Hartwood Care Limited

Hartwood House

Inspection report

Bournemouth Road
Lyndhurst
Hampshire
SO43 7DP

Tel: 02380284555

Date of inspection visit:
06 February 2018
08 February 2018

Date of publication:
06 April 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Hartwood House is a care home with nursing. People in care homes receive accommodation and their care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection. Hartwood House provides accommodation for up to 50 people. It is arranged over three floors. The Emery Down Unit is on the lower ground floor and provides care for up to 10 people. The Limewood unit on the ground floor provides care for 20 people and the Minstead unit is on the first floor and currently focuses on caring for up to 20 people living with dementia.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the last inspection, the service was rated overall as 'Good'. At this inspection we found the service remained overall 'Good' but with some areas where improvements could be made, for example, improvements were needed to how some aspects of people's medicines were managed and we found that in a small number of cases, risks to people's health and wellbeing were not being effectively managed. Staff raised concerns about how, and the number of, staff were deployed. They felt that at times, this prevented them from meeting people's needs in a timely manner.

Other areas were good or outstanding.

Staff had an excellent knowledge and understanding of the people they were supporting and this helped to ensure people received care and support which was responsive to their needs. Staff went the extra mile to provide care that was meaningful to people and provided them with opportunities to access their community and take part in events that were of interest to them.

Communication was provided in ways which met people's individual needs, including the use of information technology, so they had access to information that was meaningful to them

Appropriate checks had been made to ensure that new staff were suitable to work in the home.

Accidents and incidents were investigated and action taken to reduce the risk of further harm.

Care plans provided a record of people's individual needs and staff were provided with opportunities to develop their skills and knowledge and performed their role effectively.

Staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support. Staff worked in accordance with the Mental Capacity Act 2005 and

the Deprivation of Liberty Safeguards were applied appropriately.

People were supported to have enough to eat and drink and the premises were purpose built and their design and layout met the needs of people using the service.

Where necessary a range of healthcare professionals including GP's, dentists and speech and language therapists, had been involved in planning peoples support to ensure their health care needs were met.

People were cared for by kind and compassionate staff. Staff were passionate about their role and spoke with enthusiasm about providing person centred care. People were treated with dignity and respect.

Feedback showed that staff provided compassionate care to people reaching the end of their life. Plans were in place to develop more detailed end of life care plans to support this.

The registered manager and provider had systems in place to monitor the quality and safety of care people received. The provider sought feedback from people, their relatives and from staff and used this to continually improve the service.

People and their relatives spoke positively about the registered manager. They felt the home was well run and they all said they would recommend the home to others. Some staff felt that they would value the manager having a greater presence on the units. They felt this would help them to feel more supported and help ensure that the registered manager understood their perception of staffing pressures.

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 remained requires improvement.

Improvements were needed to how some aspects of people's medicines were managed and we found that in a small number of cases, risks to people's health and wellbeing were not being effectively managed.

Staff raised concerns about how, and the number of, staff deployed. They felt that at times, this prevented them from meeting people's needs in a timely manner.

Appropriate checks had been made to ensure that new staff were suitable to work in the home.

Accidents and incidents were investigated and action taken to reduce the risk of further harm.

Is the service effective?

Good

The service remained good.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Outstanding

The service had improved to outstanding.

Staff had an excellent knowledge and understanding of the people they were supporting and this helped to ensure people received care and support which was responsive to their needs. Staff went the extra mile to provide care that was meaningful to people and provided them with opportunities to access their community and take part in events that were of interest to them.

Communication was provided in ways which met people's individual needs, including the use of information technology, so they had access to information that was meaningful to them.

Feedback showed that staff provided compassionate care to

people reaching the end of their life. Plans were in place to develop more detailed end of life care plans to support this.

Is the service well-led?

Good

The service remained good.

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

We carried out this inspection sooner than planned as we had received information of concern about the manner in which some people's care was being provided. These concerns are under investigation and the provider and registered manager have been working with the local authority safeguarding teams to address these. During the inspection, we received additional information which indicated potential concerns about the care provided during the night, such as staff members sleeping whilst on duty or disabling devices such as alarm mats that alert staff that people might be at out of bed and require assistance. These concerns have also been shared with the local authority safeguarding teams and we are confident that the provider has taken appropriate action to mitigate these and to ensure people are safe.

This was an unannounced inspection which took place over two days on 6 and 8 February 2018. On the first day of our visit, the inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. On the second day, the team consisted of one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification tells us about important issues and events which have happened at the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 14 people who used the service and the relatives of a further seven people. We undertook a range of observations and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, deputy manager, nominated individual or representative of

the provider, care and quality manager, the assistant chef, three registered nurses and ten care workers, some of whom worked at night. We reviewed the care records of seven people in detail and aspects of another three people's care plans. We also looked at the recruitment and training records for eight staff and other records relating to the management of the service such as audits, incidents, policies and staff rotas.

