Miss Fiona Carter, Mrs Alicia Hackshall and Mrs Audrey Carter

High Hurlands Nursing Home

Inspection report

Gentles Lane
Passfield
Liphook
Hampshire
GU30 7RY

Tel: 01428751202

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of High Hurlands Nursing Home on 21 and 23 June 2016. High Hurlands Nursing Home is a residential nursing home providing accommodation and support for up to twenty two people with learning disabilities in a small village on the outskirts of Liphook in Hampshire. It is located alongside the provider's other separately registered service, High Hurlands Community Homes which are set in the grounds of the nursing home. At the time of our inspection twenty people were living at the nursing home.

High Hurlands Nursing Home had a registered manager in place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service is required by a condition of its registration to have a registered manager.

During the inspection we saw that there were sufficient staff to meet people's needs. Where shortfalls were identified, for example, through sickness, the provider managed these internally by deploying staff flexibly across the nursing home and community homes.

The provider had not always ensured that all the relevant recruitment checks were carried out for newly employed staff. This meant that people were not always protected from the risk of receiving care from staff who were not suitable for their role.

Risks to people had been assessed and measures were in place to manage them. All incidents were recorded and reviewed in detail at monthly management meetings in order to identify any potential risks to people and in order to take any required actions to keep people safe.

Staff had undertaken training in safeguarding adults and understood their role in relation to keeping people safe from the risk of abuse. Where safeguarding incidents had occurred these had been dealt with appropriately, including being correctly reported to the relevant authorities and action taken to minimise the risk of re-occurrence.

The provider used an electronic system to manage people's medicines. The system ordered, recorded the administration of, and managed the stock of people's medicines. Nurses had undertaken training to enable them to use the system and ensure that they administered people's medicines safely.

Staff received an appropriate induction and continued to receive regular supervision and relevant training in their role. People were cared for by well trained and well supported staff.

People's records demonstrated they were supported by staff to see a range of health care professionals both on a routine basis and when they needed additional support.

Deprivation of Liberty Safeguards (DoLS) applications had been made for all people who lacked capacity to make decisions for themselves. Mental Capacity Assessments and Best Interest decisions had been carried out for people on some areas such as implementation of their care plans and use of specialist beds. We have made a recommendation that the provider ensures that appropriate mental capacity assessments and best interest decisions are clearly documented for some specific decisions taken on a person's behalf, for example around other types of restraint, in order to demonstrate that the least restrictive outcomes for people were always in place.

People were supported to eat and drink enough to maintain a balanced diet. Meals were provided in the form of nutritionally balanced ready meals, cooked from frozen, which many people ate and enjoyed. However some staff and relatives told us they would prefer people to have freshly prepared meals. People's mealtime experience varied on occasion. People didn't tend to eat at the same time or together which sometimes impacted on the scope for mealtimes to be a social occasion. Some staff were very good at interacting with people while supporting them to eat while others were more focussed on the task.

People were supported to have choice in their daily decisions about their care such as what they wanted to wear or where they wanted to spend their time, and staff respected these. Staff described how they understood what choices people were making through their knowledge of the person.

Staff were able to discuss the importance of maintaining people's respect and privacy and describe how they ensured this. We saw that people's privacy and dignity was promoted by staff.

There was a person-centred culture at the home and many of the staff knew the people they were looking after very well. There were warm and caring interactions between people and staff. Relatives described positive relationships that their loved ones had developed with the staff who worked closely with them.

People's relatives were involved in the planning and reviewing of their care on their behalf. Staff had a good knowledge of each person's care needs, interests and characteristics and ensured that people's cultural and spiritual preferences were met. Staff supported people to attend a well organised and extensive programme of activities which enabled them to lead meaningful and fulfilled lives. People were supported and encouraged to maintain relationships with their relatives.

There was a complaints policy and procedure in place and relatives told us they would be confident in approaching the registered manager or provider if they had any concerns. We saw that where concerns had been recorded, these had been responded to and dealt with effectively by the registered manager.

