Methodist Homes

Hartcliffe Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Hartcliffe Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hartcliffe provides accommodation with nursing and personal care for up to 66 people. At the time of our inspection 50 people were living in the home.

At the last inspection on 28 and 29 March 2017 the service was rated Requires Improvement. We found a repeated breach of the regulation relating to Consent to Care and we issued a Warning Notice. We also found breaches of the regulation relating to safe care and treatment. Following the inspection, the provider sent us an action plan telling us how they would make the required improvements.

We carried out a comprehensive inspection on 30 and 31 May 2018. At this inspection, we found improvements had been made and the legal requirements had been met. We found further improvements were needed to make sure that care was always delivered and recorded in line with people's assessed and changing needs.

Overall, the service has improved to Good.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Sufficient numbers of staff were deployed at the time of our visit. Staff performance was monitored. Staff received supervision and training to ensure they could meet people's needs.

Medicines management shortfalls were promptly acted upon and actions taken to make improvements.

Staff demonstrated a good understanding of safeguarding and whistle-blowing and knew how to report concerns.

People were helped to exercise support and control over their lives. People were supported to consent to care and make decisions. The principles of the Mental Capacity Act (MCA) 2005 had been followed.

Risk assessments and risk management plans were in place. Improvements were needed to make sure care was consistently delivered in line with assessed needs and that accurate monitoring records were maintained.

Incidents and accidents were recorded and showed that actions were taken to minimise the risk of

reoccurrence.

People's dietary requirements and preferences were recorded and people were provided with choices at mealtimes.

Staff were kind and caring. People were being treated with dignity and respect and people's privacy was maintained.

A range of activities were offered and provided people with entertainment both in and out of the home.

Systems were in place for monitoring quality and safety. Where improvements were needed the provider took action to address identified shortfalls.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service has improved to good.

Improvements had been made to the management of medicines. Where shortfalls were identified the provider took prompt action.

People were protected from abuse because staff had received training and knew how to identify and act on concerns.

Staff were safely recruited and staffing levels were sufficient to meet the needs of people living in the home.

Accidents and incidents were reported and actions taken to reduce recurrences.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Is the service effective?

Requires Improvement

The service remains Requires Improvement.

Improvements were needed to make sure healthcare needs were met in line with assessed needs and that care monitoring was accurately recorded.

The service had made improvements and complied with the requirements of the Mental Capacity Act 2005 (MCA). People were asked for consent before care was provided. Where best interest decisions were made, these were fully recorded.

People were provided with sufficient food and fluids. Nutritional needs and preferences were recorded and people were given choices at mealtimes.

Staff received training and support to enable them to meet people's needs.

People had access to a GP and other health care professionals.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service has improved to Good.

Systems were in place to assess, monitor and mitigate risks to people. Systems needed to be strengthened to make sure shortfalls, such as those in care and monitoring records, were promptly identified and acted upon.

A registered manager was in post. People spoke positively about the leadership in the home and were able to provide feedback and express their views.

The registered manager recognised their responsibilities with regard to notifications required by the Commission.

Hartcliffe 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a comprehensive inspection of Hartcliffe Nursing Home on 30 and 31 May 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors, an assistant inspector and an expert by experience on 30 May 2018 and two inspectors, a new inspector as part of their induction training, and an expert by experience on 31 May 2018. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at the information we had received about the home. We looked at the notifications we had received. Notifications are information about important events that the provider is required to tell us about by law. We also used information the provider sent to us in their Provider Information Return (PIR). This is information we require providers to send to us at least once each year, that gives key information about the service, what they do well, and improvements they plan to make.

During our visit we spoke with 17 people who lived at the home and 11 visitors. We spent time with people in their bedrooms and in communal areas. We observed how people were being cared for and supported. Our observations included using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us.

We spoke with the provider's quality business partner and area support manager, the registered manager, the deputy manager, the hospitality manager and 11 staff that included registered nurses, care staff, maintenance, housekeeping, laundry, activity and catering staff. We spoke with two visiting healthcare professionals. We received written feedback from another healthcare professional. We have included the feedback and comments received in the main body of this report.

We observed medicines being given to people. We checked how equipment, such as pressure relieving equipment and hoists, was being used in the home.

We looked at six people's care records in detail and checked other care records for specific information. We attended a staff meeting, looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, survey results, complaints records and other records relating to the monitoring and management of the care home.

Good

Is the service safe?

