St. Matthews Limited

Hawthorne House

Inspection report

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Date of inspection visit:
10 October 2018
30 January 2019

Date of publication:
19 March 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Hawthorne House provides accommodation, nursing and personal care for up to 102 people with a variety of mental health problems combined with physical disabilities or challenges associated with behaviours. Care is provided over seven units. One unit is specifically for those people with an acquired brain injury. The other units support people with high level mental health needs, those living with dementia and those who may have developed mental health conditions as a consequence of other illnesses. When we visited in October 2018 there were 79 people living in the home. In January 2019 there were 87 people living in the home, although three were in hospital on the day of our visit.

People's experience of using this service:
•Hawthorne House opened in the summer of 2017 and there had been three managers by the time of our first inspection visit in October 2018.
•Whilst we observed some very positive care and support to people, we found the provider's quality assurance system had not ensured everyone achieved such positive outcomes. For example, people within some of the dementia care units did not receive the same level of person centred care as those on the acquired brain injury unit.
•The provider had systems to identify where there were problems in the service, but managers were not always aware of these. This included incidents involving people which had not always been reported to the managers and therefore had not been considered in the management analysis of accidents and incidents so the provider could have an accurate overview to identify any trends or patterns.
•There were sufficient numbers of nursing and care staff on duty to keep people safe and monitor the communal areas of the home. However, due to high levels of staff sickness, staff were often assigned to work in units they were unfamiliar with, and with people who did not know them.
•There was a programme of activities provided by activities staff. However, improvements were required in understanding and responding to people's individual interests and need for occupation and engagement on the individual units.
•On some units, especially for those people living with dementia, there was little of interest in the décor, such as pictures, photos, or tactile aids people could touch and hold to stimulate their minds.
•Overall, individual risks to people were managed safely.
•People were confident they received the healthcare support they needed to keep their health conditions stable and knew staff would seek further support if necessary.
•Visiting healthcare professionals spoke positively about the service and people received their medicines from staff who had been trained and assessed as competent to do so safely.
•People's needs were met by staff who were skilled, competent and suitably trained. The provider monitored training to ensure staff skills were kept up to date and they received the training they required.
•Staff worked within the principles of the Mental Capacity Act 2005. People were given day to day choices and this was reflected throughout their care plans and through our observations. Staff sought people's consent before care interventions.
•People were supported to have enough to eat and drink to maintain their well-being. Nutritional risks were

known by staff who monitored people's food and fluid intake when a need had been identified.
•Staff understood the importance of supporting people with empathy and compassion and provided reassurance when people became anxious.
•Staff were non-judgemental and responded appropriately when people became distressed or agitated. They respected people's diversity and lifestyle choices.
•People's relationships with family and friends were encouraged.
•People knew the management team and staff felt motivated by the new registered manager.
•The registered manager worked with external organisations to develop the service they provided.

The registered provider was in breach of Regulations 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Rating at last inspection:
This was the first rating inspection of this service.

Why we inspected:
This was a planned inspection based on the date of registration of the service.

Enforcement:
Action provider needs to take (refer to end of report).

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our Well-Led findings below.

Hawthorne House

Detailed findings

Background to this inspection

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

Inspection team: The first inspection visit on 10 October 2018 was carried out by an inspection manager, two adult social care inspectors, a mental health inspector, a bank inspector, two specialist advisors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. A specialist advisor is a qualified health professional. One of our specialist advisors had particular expertise on supporting people with an acquired brain injury.

Due to unforeseen circumstances, we were unable to produce our report in a timely way. We informed the provider and on 30 January 2019 two adult social care inspectors and two bank inspectors returned to assess whether the level of care we had seen at our last visit had been maintained, and to assess the impact of any actions taken since that visit.

Service and service type: Hawthorne House is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager. 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.

Notice of inspection: Both inspection visits were unannounced.

What we did: We reviewed information we had received about the service since their registration with us (CQC). This included details about incidents the provider must notify us about, such as alleged abuse. We sought feedback from the local authority and professionals who work with the service. We used all this

information to plan our inspection.