The registered manager was friendly and approachable and promoted a culture which was open and transparent. Staff applied the provider's values in their work with people. The registered manager had a good understanding of improvement and learning and identified opportunities for these. They gave clear direction and provided support to the staff team through a well-managed supervision and appraisal system.

Processes were in place to seek feedback on the quality of the service provided. The registered manager was enthusiastic and proactive in implementing systems to monitor and improve the quality of the service provided. They had implemented effective governance processes and procedures to ensure that people received high quality care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider had not ensured that all staff had completed the relevant pre-employment checks to ensure their suitability to work with people at the home.

People were protected from abuse and avoidable harm by staff who knew how to recognise signs of abuse and how to report any concerns.

Risks were effectively identified, documented and managed. Guidance was provided to staff to enable them to manage risks to people safely.

During the inspection we saw that people were supported by sufficient numbers of staff.

People were protected from the risks associated with medicines by trained staff who administered their prescribed medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people lacked capacity to consent to their care, their relatives or advocates had been consulted. Legal authorisation had been sought where people were deprived of their liberty. We have made a recommendation that the provider documents the best interest decision making process for explicit decisions taken on behalf of a person, for example, around the use of restraint.

People were supported to eat and drink enough to maintain their nutrition and hydration needs, although some people's experiences of mealtimes could be improved.

People's needs were met by staff who had received appropriate training and supervision to ensure that they had the required skills and knowledge to fulfil their role.

People were supported to maintain good health and staff

ensured that people had access to healthcare professionals whenever needed.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were kind and encouraging.

People were supported to express their views and make choices about their daily lives. Staff respected people's choices.

People received care which respected their privacy and promoted their dignity.

Is the service responsive?

Good

The service was responsive.

People's support plans and risk assessments were reviewed regularly to ensure they continued to reflect people's needs and wishes.

Relatives and staff told us they would feel comfortable in raising any concerns, and complaints were acted on. .

People were supported to take part in rewarding and stimulating day service activities.
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Is the service well-led?

Good

The service was well-led.

The registered manager was proactive and promoted a culture of learning and improvement.

Staff felt supported by the registered manager and able to raise concerns or to make suggestions for improvements.

The registered manager effectively operated systems to drive improvements and deliver high quality care to people.

High Hurlands 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.

The inspection took place on 21 and 23 June and was unannounced. The inspection team consisted of one adult social care inspector and a specialist advisor who had experience in providing nursing care to people with learning disabilities.

Before the inspection we reviewed the information we held about the home. This included previous inspection reports and any statutory notifications. A notification is information about important events which providers are required to notify to us by law. We did not request a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during our inspection.

We spoke with the provider, the registered manager, two nurses, two care staff, the training manager, the day services manager, six relatives and five healthcare professionals. We reviewed care records for five people living in the home, recruitment files for five members of staff, and training and personnel files for two members of staff. We also viewed staff rotas, policies and other records relevant to the management of the service such as quality assurance audits and systems. During the inspection we spent time observing staff interacting with people, including during lunchtimes. This helped us see how caring staff were when they were engaging with and supporting people.

The last inspection of this home was completed on 10 October 2013 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

Relatives told us that they felt that their loved ones were safe at High Hurlands Nursing Home. One relative told us that she knew that her loved one was well looked after and safe and that she "couldn't think of a better place for him to be".

Recruitment checks, such as proof of identity, provision of suitable references and a Disclosure and Barring Service (DBS) check were in place. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

