Tri-Care Limited

The Hawthornes

Inspection report

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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

The inspection of The Hawthornes took place on 8 and 11 March 2016. The registered manager was taking leave and not available to speak with us on the first day of our inspection. We therefore met with one of the deputy managers. On the second day of our inspection we spoke with the registered manager.

The Hawthornes is a care home which offers care and support for up to 40 people. All bedrooms have en-suite facilities and there are communal areas such as lounge, dining area and bathrooms. At the time of our inspection there were 38 people living at the home.

The service had 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.

People told us they felt safe living at the home and appropriate procedures were in place to help keep people safe. Risk assessments had been completed and measures put into place to reduce risks. The building was well maintained and regular safety checks took place.

Medicines were managed and stored in a safe way and staff who were responsible for administering medicines had received training to do safely.

Staff were recruited in a safe way and had received appropriate training to enable them to provide effective care and support to people. Staff received support through regular supervision.

Consent to care was sought from people and staff acted in accordance with the principles of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

The design and layout of the home was appropriate to meet people's needs and the home was fresh and clean.

People told us staff were caring. We observed a pleasant, relaxed atmosphere in the home and people's privacy and dignity were respected.

Care and support was provided in a person centred manner. Care needs were regularly reviewed and people were involved in their care planning. People told us they could make their own choices.

Staff understood their roles and responsibilities and the home was well-led. Staff were motivated to provide good care to people.

Regular staff meetings and resident meetings were held and the registered manager sought feedback from

people.

Audits took place regularly and action plans were developed and acted upon to improve the service.

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.

Robust recruitment practices were followed to ensure staff were suitable to work in the home.

Medication was managed appropriately and was administered in a safe way by staff that had been trained to do so.

The environment and premises were well managed and appropriate safety checks took place to ensure people's safety.

Is the service effective?

Good

The service was effective.

Staff knew the people who they were supporting well.

People were given support to ensure their nutritional and hydration needs were met.

Staff had received training and support to enable them to provide effective care and support to people.

Is the service caring?

Good

The service was caring.

People told us staff were caring.

We observed positive and caring interactions between staff and people.

People's end of life wishes were considered and respected.

Is the service responsive?

Good

The service was responsive.

People received care that was person-centred and personalised.

People were able to make their own choices.

Care plans were reviewed and evaluated regularly.

Is the service well-led?

Good

The service was well led.

Staff felt supported and motivated.

The registered manager ensured regular audits took place, to improve the quality of service.

The culture of the home was open and transparent and the registered manager was receptive to feedback given at the inspection.

The Hawthornes

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.

The inspection took place on 8 and 11 March 2016 and was unannounced on both days. The inspection was carried out by an adult social care inspector and an expert by experience on the first day of the inspection and an adult social care inspector on the second day of the inspection. 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 we reviewed the information we held about the home and we gathered information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with six people who lived at the home, six relatives, four care and support staff, the deputy manager and the registered manager.

We looked at four people's care records, three staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, with their permission, bathrooms and other communal areas.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "Absolutely, I feel safe." We heard another person say, "They're good to you here aren't they? Not a move they miss here." Another person told us, "You don't have to worry about this place. It's wonderful."

The registered manager and deputy manager were clear about safeguarding reporting procedures and were able to outline different types of abuse and the potential signs to look for, which may indicate if someone was at risk of harm or being abused. Staff we spoke with also understood how to identify the signs of possible abuse and the procedures to follow if they had any concerns. There was a safeguarding policy and whistleblowing policy in place and staff were aware of these. Two members of staff shared with us they had raised concerns previously about the conduct of a colleague and they felt this was dealt with appropriately. The staff members told us they would not hesitate to do this again, if they felt people were at risk of harm. This meant people were protected from abuse and improper treatment because staff had received relevant training and the registered provider had robust procedures and processes in place to protect people.

The deputy manager and registered manager told us risks were managed by assessment and putting measures in place to reduce risks, whilst also trying to ensure people maintained their independence as much as possible. We saw individual risk assessments were in place and had been discussed with people. For example, one person had fallen on a number of occasions. Possible falls reduction measures had been discussed with the person, who wished to maintain as much independence as possible and a referral had therefore been made to a specialist falls clinic.

Other risks such as those relating to skin integrity, diet and nutrition, infection prevention and control and sensory needs were also assessed. Measures to reduce risk were documented in care plans. This helped to ensure staff were aware of who was at risk and what actions to take to reduce risks.

We saw that analysis took place of accident and incident records, for example in relation to falls, skin tears and infections. This helped to identify any trends and we could see that actions had been taken where necessary to reduce risks to people.