Our findings

At the last inspection in March 2017 we rated this key question as Requires Improvement. This was because medicines that required crushing were not managed safely and call bells were not always available for people when needed. At this inspection improvements had been made in these two areas, and this key question is now rated as Good.

People and relatives we spoke with told us they felt safe in the home. Comments included "Safe, Oh Yes! A lovely place. Good people. They check you're alright. I have a high seat above the bath too and the staff make me feel safe," "It's eight months now and I've never felt insecure. Staff always friendly, helping you and things like that," and, "The carers are very attentive. My relative feels comfortable and safe with them."

Medicines were managed safely. We observed medicines being given to people. The registered nurses showed an awareness of people's needs and preferences. We heard people being asked if they were ready to take their medicines and they received the support needed. One person told us, "I have medicines for my heart and they give them to me when I need them." Another person said, "Yes, medicines are on time. They give them to me and see me take them." Medicine Administration Record sheets (MARs) provided details of the person, their photograph, details of allergies and how people liked to take their medicines. For example, for one person it was written, 'Prefers to take one at a time, from a spoon, followed by water.' The registered nurses signed the MARs to confirm they had given people their medicines.

One person had their medicines administered via a Percutaneous Endoscopic Gastrostomy (PEG) tube. A support plan was in place to provide guidance and instruction to staff. These medicines were being crushed and the records showed the person's GP and the pharmacist had been involved in this decision. This showed people could be confident their medicines would be given to them in a safe way.

One person self-administered their medicines. Their ability to do this had been assessed, and this included a mental capacity assessment and a clinical risk assessment that was reviewed monthly.

Systems were in place to record the amounts of medicines received into the home. Medicines were stored safely in each of the two floors within the home. Arrangements were in place to store medicines that required additional security and medicines that required cool storage. Records were also in place to record medicines that were disposed of.

Some people were prescribed topical creams that were applied to their skin. Topical MARs included details of the cream, the frequency of application required and body charts to show where the creams were to be applied. These were kept in people's rooms and the records signed after care staff had applied the prescribed creams. There were occasional gaps in the administration records, and on the second day of our visit, we saw that records for one person had been completed retrospectively. We brought this to the attention of the management team at the time. They sent us an action plan that included, 'A checking system has been initiated for the Nurses to verify checking of all monitoring charts during their shift.'

Where people were prescribed medicines to be taken PRN or 'when required,' such as pain relieving medicines, the records provided guidance for staff about the circumstances in which the medicines may be needed. This meant people could be confident they would receive these medicines when they were needed.

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They were able to give examples of signs and types of abuse and what they would do to protect people, including how to report any concerns. The care home had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace. Staff were given prompt cards and told us they felt confident to whistle-blow if necessary. We received feedback from a health professional who had been involved in a previous safeguarding issue at the home. They noted the registered manager had responded positively and the safeguarding issue was resolved. They also noted they were, 'comfortable informing management of any safety issues and potential safeguarding incidents' and that the registered manager would, 'act appropriately and quickly to any concerns I have.'

Risk assessments were in place and these were reviewed monthly. These included risks associated with skin condition, choking, use of bed rails, falls, moving and handling, nutrition and dehydration. Where risks had been identified actions were planned, along with provision of equipment such as bed rails, hoists and pressure relieving mattresses. The records showed that people had been involved in discussions about the risks involved with the use of equipment such as bed rails. For one person the records noted the person had commented, 'Yes we talked about the risks I wish to take by using my bed rails.'

Accidents and incidents were recorded and actions taken to reduce future risks of injury. Where people had fallen, post fall monitoring records and falls diaries were maintained. The provider's quality assurance system triggered that additional actions were to be considered if people had two or more falls. We saw for one person, who had four falls from their bed, in addition to involving the person's GP, they had been provided with a lower bed and a 'crash mat' beside their bed to reduce their risk of injury.

We received mixed feedback about staffing levels from eight people and relatives who commented specifically. Overall, people told us the staffing was improving with one relative telling us, "Answering call bells is better now than it was. One day, two months ago, it was an hour which is not acceptable. It is better since we mentioned it. When called they do come." People had access to call bells or wore pendants so they could call for support when needed.

In their PIR the provider told us one of the improvements they were making was that, 'We are currently recruiting nurses which is going really well.' When we visited, the registered manager told us they had recruited successfully, and shortly after our inspection, contacted us and confirmed they had filled all vacant posts. They told us this meant they were less reliant on the use of agency staff. We checked the staff rota's and saw that staffing was maintained at the levels the provider determined was needed to meet the assessed needs of people living in the home.