However, the provider had not completed all the required pre-employment checks to ensure that new staff employed were of a suitable character and experience before starting their role. Three of the recruitment records we viewed did not document the applicants' full employment history, with an appropriate explanation of any gaps, which contravened the provider's own recruitment policy. For two records we viewed, the references provided from previous employers did not match the stated employment dates and in one case there was not always a reason provided for leaving previous employment. Although we didn't see any impact of this on people's care, it meant that the provider did not have all the information they needed to judge whether an applicant's employment history might indicate concerns about their previous work conduct or character that might put people at risk. There was a risk that staff being employed by the provider may not be suitable for the care roles they held. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing consisted of two teams of ten staff, each led by a nurse. The provider had one staff vacancy, which they were recruiting to during the inspection. The provider told us, and we saw from staff rotas, that there was one nurse on duty at weekends, and a minimum of two during the week. One person living at the home was funded to receive one to one care from staff at all times. Staff and relatives told us that occasionally it felt like there was not enough staff, particularly if someone was off sick. Staff told us that the provider managed this by calling in someone who was off duty or by seeking support from staff at the neighbouring community homes location. During the inspection we saw that there were sufficient staff deployed to meet peoples' needs. There were appropriate on call arrangements in place, which involved staff being able to contact the Registered Manager, the training manager, who was also a qualified nurse, or the provider for support.

Many of the staff employed were from overseas and there were some concerns from some staff and relatives that their English language skills were a barrier to them understanding information in people's care plans or understanding instructions. We did not see that there had been any impact of this on people's care. Current staff who were tasked with training new staff managed the risk by explaining things more than once if they needed to and by showing new staff how to do something in practice, as well as explaining it verbally. The provider also managed the risk by completing competency assessments for all staff to ensure that they were competent to deliver people's care safely and effectively.

The home had clear safeguarding policies and procedures in place to keep people safe. People were

protected from the risk of abuse because staff knew the signs of abuse and were able to describe how they would recognise changes in a person's behaviour or actions. They were confident in what action they would take to protect people if they identified these. We viewed four safeguarding records, all of which confirmed that the registered manager had liaised appropriately with the relevant health and social care teams and CQC and put appropriate actions in place following safeguarding incidents.

Detailed and personalised risk assessments were in place for people. Records demonstrated these were reviewed regularly in accordance with people's changing needs. Clear accident and incident reporting procedures were in place at the home to help manage risks to people, which were followed by in practice by staff. All health and safety, infection control and medication incidents were reviewed monthly to identify any potential risks to people and take ensure the required action to keep people safe had been taken.

People living at the home had Personal Emergency Evacuation Plans to ensure that people could be kept safe during an emergency. The provider had a business continuity plan which was reviewed annually or when there were any changes. This included procedures to ensure the service continued in the event of an emergency such as a flood, or a loss of utility services such as gas or electricity.

Medicines were administered by a new system introduced by the provider in October 2015. The Proactive Care System (PCS) worked by means of scanning barcodes on medicines using an electronic handheld device to match what medication was needed and when for each person. The system was linked to the pharmacy so was also able to continually provide an update on stock levels and was used to help order medicines. The system also flagged up any instances of a medicine being missed or when it had not been noted as administered by staff on the electronic system. The system generated a daily report for the registered manager to check and investigate these. The registered manager carried out additional daily checks and a monthly medicines audit.

We saw that the provider had amended their medicines policy to reflect the use of the PCS system, and nurses had been trained on its use. We observed nurses on their medicines round using the system. They told us they generally liked the system as it was easy to use and saved them time.

We saw that there had been two medicines errors since the provider had started to use the system. The registered manager had taken appropriate action in both cases, which included notifying safeguarding and communicating with nurses to explain the errors and how to avoid them happening again. Medication errors were recorded by staff on an appropriate incident form, which was a different colour to other incident forms. This helped the home monitor and keep track of medicines errors separately to other types of incidents.

While the new PCS system was still quite new and to some extent still bedding in, the provider had implemented appropriate controls, systems and procedures to ensure that medicines were administered to people safely.

Requires Improvement

Is the service effective?

Our findings

People's relatives we spoke with were positive about the staff and their ability to meet their loved one's care needs. Relatives said that they felt staff were well trained and had sufficient knowledge and skills to deliver care. One relative told us "The care is excellent, the best we could have hoped for". Another told us that although staff changed a lot, they were very good.

