The Hawthorns Lodge Limited

Hawthorns Residential Home

Inspection report

8 High Street
Loftus
Cleveland
TS13 4HW

Tel: 01287641508

Date of inspection visit:
19 January 2016

Date of publication:
01 March 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 19 January 2016 and was unannounced. This meant that the provider did not know we would be visiting. The service had not previously been inspected.

Hawthorns Residential Home is situated in Loftus and provides care and accommodation for up to 15 people. The service is adjacent to Hawthorn Lodge, another service operated by the same provider. At the time of the inspection 13 people were using the service, most of who were living with dementia.

There was a registered manager in place. 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. The registered manager managed the service from an office located in Hawthorn Lodge, and also managed that service.

Risks to people across a wide range of areas were assessed and reviewed on a regular basis, and steps were taken to mitigate them. The safety and suitability of the premises was regularly checked, and required test certificates in areas such as gas safety, hoist equipment and PAT electrical testing were in place.

Plans were in place to support people in emergency situations, and these were regularly reviewed.

Medicines were managed safely and people were supported to access them in a safe way. A clear audit trail of medicines was in place, and people's medicine administration records were accurately completed.

There as a safeguarding policy in place, and staff understood safeguarding issues and were confident to raise any concerns with the appropriate authorities.

Recruitment procedures were robust in ensuring that only suitable staff were employed. Pre-employment checks were undertaken to ensure the suitability of staff.

Staff received the training they needed to effectively support people, and the service was in the process of becoming an accredited training centre.

Staff were supported through regular supervisions and appraisals, and said they would be confident to raise any issues or support needs with the registered manager or provider.

The principles of the Mental Capacity Act and the Deprivation of Liberty Standards were applied when people received care and support. Mental capacity assessments took place in a number of areas, and there was evidence of best interest decisions on people's care plans.

People received suitable support with food and nutrition and were able to maintain a balanced diet. People

had a choice over their meals, and could access food and fluids between mealtimes.

The service worked with outside agencies to support and maintain people's health, and there was evidence on people's care plans of frequent visits to people by external professionals.

Staff treated people with dignity, respect and kindness. This contributed to a homely atmosphere at the service, where people seemed relaxed and happy.

Staff knew the people they were supporting well, and had positive and caring relationships with them.

People had access to advocacy services, and one person was using an advocate at the time of the inspection.

Care records were detailed, personalised and focused on individual care needs. People's preferences and needs were reflected in the support they received. Where people had specialist support needs additional care plans were in place to assist in this.

People had access to a wide range of activities, which were tailored to their preferences and abilities. These were delivered by a committed and motivated activities co-ordinator.

The service had a clear complaints policy that was applied when issues arose, and this was publically advertised at the service.

The provider and registered manager worked together closely to monitor and improve standards, and were a visible presence at the service.

Staff felt supported and included in the service by the registered manager and provider. The service sought feedback from people and their relatives on how the service could be improved.

The registered manager understood their responsibilities in making notifications to the Commission.

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 was safe.

Risks to people were assessed and steps taken to mitigate them.

Medicines were managed safely and people were supported to access them in a safe way.

Staff understood safeguarding issues and procedures were in place to appropriately deal with safeguarding incidents.

Recruitment procedures were robust in ensuring that only suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff received the training they needed to effectively support people. Staff were supported through regular supervisions and appraisals.

The principles of the Mental Capacity Act and the Deprivation of Liberty Standards were applied when people received care and support.

People received suitable support with food and nutrition and were able to maintain a balanced diet.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity, respect and kindness.

Staff knew the people they were supporting well, and had positive and caring relationships with them.

People had access to advocacy services.

Is the service responsive?

Good

The service was responsive.

Care records were detailed, personalised and focused on individual care needs. People's preferences and needs were reflected in the support they received.

People had access to a wide range of activities, which were tailored to their preferences and abilities.

The service had a clear complaints policy that was applied when issues arose.

Is the service well-led?

Good

The service was well-led.

The provider and registered manager worked together closely to monitor and improve standards.

