Mrs J I Mirjah

Halwill Manor Nursing Home

Inspection report

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Date of inspection visit:
05 April 2017
07 April 2017

Date of publication:
03 May 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Halwil Manor Nursing Home provides personal and nursing care to a maximum of 25 older people. Most live with the condition of dementia. There were 24 people using the service at the time of the inspection.

At the last inspection April 2015, we gave the service an overall rating of 'Good'. However we rated the 'safe' domain as requires improvement because we found a breach of regulations. This was because the provider had not ensured medicines were safely managed at the service. At this inspection we checked that they had followed their action plan and to confirm that they now met legal requirements. We found improvements had been made and medicines were being safely managed. At this inspection we found the service remained good.

Why the service is rated good.

Medicines were safely managed and procedures were in place to ensure people received their medicines as prescribed. Improvements were being made regarding the monitoring that topical creams had been administered as prescribed.
People were supported by staff who had the required recruitment checks in place. Staff received an induction and were knowledgeable about the signs of abuse and how to report concerns. Staff had received training and developed skills and knowledge to meet people's needs. Staff relationships with people were caring and supportive. They delivered care that was kind and compassionate.
Individual risks to people's safety had been assessed and care plans written to show how these were being addressed. The home had a contingency plan and had also developed individual personal evacuation plans to support each person.

There were adequate staffing levels to meet people's needs. People received person centred care. Staff knew people well, understood their needs and cared for them as individuals. People were relaxed and comfortable with staff that supported them. Staff were discreet when supporting people with personal care, respected people's choices and acted in accordance with the person's wishes. People where possible and appropriate family members were involved in developing and reviewing their care plans.

People's views and suggestions were taken into account to improve the service. Health and social care professionals were regularly involved in people's care to ensure they received the care and treatment which was right for them.

Staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were supported to eat and drink enough and maintain a balanced diet. People were positive about

the food at the service.
The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. There had been no complaints received at the service since our last inspection. Where there were niggles or concerns action was taken to resolve them.

The premises and equipment were managed to keep people safe.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service had improved and is now Good.	Good
Is the service effective? The service remains Good.	Good
Is the service caring? The service remains Good.	Good
Is the service responsive? The service remains Good.	Good
Is the service well-led? The service remains Good.	Good

Halwill Manor Nursing Home

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.
This comprehensive inspection took place on 5 and 7 April 2017. The first day was unannounced and we made arrangements to return on a second day to complete the inspection. The inspection was carried out by one adult social care inspector.
The provider had not been requested by the Care Quality Commission (CQC) to complete 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. Therefore we reviewed the information we held about the home. This included previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met and observed the majority of the people who lived at the service and received feedback from two people who were able to tell us about their experiences. Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/ complex needs. We therefore 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 also spoke with two visitors to ask their views about the service.

We spoke to 14 staff, including the registered manager, provider, provider's representative, manager's assistant, nurses, senior care workers (referred at the service as 'team leaders'), care workers, the cook, activity workers and training officer.

We reviewed information about people's care and how the service was managed. These included two

people's care records and five people's medicine records, along with other records relating to the management of the service. These included staff training, support and employment records, quality assurance audits and minutes of residents and team meetings. We also contacted health and social care professionals and commissioners of the service for their views. We received a response from one health and social care professional.

Good

Is the service safe?

Our findings

At our last inspection, there was a breach of the regulation. This related to the safe management of medicines. At this inspection, improvements had been made. People received their medicines safely and as required. People's medicines were administered by nurses. The nurses had received medicine training and had their competencies assessed. Nurses were seen during our visits administering medicines in a safe way.

The registered manager had identified in a medicine audit in February 2017 that improvements were needed in relation to the administration of topical creams, as this was not always safe. Prescribed creams were recorded on people's medicine administration records (MAR). The information had been transferred onto cream administering sheets held in people's rooms for care staff to sign when topical creams had been administered. However there was no system in place to monitor that creams had been administered as prescribed. The registered manager had been in discussions with the nurses to find a suitable system to monitor that creams had been administered.

Where people had medicines prescribed as needed, (known as PRN), there were not protocol in place for when and how they should be used, which is good practice. The registered manager said they would speak with the pharmacist and have these put in place.

There was a system in place to monitor the receipt and disposal of people's medicines. There was a procedure to monitor daily the temperature of the medicine fridge and the medicine trolleys where medicines were stored and that it was at the recommended temperature. Medicines at the service were locked away in accordance with the relevant legislation. Medicine administration records were accurately completed and any signature gaps had been identified by the nurses and action had been taken to ensure people had received their medicines. The pharmacy that supports the service undertakes two monitoring visits each year. The last pharmacy review on 27 February 2017 raised no significant concerns.