New staff undertook an induction programme delivered by the training manager which was mapped to the Care Certificate standards. The Care Certificate is the industry standard which staff working in adult social care need to meet before they can safely work unsupervised. Staff's competence was assessed by the training manager after two weeks, three months and annually, which formed part of a regular ongoing assessment for staff called the Care Competency Assessment.

Staff told us they felt supported in their roles. One recently recruited member of staff described the induction training as "Everything I need to know".

People were cared for by staff who had undergone a suitable induction to their role to ensure they could provide people with effective care.

The training manager ran a comprehensive training programme for staff and kept an electronic schedule to keep track of when training was last undertaken and when it was next due. This ensured that people were supported by staff who were up to date with their training and therefore able to provide safe and effective care. The home had its own training room and most training was delivered internally by the training manager. There was some external training in first aid and fire safety. We saw that nurses were enabled to maintain their Continuous Professional Development (CPD) through ongoing training opportunities provided by the home. These included training on the PCS medicines system, an epilepsy study day, and a tissue viability course to help learn more about skin and wound care. This enabled nurses to be able to both maintain their professional nurses' registrations and ensure that they were providing safe, up to date and effective care for people living at the home.

Staff told us, and records confirmed, that supervisions took place approximately every 8 weeks for new staff and then every 12 weeks thereafter. Supervisions could be held more regularly if staff needed additional support. This process was in place so that staff received the most relevant and current knowledge and to enable them to conduct their role effectively.

People were supported by staff who received guidance and support in their role through a thorough induction, training, and programme of supervision and appraisals.

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

possible.

People can only be deprived of their liberty 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the time of our inspection, the registered manager had received DoLS authorisations for 17 people living in the home and was awaiting the outcome of a further three applications. Records showed that the service had carried out some mental capacity assessments and that accompanying decision-specific best interest decisions had been made for people when they lacked the capacity to agree to decisions involving their care. These included decisions relating to choice of GP, implementation of care plans, and the use of specialist beds. We saw that these best interest assessments were carried out in consultation with relatives, friends, advocates and health and social care professionals and were subject to regular review.

We did not see, however that mental capacity assessments and best interest decisions had been carried out specifically in respect of the use of restraint for people, which included the use of bed rails, lap belts and shoulder straps for wheelchairs. In one instance, we were told that a person used a wheelchair in busy and crowded areas for their own safety. The use of these restraints might have been appropriate in order to keep people safe and enable them to have a better quality of life. However, we could not always see how the provider had gone through the process of considering how the use of restraint was necessary and proportionate and that less restrictive alternatives had been explored.

We recommend that the provider ensures that they are able to demonstrate that an appropriate best interest decision making process has been followed in relation to the use of restraint.

We saw that people were supported to eat and drink enough to maintain a balanced diet. Half of the people living at the home received their meals and medication via percutaneous endoscopic gastrostomy (PEG). This is a procedure by which people receive their food and medicines via a tube when they are unable to swallow. People were supported to receive their nutrition and medicines via the PEG in accordance with their care plans.

Lunches and dinners were provided in the form of ready meals cooked from frozen. As these meals were nutritionally balanced and calorie controlled, they enabled people to maintain a regular and healthy weight. The meals also came with soft pureed options for people who had been identified as at risk from choking. We saw people being supported to eat these in accordance with their care plans.

Relatives and staff had mixed views about the pre-prepared frozen meals. Some told us that they were happy, while others told us they would prefer for people to have freshly prepared food. We did not observe any fresh fruit or vegetables being offered to people during our inspection, although staff and relatives told us that fresh fruit was made available. Relatives told us that they had not had input into the decision to move from having an in-house chef to the pre-prepared frozen meals.

At lunchtime, people had a choice between two of the ready meals. Staff told us that they supported people in making this choice based on their knowledge of the person and the information in their care plans.

We observed people's mealtimes to be a mixed experience. We saw one person being supported to eat their lunch. Staff explained to them what the food was and encouraged them to wait until the food had cooled.