Staff felt supported and included in the service by the registered manager and provider.

The registered manager understood their responsibilities in making notifications to the Commission.

Hawthorns Residential 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, 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 19 January 2016 and was unannounced. This meant that the provider did not know we would be visiting. The service had not previously been inspected. At the time of the inspection 13 people were using the service, most of who were living with dementia.

The inspection team consisted of one adult social care inspector and three specialist advisors. One of these was an occupational therapist, the second a nurse and the third was a CQC team manager.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider completed a provider information return [PIR]. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team and health and social care professionals to gain their views of the service provided at this home.

During the inspection we spoke with three people who lived at the service and four relatives. We looked at three care plans, and Medicine Administration Records (MARs) and handover sheets. We spoke with eight members of staff, including the provider, registered manager, the deputy manager, a senior carer, two care assistants, the activities co-ordinator and the cook. We looked at four staff files, including recruitment

records.

We also completed observations around the service, in communal areas and in people's rooms with their permission.

Good

Is the service safe?

Our findings

Many of the people who used the service were living with dementia and found it difficult to express their views. A relative we spoke with said, "[People] are safe here."

The service had procedures in place to manage people's medicines safely. People's medicine records contained their photograph to assist in identification, and known allergies were recorded on the same sheet. We reviewed four people's medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. The MAR folder contained the procedures for ordering and administering medicines and sample staff signatures to assist in record keeping. MARs were completed accurately. Any omissions – with explanations - were recorded on the rear of the MAR sheets. People had clear, individual guides on the administration of their 'as and when required' medicines which included descriptions of when it should be administered and in what amount. Two people were prescribed controlled drugs. Controlled drugs are medicines that are liable to abuse. These were securely stored and appropriately recorded. The service had a system for monitoring medicine storage temperatures, and individual thermometers were located within trolleys, refrigerators and the controlled drug cupboard. We did note that some loose tablets were being stored within a medicines pot in the controlled drug cupboard. We asked the senior carer about this, and were told that this was due to the prescribed dosage of that particular medicine requiring tablets to be halved. Medicines being returned to the pharmacy were properly recorded and returned in a sealed box. We observed a medicines round, which was carried out safely and competently. This meant that people were supported to access their medicines in a safe way.

Risks to people were assessed and steps were taken to reduce them. People's care plans contained risk assessments in areas including moving and handling, physical and social aspects of care, nutrition, continence, skin integrity, cognition, hygiene and dressing and 'capacity to summon help.' The assessments were reviewed on a monthly basis and updated if risks to people had changed. This had last been done in December 2015. People's care plans also contained a detailed medical profile, so that staff had information on general risks to their health and well-being.

Accidents and incidents were monitored and steps were taken to reduce the risk of them occurring. Where accidents occurred, and investigation took place and remedial action was taken. For example, one person had six falls in a relatively short period of time and this led the service to reviewing their care and purchasing some supportive equipment for them. After this was done, the persons did not suffer any further falls. A monthly 'accident analysis' record was produced which the registered manager used to identify any patterns emerging from accidents and incidents.

Checks were made to the premises and equipment to ensure they were safe to use. For example, people that needed hoists to assist them with mobility had their own set of slings for personal use which ensured they were suitable for the person's needs. Fire alarms, fire extinguishers and emergency lights were checked on a regular basis. Cleaning logs confirmed that the premises were frequently cleaned, and throughout the inspection we observed staff moving items away from communal areas to reduce the risk from trip hazards.

Communal areas were clean and tidy, and staff had ready access to supplies of disposable gloves, aprons and waste disposal bags to assist in infection control. Staff washed their hands before and after delivering support and gloves were also used by both care staff and ancillary staff at appropriate times.

The service had plans in place to provide care and support in emergency situations. Each person had a personal emergency evacuation plan (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The PEEPs were stored in a convenient place next to the front door, for easy access in an emergency situation. Each PEEP contained information on the person's mobility and support needs, and the assistance they would need in an emergency. The PEEPS were regularly reviewed, and had been updated in January 2016. We saw a notice on the staff room wall which informed staff that this had been done, and asking them to review the updates to ensure they had the latest information on people's support needs in emergencies.

