help create a new 'dementia friendly generation'. Visits took place on a weekly basis and it was hoped that this scheme would be rolled out to further homes and schools in future. The success of this was publicised on the local council's website and the registered manager told us it had been highly successful with all parties involved. She told us, "It was brilliant, really fantastic."

During our inspection we saw that one person was being considered for a possible long term move to another home. We saw that staff from the home the person might be moving to had attended a meeting with the registered manager and a relative, and had spoken with the person and looked at their care plan. This showed a holistic approach was undertaken by the service when working with other agencies. This helped to promote continuity of care and ensure that the person's needs were able to be met effectively.

The manager was aware of their responsibility of submitting notifications to the CQC for certain notifiable events and circumstances as set out in the Health and Social Care act 2008.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Appropriate recording and monitoring arrangements were not in place to ensure people were protected from the risks associated with the unsafe use and management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	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.