During the inspection visits, we reviewed 15 people's care records to ensure they were reflective of their needs, and other documents relating to the management of the service such as quality audits, people's feedback, meeting minutes and six staff recruitment files.

During our inspection visits we spoke with 19 people living at Hawthorne House and 11 visitors or relatives of people who lived there. We also spoke with the registered manager, deputy manager, area operations director, the mental health lead, five nurses, five senior care assistants, nine healthcare assistants, three activities organisers, two trainers, a chef and a member of the housekeeping team. We also spoke with four visiting healthcare professionals and two ambulance transfer staff.

Some people were not able to tell us what they thought of living at the home; therefore, we used different methods to gather experiences of what it was like to live there. For example, we observed how staff supported people throughout the inspection to help us understand peoples' experiences of living at the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Requires Improvement: Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
•Overall, people felt safe at Hawthorne House because of the security of the home and the presence of staff. Comments by people included: "I feel safe as the staff are here to help me", "I do feel safe here, there is good security" and, "There are enough staff and I feel safe here."
•However, at our visit in October 2018 some people told us they felt anxious at night when other people became agitated and more vocal. One person commented, "I don't feel safe all the time on this unit. I've been woken up at night by noises from the outside and other people make a lot of noise at night." When we returned in January 2019 we continued to receive concerns. One person told us they did not feel safe because they had a severe sore on their skin, and the previous night their mattress pump had been knocked of the bed by night staff resulting in their airflow mattress being deflated. This had not been identified until the morning or reported to the management team. They also said they felt they had been roughly handled by agency staff the previous week-end. A second person said they had been scratched by another person, showed us some scratches on their lower shoulder and described the person who had done it. This information was given to the registered manager to investigate and make the appropriate referral to the safeguarding authorities if required.
•Relatives mostly felt confident their family members received safe care. One relative told us, "My relative is 100% safe here" and another commented, "They have been very safe here."
•Staff completed regular safeguarding training to keep their knowledge up to date. They told us they would have no hesitation in raising concerns with a manager if they suspected abuse and would escalate issues further if they felt appropriate action had not been taken. One member of staff told us, "If nothing was done I would carry on speaking up until I saw people were made safe – even if I had to speak to you (CQC)."
•Records were kept of known safeguarding concerns and alerts and, where necessary, information was shared with the local authority. A senior member of staff said, "I have told all staff if they witness anything they need to report it. We use safeguarding alert forms and send them straight to the local authority."
•However, when looking through one person's daily records for January 2019 we identified two occasions when it was recorded they had hit another person or thrown objects at other people. Neither of these incidents had been put on an incident form so the management team could consider whether a safeguarding referral needed to be made. The registered manager assured us they would review the records and if necessary, refer it to the safeguarding authority. Retrospective referrals were made the day after our inspection visit.

This was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Staffing and recruitment

•On both inspection visits, there were sufficient numbers of nursing and care staff on duty to keep people safe and monitor the communal areas of the home.
•Staff felt the staffing levels were sufficient to meet the needs of people when the units were calm. However, they said that when one person became more anxious or agitated, this usually meant others would start to behave more challengingly as well. At such times, they said it could be 'chaotic' and difficult to respond so effectively to people's needs.
•At our visit in January 2019, because of higher than average sickness levels in the home, we found staff were often assigned to work in units they were unfamiliar with, and with people who did not know them. A member of staff told us if they were assigned to a different unit, they often did not have the chance to read people's care plans and just had to "get on and do it." This meant staff did not always know how to respond effectively to people's needs to keep people and themselves safe. Relatives told us people showed increased levels of anxiety, when different or new staff were around. We were told by senior staff that whilst this continued to be an issue, it was beginning to 'settle down' and there were more times than not when staff were in the units they expected to be in.
•People and relatives told us staff were mostly available when they needed them. One person told us, "Oh yes, there are enough staff. When I ring my buzzer they usually come straight away. If I have to wait, it is not very long." Comments from relatives included: "Yes there are enough staff, they support their needs; they have enough support" and, "There are problems now and again because my relative needs two members of staff to support them. Sometimes I have to explain to my relative that they have to wait a little while."
•Some people felt staffing levels at night were not good. One person commented, "There are enough staff, but at night, there are hardly any staff" and a relative said, "There are getting to be enough staff, but they could do with another member of staff at night." We shared these concerns with the registered manager who told us they were confident there were enough staff on duty because they made unannounced spot checks at night-times to monitor the care provided.
•At the time of our first visit the provider was reliant on agency staff to cover some shifts. When we returned in January 2019, the registered manager told us they had recruited more staff, but were still relying on agency staff because of sickness levels. They were confident this would resolve as action was being taken to reduce staff absence in the home.
•During our inspection, one person fell and staff rang the emergency bell for assistance. Several senior staff from other units arrived promptly to help which demonstrated that staff were alert and responsive to emergencies.
•The provider had a safe recruitment process to help ensure staff recruited were suitable to work with the people they supported.