Fire exits were clearly marked and notices indicating the action to take on discovering a fire were displayed. The fire risk assessment for the home had been reviewed and was up to date. Regular safety checks were carried out such as fire alarm systems, emergency lights, portable appliance testing and gas safety. Lifting equipment was regularly serviced. This helped to ensure the premises and equipment in the home were safe.

We saw a notice which stated, 'Call buzzers are situated on the wall near the window in the lounge area and on walls at the side of windows in the dining area.' This helped to ensure people and relatives were aware of how to summon help if necessary. On the first day of the inspection, an emergency buzzer sounded. We saw this was treated as an emergency and staff attended to the person immediately, but in a calm reassuring manner. This showed the call bell system was working effectively and this helped to keep people safe.

We discussed staffing levels with the deputy manager. A dependency tool was used to determine the number of staff required. This took into account people's level of dependency, for example in relation to personal care needs and moving and handling needs. This helped to ensure safe numbers of staff were deployed. The registered manager told us this was updated monthly. Although people's needs were met, a number of staff felt that more staff were required. However, one staff member told us, "This has been in the last two or three weeks, and I know some new staff will be starting so it will improve again."

We looked at three staff recruitment files. We found safe recruitment practices had been followed. For example, the registered manager ensured reference checks had been completed from two referees and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at whether medicines were managed and administered in a safe way. An electronic medication administration record (MAR) was in use at the home. A member of staff we spoke with said, of the new electronic system, "Love it. It's all there on the screen to look at. It's more efficient." Each member of staff responsible for administering medicines had their own password to access the information. This meant the member of staff who had administered medicines was easily identifiable.

There was a photograph on the system of each person and this helped reduce errors in relation to people being given the wrong medicine. Information relating to each person's medicine was entered directly onto the system by the pharmacy and the person responsible for administering the medicine accessed this information. For each type of medicine administered, the staff member responsible was required to enter information to show the person had taken their medicine or, if the medicine was not administered for any reason, the reason for this was also recorded. The system recorded the time the medicine was administered and the remaining amount of medicine.

Some people were prescribed PRN medicine. This is medicine that is taken 'as and when required'. The computer system prompted the staff member to ask the person whether they required their PRN medicine. The staff member was able to explain to us the signs they would look for which would indicate a person may require their PRN medicine.

We observed a member of staff assist people to take their medicines. The staff member carefully prepared the medicines in individual pots, following good infection control practice. People were asked for consent and given information relating to what their medicine was for. We observed the staff member say, "Take your time, there's no rush. It's alright." Medicines were administered in a calm and relaxed manner.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely and we saw that, whenever these were administered, two members of staff checked the remaining amounts and signed the controlled drugs register. We checked the amount of medicines remaining and these reconciled correctly with the records. This showed that controlled medicines were being properly managed.

Anti-bacterial gels were placed around the home and we saw staff make use of these. Signs displaying effective hand-washing procedures were displayed adjacent to sinks. This helped to reduce the risks associated with infection.

Good

Is the service effective?

Our findings

One person told us, "They can't do enough for you. It's lovely." Another person said, "I take the food as it comes. It's good you see."

We looked at staff training and induction records. Two of the staff recruitment files we sampled showed the staff were currently being inducted. Each staff member had a clear plan and could evidence they had shadowed staff on different shifts prior to commencing work on their own. This helped to ensure new staff developed the necessary skills and were given the support they required to perform their roles effectively.

Staff had received training in areas such as safeguarding, infection prevention and control, food safety, fire safety, moving and handling, first aid and medicine administration where staff were administering medicine. Staff had also completed training in relation to the Mental Capacity Act 2005. We saw competency testing took place which helped to ensure staff had understood their training and were able to apply this effectively in practice. One member of staff told us they had asked for additional training in a specific area and this was provided. This showed staff received appropriate training to enable them to provide effective care and support to people.

Some staff had received specific training which helped to ensure people received effective care. For example, the deputy manager had received training and been provided with a repair kit in relation to basic repairs of spectacles. This meant people would not need to wait for an appointment with an optician if minor repairs were required.

Students from a local college were supported on placements at the home. A certificate was displayed which had been presented from the local college, stating, 'In recognition of exceptional support for students on placement from [name] college.'

The deputy manager told us staff had one to one supervision sessions six times per year as well as an annual appraisal and we saw evidence of this. Items discussed within supervision sessions included infection control, training requirements and policies and procedures. Additional group supervisions were held when issues such as team-working were discussed. This showed staff were receiving regular supervision to monitor their performance and identify development needs.