We saw the staff member interacting kindly with the person while supporting them to eat, checking with them all the time "Are you hungry?" and "Are you ready?". At other times we saw that staff were more focussed on the task of ensuring people ate their meal quickly and didn't always take the time to engage with the person they were supporting. We saw other people eating independently and appeared to be enjoying their food.

The food was often too hot for people to eat when it was served and they had to wait while it cooled. We observed one person was waiting some time to receive their meal while staff supported others to eat. By the time they came to eat it, the person didn't want their meal and continually refused it, although we observed that they did eventually eat it.

People had regular visits to healthcare professionals. We saw that people had annual health checks with their GP and we saw that there was engagement with other specialists including the speech and language therapist (SALT), dietician, physiotherapist and epilepsy specialist according to people's needs. In one person's care plan we saw that there had been involvement with the tissue viability nurse, physiotherapist, neurologist and PEG care nurse. People were supported to have access to all the healthcare services they needed to maintain good health.

Care plans included 'Hospital Passports' which contained up to date facts about people if they needed to attend hospital, including information about their health and social care needs, and guidelines around areas such as their positioning requirements and food regimes. Detailed information about people's condition and support needs was available to other healthcare professionals to ensure continuity of care for people.

Good

Is the service caring?

Our findings

People's relatives told us they were happy with the care provided at High Hurlands Nursing Home.

We observed warm, positive and caring interactions between people and staff during our visit. There was a person-centred culture and many of the staff knew the people they were looking after very well. Relatives told us of the strong relationships their loved ones had with their key workers. A key worker is the member of staff who has the main responsibility for the care of the person.

Some relatives spoke of language barriers due to some staff not having English as their first language, and we saw that this sometimes impacted on staff's ability to engage with and develop close relationships with the people they cared for. However, we noted that staff who had been working at the home longer had improved their English skills and were therefore able to communicate with people more effectively and with more confidence.

One healthcare professional told us she had observed staff interacting with her client appropriately, demonstrating an understanding of their needs and communicating with them when supporting them to move. We saw one person being supported to take their tablets from a spoon and staff talking to the person patiently while they were doing this. One staff member described how one person had missed their birthday through being in hospital so she had visited them and took in the birthday decorations they had got ready for them. We saw that another person wasn't able to leave their room very often, so had been given a bedroom close to the communal areas of the home so that they felt part of the home and didn't feel isolated. Staff were thoughtful and caring towards people.

Staff were able to describe to us how they enabled people to have choice, such as by showing them different colours of nail polish to choose from, or offering two outfits to choose from when they were getting dressed in the mornings. Staff described how they watched for their responses according to how each person communicated, for example by their eye movements or sounds they might make. A member of staff described how the person she cared for communicated and made choices through her body language.

We viewed one care plan which described how choice should be promoted for the person; that they liked to choose their own clothes and how they vocalised to express an opinion. We saw this person was being encouraged to leave their bed and move into their wheelchair. However they didn't want to do this, so the staff member said "OK, I'll come back later". Later on in the art room, the person made clear that they didn't want to be involved in the session, so staff supported them to do something else. Staff understood and respected people's choices.

We saw staff treating people with dignity and respecting their privacy. Staff knocked on people's doors before entering their rooms and appropriate arrangements were in place at the hydropool to ensure that people's privacy was protected when they were getting changed. Staff showed an awareness of the need to protect people's dignity; we saw one member of staff adjusting a person's clothes as they left the table to ensure they were suitably covered. Another described how they would cover people appropriately when

delivering personal care and told us "I like to treat people the way I would like to be treated". Another member of staff described how she encouraged the ladies she looked after to wear blouses and leggings rather than a skirt if they were going to be using the hoist in order to protect their dignity.

A healthcare professional told us "I have observed them [staff] to be kind, caring and always advocate for the patient in terms of dignity and respect".

Good

Is the service responsive?