Assessing risk, safety monitoring and management
•Overall, individual risks to people were assessed and managed safely. All care plans included risk assessments which specified the actions required to reduce risks. These included the risks of people falling, nutrition, moving and handling and developing pressure injuries. Generally, risk assessments had been reviewed to identify any changes in people's needs which helped to keep them safe from avoidable harm.
•However, during both of our visits we found risk management plans were not sufficiently detailed. For example, one person's 'falls care plan' did not adequately inform staff of what actions they needed to take to reduce the person's risk of falling. This person had fallen twice in August 2018, but there had been no review of their falls care plan in August. The review in September had not considered the information about the falls. A registered nurse informed us they were still in the process of updating records and care plans. They recognised the shortfalls in the care documents and knew what should have been included in the record.
•People who were at risk of skin damage sat on special cushions and had pressure relief mattresses to reduce the risk of damage to their skin. Records confirmed people were re-positioned in accordance with their care plans to reduce pressure on vulnerable areas. However, mattresses were not checked to ensure

they were on the right setting to provide effective pressure relief. Some mattresses we checked were on the wrong setting. The registered manager assured us they would implement a system to check the mattresses which would be the responsibility of the clinical staff.
•Staff received training on how to respond to people's behaviours that may place them at risk, which included safe physical interventions. Care plans identified what might trigger behaviours, so staff knew how they could be avoided. This information detailed what strategies to use to engage and stimulate people, so that risks were minimised.
•Environmental risks were managed effectively. Gas, water, electrical appliances and fire safety systems were checked and serviced regularly. There was a system to ensure health and safety systems were checked regularly and equipment was serviced in accordance with specified timescales.
•Each person had a personal emergency evacuation plan detailing the support they would require if the building needed to be evacuated. Staff had received training in fire safety and knew what action to take in the event of an emergency.

Using medicines safely
•Medicines were managed and administered safely and in accordance with best practice. Medicines were stored securely and at the recommended temperature to ensure they remained effective, although the temperature of medicines fridges was not always recorded.
•Only clinical staff and senior staff who had been trained and deemed competent in medicines management gave medicines. Staff were seen to follow good medicines practice when giving people their medicines.
•We looked at a sample of 'as required' medicine plans. One person's medicine plan was for paracetamol to be taken for pain. The plan talked about the person verbalising if they had pain, but the person could not do this. There was no information about why the person might be in pain. Another of the person's 'as required' medicines was for 'agitation'. There was no information about what might cause the person to be agitated or what staff should do to try and reduce the person's agitation before proceeding to administer medication. The nurse we spoke with was aware of the shortfalls in 'medicine plans' and said they were in the process of updating them all.
•A pharmacist told us staff used the electronic medicines system effectively. They explained the system meant the pharmacy received prescriptions straight from the GP so there were no delays in people receiving their prescribed medicines.
•in October 2018 some people told us they did not receive their medicines at times they expected and as prescribed. In January 2019 this had been addressed.
•We looked at medicines taken covertly (disguised in food). We found that the GP had been consulted about medicines needed to be taken in the person's best interests, and the pharmacist had also been involved to determine whether they could be crushed or whether liquid medicines could replace tablets to make them easier to give in disguise.

