Hastings Court Ltd

Hastings Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

Hastings Court provides accommodation and nursing care for up to 80 people, who have nursing needs, including poor mobility, diabetes, as well as those living in various stages of dementia. There were 57 people living in the home during our inspection.

The home was purpose built to provide a safe environment for people living there. Bathrooms were specially designed and doors were wide enough so people who were in wheelchairs could move freely around the building. Accommodation was provided over three floors and split into three units. One unit provided nursing care with the second and third units providing care and support to people living with dementia.

Hastings Court is owned by Hastings Court Ltd and the organisation has one other care home in Essex.

We last inspected Hastings Court in October 2015 where the overall rating was good. We received multiple concerns in September 2016 from whistleblowers in relation to people's safety. As a result we undertook an unannounced focused inspection on the 18 and 21 September 2016 to look into those concerns and be assured of people's safety. This report only covers our findings in relation to the key question of whether the service is safe.

The service did not have a registered manager. The registered manager resigned from post in August 2016. 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. There is an acting manager in post who has a good knowledge of the home and the people who live there. Interviews are currently being held to recruit a manager.

Before this inspection we received concerns that medicines were not always dispensed and handled by appropriately qualified staff. We found all staff that dispensed and handled medicines had received training and been assessed as being competent. However the handling of medicines was not always safe and some people did not always receive their prescribed medicines. The staff in Hastings Court had identified the errors and taken immediate action to mitigate risk to people's safety. We found that there were sufficient appropriate and qualified staff to meet people's needs. Clarity to staff role and duty rotas was an area that required improvement as it was unclear of staffs' qualifications and experience to take responsibility for safe care delivery.

People said they were happy and well looked after. We found people were comfortable and happy moving around the home and spending time where they wanted to. The provider ensured a thorough recruitment procedure was followed when new staff were employed. Staff understood how to recognise any possible abuse and how to respond to any suspicion or allegation of abuse to safeguard people.

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

Hastings Court was not consistently safe. Systems for the handling of medicines when people moved into Hastings Court did not always ensure people's safety.

Whilst there were sufficient appropriately qualified staff to meet peoples assessed needs safely, the duty rota did not evidence staff responsibilities or qualifications. This meant that not all visitors and staff were confident of the staff deployment.

Staff knew how to recognise different types of abuse and were clear on how to respond to any allegation or suspicion of abuse. Appropriate checks were undertaken to ensure suitable staff were employed to work at the service.

People told us they were happy living in the home and felt they were safe.

Hastings Court

Detailed findings

Background to this inspection

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

This inspection took place on 18 and 21 September 2016 and was announced. The inspection team consisted of one inspector. We last inspected Hastings Court in October 2015 where the overall rating was good. We received multiple concerns in September from whistleblowers in relation to people's safety. As a result we undertook an unannounced focused inspection to look into those concerns and be assured of people's safety.

Before our inspection we reviewed the information we held about the home. We considered information we held about the service which included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. The provider was not asked to complete a Provider Information Return (PIR) as this inspection was carried out in response to concerns raised. The PIR 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.

We spoke with the commissioner of care from the local authority before the inspection. During the inspection we talked with eight people who used the service and seven staff members including the acting manager, clinical lead and area manager. We also 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 observed staff working and how staff communicated with people. We looked at areas in the home including people's rooms with their consent. We reviewed a variety of documents which included the care records relating to four people. We looked at five staff recruitment files, and records of staff training. We viewed medicine records and looked at policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People said that they were safe and had their care needs attended to well. One person said "Yes I am absolutely safe, staff are available at any time and look after me very well." However, our own observations and records showed people were not always protected from risk of harm.

Before this inspection we received concerns that medicines were not always dispensed and handled by appropriately qualified staff. Whilst we found that all staff that dispensed and handled medicines had received training and been assessed as being competent there was evidence that the organisational procedure for the checking in of medicines had not always been followed by staff. The provider used an electronic medicine administration record system (E-MAR) for people who live permanently at Hastings Court. People who were at Hastings Court for a short term stay had a hand written medicine administration chart. There had been a recent medicine error where a person received twice the amount of one medicine during their short term stay. Staff referred this to the GP and the local authority safeguarding team. The investigation identified that the staff had not checked the discharge letter against the boxes of medicine to ensure the dosage was correct. The box identified 12mgs per day but the hospital discharge stated 6mgs. Following the error, a new medicine policy was introduced which stated all medicines are to be checked in by two staff, one whom must be a trained nurse and both must sign that the medicines have been checked against the doctors discharge letter. Medicine training for those staff involved in the medicine error was booked and the clinical lead was to undertake medicine supervisions. The E-MAR system would be used for all medicines which would mitigate risk by the use of one system. It was acknowledged that the medicine error was due to a procedural failing. The management team and staff have used reflective discussions as a method of improving their practice.