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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. There were no coded keypads to restrict people's movement and some people accessed the community independently. The registered manager, deputy manager and staff we spoke with had a clear knowledge of the principles of the MCA and DoLS. The registered manager had considered that one person living at the home, who lacked capacity, was being deprived of their liberty in order that safe care and treatment could be provided. Therefore authorisation had been sought and approved by the local authority. The registered manager had identified a further four people who they considered were being deprived of their liberty and had sought advice from the local authority and submitted applications to request these be authorised.

Consent was sought from people. For example, in care plans we saw people had consented to photographs being taken and used, and to the sharing of information in relation to care planning and reviews. Staff we spoke with were clear they would always seek consent to care for people and we saw this in practice.

We observed a lunchtime experience. The food looked and smelled appetising. People were given the choice of where they wanted to sit and eat their meal. There was a relaxed and pleasant atmosphere as people chatted about what food they had chosen. The television was changed to a music channel and there was appropriate background music playing. Choices were offered in relation to food and drink. Where people chose hot drinks, these were made to their liking. Information relating to people's dietary preferences were detailed in their care plans, including the level of support people may require.

We heard people being asked if they would like gravy with their meal. Staff assisted people and we heard staff saying phrases such as, "Is that enough?" and "Would you like more?" and "Would you like your gravy all over or just on the meat?" The cook was visible and could be heard asking people if they had enjoyed their food. This showed staff ensured people were given choice and control and people were supported to maintain their nutrition and hydration needs.

Signage was clear throughout the home, for example where to find the lounge or a bathroom. The Hawthornes was homely with pictures and flowers on display. There were thank-you cards on display and pictures of people participating in various activities. Books and games were accessible throughout the home.

People living with dementia can experience difficulty with orientation. Displaying information such as the day, date and time can be beneficial in reducing anxiety. We saw there were some orientation boards on display. Additionally, pictorial signage was used to help people to navigate around the home.

The layout of the home meant people were able to choose to sit in quieter areas as well as the main lounge area. The lounge area was split into two halves; one half with a television and the other half was quieter. This meant people could choose to sit and talk in the lounge area without being disturbed by the television and people who wanted to watch television were able to do so with minimal disruption.

People had access to health care and we saw that referrals were made to other agencies or professionals. For example, we saw referrals to an optician, general practitioner, physiotherapist and falls clinic. This showed people received additional support when required in order to ensure their needs were met.

Good

Is the service caring?

Our findings

One person told us, "All these girls (staff) are lovely. They do everything for you. They are wonderful."

We observed a person was sat alone in the dining room, and they were upset due to a family altercation. The cook identified this and consoled the person in a kind and caring, reassuring manner.

A person was sat in a lounge on their own and not engaged in any conversation or activity with anyone. The activities coordinator identified this and said to the person, "Hiya [name]. You sat in here all on your own? I'm just going to the upstairs lounge if you'd like to join me?" The person accepted the offer and accompanied the activities coordinator to a different lounge. This showed the member of staff was caring and had been proactive in ensuring the person received good care and support.

We observed a pleasant atmosphere in all areas of the home. Our observations were that people felt at ease in the presence of staff. We saw people laughing and joking with each other and with staff. Throughout the day, we observed staff smiling and being kind, caring and friendly towards people. People were supported by staff at an appropriate pace and there was no sense of being rushed or hurried.

We observed that, when people were assisted into the lounge area, staff asked people where they would like to sit, ensuring that people were given control.

The deputy manager observed that a person was sat wearing only a t-shirt style of clothing. The deputy manager asked the person if they would like a cardigan bringing, to keep them warm. The person declined and this was respected. Nevertheless, this showed the deputy manager had identified the person may be feeling uncomfortable and had been proactive in assisting the person.

One person was being assisted to the table at lunchtime and we heard the person say to the carer, "Oh, you're wonderful you are." The carer was assisting the person to move at the person's pace. The carer was patient and kind and the person was asked where they would like to sit. Once the person was seated the carer addressed other people, asking how they were and making conversation.

Staff, deputy managers and the registered manager knew people at the home well. They continually used people's names when addressing them and we heard staff and people talking about their own experiences and families throughout our inspection.

People were supported to practice their chosen faith or religion. A religious study group took place once a month and a religious leader visited the home monthly.

The staff members we spoke with were clear about how they tried to maintain people's privacy and dignity and also that they wanted to promote independence as far as possible. We observed people's privacy being respected and staff knocked on people's doors.