Our observations and discussions with people and visitors showed there were sufficient numbers of staff on duty to keep people safe. Staff appeared to have time to meet people's individual needs. During our visits call bells were answered in a timely way. People said staff responded quickly to call bells. One person commented, "If I need help there is usually someone around all day long." When asked about staff response times to call bells they responded, "usually five minutes… at night it is almost instant."

The staff schedule showed during the morning there was a nurse on duty, with the majority of the time a designated team leader and six care workers. In the afternoon there was one nurse and five care workers. At night there was a nurse and two care workers. There were two housekeeping staff on duty each day with one having designated responsibility regarding supporting people with their meals and preparing the evening meal. There was also the registered manager, the provider and the provider's representative who lived on site, assistant manager, training officer, a cook, two activity staff and two maintenance staff. They also interacted with people while undertaking their roles and assisted as required.

Where there were gaps in the staff schedule, staff would take on extra duties and if absolutely necessary

agency staff would be used. One care worker said, "Staff levels are good if nobody is off."

The recruitment and selection processes in place ensured fit and proper staff were employed. Staff had completed application forms and interviews had been undertaken. Any employment gaps had been explored. In addition, pre-employment checks were done, which included references and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work in line with the organisation's policies and procedures.

People were protected because risks for each person were identified. Risk assessments about each person were undertaken which identified measures taken to reduce risks as much as possible. These included risk assessments for falls, skin integrity, choking, bed rails, nutrition, taking a bath or shower, environmental factors, risks from activities, infection and risk of harm to others and self . People assessed as at risk of causing harm to others had a plan of monitoring and supporting in place.

The environment was safe and secure for people who used the service and staff. The provider's representative supported by a designated team of two maintenance staff over saw the maintenance at the service. They undertook checks which included regular checks of the water temperature and window restrictors. External contractors undertook regular servicing and testing of moving and handling equipment, electrical and lift maintenance. Fire risk assessments and general risk assessments and the monitoring of environment had been undertaken.

Fire checks and drills were carried out and regular testing of fire and electrical equipment. There were keypads on external doors around the building. We were told by the registered manager that these were linked to the fire alarm system and would deactivate in the event of an alarm. Legionella precautions were in place. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance team.

The home was very clean throughout without any odours present and had a pleasant homely atmosphere. Some areas of the home were in need of decorating. The provider said they were undertaking refurbishment and doing one room at a time. One relative said, "always clean and tidy." Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. Staff had access to hand washing facilities and used gloves and aprons appropriately. The laundry was well managed and had adequate chemicals. Soiled laundry was segregated and laundered separately at high temperatures in accordance with the Department of Health guidance. The staff had designated red laundry baskets for soiled laundry and blue for clean laundry in order to minimise cross contamination.

Emergency systems were in place to protect people. There were individual personal evacuation plans in each person's care file which took account of people's abilities and the assistance they required. A synopsis of people's needs was also available for the fire services in the event of a fire emergency. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely. The provider also had a contingency plan in place in the event of an emergency such as fire or loss of utilities. This included a reciprocal arrangement with another local provider to provide shelter in the event of the need to evacuate the home.

Accident and incidents were reported and identified the immediate actions taken to reduce risks. For example someone had numerous falls. Staff had been working with healthcare professionals and the person's family to find ways to minimise the amount of falls they were having. The registered manager

reviewed all accidents and incidents each day as part of their duties to identify trends about, time of day/night and the frequency of accidents.

Good

Is the service effective?

Our findings

People received care and support from staff that received training and support on how to undertake their role safely and effectively. There was a training officer at the service who worked four days a week. They ensured staff undertook the provider's mandatory training which staff were required to complete. This included, fire safety, basic first aid, infection control, moving and handling, food hygiene, health and safety and safeguarding vulnerable adults. They were also working with staff to undertake higher qualifications in health and social care. The training officer was also in discussions with the local college regarding further dementia training and level two first aid courses. Staff were positive about the training they had received. Comments included, "all relevant" and "is good, it boosts your confidence and knowledge." Staff were observed moving people with the assessed equipment they required, this included hoists. They were skilled and confident and people seemed quite relaxed being moved around.

Checks were made to ensure nurses working at the home were registered with the Nursing and Midwifery Council (NMC) and able to practice. The NMC is the regulator for nursing and midwifery professions in the UK. They maintain a register of all nurses eligible to practise within the UK. Nurses were supported to undertake training to support them to perform their roles. Training they had undertaken included, management of diabetes, pressure ulcer prevention, seating and posture, verification of death, syringe driver and sepsis awareness.