Staff were safely recruited. Staff files included application forms, proof of identity and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Additional checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council.

The environment was maintained to ensure it was safe. For example, water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks had been completed. Fire safety measures and

checks were in place. Personal emergency evacuation plans were recorded for each person. They provided guidance about how people could be moved in an emergency situation if evacuation of the building was required. A business continuity plan was in place and this set out the procedures to be followed in the event of an emergency situation, such as power failure or significant equipment failure that caused disruption to the normal running of the home. This meant people could be confident their care needs would continue to be met in the event of such a situation occurring.

The environment was clean throughout. We spoke with a member of the housekeeping team who described their role and responsibilities. We observed staff using gloves and aprons when needed which showed good infection control practices.

A complete redecoration programme had taken place since our last visit. This included redecoration of bedrooms, communal areas and hallways. Soft furnishings had been replaced and lighting had been upgraded. This programme of redecoration showed the provider's commitment to investing and making improvements to the environment.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2017 we rated this key question as Requires Improvement. We found that people's care was not always delivered in line with assessed and changing needs and equipment was not always used correctly. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and the legal requirement had been met. However, we found that further improvements were needed to make sure changes were embedded and consistent. This key question continues to be rated as Requires Improvement.

We checked the records for seven people over a two day period who had been assessed and needed to have their food and fluid intake recorded. Five records were fully completed. Two records were not fully completed. For one person the amount of fluids they required each day was not stated and their monitoring chart was not fully completed. For another person it was noted at 3.45pm on the first day of our visit there had been no entries on the food and fluid charts since 10.30am. The person was not able to tell us what they had to eat or drink and there was a full beaker of cold tea on their bedside table.

We checked the records for 18 people who had been assessed and needed assistance to move or change position on a regular basis. Pressure relieving equipment, such as mattresses and chair cushions were provided and the records confirmed the equipment was regularly checked to make sure it was working correctly. The records also stated the frequency people needed to be supported to change position. The positional change records for a two day period were fully completed for fourteen people. The records for the four other people were not fully completed and did not show that people had been supported to change position as often as they needed.

In most cases, where people required wound care, records were available regarding their treatment, progress and evaluation. However, for a person who had blistered area, a care and treatment plan was in place that included foot protection and a pressure relieving mattress. However, the records had not been updated to confirm the area had been checked for over one week. We brought this to the attention of senior staff at the time who told us the lack of recording was an oversight. The care and treatment had remained appropriate for the person and the area had not deteriorated.

The registered manager sent us an action plan soon after out visit to confirm the actions they had immediately taken in response to the findings noted above.

The care plan for a person who required insulin injections to control their diabetes showed their condition was being well managed. Information in their support plan included the National Institute for Clinical Excellence (NICE) guidelines for diabetes management and information was available to inform staff of actions required in response to high and low blood glucose readings. This meant people with diabetes could be confident their healthcare needs were recognised and were being met.

At our last inspection in March 2017 people's consent to care was not sought in line with legal requirements. This was a repeated beach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014 and we issued a Warning Notice. At this inspection we found significant improvements had been made, as we have reported on below, and the legal requirements were met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 had been assessed for their capacity to consent to specific aspects of their care. When they lacked capacity to consent, best interest decisions were made in consultation with relevant others, such as relatives or GP's. People told us that staff asked before they provided support. One person told us, "They treat me like family. They know what I want, but they still ask me if I want the same as yesterday." We heard staff asking people for consent before they provided support to people on a number of occasions during our inspection. Staff had a good understanding of the MCA. They told us they had received, 'lots of training and have prompt cards so we don't forget.' The provider's quality business partner told us they had also reviewed the provider's policy for consent to care. They had provided additional training for staff and had trained two designated consent 'champions' in the home. These designated staff made sure that people in the home had comprehensive assessments completed and where support was needed with decision making, this was accurately and clearly recorded.

People who lack capacity can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. The service had submitted a DoLS application for one person that was waiting to be processed by the local authority.

People using the service and relatives told us they felt staff were knowledgeable and understood their needs. Comments included, "They are all trained and know what they are doing" and, "The care assistant's meet her needs. Not in contact with the registered nurses that often but they do answer our questions all the time." Staff told us they received sufficient training to enable them to carry out their roles with one member of staff commenting, "The training is good and I am up to date. You can ask for extra training if you want it."