We observed a person being assisted to eat their meal. The staff member told the person what the food was. The person was then given the spoon to eat their meal. The person asked the member of staff to do it for them. The staff member said, in caring tones, "But I'm not here every day and if I do it and you get used to it you won't be able to do it on your own." The person then continued to eat the meal independently and was able to do so. This showed the staff member enabled the person to be as independent as possible, whilst still being there to offer support in a caring manner.

A person living at the home was benefitting from the services of an advocate, following a recent bereavement. An advocate is a person who is able to speak on another person's behalf when they may not be able to do so, or may need assistance in doing so, for themselves.

We saw Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were recorded and kept in care plans. Furthermore, this information was shared at staff handovers and with other relevant professionals. This showed people's wishes, in relation to the end of their life, were respected.

The deputy manager had completed specific end of life training and told us they felt it was important that people were able to live the end of their life how they chose, in the home if they wished. The deputy manager felt they had a positive relationship with other health professionals such as district nurses and general practitioners to enable this. Hospital transport forms were used to ensure that important information in relation to people's end of life wishes were shared with other relevant people, should the person be transported to hospital.

Good

Is the service responsive?

Our findings

One person told us, "I choose whatever I do or don't want to do."

We looked in people's bedrooms, with permission, and found these to be personalised to the individual, for example with family photographs, items of sentimental value and flowers on display.

We sampled four care plans and found care planning to be person centred. Each plan we sampled contained a clear photograph of the person to whom it related. Important documents such as DNACPR decisions were contained within the plan and were easy to find. Plans contained information relating to the person's likes, dislikes, personal and family history and relevant interests. Information included within care plans was thorough and gave staff a clear indication of the support the person required with personal care, diet, communication, oral health, foot care, mobility, continence, medication, mental health, social and cultural needs, personal safety and maintaining family involvement. This helped to ensure staff were able to provide personalised support to people.

People's needs were assessed and plans were formulated with the person. Preferences were recorded such as whether people preferred a bath or shower, how much assistance they would like, their preferred dress code, preferred footwear, preferred personal care routine such as moisturising and shaving. This showed people's choices were considered during the care planning process.

Care plans indicated that people were given choices and could make their own decisions. For example, one care plan we sampled stated, '[Name] will choose their own clothes for the day. [Name] will let care staff know when they would like to go to bed.'

We saw care plans, including risk and needs assessments, were evaluated monthly. People were invited to be involved in reviewing their care needs. We saw copies of letters which had been sent to people, inviting them to be involved in their care planning. The letters also highlighted the person could invite a friend or relative to be involved. This showed people's needs were regularly reviewed with the person.

Activity plans were displayed in communal areas throughout the home and an activities board was in reception, which showed photographs of people participating in varied activities. We observed positive interactions between the activities coordinator and people living at the home. However, one member of staff and one person who lived at the home shared with us they felt meaningful activities were not varied enough and they wanted more to be offered. We shared this information with the registered manager who agreed to address this.

During the afternoon on the first day of our inspection we observed five people sat with the activities coordinator, looking at pictures of film stars and other icons. This generated conversations around the lounge and other people joined in, talking about their past experiences. There was a pleasant, warm and respectful atmosphere.

We observed the activities coordinator facilitate a game of 'forfeit dominoes'. Six people chose to join the game. The group appeared at ease and relaxed. We observed laughing and positive interactions. The pace of the game was appropriate and the activities coordinator used the game to prompt further discussions and reminiscence. People who were not actually playing the game were also encouraged to join in these conversations.

On the first day of our inspection, a person was taken to hospital in an ambulance. We observed good communication between the deputy manager and the ambulance personnel. Information was shared in relation to the person's relevant recent medical history and whether they had any advance decisions or DNACPR in place. This helped to ensure the person received appropriate care and support when making the transition between services.

The deputy manager told us there was a handover each day at the commencement of a new shift. Information was shared verbally and we also saw written handover sheets being used which included relevant information relating to, for example, people's care needs, allergies and medication. This meant that important information was shared between staff so people received appropriate care and support.

We looked at complaints received and saw these were dealt with appropriately. We saw a complaint had been received on 24 September 2015 regarding the decoration of a person's bedroom. This had been addressed almost immediately and the complaint log identified that, on 28 September 2015, the process of redecorating and replacement flooring had been ordered. This showed the registered manager acted upon complaints.

We saw family members, some with young children and some with pets, visited the home throughout the day. Some relatives and visitors sat and chatted with their family member and with other relatives and some joined in activities. This showed people were able to maintain contact with those who were important to them and this helped to reduce social isolation.

Good

Is the service well-led?

Our findings

The home had a registered manager in post, who was registered with the Care Quality Commission and had been managing the home since October 2010.