Required test certificates in areas such as gas safety, hoist equipment and PAT electrical testing were in place. Where certificates were missing, the registered manager told us inspections and tests had been arranged. This meant procedures were in place to monitor and mitigate risks to people.

There were procedures in place to reduce the risk of safeguarding incidents occurring. There was a safeguarding policy in place, and this was publically displayed so that it could be accessed by people and their relatives. Staff we spoke with demonstrated a good awareness of safeguarding issues and procedures and how to raise concerns. Where incidents had occurred, investigations had taken place and remedial action was taken. This included an action plan being developed and changes being made to the way the service recorded what care had been delivered. Monthly reports were submitted to the local authority on safeguarding incidents (even when none had occurred) which the registered manager said helped them to monitor any trends or patterns.

The service's recruitment procedures helped to keep people safe. People were interviewed and asked about their employment history, and the service sought written references before staff started work. Disclosure and Barring Service checks were also carried out before staff started in post. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

Staffing levels were based upon people's assessed level of need. The registered manager said these were regularly reviewed to ensure that any changes were detected and to see whether additional staff were needed. Day staffing (during the week and at weekends) levels were one shift, one senior carers and two carers working from 8am to 4pm, with the same staffing levels between 4pm and 10pm. Night staffing levels (during the week and at weekends) were one senior carer and one carer working from 10pm to 8am. Throughout the inspection we saw that people were assisted promptly and that staff had time to talk with people as they moved around the building. The registered manager told us that staff moved between the service and Hawthorn Lodge, the other service operated by the provider on the same site, if absences through sickness needed covering. One member of staff said, "I think we have enough staff. It can be busy but every shift is different. It's a big building but we can manage, and if we need help [the provider] always gets people in." A visiting relative said, "There are absolutely enough staff. They always have enough."

Good

Is the service effective?

Our findings

Staff received training in a number of areas to help them support people effectively. These included first aid, fire safety, infection control, safeguarding, food hygiene, moving and handling, end of life care, medicines administration and COSHH. COSHH details what is contained in cleaning products and how to use them safely. Staff we spoke with confirmed that they received training, though they also said they would welcome more on the Mental Capacity Act 2005 and had raised this with the registered manager. We noted that the service had already identified this as an issue, and was in the process of arranging additional training. This meant that staff felt confident to request additional training should they need it, and that it would be arranged. The service employed a 'training co-ordinator' who was responsible for ensuring that staff training was up-to-date and to source any specialist training that staff requested. The provider told us that the service had plans to become an accredited training centre which other providers could use, which would allow expertise and best practice to be shared.

Staff were supported through regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff told us that supervisions and appraisals were undertaken by the registered manager and deputy manager, and that they were free to raise any issues they had at these. The registered manager also undertook competency checks on staff.

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, two people were subject to DoLS authorisation. Mental capacity and best interest assessments had taken place, and staff were able to describe how an assessment would be triggered. Mental capacity assessments and best interest decision records were undertaken for areas including consent to treatment, lifestyle choices, accompanying outside of the service, sharing information and consent to medication.

One person was being supported by a Deputy appointed by the Office of the Public Guardian, and we saw that the relevant documentation was stored in their care plan. We did note that one person's DoLS authorisation paperwork had not been place with their care plan, and when we asked about this staff told us that they would rectify this immediately. The registered manager was aware of their responsibilities in relation to DoLS and was able to discuss when an assessment would be requested. This meant that procedures were in place to ensure that care and support was delivered in a way that respected and protected people's legal rights.

People were supported to maintain a healthy diet. The service used a MUST tools to monitor people's weights to ensure they were within healthy ranges. MUST is a tool designed specifically to assess people's risk of malnourishment using a combination of their height, weight and body mass index, to identify this. Staff could describe how they would support people on specialist diets such as diabetic or soft foods, and were aware of people's dietary preferences. There was a menu in place, but the cook said, "people can choose whatever they want. We have a menu, but there's always choice. People will always tell me what they like. For example, a few wanted curry tomorrow so they will get that, but others don't like it so they will get corned beef hash." A relative told us, "[The cook] tried everything when [my relative] stopped eating."