When new staff started in post they completed an induction programme and shadowed colleagues to gain practical experience. The induction programme incorporated the care certificate, a national training process introduced in April 2015. This was designed to ensure staff were suitably trained to provide a basic standard of care and support.

The staff we spoke with told us they felt supported with supervisions and appraisals with a member of staff telling us they felt, "Listened to" and another member of staff saying, "We have supervisions and appraisals and they are really good." Staff were required to complete an 'It's all about you' form in preparation for supervision meetings. The registered manager told us they had not completed supervisions as frequently as expected by the provider in 2017. However, they told us their plan for 2018 was proving more successful. They had provided training for more senior staff members to become supervisors. Senior staff were then allocated staff they were responsible for supervising, in line with the provider's policy requirements.

Staff told us they were provided with regular update and refresher training for topics such as fire safety, moving and handling, safeguarding, mental capacity act, infection control and food safety. In addition,

where registered nurses needed training to meet the specific needs of people living in the home, they told us this was provided. For example, additional support with training was provided by the local hospice, the tissue viability nurse and the care home liaison team.

We received positive feedback about the quality of the food served in the home. People's comments included, "The food is lovely. You get a choice. I'd tell them off if it wasn't" and, "The food is very good. There is enough and cups of tea all the time. I eat in my room." We also received comments from relatives that included, "I can't complain about the food. Like a restaurant, really good."

We observed meal service, to people in the dining rooms and in their rooms. The tables in the dining rooms were laid in advance and menus were displayed on each table. On the reverse of the menu, the activities for the day were displayed. One person who had difficulty communicating and needed assistance with eating and drinking was supported by a member of staff. They reminded the person of the choices available and waited patiently for the person to communicate what they would like. The member of staff sat with the person throughout the meal service, often checking they were enjoying the meal. There were two main courses with alternatives such as jacket potatoes, omelettes or salads available. Desserts were presented on a trolley and for people eating in their rooms, the trolley was wheeled around the home so people could see what was available. In addition, a 'light bite' menu was available for people at other times of the day or evening.

We spoke with catering staff who were able to tell us about people's individual needs and preferences, likes and dislikes. They told us they spoke with people on a regular basis to obtain feedback, so they could adapt meals and make changes if needed.

Care plans contained nutritional assessments and people's weights were monitored. When people had lost weight, support and advice was sought and people were referred to the GP.

People were supported to access the healthcare services they needed. One person told us, "They pick up when I'm not well and I can see the doctor when I need to." A relative said, "They have got to know her well. At first, they didn't always appreciate that we know Mum best and recognised when she wasn't well, even if she didn't have a temperature. They know her well now."

Registered nurses were employed to monitor people's healthcare needs and refer people to external services when needed. The healthcare professionals we spoke with and received written feedback from were positive and told us that improvements had been made in recent months. They commented they had previously experienced problems with communication in the home, but felt this was improving as more permanent staff were being employed.

There were seven contracted 'rehabilitation' beds in the home, where people stayed for approximately six to eight weeks. A healthcare professional told us they were pleased to hear the home had plans to make further improvements and were planning to train and develop staff who would become 'rehabilitation champions.'

Good

Is the service caring?

Our findings

People were treated with kindness, respect and compassion. They told us they had good relationships with staff and were well looked after. Comments from people and relatives included, "Oh yes, they are very caring here. I have no complaints. I am treated with respect and they help me keep my dignity," "Definitely kind, caring and compassionate. They hold her hands and make eye contact. I hear what they say to other service users and it's lovely. They always knock, draw the curtains and close the door," and, "The staff are wonderful. I'm on my own in here. When they come into my room it's wonderful."

Throughout the two days of our inspection, we observed people being treated in kind and respectful ways. Staff were helpful and friendly and people looked relaxed and comfortable in their presence. They provided reassurance and emotional support to people when needed. A member of staff told us how they supported one person who became anxious on occasions. They told us, "We sit and talk with her until she becomes calm and happy again, and I hold her hand." We saw several occasions when staff provided gentle touches and words of encouragement to people.

People's equality and diversity was recognised and respected. We heard staff referring to people by their preferred names, using appropriate volume and tone of voice. Staff communicated in ways that were meaningful to people. A member of staff providing support to a person who was profoundly deaf. They supported the person to walk into the dining room. Along the way, the member of staff was encouraging and patient. They communicated by touching the person's back gently for encouragement when they reached the chair. For another person, a communication board was used successfully

Staff clearly knew people well and were able to describe people's personal histories, interests and preferences. These were also recorded the care plans and included preferences for gender of staff to provide personal care. We heard a member of staff reminding a person their relative may be due back from holiday, and then discussed what day they may be returning home.