During and following the inspection we sought feedback from a number of health and social care professionals about the care provided at Hartwood House. Four of these provided a response.

The last inspection of Hartford House was in February 2016 during which we identified that improvements were needed to ensure that care was provided by a stable staff team and to how some aspects of medicines were managed.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Hartwood House and this was confirmed by their relatives. One person told us, "Oh definitely [I feel safe] and it helps my daughter to know I feel safe". A relative told us, "[the person's] condition makes them vulnerable but he's quite safe here". A second relative told us, "I'm over the moon with the care, I'm in most days, have talked to all the staff, I've never had any sense of mistreatment".

Our last inspection had identified that improvements were needed to how some aspects of people's medicines were managed. This inspection found that whilst overall medicines were managed safely, some improvements could still be made. For example, topical medicines administration records (TMAR's) were not always being fully completed to demonstrate that people were having their topical creams as prescribed. We found a number of medicines awaiting disposal but which had not yet been recorded in the disposals book. Handwritten entries on the MAR had not been countersigned in line with best practice guidance and we found four recording errors where people's medicines had been administered but not signed for. We discussed these issues with the leadership team and we are confident that measures have or are being taken to address these.

Controlled drugs were stored and administered safely. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. Staff administering medicines had received training and had their competency assessed on an annual basis. Homely remedies were available within the service. Homely remedies are medicines the public can buy over the counter to treat minor illnesses like headaches and colds. The use of these medicines had been agreed with the GP and protocols were in place for their administration. Each person had a medicines administration record (MAR) which contained the information needed to support the safe administration of medicines. The temperature of the fridge and treatment room was now being monitored regularly.

We observed people being given their medicines, this was managed in a safe and person centred manner. Medicines care plans gave information on how people liked to take their medicines and care plans described risks associated with medicines. For example, one person was taking a medicine which thins the blood and could cause excessive bruising or bleeding. This was clearly identified in their moving and handling and falls care plans. Medicines reviews took place regularly to ensure these were effectively managing people's pain, anxiety and physical health symptoms.

At our last inspection, feedback from people and staff about the staffing levels had been mixed. At this inspection, people and their relatives were overall more positive, for example, one relative said, 'They have a bell push and an alarm mat as they have had falls, they come quickly if you press the button". Another relative told us, "In an emergency someone is there within 30 seconds at the most". Our observations during the inspection indicated that people's needs were being met in a timely and attentive manner and we found that whilst staff were busy, care was still delivered in an unhurried and person centred manner. Current staffing levels on the Emery Down unit was one registered nurse and two care workers. Both Limewood and Minstead units had four care workers in the morning, reducing to three care workers for afternoon/late

shifts. Night shifts were staffed by one registered nurse and five care workers. The rotas showed these staffing levels were usually achieved albeit it with the use of regular agency staff. An ancillary team of housekeeping, administration, kitchen and maintenance staff were also employed.

Whilst people were more positive, some of the staff we spoke with still raised concerns about how, and the numbers of, staff deployed. For example, some staff felt that there should be four staff on late shifts as well as early shifts. One care worker said, "The mornings are ok, but they [people] are more tired in the evening and so need more support but you have to rush them a little bit". Another staff member told us that in the evenings, people might, at times, have to wait for the toilet if two staff were assisting one person and a third was administering medicines for example. A third care worker said, "We can be short staffed and not feel supported, we cannot always give the care we want especially when more full, there is an impact on the residents as we can't be everywhere". We noted that dedicated time had not been provided for senior staff to complete tasks such as booking in medicines which meant they had to balance this alongside their caring responsibilities.

Staff also felt more could be done to effectively deploy staff in a manner that helped to achieve a better skill mix between the number of permanent and agency workers on a given shift. For example, rotas showed that on the 1 February 2018, Minstead unit was staff by one relief worker and three agency staff, whereas Limewood Unit had four permanent staff members and just one agency. There were other similar examples. The registered manager told us that staff could always seek help from other floors, but staff told us this was not so easy in practice.

The registered manager did not currently use a specific tool to determine the number of staff and the manner in which they were deployed. They told us that decisions about staffing levels were based upon their knowledge of people's needs and of their assessed needs. The provider's head of care and quality explained that the provider was reviewing a number of options in order to assess whether a tool would assist with determining staffing arrangements and if so to find the most appropriate tool for the service.

To support ongoing decisions about staffing numbers and their deployment in future, we recommend that the provider adopt a more systematic approach to determining numbers of staff deployed to ensure that this reflects people's assessed needs.