Our findings

People took part in programmed daily activities, which were run by a dedicated day services manager and their staff. As well as planned trips out such as walks and coffee, feeding the ducks and trampolining, daily activities included use of High Hurland's own facilities. These included a multi-sensory room, pottery room, art room and hydropool. We observed some of these rooms in use during our inspection and saw how people were encouraged to take part in sessions which were run by skilled members of staff. People's art and pottery work were on display around the home. We saw how people's involvement in activities were facilitated in the multi-sensory room with the use of big switches which people were able to activate for themselves and be stimulated by the cause and effect process. We saw people taking part in a "tac-pac" session, which provided a sensory experience for people with lights, music and touching and feeling different materials. We observed a music session during the inspection and saw people enjoying this, moving in time to the music and taking part through vocalising or shaking the tambourine.

A care manager spoke positively of the activities available at the home and how people were "always out and about doing things" and described how important this was given the age groups of the people living at the home. The provider took pride in the activities offered at the home and took seriously their responsibility to ensure that people were supported to live full, interesting and active lives. A relative told us that their loved one enjoyed the activities and got to go on holidays which they loved. They would like their loved one to get out even more, for example, by attending clubs and discos they used to attend before they lived at the home, to keep them stimulated and stop them from becoming bored or frustrated. They told us that they had discussed this with managers at review meetings, who were receptive to the need for the person to keep busy and able to maintain their skills and independence. The said that the provider was looking into implementing a 'storyboard' for the person to enable them to keep up their communication skills and enhance their ability to express themselves.

The home was open to promoting family relationships and involvement in people's care. Relatives told us about how the home kept them up to date with their loved one's needs and progress. A care manager told us how one person's relative accompanied their loved one to activities sometimes. Another relative explained how the home had facilitated their loved one to come home for their weekly visits when they were unable to collect them. People were supported to maintain relationships with their families.

People's care needs were documented clearly in their care plans, which were reviewed every six months, or more often if there were changes to people's needs. We saw that care plan reviews included the person, their family and staff. There was a more formal review annually which included social services. Care plans were well structured and comprehensive and reflected people's support needs effectively.

People's care plans were personalised to each individual. We saw from one person's care plan that they got distressed when they were presented with alternative positioning outside of their wheelchair. The care plan provided guidance to staff to try and focus on the activity the person was about to do rather than their positioning and to associate the change of position with a positive experience for the person.

People were supported to follow their religious and cultural beliefs. We saw in one person's care plan that they were supported to maintain their links to the church and that bible reading formed a regular part of this person's activities.

Care plans for people who had epilepsy included a graph which monitored seizures every month to help staff see the frequency and type of seizures occurring. This information was then forwarded to the GP for them to consider whether a change in medication was necessary.

Overall, relatives told us that people received person-centred care which was responsive to their needs. They told us that they were kept informed with what was happening with their loved ones at all times, how they were, what they had been doing and any concerns. Some relatives felt that communication could be better at times, in terms of involving relatives in decisions which may impact on people, such as changes to meal arrangements and changes to people's key workers. However, the relatives we spoke with were mainly happy, with one relative telling us that the service was the "best they could have hoped for" and "It is good, and could be great with just a few tweaks".

The provider had a complaints policy and procedures in place to act on feedback. People's relatives confirmed that they would know how to make a complaint if they ever had cause to, by going straight to the registered manager or provider. We saw positive feedback from health and social care professionals. We reviewed one complaint from a relative regarding how staff were engaging with people during an outing. We saw that the registered manager had responded to this robustly, carrying out a full investigation and considering action in accordance with the home's disciplinary procedures.

High Hurlands sought feedback on what relatives, health professionals and staff thought of the service by means of an annual questionnaire. The feedback we viewed across these formats was positive.

Good

Is the service well-led?

Our findings

The provider and registered manager promoted an open and positive culture. Staff told us they felt able to speak up if they had any concerns, ideas or suggestions. The registered manager was a visible presence in the home and staff clearly felt comfortable around them. A healthcare professional described that they had a very open relationship with the registered manager. We saw that the registered manager had been honest and transparent about safeguarding and other incidents, thoroughly documenting and investigating them and seeking to learn from them. They had taken a positive approach to responding to recent medicines errors, dealing with them professionally but also seeing them as an opportunity for learning and improvement, recognising what factors had contributed to the errors and emailing staff to remind them of policies and procedures.