We saw that people were given a choice of meals, and people were eating different things at lunchtime. The service had two dining areas, and both had a pleasant and relaxing atmosphere. Staff – and the provider – ate their lunch alongside people, which added to the homely atmosphere. Where people required support with eating, this was done with patience and kindness. In between meals, a range of drinks and snacks was offered and there were drinks stations in communal areas so people always had access to fluids.

The service supported people to access external services to maintain and promote their health and wellbeing. A record was kept of visits by external professionals, and care plans were updated to reflect any changes made. For example, one person received regular visits from the chiropodist and these were recorded in their care plan and any changes to the person's need noted. The same person had also recently had an eye test, and the results were recorded in their care plan. This meant that people who used the service were supported to maintain and promote their health by accessing health and social care professionals.

Good

Is the service caring?

Our findings

Many of the people who used the service were living with dementia and found it difficult to express their views. We carried out observations during the course of the inspection, and people looked happy with the care and support they received and relaxed around staff.

Staff treated the people they were supporting with dignity and respect. Staff knocked on people's doors before entering their bedrooms, and when they were supporting people to the bathroom made sure doors were closed behind them. Though lots of people were sitting in the lounge area during the inspection, staff made a point of approaching them and speaking to them directly and privately if they wished to discuss something rather than calling across the room. Where people indicated to staff that they needed support, staff responded quickly and discreetly asked how they could help in order to maintain people's privacy and dignity.

Care and support was delivered in a relaxed and unhurried way, and often with humour between people and staff. We saw staff and people sharing jokes, though staff always maintained professional boundaries with people.

Staff clearly knew the people they were supporting well, and were able to talk with them about things that were important to them. For example, we saw one member of staff talking to someone about a trip they were taking with their family later in the year. In another example, two members of staff were talking with a person about the activities (games) they would be doing later that day and this turned into a joke between them all about the chances of the person winning.

Staff took time to talk with people as they moved around the building, and we saw many examples of them stopping for a couple of minutes to sit and talk with people. The provider also did this, and clearly knew people well. Where people had specific communication needs, such as sight or hearing impairment, staff responded adapted how they spoke with people and used appropriate touch to do this. A member of staff told us that they had spent 30 minutes that day with a resident who was bedbound because they thought it was important to, "sit and talk to [the person] and hold their hand and stroke [the person's] forehead."

Staff also knew visiting relatives well, and we saw them being welcomed into the service and included in discussions and activities. This helped to add to the homely atmosphere of the service, and people clearly enjoyed spending time with their relatives in this way.

Relatives we spoke with spoke highly of the service. One spoke very highly of all staff and was very appreciative of the care their relative was receiving. They said, "I have nothing but praise for them. They couldn't do more." Another said, "It's beautiful here. [My relative] loves it and [staff] can't do enough for them."

At the time of the inspection one person was using the services of an advocate. Advocates help to ensure that people's views and preferences are heard. The registered manager was able to explain how referrals to

advocates would be made on behalf of people who needed them.

Good

Is the service responsive?

Our findings

Care plans reflected people's preferences and described the kind of care and support they wanted. Each plan began had a photograph of the individual, and contained a section detailing what was important to the person, a summary of what people who knew the person would say about them and an overview of how staff could best support them. There was then an overview of the person's life history, which included details of their background, family life and interests and preferences. This assisted staff in getting to know the person and deliver and plan care in a person-centred way. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person.

Care plans contained a comprehensive set of assessments and plans in areas covering moving and handling, physical and social aspects of care, nutrition, continence, skin integrity, cognition and hygiene and dressing. Logs were kept of care and support delivered throughout the day and at night, and these were accurate and detailed. Care records were, personalised, easy to understand and were easy to work through. For example, one person's plan stated, "[The person] washes themselves independently and will buzz for staff when ready to get out of the bath. [The person] will dry themselves and put on their own deodorant." Another said, "[The person] likes to get up [themselves] around 06.00, washing [themselves]. [They] prefer to use Dove soap."