The provider had appropriate safeguarding policies and procedures in place which made explicit links to the local authority's safeguarding procedures. Most staff had received training in safeguarding adults and there were systems in place to report concerns about abuse. We found however, that whilst staff had a positive attitude to keeping people safe and protecting them from harm, some staff were not fully confident about how and with whom to raise concerns about people's safety. The registered manager told us that the systems in place for raising safeguarding concerns would be reiterated at the next staff meeting and that there were plans already in place for staff to be given reference cards, to keep on them, reminding them of safeguarding procedures. A whistleblowing policy was in place and readily accessible to staff and staff told us they were aware of this.

Risks associated with people's care needs had been assessed and informed plans of care to ensure their safety. People had individual risk assessments relating to needs such as maintenance of skin integrity, choking, nutrition, mobility, inability to use the call bell and moving and handling. Where equipment was used to ensure the safety and welfare of people, such as bed rails, pressure relieving mattresses and alarm mats, the risks associated with this equipment had been assessed. For example, for people who were at risk of a breakdown in their skin integrity, a system was in place to ensure air mattresses were correctly set at therapeutic levels to reduce the risk of skin damage. Care records gave clear information on the setting for

this equipment and this was monitored daily by staff. To enhance post falls care pathways, there were plans to roll out a new post falls protocol across the home.

Risks associated with long term health conditions such as diabetes, epilepsy and asthma were clearly identified in care plans. For example, one person was at risk of seizures. Their care plans clearly identified the risks associated with this and how staff should support this person to manage this condition. Where people were at risk of displaying behaviour which might challenge others, behaviour care plans were in place. We did note that some of these could be more detailed, but the staff we spoke with had a good and consistent understanding of how to try and support people and to de-escalate behaviours.

We did note two areas of concern. One person was at risk of falling from bed. Their mobility plan stated that bed rails must not be used due to their risk of climbing over these and sustaining injury. We noted however, that the person had a bed rail risk assessment, which stated that rails could be used when the person was agitated. A staff member had felt that this helped the person to feel more settled, however, we were concerned that being in an agitated stated increased the risk that the person might try and climb over the bed rails, actually exacerbating their risk of harm. We discussed this with the registered manager and we have been advised that upon review, bed rails will no longer be used for this person. We also noted that on the Minstead unit, eight of the 13 people had lost weight within the last month. Staff told us that the weight loss was due to people being unwell with flu and that this was being monitored. However, one person losing weight had been placed on food and fluid charts so that their nutritional risks could be monitored more closely, however, we found that a number of their daily charts had not been completed fully. This was of particular concern bearing in mind the person's weight loss and meant staff could not be confident that the person was being provided with adequate nutrition.

There were a range of systems and processes in place to identify and manage risks associated with the environment. Maintenance staff completed a range of health and safety checks, for example, the lift was regularly serviced and checks were made of the safety of gas appliances, the call bell system, profiling beds, bed rails and window restrictors. Clinical equipment such as the suction machine was checked to ensure this was in good working order before staff used this. A fire risk assessment had been completed in November 2017 and regular checks were undertaken of fire and water safety within the service. We did note that there had been a poor response to the two most recent fire drills at night. In response, the registered manager planned to repeat the drills on a fortnightly basis, to ensure that staff understood and acted upon their responsibilities. People had personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. A business continuity plan was in place and set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies.

Recruitment practices were overall safe. Most of the relevant checks had been completed before staff worked in the service unsupervised. These included identity checks, references and Disclosure and Barring Service checks. Checks were also made to ensure that the registered nurses were registered with the body responsible for the regulation of health care professionals. We did note that in the case of two staff members, their records did not include a full employment history. We pointed this out to the registered manager who obtained this information during the inspection.

Each of the people we spoke with felt that the home was clean. Throughout our visit, we did not find any malodours and we observed that staff used appropriate personal protective equipment (PPE). The kitchen was clean and the service had recently been awarded the highest rating following a food hygiene inspection. Suitable cleaning schedules were in place. We did note that these were not always being completed at weekends. We discussed this with the registered manager who told us that additional cleaning staff had just been recruited and that in future, records would evidence that cleaning was being completed on a daily

basis.

Incidents and accidents which occurred in the home were recorded and monitored for trends or patterns. In most cases, the actions which had been taken to address any concerns were clearly documented. For example, one person had had three falls in three days. Staff had alerted the GP after the second fall and had identified this person had an infection. We did identify concerns in relation to how one incident had been dealt with and we have asked the registered manager to investigate this and feedback to us any learning or recommendations in light of this. The registered manager prepared monthly reports for the provider which recorded the number of incidents, infections, safeguarding concerns or wounds. This enabled any trends or themes to be identified, learning to be shared and also enabled the provider to have oversight of risks within the service.