Care staff told us how they made sure people's dignity and privacy was promoted and maintained. They made sure people were fully covered and that others didn't enter rooms when they were supporting people with personal care. A relative commented, "These are the kindest and most caring people there are. They respect privacy and dignity-yes. They touch her, stroke her and ask how she's feeling. They even make me feel better."

People told us they were asked and felt involved in decisions about their care. Comments from people included, "I decide when I wanted to get up and if I want to wash or bath," "I feel comfortable expressing my opinions and yes, I am listened to'" and, "They take notice of what I say."

Staff spoke positively and affectionately about the people they provided care for. Comments included, "I treat people here like they were one of my own relatives and like I would want my own Mum and Dad treated. I have empathy towards them and hope they feel I am genuine," and, "The people that live here are in charge and I am just here to help them."

People's rights to a family life were respected. Visitors were made welcome at any time. One relative told us, "We feel able to come in when we want. We help ourselves to drinks and yes we do feel welcome. The staff are lovely."

We read recent compliment cards and letters received in the home. They included the following extract, 'Since (relatives) have been here we have nothing but praise and gratitude for the team and the care offered specifically. Warm and caring manager whose passion for residents' well-being is outstanding. Comfortable, warm and spacious accommodation. Friendly and professional caring staff. Tasty and well-presented food. Knowledgeable and caring nursing team. We are hugely impressed with positive activities that are organised and believe them to be the key in the engagement and well-being of residents. Thank you for the first class care that you've given.'

Good

Is the service responsive?

Our findings

Most people and relatives we spoke with told us they were involved with care planning and that care was responsive to their individual needs. Comments included, "My relative is in every day and they are involved in my care too," "On the whole I go to bed when I want. I get regular showers and baths", "I choose what I want to wear and all staff use my preferred name," and, "I can't fault the care. They take time out to talk to us too."

We did receive feedback from two relatives that showers had not always been provided for their relative on the weekly basis agreed when they moved into the home. We brought this to the attention of senior staff at the time.

Before new people moved into the home they were assessed by the registered manager or senior staff to make sure their care needs were known. Care plans were designed to reflect individual needs, choices and preferences. Care was well planned and records were checked and reviewed every month. People and relatives told us they were kept up to date and involved when there were changes and in making decisions, and one person said, "I am asked if I would like to be involved. We go through the care plan together. I have my say and I am listened to."

Care plans provided details of people's physical, mental, emotional and social needs. Where people had additional and specific needs, such as a percutaneous endoscopic gastrostomy tube (PEG), urinary catheter, wound care or insulin dependent diabetes, detailed plans were in place regarding the support required. For example, the records showed that appropriate care and support for person was provided for a person with a PEG. There were records of when the PEG site had been cleaned and dressed. There was also detail of actions needed and completed to prevent complications such as blockages. Records of the prescribed 'PEG feeding regime' were completed and showed the person had received the correct amount of nutrition and fluids. Their weight had remained stable over the previous six months.

'Daily handover sheets' provided short descriptions of peoples needs and were used for staff to provide up to date information about each person. Staff told us this was useful especially if they had been away from the home for a while, and until they had a chance to read the people's care plans.

A range of activities were provided. One person told us, "I join in everything and knit all day as well, scarves for the homeless." People were reminded and encouraged by the community coordinator to participate in the activities of the day. These included singing, bingo, a quiz and an upper body exercise class to music. People looked animated and enjoyed themselves and the company of the community coordinator who provided guidance and support for each activity. Relatives joined in too, and there was a lot of laughter, friendly banter and encouragement throughout.

The community coordinator told us they were able to provide two activities each day and one to one support for people who stayed in their rooms. They were supported by a group of 17 volunteers. A copy of the weekly programme was given to each person in their room. Outings to places of local interest were

arranged. The local toddler group and primary school children visited the home twice each week. The community coordinator told us they were always looking for new ideas and welcomed input from people and their relatives. They also told us of the plans to refurbish the reminiscence room to enable a wider range of activities, including cooking facilities.