Staff we spoke with told us staff morale was good. A staff member told us they would feel comfortable and confident to approach the deputy managers if there were any issues. Another member of staff told us, "I love it," when talking about their job and told us, "I enjoy coming to work." Staff felt there was a good team-work ethic in the home and we witnessed this. Staff told us they felt they were well treated by their employer.

We asked a member of staff if they would be happy for a relative of theirs to live at the home. We were told, "Yes. I've even told my kids I want to come here."

On the first day of our inspection, the registered manager was taking a day of leave and was therefore not present at the home. The home nevertheless maintained a well organised and motivated staff team in the registered manager's absence and the deputy managers provided continuity of service. This demonstrated the home was well led.

We saw resident meetings were held monthly with the activities coordinator in order that people's views could be sought. The deputy manager felt it was important that residents could have meetings both with and without their relatives present. Relatives were also invited to meetings twice a year. This showed that views of people who lived at the home, and their relatives where appropriate, were sought.

We looked at minutes from regular staff meetings. Appropriate items were discussed such as staff being reminded about policies and procedures, information to be included in daily communication notes and reminding staff to complete documentation when applying topical creams. We saw staff had been reminded that, 'any resident may refuse assistance from a carer if they choose. However, carers cannot refuse any resident assistance.' This helped to ensure staff were clear of their responsibilities and of the need to obtain consent to care from people.

Community links were evident. For example local scouts and brownies visited the home, a hearing aid drop in centre had been set up and local schools engaged with the home.

We saw an action plan from a recent satisfaction survey was displayed in the reception area. This clearly showed actions that were being taken following the survey, for example, the complaints procedure was placed on display in the main entrance as a result. This showed that action was taken, when necessary, in response to people's feedback.

We looked at surveys that had been returned from November 2015. 15 surveys had been returned and all stated, 'yes' to questions such as, 'Are you made to feel welcome when you visit the home?' and 'Do you know who the manager of the home is?'

We looked at feedback which had been received. A comment dated September 2015 stated, 'The staff are so polite and caring. Also good sense of humour and patient. If I get to being in a care home, this is where I would like to come." This comment was submitted by a relative of a person living at the home. A person who had resided temporarily at the home on a respite care basis had fed back, 'Received good care whilst in home. Staff and management were helpful. Would choose the home again.' Another relative had commented the home provided appropriate care and support for someone who was registered blind without making the person feel self-conscious about it.

The deputy manager we spoke with told us they felt supported by the registered manager and the operations manager. The deputy manager felt there was good, effective, peer support. This showed support was provided to staff to help ensure they were able to perform their roles effectively.

The registered manager was able to access the resources required to manage the home effectively. For example, the deputy manager told us items such as slings and pressure mats could be ordered as and when they were required and approval was required for more significant items such as a freezer that had been recently required.

The registered manager told us they felt supported in their role, by staff and the head office of the registered provider. Monthly area meetings were held which provided peer support to the registered manager and the operations manager visited the home regularly. This showed the registered manager received appropriate support in order to manage the home effectively.

A home administrator had recently been appointed and had begun working at the home during the week of the inspection. The registered manager told us they hoped this would mean they could spend more time, 'on the floor.'

The home was taking part in an Enhancing Person-centred care In Care homes (EPIC) trial study, in conjunction with a local university. This was ongoing research into better support for care home staff, to help them be better equipped to meet the needs of people with dementia and to reduce the use of drugs to treat or manage behaviours. This demonstrated partnership working and showed the registered manager was contributing towards research and improving standards.

There is a requirement for the registered provider to display ratings of their most recent inspection. We saw the registered manager had due regard of the duty of candour and the most recent inspection report was clearly displayed.

As well as regular safety checks, we saw records of daily checks in relation to the environment, such as outside security and repairs and maintenance checks. We saw that where repairs were identified these were actioned. Weekly checks took place in relation to the fire alarm, nurse call bell system and water temperatures. Building and environmental checks were well organised and planned and this reduced the risk of these not being carried out regularly and properly.

Regular audits took place. For example, we saw regular mattress audits took place. We looked at records and could see that a recent audit identified a new mattress was required. This had been actioned. Other audits included regular pillow and pressure cushion audits. Care plans were regularly audited as well as medication. Audits were well organised and clearly documented any actions required. This showed the registered provider had systems in place for regular audits to enable them to monitor and improve the safety and quality of service.

We looked at policies and procedures the home had in place. Policies were in place for complaints, concerns and compliments, infection control, mental capacity, emergency procedures, management of medicines, whistleblowing and safeguarding adults for example.