Good

Is the service effective?

Our findings

People and their relatives told us that the staff were skilled and met their needs effectively. For example, one relative said, "Yes they are well trained, I have never felt they [staff] did not know what they were doing" and another said, "Everyone deals with [the person] very professionally". A health care professional told us, "The home atmosphere is peaceful and calming, the decoration is excellent and all residents appear to be well cared for and happy".

Before a person came to stay at the service, a comprehensive assessment of their care needs was carried out to gather information from the person and where appropriate from their relatives and any professionals involved in their care. This helped to ensure that appropriate decisions were made about whether the service would be able to meet the person's needs. These initial assessments were used as the basis for more comprehensive care plans which described the person's needs in a range of areas such as personal care, eating and drinking, mobility and social activity. Short term care plans were in place for people with acute health care needs and where required people had care plans which described how chronic pain was to be managed. We did identify however that the system did not always ensure care plans were always up to date and reflected people's current needs. Key information about changes to people's needs were sometimes, only reflected in the monthly evaluation document which was filed separately to the actual care plan. We found for example, that one person's eating and drinking plan stated that they were eating well. It was not until we read the monthly evaluation document that we discovered that in fact the person had lost a significant amount of weight. Whilst action was being taken to address this, the person's care plan had not been updated to reflect this. The registered manager advised that there were plans to shortly introduce an electronic care planning system which they were confident would help to ensure that people's records were updated in a more contemporaneous manner.

New staff received an induction to the home and were supernumerary for a period of time during which they had opportunities to shadow the more experienced staff. Inexperienced or staff new to care completed the Care Certificate. The Care Certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. A small number of staff had not completed the care certificate in a timely manner. We discussed this with the provider and action is being taken to address this.

The provider designated certain training as mandatory and this was provided through a mixture of face to face and online training. This included subjects such as moving and handling, health and safety, fire training, infection control, safeguarding, dementia awareness, food hygiene and emergency first aid. Staff were able to complete additional training relevant to the needs of people using the service. For example, falls awareness and continence care. Further, more detailed training on caring for people with dementia was also planned. We did note from a review of the training records that some staff had not received all of the training relevant to their roles. For example, the manual handling training for 14 of the 30 care and nursing staff had expired. In a small number of cases, staff had been working at the service for over a year but had only undertaken minimal training. We have discussed this with the registered manager and since the inspection, additional manual handling training has been completed and a more robust approach is being taken to ensure that all staff complete the training required for their role in a timely manner.

Staff were encouraged to undertake nationally recognised qualifications in health and social care. The provider was also committed to supporting registered nurses to gain their revalidation and had supported staff to attend external training in a range of clinical skills such as verification of death and in the use of syringe drivers. Revalidation is the way in which nurses demonstrate to their professional body they continue to practice safely and effectively and can therefore remain on the nursing register. The registered nursing team was quite stable and helped to ensure that people received effective clinical care. For example, the service had recently effectively managed a potential outbreak of flu, managing to contain this to one floor. There were a number of plans being developed to introduce more clinical pathways and incorporation of best practice guidance in areas such as dementia care and end of life care. Whilst clinical governance meetings had not taken place for three months, these were now back in place and working well as a tool to share skills and knowledge and problem solve amongst the nursing team.

Supervision was taking place, but not always at the frequency determined by the provider. We looked at the supervision records for 2017, this showed that some staff had received four or five supervisions, but others had received just two or three. Supervision is an important tool and ensures that staff fully understand their role and responsibilities. Feedback from staff about the effectiveness of supervision was varied, some staff felt it was helpful and informative, whilst others felt it was less so with one care worker saying, "Useful? No, it's something I go through". We fed this back to the registered manager and head of care and quality who advised that they would do some work with staff to explore this further and see how this might be improved upon.

People were mostly positive about the food. One person told us, "The food is excellent, served up nicely and always hot". A relative said, "The food is second to none". Care plans identified specific dietary needs, likes and preferences and the cook was aware of these as well as any food allergies or intolerances. The menus had recently been revised in response to feedback from people and included a range of options for breakfast and a three course lunch and dinner. People were positive about the amount of choices available and told us that an alternative menu was always available if they did not like what was on the main menu. A selection of hot and cold drinks were available throughout the day and each person we visited had water or juice in their rooms. People also had access to fresh fruit and we observed people being supported to eat fresh pineapple during the inspection.

We observed people having their lunch on the first day of our inspection. The meals were presented attractively and looked appetising and people were able to have wine with their meal if they chose. Where people needed support to eat and drink, this was provided in a way that was safe, dignified and respectful of the individual. For example, one person's needs fluctuated between needing full support taking foods and drinks from a small spoon with thickener added, to being able to drink normal fluids from a beaker with support. Staff were patient and supportive in providing this person's meal. Staff readily chatted with people whilst serving the meals and clearly explained to people what the meal was.