Training was delivered by the pharmacy provider, this included regular updates and telephone support. Some senior care staff were 'super-users'. Super-users within Hastings Court give people medicines under the supervision of the registered nurses. We looked at the staff contracts for senior care staff and found that medicine giving was not included on their job description. This was immediately rectified and new contracts issued by the end of the inspection.

The provider did demonstrate they were making improvements in how the managed people's medicines, however it was an area that required further improvement and time to fully embed. One person had recently moved into Hastings Court. They had come from their home and their medicines were not labelled and were therefore unidentifiable and unsafe to give. Staff had requested a prescription from the GP but the medicines were not received for four days. This meant that the person did not have their medicines as prescribed.

EMAR charts indicated that medicines were administered appropriately and on time. Records confirmed medicines were disposed of and administered correctly. People confirmed they received their medicines on time. One person told us, "I get my medicines on time." People's medicines were securely stored in clinical rooms and they were administered by registered nurses and senior care staff who had received appropriate training. As required (PRN) protocols were in place , for example, it gave the time the pain killer was given

with the number of tablets given. There were also directives of what the medicine was for, how it worked and any known side effects.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Equipment such as hoists and wheelchairs were stored securely but were accessible when needed. Regular checks on lifting equipment and the fire detection system were undertaken to make sure they remained safe. Hot water outlets were regularly checked to ensure temperatures remained within safe limits. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. People's ability to evacuate the building in the event of a fire had been considered and where required, each person had an individual personal evacuation plan. The provider employed a dedicated facilities manager who was responsible for overseeing the safety of the environment and premises.

Risks to peoples' health and safety were well managed. Care plans showed each person had been assessed before they moved into the home and any potential risks were identified. Risk assessments included, falls, skin damage, behaviours that distress, nutritional risks including swallow problems and risk of choking and moving and handling. For example, low beds were in place for those that may fall out of bed and pressure mattresses and cushions were in place for those that were susceptible to skin damage and pressure ulcers. The care plans also highlighted health risks such as diabetes and epilepsy. Where risks were identified there were measures in place to reduce the risks as far as possible. People who lived with diabetes had their blood sugar levels checked regularly to ensure it was within their normal range. Guidance for staff to recognise when their blood sugar was either too high or too low was in place for staff to refer to. People who live with diabetes need regular eye checks and foot checks as the disease has potential side effects. These were in place and evidence that risks to their health were mitigated. All risk assessments had been reviewed at least once a month or more often if changes were noted.

We had received concerns before the inspection about staffing numbers and staff competency. We found that there were sufficient appropriately trained staff on duty to meet the needs of the people who lived there. People told us there were enough staff to look after them. They said, staff responded quickly if they used their call bells during the day or at night. One person said, "Staff come when you need them." There were 57 people living in Hastings Court and the staffing levels were calculated by a dependency tool that reflected people's needs. From our observations, people received care in a timely manner. Staffing levels were sufficient to allow people to be assisted when they needed it. We saw staff giving people the time they needed throughout the day, for example when accompanying people to the toilet, and helping people to move to the dining area at meal times. Staff were relaxed and unrushed and allowed people to move at their own pace.

Staff felt there were enough staff working in the home. One staff member told us, "Yes, there are. We are well staffed, Some days are busier than others but we are lucky to have so many staff." Another staff member said, "We are using agency staff sometimes at the moment, but I know they are looking to recruit more staff, we have lost some registered nurses lately, but we have the same agency nurse so all is good." The staff rota revealed that staffing levels were consistent across the four weeks we looked at in addition to the registered nurses. However, these numbers were only achievable by allocating extra hours to existing staff or agency members.

The concerns we received before the inspection stated that there was no registered nurses or competent person on duty to ensure safe care. The duty rota identified who was on duty but lacked the clinical leads hours on the nursing unit and the senior care staff qualifications. This would then ensure that there were clear lines of accountability and all staff would know who was taking responsibility of care delivery. We

identified that this was an area that requires improvement.

Staff training was in place and all staff had received essential training including, Mental Capacity Act and Deprivation of Liberty safeguards. Specific training to meet people's needs was in place, such as dementia care, end of life training, catheter care and diabetes.

There was a safe recruitment procedure in place. The provider was responsible for staff recruitment and ensured appropriate checks were completed on staff before they started working in the service. We found staff records included application forms and confirmation of identity. The recruitment process included an interview and the sourcing of references that informed the provider of staff suitability. Each member of staff had a disclosure and barring checks (DBS) completed by the provider.

Staff told us they had received training on safeguarding adults, they understood their individual responsibilities to safeguard people. Staff were able to talk about the steps they would take to respond to allegations or suspicions of abuse. They were confident any abuse or poor care practice would be quickly identified and addressed immediately by the manager and provider. They knew how to access the contact number for the local authority to report abuse or to gain any advice.