The provider had a range of values they required staff to exhibit in their work with people and these were contained within their Statement of Values (Philosophy of care). These included the commitment to "preserve the dignity, individuality and privacy of all service users within a warm and caring atmosphere and in so doing will be sensitive to the service user's ever-changing needs". We observed staff following these principles during the inspection.

Although the registered manager was the key person in the leadership of the nursing home, it was evident that members of the management team, including the provider, worked closely together in ensuring the delivery of effective care and were proud of the service. A member of staff told us "I love my job, the service users and the staff. It's always a lovely atmosphere here. Managers not only care about the service users, but the staff as well." Another told us "They appreciate the way I work, they say thank you and well done".

Staff spoke warmly of the registered manager, describing them as being positive and open to new ideas, approachable and friendly. One staff member said "He always comes up with brilliant ideas. And if I went to him with an idea, he would work with me on it. His enthusiasm is incredible. He is extremely approachable, even when he is busy". A healthcare professional described that they were "very impressed" with the registered manager, who had always been able to respond to their often complex requests in a timely manner.

A healthcare professional we spoke with described how the home had "stepped up and modernised its approaches over the last 20 years". They also described that the managers were "careful not to bite off more than they can chew" and had the confidence to be able to say no to admitting people whose needs they did not feel able to meet. At the same time they were prepared to "pull out all the stops" to deliver appropriate care for people, describing how they were looking to install a specialist bath for someone who was going to be moving to the home.

Staff were supported to do their jobs effectively through training, regular supervision and appraisal processes. The provider set high expectations of staff in order to provide the best care for people. Clear standards of behaviour were set by the provider. We saw from records that poor staff performance was not tolerated and was managed accordingly though appropriate disciplinary procedures.

Management meetings were held two monthly and staff team meetings for support workers and nurses were held every Wednesday and Friday of each week. Staff told us that communication between staff at the home was good.

The registered manager was an enthusiastic and effective leader, proactively identifying opportunities for improved governance processes and procedures to ensure that people received high quality care. They operated a "Quality Management and Assessment Audit Plan" which detailed what areas were to be assessed each month and by who. This programme enabled regular reviews and audits of areas such as polices, infection prevention and control, first aid, health and safety, medicines and staff training. These audits had enabled the registered manager to pick up and follow through on any issues identified, for example; there was a pattern of infection control incidents that the registered manager was able to identify through the infection control audit, attribute to a member of staff and then address through the supervision process. On another occasion, through a health and safety audit, they had been able to notice a relationship between skin breakdown and urinary tract infections (UTI) for one person. In response, they now did a weekly urine test to check for any abnormalities to try and manage the occurrence of UTIs.

We saw that other actions had been taken in response to other audits, for example; an audit completed in May 2016 noted the freezer readings were higher than the recommended level. This had been actioned immediately by the provider who had arranged for the freezer to be repaired.

Copies of policies and procedures were in place and were reviewed annually by the registered manager and were signed by staff to say they had read them, including any updates. This helped ensure that staff working at the home were delivering high quality care in accordance with current guidance and practice.

The provider had recently introduced a new procedure called "Resident Quality of Service Assessments" in March 2016. The aim of these was to audit people's quality of life living at High Hurlands Nursing Home and involved the registered manager spending time with each person and observing their experiences, based around the Care Quality Commission's key questions of Safe, Effective, Caring, Responsive and Well-Led.

The provider operated processes to monitor the quality of the service people received. These processes were implemented effectively by the registered manager to drive service improvements for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate effective recruitment procedures to ensure that persons employed were of good character. The provider had not protected people by ensuring that the information specified in Schedule 3 in relation to each person employed was available. This was a breach of Regulation 19(1)(a)(2)(a)(3)(a).