One person required a registered nurse to provide nutritional support through a feeding tube. Care plans gave clear information on how this was to be managed. These included how the person should be supported to take a suitable position when their food was being administered and also clear actions on how to maintain the feeding tube and reduce the risk of infection or other complications with this equipment. Registered nurses had been assessed as competent to administer food and there was clear information for staff on who to contact should there be any difficulty with this. We saw this person was also offered very small amounts of fluid or liquid diet safely to enhance their quality of life.

Staff worked closely with health and social care professionals to ensure people received effective care in line with their needs. A GP attended a weekly routine visit to the home, during which they were able to review

people about whom staff had concerns or who were presenting as being unwell. Registered nurses recorded a range of observations for people on a monthly basis and these were used to inform consultations with the GP. A visiting GP told us registered nursing staff gave them clear information about people's needs and that this enabled them to clearly assess any concerns they had about people's condition.

Other health care professionals such as specialist nurses, speech and language therapists, community physiotherapists and occupational therapists had also been involved in people's care. People were supported to visit the dentist and optician. Clear records of all communications with health and social care professionals were kept and informed plans of care for people. For example, one person had complex moving and handling and mobility needs. Staff had ensured information from a physiotherapist and occupational therapist was clearly included in the person's care plan and staff had a good understanding of this need.

The design and layout of the premises met people's needs. There were a range of pleasant areas where people could choose to spend their day or entertain visitors. Each floor had a kitchenette where people could make drinks or snacks for themselves or their guests. People's rooms were spacious and were furnished with their own personal possessions. There were landscaped and fully accessible gardens which included a variety of areas for people to enjoy. Minstead unit had been designed and decorated with the needs of people living with dementia in mind. For example, toilets were all clearly signed and the doors painted in the same colour. There was a variety of reminiscence items people could engage with. We did note that throughout the day on Minstead Unit, a contemporary music radio channel was playing. We felt this might not be in keeping with people's known musical preferences. We brought this to the attention of the registered manager so that this could be explored with staff. Equipment such as specialist baths, chair raisers, raised toilets and wheelchairs were readily available in the home and were clean and ready to use. The home had Wi-Fi throughout and laptops people could loan to keep in contact with family members. Technology was used to effectively support the safety and welfare of people . Pressure mats were in use to reduce the risk of falls for people.

People and their relatives told us that staff sought their consent before providing care and that they were encouraged and supported to make decisions about their care and support. For example, a relative told us, their family member was never made to take part in events saying, "She is encouraged at certain events, but they accept her choices…they encourage you nicely". People had signed consent forms in relation to their care plans and to having their photograph taken. Where people had appointed a legal representative to make decisions on their behalf, copies of the legal documents were maintained within the service, or action was being taken to obtain these.

Where there was doubt about a person's capacity to make decisions about their care, mental capacity assessments had been appropriately undertaken and documented in line with the Mental Capacity Act (MCA) 2005 which ensured that the person's rights were protected. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some people who lived at the home were subject to a DoLS and staff had a good understanding of the reasons for these safeguards and the implications this had on people. We did note that one person's DoLS was subject to two conditions. One of these stated that the

person be reviewed by the community mental health team. This had not yet taken place. We spoke with the registered manager who explained that this had been due to the fact that the person was a temporary patient at the local GP surgery. We have been told that arrangements have now been made for this to take place.

Good

Is the service caring?

Our findings

Throughout the inspection a number of people told us how happy they were living at Hartwood House. For example, one person said, "It's a lovely place in every respect, I couldn't find a better place, its very peaceful, no rules or regulations…the staff are very happy…I would choose this place above any other". This view was shared by a number of relatives with one saying, "We feel really lucky we have found this place" and another telling us, "We have been impressed with the commitment of the management and staff towards [the person's] welfare. The staff are very approachable and friendly and happy to listen and help with any concerns we have about [the person] and their health. Everybody shows high levels of patience in what can sometimes be trying behaviour".

People told us they were cared for by staff who were kind and caring. For example, one person told us, "They [the staff] are all kind and caring, there is nothing I don't like". Relatives also commented on the caring nature of staff with one saying, "All the agency staff are nice, but the permanent ones are special". Another relative told us, "I ask myself, how can [the staff] be so kind and patient". A social care professional gave us positive feedback about the caring nature of the service saying, "Whenever I have been in the home I have seen a caring attitude from the staff and the clients appeared to be well looked after".