People and relatives who told us they had made complaints about the service, also told us they had been satisfied their complaints had been managed well and had been resolved to their satisfaction. A complaints procedure was in place that was readily available to people and relatives. Everyone we spoke with told us they would feel comfortable to raise concerns if needed. We looked at the complaints file and saw that, overall, complaints were managed in accordance with the provider's policy. We looked at six complaints, and four provided detailed information including the outcome and communication with the complainants. The other two did not provide so much information, although we were told by the registered manager the complaints had all been resolved. We also brought to the attention of the registered manager an entry in the 'communication with relatives' section of one care plan, that included details of concerns raised. The entry had been made by an agency member of staff and had not been communicated. The registered manager told us this was an oversight which they would address.

Staff had discussed end of life plans and recorded what people wanted to happen if they became very ill. Relatives were involved in discussions and when DNACPR's had been agreed. This is a way of recording a decision not to resuscitate a person in the event of a sudden cardiac collapse. The registered manager told us they received good support from the local hospice who provided advice and guidance when needed for people receiving end of life care. We read a recent email received from a relative of a person receiving end of life care. The letter included, 'Whilst he hasn't been there long, he has been very happy and [name of registered manager] and her team have amazed us with their kindness. As I am writing this email, [person] is in the final few days of life and I wanted to share my gratitude. The love shown by the carers is a huge credit to MHA and starts at the top with [Registered Manager's] leadership'.

Good

Is the service well-led?

Our findings

People and their relatives told us the home was well managed. Feedback included, "Yes I have met the manager. She is approachable and always speaks," "Can't remember her name but I know who she is and she's really nice," "The staff are well managed," and, "Yes, there is no messing about. I'm quite happy here in my own way." We also receive comments from people and relatives who told us they had seen but had not met the registered manager.

Systems were in place that identified shortfalls, a range of audits and monitoring checks were completed by the management team. However, we identified shortfalls, such as those reported on mainly in the effective section of the report. These related to monitoring of positional changes and food and fluid intake. The provider had introduced a monitoring system. However, this was not robust enough. They took immediate action in response to our findings and introduced a detailed checking and monitoring system, which they confirmed was in place before the end of our inspection.

We saw that actions had been taken in response to shortfalls the provider identified in their monitoring systems. For example, the audit of medicines in March 2018 identified actions were needed when PRN medicines were given. The actual times had not been recorded. By May 2018, the audit confirmed the actions had been completed and the overall percentage compliance with the detailed medicines audit had increased. Actions required were incorporated into the home action plan. We looked at the most recent action plan that contained 21 required actions that were graded from red to green to confirm the actions in order of priority for completion. The actions included those related to records for people with distressed behaviour, management of medicines, storage of fluid thickeners and completion of supervisions and appraisals.

People using the service and relatives were provided with opportunities to provide feedback at meetings which were held every three months. At the most recent meeting there was a discussion about the development of a 'Friends of Hartcliffe Nursing Home.' We also saw the improvements had been made in response to feedback about people's clothes not always being ironed. We spoke with laundry staff who told us the ironing of clothes had improved since the feedback was received. They told us people were now satisfied with how their clothing was returned after being laundered.

The registered manager was able to tell us how they kept up to date with current practice. They told us they received support, direction and guidance from the provider's support team that included the quality business partner, area support manager and area manager. They told they participated in 'lessons learned' meetings and reflective sessions.

The management team spoke positively about the improvements made since our last inspection. These included a complete review and redesign of care records to support a person centred approach to care planning. The home had been refurbished and redecorated, the dining experience for people had been reviewed and enhanced, with particular attention to the presentation and ambience of the dining room. The quality business partner told us how they supported and developed staff into enhanced roles. For example,

they had introduced champions, such as the 'consent' champion role. We found during our inspection that this had proven successful and all staff had a good in-depth understanding and awareness of the importance of people being supported to consent to care.

Staff had the opportunity to express their views at general staff meetings. Minutes were recorded and circulated. Staff had the opportunity to contribute and the registered manager shared information and discussed changes and improvements they were planning to make. Staff were aware of the provider's values. They spoke positively and told us they felt able to openly discuss any issues and were confident they would be listened to. They told us, "I love working here. An awful lot of changes have taken place and there have been improvements in care," "Before [registered manager] was here morale was quite low but things are good under her. I have personally found her fair. MHA are very supportive too," "[Registered Manager] came in and it has been a difficult transition with the refurbishment as well, but things have got better since the last inspection," and, "This manager has taught me a lot. She has let me get involved in care planning and has encouraged me to develop."

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.