Induction training for new staff consisted of a period of 'shadowing' senior care workers to help them get to know the people using the service. One new care worker said, "Absolutely lovely, I have worked in many care homes and this is the best. When I started I felt a little out of place but everyone was very kind and nothing was too much trouble." New care workers who had no care qualifications were supported by the training officer to complete the 'Care Certificate' programme which had been introduced in April 2015 as national training in best practice. One care worker who was undertaking it said, "It is quite interesting it helps me do the job." All new staff were offered the opportunity to undertake the care certificate. This had recently been undertaken by the cook who wanted to refresh and extend their knowledge.

Staff confirmed they received six supervisions a year and an annual appraisal and that they felt supported in their roles. The registered manager had delegated supervision and appraisal responsibilities. For example, the nurse would undertake the team leaders supervision and the manager's assistant would do care workers. The registered manager would be supervising the nurses and heads of department who would undertake supervisions of their teams. Staff were positive about the support they received through supervisions. Comments included, "I like feedback of what I am good at and what can be improved and different ideas" and "I am able to talk, go through mandatory training and opportunities for extras."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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.

The nurses at the service assessed people's capacity to make specific decisions. Where people had been assessed as not having capacity, for example whether they could consent to the use of bedrails there were processes in place to make best interests decisions on their behalf. For example one person had a best interest decision regarding specialist personal clothing required to protect them when falling.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under MCA. The application procedures for this in care home are called the Deprivation of Liberty Safeguards (DoLS). The staff had identified people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body, although they said they were all waiting to be assessed. The registered manager was fully aware of the procedure to follow should a DoLS application be necessary.

People had access to healthcare services for ongoing healthcare support. They were seen regularly by their local GP. People's care records contained the contact details of GPs and other health care professionals for staff to contact if there were concerns about a person's health. Health care professionals confirmed staff at the home sought advice appropriately. One health professional commented, "I have much confidence in the ability of the staff to manage their clients. Their care is appropriate for the needs of the patient, and my advice is followed. The team including the manager work well and effectively."

The staff had worked with health professionals in relation to a person who produced excessive secretions. The GP had prescribed medicines which had helped reduce the problem. This had meant the person was able to communicate more effectively and not require the use of protective clothing.

Staff managed people with some challenging behaviour really well during our visit. These people were very active and did not always recognise other people's personal boundaries. Staff were always nearby and skilfully engaged with the people and diverted them without any confrontations caused. The staff had involved health professionals including the person's GP and Community Psychiatric Nurse (CPN) to manage their needs.

People reported positively on the food choices at the home. The cook spoke with pride about their work and the importance of food for each person. The cook chatted to people regularly about their food likes and dislikes and changed the menu every two weeks. The nursing staff had ensured the cooks had good information about any allergies, and people who needed a specialist diet. For example, vegetarian or a soft consistency.

For lunch there was a main course and alternatives available. On the first day of our visit the main meal was roast beef. The cook had also prepared fish for one person, a vegetarian option and a cultural dish for another person. People could have snacks at any time. Kitchen staff were aware of which people needed encouragement to eat and drink and increased calorie content of their food using cream and butter. Where required the cooks were advised if people were unwell or required a modification in their diets. For example if a person had had loose stools they might have scrambled eggs for breakfast and might omit certain foods. Where people had any swallowing difficulties, they had been seen and assessed by a speech and language therapist (SALT). Where the SALT had recommended soft or pureed food, each food was separately presented. Where people had been assessed as at risk of weight loss, they had their weight monitored regularly.

We observed a lunchtime meal in the dining room during our visit which was in the process of being refurbished. Lunchtime was very sociable; care workers were very attentive to people's needs. People were offered wine and refreshments of their choosing. It was evident that people were enjoying their food. One

person commented, "Food is lovely we get plenty. I can have something different…always something they can jump to if you don't like something. Even if you missed a meal you wouldn't notice, you couldn't starve here." The registered manager said they were in the process of improving the dining experience for people. Along with the redecoration they were putting in place menus on each table.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. We spent time talking with people and observing the interactions between them and staff. Staff were thoughtful, friendly and considerate towards people.

People were seen positively interacting with staff, chatting, laughing and singing. People appeared happy and settled at the home. One person said, "They go beyond the call of duty, there are a couple who are a bit tight with their time but on the whole they are all very good." Another said, "Staff here who are real carers, they are brilliant." A visitor said, "Excellent friendly staff. All of the staff smile and say hello."