Staff spoke fondly about the people they supported and it was clear they had developed meaningful relationships with them. For example, one care worker said, "I have the feeling that this is my family" and another said, "We care really well and know people really well, we are quite passionate, see them as our extended family". A third care worker said, "I am doing with my heart what others do for a wage".

We saw a considerable number of warm and friendly exchanges between staff and people. For example, staff were heard to chat to people about the weather and about the rugby that had been on at the weekend. Staff bent down to speak with people at their level and spoke in a calm and reassuring manner. Staff were seen to be attentive, offering to help people get into comfortable positions and providing regular drinks. We saw one staff member note that a person had just woken, they said tenderly, "Hello, are you waking up now sleepyhead, are you going to have something to drink". They proceeded to support the person to take a drink in an unhurried manner giving them plenty of time to rest between sips.

Staff spoke of the importance of promoting a family environment and a number of relatives commented on how welcome they were made to feel at the service, for example, one relative told us, "All the staff are welcoming, I find it very good here, I'm always offered drinks". Another relative said, "We have been to a BBQ and a curry night". They explained that as they didn't like curry, the chef had made them an alternative. They told us, "They do spoil us". They went on to say, "We, relatives, pets, dogs are always welcome, there are no restrictions, it's so open and friendly".

Staff tried to promote people's independence wherever possible. For example, one person had expressed a wish to increase their mobility and to retain their independence. To support this staff had suggested that a treadmill be obtained in order that they could exercise daily. This had increased the person's confidence and they had now expressed a wish to walk to the local village to collect their own newspaper. Staff were in

the process of supporting the person to do this.

People told us they were treated with dignity and respect and when staff spoke with us, they referred to people in a respectful and dignified way. A relative told us, "All staff show such genuine respect". Our observations indicated that care was provided in a discreet manner and that staff were mindful of people's dignity. For example, we saw a staff member discreetly suggest to one person that they change their jacket for one which was cleaner. People looked well cared for and were observed to be smartly dressed, wearing jewellery and nail polish, where this was their wish, and having hair that was brushed and styled.

People were provided with opportunities to follow their religious beliefs. A staff member told us how one person loved the 23rd psalm and so they spent time reciting this to them. They told us how they would also pray with people if this was important to them. Twice a month religious services were also held.

Outstanding ☆

Is the service responsive?

Our findings

People and their relatives told us that staff provided care that was responsive to people's needs. For example, one person said, "They take me as an individual" and a relative told us that staff had "An awareness of [family member] needs almost before she does".

Throughout our inspection we saw staff responding to people's needs and providing care and support in a person centred manner. We observed that staff were aware of people's needs and were knowledgeable about how people liked their care to be provided. For example, we observed one person became distressed whilst they sat in a communal area; staff had a very good understanding of how this person communicated their needs and understood that this person needed staff to assist them to the toilet. Staff calmly and discreetly supported this person, reassuring them at all times.

Staff knew the 'little things' that were important to people, such as when one person liked to have the first cup of tea of the day and which people enjoyed a warm milky drink before bed. Staff knew another person was reluctant to attend most activities but knew she loved to hear the pianist play and would sing along so they ensured she was encouraged to attend when this activity was on. The registered manager told us of an example where by one of the nurses had, through spending time with a person, discovered they had previously worked in a job where it had been important to them to be smartly dressed and attention paid to their appearance. The nurse also discovered that the person liked to read the Daily Telegraph and do the crossword. The nurse liaised with the person's legal representatives to ensure they had sufficient funds to purchase clothes, makeup and toiletries and the newspaper of her preference. In addition, the nurse arranged for the resident to visit a hairdresser on a weekly basis. This all helped to ensure that the person was able to maintain their personal appearance in line with their preferences.

One care worker had written about how they provided care that was responsive to people's needs noting, 'I like to think that I make a difference to our residents. Sometimes by doing little things like picking up a favourite loaf of bread on my way into work. I have also come in on a day off to walk a resident to the shop, or maybe to something that is happening in the village e.g. memorial parade or perhaps to the church. When I am on shift I talk to residents, look through family photos with them, also sometimes helping them to phone a family member so that they can talk to them. Of course, there are other things that I like to help them with but often it is the small and simple things that bring a smile!'

The service operated a 'Resident of the Day' arrangement. This involved the whole team including the care staff, chef, housekeeping staff and maintenance team reviewing all aspects of a person's care to ensure that it remained tailored to their individual needs and wishes and remained relevant. People also had a key worker, whose role was to develop a special relationship with the person, by for example, helping them settle when they first arrived at the home or co-ordinating their reviews and keeping their care plans up to date.

People and their families had been involved in developing plans of care which reflected people's wishes and preferences. 'This is Me' documents were being introduced. These contained a summary of people's needs

and described the routines that were important to them and the things that might make them anxious or upset and how staff might respond best to this. These measures enabled staff to understand the person and the things that were important to them.