Care plans were regularly reviewed by the staff and the registered manager, and this had last been done in December 2015. There was evidence of people and their families being involved in such reviews. Staff were able to describe how reviews had led to changes to people's care, for example, when a person was assessed as needing hoist support and the service sought advice from the local occupational therapy service. A relative told us that the service had quickly responded to a change in their relative's support needs. They said, "[My relative] started getting dizzy using the stair lift so they moved [them] to a downstairs room straightaway."

Where people were receiving end of life care, an additional strategy document was used which was reviewed on a daily basis with support from the district nurse and GP. This clearly outlines what is being carried out and why. This helped people to get support that was responsive to their needs.

People had access to activities that they enjoyed and were responsive to their physical and social needs. An activities co-ordinator was employed, and we observed that they were enthusiastic and motivated about their role. We observed the activities coordinator leading a game which involved throwing a rope hoop over a peg to score points. This enabled most people at the service to be involved if they wanted to be, and we saw that people enjoyed being active. We asked people if they enjoyed the activities, and they indicated that they did. The activities co-ordinator told us that they kept records of what people enjoyed doing, and planned activities to suit their preferences. The service had access to a mini-bus which was used to take people out on trips in the local area. People living with dementia had access to a 'remembrance corner' in the lounge area, which contained visual and touch objects from the local area for them to use and enjoy. A relative spoke positively about the activities offered by the service. They said, "[Staff] take [my relative] to the library, or they go out on the bus with them. Brilliant."

There was a complaints policy in place, which set out how they would be investigated and the relevant timescales that would be applied. This was publically displayed so that it could be accessed by people and their relatives. The registered manager told us no complaints had been lodged in the 12 months up to the inspection. Where complaints had occurred in the past they had been investigated, outcomes had been sent to people and remedial action taken.

Good

Is the service well-led?

Our findings

The registered manager and provider undertook a number of quality assurance checks to monitor and improve the quality of the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. We provider told us that the training co-ordinator undertook "roving quality assurance checks."

Between the provider, registered manager and training co-ordinator audits were undertaken in areas including medicines, care plans, staffing levels, accidents, training and the environment. The provider had recently invested in a bespoke IT system that would allow them to monitor audits and the progress of any remedial action taken. They said, "People will have to put [updates] in, it won't just be a tick box approach." The service had been using the new system for two weeks at the time of the inspection, and we saw that audits were being undertaken and actions required were checked by the provider. Records confirmed that audits had taken place before the new system was installed.

Feedback was sought from people and their relatives on how the service was operating and on any improvements that could be made. Questionnaires were sent out to people and their relatives every six months, and resident and relative meetings were held. Records confirmed that a wide range of topics were discussed at these, for example food and activities, and that were people or their relatives made specific requests actions were taken to address this. The deputy manager told us that they would also seem feedback from people more informally. They said, "I will go down and chat with people. The more informal it is the better response you get."

Staff said they felt supported by the provider and registered manager, and would be confident to raise any issues they had or to request more support. Records confirmed that staff meetings took place. These were usually joint meetings for all staff at the service and the adjacent Hawthorn Lodge, but where issues were relevant to only one service meetings were held there. Additional meetings were arranged for the convenience of night staff.

The registered manager and provider were visible and active in assisting people and staff throughout the inspection, and clearly knew people and their needs well. When we arrived to begin the inspection, the provider was helping to clean a communal area and the registered manager was talking with people in one of the lounges. We saw that staff discussed people and service issues with the provider and registered manager throughout the day, and there was clear evidence of positive teamwork in the delivery of care. One member of staff, in describing how much they enjoyed their role, said, "I love it… [the provider, registered manager and staff] are really nice and it's homely."

The registered manager had a clear understanding of their role and responsibilities, and was able to discuss the notifications they were required to make to the Commission. They said that they felt supported by the provider in carrying out their role, and that all staff were alert to opportunities to improve the service.