Staff said they felt the care was good at the service. Comments included, "The staff here are like one big family, they don't see residents as people who need care but as their extended family" and "The best we can give them is here."

Staff treated people with dignity and respect when helping them with daily living tasks. Staff said they maintained people's privacy and dignity when assisting with intimate care. Comments included, "I make sure rooms are shut… if hoisting make sure you shut the curtains and everything is private. If hoisting a lady wearing a skirt, cover them with a blanket"; "knock on door before entering a room, pull the curtains closed when doing personal care, keep them covered up. In shared rooms make sure the curtain is fully across" and "Ensure the door is shut, if someone is using the loo and make sure they are safe."

At lunchtime people who needed it were offered a protective covering to keep their clothes clean and maintain their dignity. Where a person needed help and prompting to eat, a staff member sat patiently with them, made good eye contact and went at the person's pace, encouraging and praising them. Where people needed assistance, for example to cut up their food, this was offered discreetly. For example, one care worker was observed assisting a person. They were totally engaged with the person and talked about the food and topics of interest.

Staff treated people with kindness and compassion in everything they did. Throughout our visits staff were smiling and respectful in their manner. They greeted people with affection and by their preferred name and people responded positively. Staff involved people in their care and supported them to make daily choices. Staff were heard offering people choices about whether they wanted refreshments, would like to go to the dining room for lunch or to go for a walk.

Family members and other visitors were welcomed in the home and could pop in any time. One relative said, "Able to visit when able. No restrictions."

People's bedrooms were very personalised with things that were meaningful for each person, family photographs, items of furniture and pictures. The registered manager said how one person had been involved in choosing the colour of their room.

The provider offered end of life care . There was a designated 'End of Life Champion' who was just completing the six steps to end of life care. The six steps programme is a national end of life qualification that aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. They had developed an advanced care plan to be completed with people and their families about their thoughts and wishes regarding the end of their life. They had spoken with people and their families to ask them about where and how they would like to be cared for when they reached the end of their life. If they had any specific wishes or advanced directives, including the person's views about resuscitation in the event of unexpected illness or collapse. People and relatives had been kept informed about the 'six steps' programme in the home's quarterly newsletter. The end of life champion said "The next step is to produce an organisational profile in relation to six steps end of life programme that looks at the five priorities of care.

The registered manager said they had recently purchased a syringe driver (a small infusion pump used to administer medicines under the skin often to keep people comfortable at the end of life) to have available if the need arose. The nurses had undertaken training and the registered manager was working with the local hospice team to support the nurses acquire competence in the use of the syringe driver.

There were recent messages of thanks which had been sent to the management team and staff from relatives. These included, "The staff at Halwil Manor have shown the very human face of care in what must be demanding circumstances."

Good

Is the service responsive?

Our findings

The service was responsive to people's needs because people's care and support was delivered in a way the person wished. Wherever possible a pre admission assessment of needs was completed prior to the person coming to the service. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. This enabled staff to complete care plans about people's wishes.

The care plans related to people's activities of daily living. These included communication, continence, mobility, nutrition and personal care needs. The plans identified people's needs and the planned outcome and how the staff needed to support people to achieve them. People had specific nurses and keyworkers to review their care plans and assessments.

The registered manager made us aware that they had reviewed the current care documentation and had decided there were areas which required improvement. They had decided with the provider to implement a new documentation system from an external provider. The staff had already received training in the use of the new system. Measures had been put into place to ensure the safe transition of people's information onto the new documentation. The registered manager said the system would be clearer to audit and capture relevant information.

In people's rooms there were folders which contained a support plan of the person's needs. This enabled staff to have a synopsis of people's needs easily accessible when they were supporting them with personal care, The folder also contained a service user guide which contained the complaints guide and monitoring sheets and topical cream charts.

The registered manager wanted to add more detailed information about people's life history so staff would know about the person before they came to live at Halwil Manor Nursing home. They had met with the activity staff and requested they gather more social history about each person. The registered manager also wanted to implement an oral health champion at the home. They were working with staff to find a suitable candidate to improve oral health at the home.

People were supported to follow their interests and take part in social activities. The registered manager recognised the importance of social activities and was looking at ways to extend the range and timescale of activities at the home. They had recently increased from one to two designated activity staff to oversee activities. They were working with the registered manager regarding putting together a more planned programme of activities for people. There was a house cat at the home who was well liked by people and was seen being stroked on several occasions.