Relatives told us they were kept fully informed about their family member's wellbeing and told about concerns about their health or welfare and the outcome of health appointments. For example one relative told us, "Yes we have just had a three month assessment with [keyworker], they keep us up to date". People and their relatives told us that staff were good at identifying promptly any changes in their health or wellbeing. For example, a relative told us, "There have been three episodes where there has been a fantastic response…. [The person] had a bad infection and there was excellent communication with the GP and [the person] went into the community hospital for intravenous antibiotics". They went on to tell us how their relative had slipped out of bed. They told us, "Staff phoned me immediately, the paramedic came and the nurse knew her history and could tell the paramedic which were old and new bruises, the nurse knew her so well". We were told how another person moved into the home with diabetes which was insulin controlled. Regular blood sugar testing was undertaken by staff as part of the diabetes care plan management. Staff worked with the GP to adjust the treatment plan and support the person with the management of their diet. We were told that this had been successful and had resulted in the person no longer needing insulin or medicines to assist with the control of their diabetes.

There was evidence that the activities staff were looking for innovative ways of providing activities that met people's individual interests. For example, we were told how the activities team were planning a special day to celebrate the 100th anniversary of the death of one person's family member who had been a poet and a pilot in the war. There were plans for the day to include poetry readings accompanied by another family member interpreting the words in sign language for the hard of hearing or deaf. The person's relative told us, "They have gone the extra mile, it means so much to her".

Other activities included, seated exercise, musical bingo, themed coffee mornings, games, painting and a range of other interactive sessions including talks and quizzes. A range of external entertainers were provided including singers and musicians. During the inspection, people were observed to be enjoying a sing song led by a pianist. We saw that staff danced with one person and all those present sang happy birthday to another person. Therapy pets visited and time was set aside to ensure the animals, which included snakes and spiders, also visited people on an individual basis. We visited one person whose relatives showed us a picture of the person holding an owl. They told us, "They have managed to have some recent interesting things, like inside gardening and cooking, its very varied, all brilliant, their [people's] faces light up". Another relative told us, "There is always so much going on".

Time was set aside to provide one to one activities with people cared for in their rooms who could not or did not want to take part in the group activities. A member of the activities staff told us how she would read to people or discuss the news headlines with them and give hand massages. Some of the activities were focused around the needs of people living with dementia. For example, listening bingo was played with age appropriate pictures, which staff had found to be more inclusive for people with cognitive problems.

Special occasions were celebrated. For example, a party had been held on Burns Night. This had included a piper and the chef had made a haggis. A number of the people we spoke with recalled this event as being one they had greatly enjoyed. A relative told us how they had not been able to attend, so staff had sent them a video of their family member at the event. They said, "It was lovely to receive that". Other events were held throughout the year which family were invited to including a summer BBQ and Christmas celebrations. A pantomime had also been held at Christmas and a Valentine's Day tea dance was planned. The provider had purchased a mini bus for shared use by three of its local homes and on the first day of our inspection,

some people were going out for a trip to a local museum. Other trips were planned to local attractions such as gardens.

People were supported to maintain links with the local community within which they lived. For example, people were supported to go for walks locally and to use the local shops and cafes. Staff at Hartwood House had been part of the drive to make Lyndhurst a dementia friendly town and people had been supported to go and watch the local remembrance day parade. Plans were being made to start holding quarterly meetings led by the Parkinson's Society to provide support to people newly diagnosed with the disease. These meetings were going to be open to members of the local community to attend if they wished. Children from the local primary schools came in to sing carols and there were plans for students from the local college to visit the home to lead art and design sessions. The activities staff had arranged for the local drama group to use Hartwood House to stage some of their dress rehearsals.

Action was being taken to embed the Accessible Information Standard (AIS) within the service. The AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The registered manager showed an understanding of the AIS and of the need to support people's right to have information provided to them in a format that met their communication needs. To support staff with their understanding of this framework, they had each been given an information sheet on the standard and its implications for practice.

Staff supported people's communication needs, for example, one person could become frustrated when they were not able to express themselves clearly to others. Staff had requested the support of a speech and language therapist to support this person. A communication book and alphabet board had been introduced which staff were using to support the person to express their needs. We saw that another person had been referred to the visual impairment team following which aids had been provided to assist their vision and other people had access to talking books. One member of staff told us they were shortly going to be starting a course on the use of British Sign Language.

Information about how to complain was readily available within the service and within the service user guide. Records showed that when issues or complaints had been raised, these were investigated promptly and appropriate actions taken to ensure similar complaints did not occur again. People and their relatives were confident they could raise concerns with the registered manager and that these would be dealt with. For example, one person told us, "I'm not afraid to ask questions, I'd see the manager, I'd have no worries about speaking to the manager". A relative said, "I'd have no hesitation in raising anything and I know it would be dealt with straight away".