Learning lessons when things go wrong
•Staff were not consistently following the provider's policies and procedures for recording incidents and accidents. Some incidents were recorded in people's daily notes, but incident forms had not always been completed. This meant managers were not aware of the incidents.
•When staff completed body maps for unexplained marks or bruises, it was not always clear what action had been taken to identify the cause.
•When we looked at the falls monitoring of the service, we found one person's falls had not been counted in the numbers and therefore management could not consider whether there was any trends or issues they needed to put right.

Preventing and controlling infection
•There were systems to prevent and control the risk of infection. Staff had completed infection control

training, had access to personal protective equipment (PPE) and wore this whenever appropriate.
•All areas of the home were clean and tidy. A member of housekeeping staff knew about maintaining good hygiene standards. They told us the provider ensured they had appropriate and suitable cleaning products so they could clean the home effectively.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•Before people moved to Hawthorne House, a comprehensive assessment of their needs was completed with the person, family or others who knew them well. This included their physical, mental health and social needs.
•From this, a personalised care plan was developed tailored to each person's individual needs.

Staff support: induction, training, skills and experience
•People's needs were met by staff who were skilled, competent and suitably trained. Newly recruited staff followed a formal induction programme and were required to undertake the required training when they commenced employment. They could 'shadow' existing and experienced staff members to gain an understanding of their role. One staff member told us their induction gave them confidence to provide effective care. They explained, "The induction included three days of training, all the mandatory topics, then I did three 'shadow' shifts followed by a fourth where I was paired up with another nurse."
•The provider's induction was linked to the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors.
•The provider had their own in-house trainer who ensured all staff received relevant, ongoing training for their roles. Staff told us the training gave them the knowledge and skills to support people according to their individual needs. A typical comment was, "The training is really good, this is the best training I have had. It's not just training, it is interactive training." Another staff member told us, "I've just done a mental health course that was a few hours every week for 12 weeks. It was really helpful."
•Staff told us they had training in dementia care. We saw the training was effective in how they responded to people's emotional needs. For example, for people who were unable to retain information, staff replied kindly and reassuringly when people repeatedly asked the same questions.
•The provider monitored training to ensure staff skills were kept up to date and they received the training they required. For example, the provider had identified that staff required more training in supporting people with behaviours that could challenge themselves, other people or staff. This training had been provided and gave staff confidence to provide effective support to people who were distressed or agitated. One staff member told us, "Challenging behaviour is new to me but I have had training and I feel confident to manage situations."
•People and relatives told us staff had the knowledge and understanding to meet their needs. Comments included: "The staff are well trained, they are always going on training" and, "The older ones know the standards, they show the new ones."
•Supervision meetings provided staff with an opportunity to discuss any concerns, their own development needs and make suggestions for the improvement of the service. At our October 2018 visit, supervisions did

not take place regularly. When we returned in January 2019 the registered manager told us improvements had been made and they were working towards providing every staff member with a supervision meeting every two months.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•People were given day to day choices and this was reflected throughout their care plans and through our observations.
•People told us staff asked for their consent before providing care. Comments included: "They ask me if it is okay to help me" and, "They ask before helping me with my shower."
•People's care plans identified whether they had the capacity to consent to living at the home. Where people were identified as lacking capacity and had someone who could legally act on their behalf when making important decisions, this was recorded in their care plan.
•Where staff had to make decisions in people's best interest, for example if people were resistant to personal care, their care plan explained the steps staff should take to minimise the need to restrict the person's liberty, and to minimise the risks of harm to the person and staff.
•Where restrictions were placed on people's care, the provider had made appropriate DoLS applications for authority.