People were kept informed by a newsletter produced by the activity team four times a year. This contained information about people's birthday celebrations, information about the home and scheduled entertainers. For example the June 2016 issue contained an analysis of the results of a relatives survey and information about a course staff would be attending regarding end of life care, called 'six steps'

Visitors were happy they could raise a concern with the registered manager, provider or assistant manager. People were made aware of how they could raise a concern. One relative said "If any queries can go and ask. No complaints at all and would recommend the home, first class. Always sorted doesn't matter who I go to."

People had access to the provider's complaints policy. The complaints procedure did not identify outside agencies people could contact. This was amended by the provider following our visit. People said they would feel happy to raise a concern and knew how to. There had been no complaints received by the registered manager since our last inspection. The registered manager was aware of the provider's complaints procedure and knew what action they would need to take. They were very active within the service to manage niggles and concerns before they became an issue.

Good

Is the service well-led?

Our findings

The culture of the home was open, person centred and inclusive. Staff were all very positive about working at the home and said they worked well together as a team and there was good communication.

The registered manager was supported by the provider and provider's representative who lived on site. The provider was a nurse who undertook duties when there were gaps in the nursing schedule. They all worked closely together and discussed changes. The position of manager's assistant had been implemented to support the registered manager with their responsibilities. At the time of our visit there was not a designated lead nurse at the service. The registered manager said the nurses communicated together very well. They said there was a nurse who was very experienced, had been at the service some time who they were going to approach to take on the responsibilities of being the lead nurse.

The registered manager and provider were actively involved in the day to day running of the home. People and their relatives were positive about the registered manager and provider. They said they were approachable and always available if they wanted to talk with them. One relative said "nothing is too much trouble they are always available to answer questions. They are brilliant."

Staff were positive about the registered manager and provider. Care worker comments included, "So calm, so caring…door is always open…can go to her about anything. If you talk to her in confidence you know it is not going to go anywhere"; "very helpful, can approach…is very discreet" and "(registered manager) is so lovely, she listens. She is not a manager who wipes it away if you have a problem. I also feel happy to approach (provider) about anything."

Everyone had a clear understanding of their responsibilities and referred people appropriately to outside healthcare professionals when required. The staff knew each person's needs and were knowledgeable about their families and health professionals involved in their care. Any concerns staff had regarding people's presentation were quickly communicated to the nurse in charge. One care worker said, "You can approach the nurses, they actually listen to what you say…always talk and let you know."

There were accident and incident reporting systems in place at the service. The registered manager monitored and acted appropriately regarding untoward incidents. They checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns they took action to find ways so further incidents could be avoided.

The provider had a range of quality monitoring systems which were used to continually review and improve the service. These included an audit program which the registered manager completed with the nurses and responsible staff. For example monthly medicines and home audits. The home audit looked at all areas of the home. These included, exterior, enquiry management, care documentation, keyworkers allocated and carrying out their responsibilities, personnel files, maintenance and complaints management. Where concerns were identified these were addressed and staff advised. For example, the home audit had

identified that menus were not clearly displayed. Action had been taken and menus were being implemented.

The provider's representative completed a six monthly environmental audit of each room. They looked at all areas including flooring, cleanliness, décor, equipment and furniture. An action list was put in place and monitored to ensure completion. The provider's representative said they were looking to make changes regarding the environment using the University of Stirling dementia decision audit tool.

The service encouraged open communication with people who used the service and those that matter to them. There were regular opportunities for people and relatives to share their views. A 'residents meeting' was held every month where people were asked their views. The registered manager said they did not have formal relatives meeting but arranged an evening social activity three times a year to introduce relatives and have a chat. They also confirmed that they were available all the times, saying, "I know families well." There was also a comments and suggestions pad in the main entrance for visitors to leave feedback.

The provider conducted an annual survey of relatives. The responses from the last survey had been very positive and were included in the quarterly newsletter to keep people informed.

Staff were actively involved in developing the service. Staff meetings were held every quarter for different staff groups. For example the nurses, care staff and kitchen and support staff. Staff had a staff handover meeting at the changeover of each shift where key information about each person's care was shared and any issues brought forward. The registered manager attended morning handovers on the days they were at the service. The registered manager said they encouraged open communication amongst the staff. They had implemented a new 'honesty policy' where staff were obliged to tell colleagues if they had any concerns about their practice.

In October 2015 the service was inspected by an environmental health officer in relation to food hygiene and safety. The service had the highest rating of five. This showed the provider was working to ensure good standards and record keeping in relation to food hygiene.

The provider was meeting their legal obligations such as submitting statutory notifications when certain events, such as a death or injury to a person occurred. They notified the CQC as required and provided additional information promptly when requested. The provider had displayed the previous CQC inspection rating in the main entrance of the home and on the provider's website.