There was evidence that people were supported to have a comfortable and dignified death with their pain and other symptoms well managed. Nursing staff attended link meetings with the local hospice to develop their skills and knowledge and some had also undertaken additional training to help ensure that appropriate medicines were available to people nearing the end of their life to manage their pain and promote their dignity. Many of the compliments received by the service related to the compassionate manner in which end of life care had been provided, for example, we saw that one family member had recently written, "Thank you for all you have done for [the person]…you handled his last few days with compassion and understanding, we were so lucky to have found you".

Not everyone, as yet, had a detailed end of life care plan. The registered manager had already identified this as an area where improvements could be made and a staff member had been tasked with using a variety of resources to start helping people and their relatives feel empowered and positive about talking about death

and dying and recording their wishes in relation this.

Good

Is the service well-led?

Our findings

People and their relatives told us the service was well led. One relative said, [The registered manager] is marvellous, a lovely lady". A second person's relatives said, "We've both had a lifetime working in health and social care. We've never seen such a brilliant home, [The registered manager] is incredible, but it goes through the whole team….any maintenance is done by [maintenance person] as soon as possible, I can't find fault".

The registered manager demonstrated a passion and enthusiasm for their role and spoke knowledgeably about the people living at the home and of the staff team that provided people's care. They explained that whilst they did not supervise all staff, they did perform all of the appraisals so that staff could have 'quality time' with them, but also to serve as an opportunity to be clear about responsibilities and set expectations in relation to performance. They told us they were proud of the staff team and of how they cared for people and they were confident that staff shared their vision for the service which was to continue to provide people with care focused on them as a person. The registered manager felt well supported by the provider who visited the service on a regular basis and demonstrated during our discussion with them, an understanding of the performance of, and challenges within, the service. The registered manager met with their peers every quarter and the provider had a leadership programme in place to support the continued professional development of the registered manager and senior team.

The registered manager and provider had systems in place to celebrate best practice and to demonstrate their appreciation of the staff team for going above and beyond in how they provided care and support to people. For example, staff could be nominated for the 'making a difference award' and the registered manager told us about how they brought in cakes every other Friday as recognition and thanks for the care they provided. However in spite of these measures, some staff told us they did not always feel supported and spoke about morale being low at times due to challenges around staffing levels and not always being able to give the level of care they wanted to. For example, comments included, "Teamwork is good, but we would like to see [the registered manager] on the floor more, they just leave it up to us", "We are hard workers, but are expected to do more, its very demanding, everyone is feeling it, we don't feel valued" and "No-one comes up to make sure I'm ok".

A number of staff also made reference to communication needing to improve, reporting mixed messages and at times lack of clarity about roles and responsibilities. We discussed this feedback with the registered manager and head of care and quality. They took the feedback seriously but were surprised, as the feedback was not in keeping with that from the staff survey from June 2017 where staff had reported relatively high job satisfaction. However, we were advised that action would be taken in response to the feedback and an open discussion held with staff about how morale could be improved.

There were effective systems in place to monitor and improve quality and safety within the service. A range of audits were undertaken on a regular basis including care documentation, infection control, health and safety and medicines management. Clear action plans were drafted in response to these audits or when shortfalls were noted. For example, additional measures had been put in place to ensure that the controlled

drugs and medicines fridge temperatures were checked daily in line with the provider's policies and procedures. An audit based upon quality standards for dementia care had identified a number of key priorities for the service to work towards in order to enhance the care provided to people living with dementia. Staff were also considering options for achieving accreditation with recognised best practice schemes in end of life care. A service development plan had been created and it was evident from this that some of the concerns we had identified, for example in relation to the completion of records and charts had already been identified by the service and that plans were in place to try and address this. The provider had arranged for an external consultant to undertake a mock inspection of the service and had recently strengthened their quality assurance team to assist with auditing and supporting services and to help drive improvements. This helped to ensure that the provider retained oversight of quality or risks within the service.

The provider sought feedback from people, their relatives and from staff and used this to continually improve the service. 'Residents and relatives meetings' were held on a quarterly basis and gave people and their relatives the opportunity to hear about developments and changes within the service, but also make suggestions about how care might be enhanced. One relative told us, "It was mentioned at one meeting about people having a fruit bowl for snacking, in response, everyone was given a fruit bowl". The registered manager told us how one relative had also been very involved in designing the new menus. The provider had undertaken surveys with people and their relatives. The most recent surveys were completed in June 2017 and the results were positive, with 100% of people saying they would recommend the home and 93% of people saying staff were responsive to their needs and that their care was delivered professionally.