Supporting people to eat and drink enough with choice in a balanced diet
•People were asked about their dietary needs, preferences and any allergies during their initial assessment, before they moved into the home. Where people had specific likes and dislikes, allergies and other dietary requirements, these were recorded in their care plan and on lists in the dining rooms and kitchen. This included the names of those people who needed soft or pureed meals and any other specific requests. Meals were delivered separately to the dining room for named people to minimise the risk of them being offered unsuitable foods.
•Staff knew about people's individual needs and ensured they had enough to eat and drink to maintain their well-being. During mealtimes people were offered a choice of different meals, and those who required it were given sensitive assistance by staff to eat, at the person's pace with good interactions throughout. Meal times were relaxed and not rushed.
•Overall people spoke positively about the quality and variety of the food. Comments included: "The food is lovely, loads of choice and I get enough to drink" and "You can always get a snack when you want to and the food is good with plenty of choice on the menu." However, one person commented, "Plenty of choices, however, big chunks of chicken and the knives are dull. A lot of people have dementia, how do they cope with cutting that up. There are plenty of drinks on offer."
•When it was needed care staff monitored people's food and fluid intake and referred onto healthcare professionals for advice and guidance. For example, to the GP or dietician.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
•Healthcare professionals we spoke with were positive about how care staff worked with them during their

visits. When speaking about one person a healthcare professional said, "They do a lot for [name] here, they have involved psychology, the occupational therapist and the physiotherapist so we are happy with their care here and are hoping that they will stay here to maintain the improvement."
•People were supported to attend regular appointments with their GP, dentist, optician and chiropodist to maintain their health. One member of staff told us, "There is a GP round on a Friday. They are looking as to whether they need to increase the frequency. There are no issues getting a GP out as and when needed as well."
•People said they were able to access the healthcare support they needed. Comments included: "They have a dentist and GP here, I just let the staff know if I need to see them and they sort it" and, "I don't go with the staff, my relative goes with me but staff sort out the appointment and the paperwork."
•Where a need was identified, people were referred to other healthcare professionals such as the falls clinic or occupational therapist for further advice about how risks to their health could be reduced to promote their wellbeing.
•We spoke with two ambulance transfer staff. They spoke positively about the home and the information they were given about people. They told us, "This is a good home and they always make us welcome and give a good handover. People are always ready on time. The home always has any documents that need to go with the person ready – there's no waiting while they find them."

Adapting service, design, decoration to meet people's needs
•The purpose-built premises were spacious enough to accommodate people's needs for mobility equipment and allowed easy access to all the rooms.
•The environment was well maintained and the communal areas between units enabled people to go out of their usual environment and take part in shared activities and to socialise. A visiting healthcare professional told us one person's well-being had improved and commented, "The environment seems to have contributed to their improvement."
•Staff made appropriate use of technology to support people. For example, movement sensor equipment was used to alert staff of the need to support people who were at risk of falls. An electronic call bell system allowed people to call for assistance when needed.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. .

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
•People and relatives told us staff were kind and thoughtful and one stated, "They treat me well."
•There was good interaction between staff and people. Staff used humour when speaking with people and demonstrated a readiness to spend time with them, helping them in whatever way they wanted. One person told us, "The girls are good sports, they have a laugh and a joke with you."
•Staff received training in dementia care and understood the importance of supporting people with empathy and compassion and provided reassurance when people became anxious. For example, one person became distressed because they mistakenly thought a visitor had taken their drink. A member of staff diffused the situation and calmed the person down by giving them options for a drink of their own. The staff member treated the person with courtesy and kindness which had an immediate and positive effect on them.
•Staff were informed about the medical causes of people's complex needs, which resulted in behaviour that challenged others. Staff were non-judgemental and responded appropriately when people became distressed or agitated. They understood that people's behaviours were most likely as a result of their frustrations. When one person suddenly became angry when leaving a room, staff attended quickly. They took the person a chair and crouched down to speak with them at eye level in a calm tone. They encouraged the person to follow their breathing exercises which quickly reduced the person's anxiety. The member of staff worked at the person's pace and made sure they were comfortable and continued to offer them choices throughout the intervention.
• Staff enjoyed their role in supporting people to ensure they had the best life possible. One staff member told us, "The residents are the best thing about working here. Seeing a smile on their face makes the job worthwhile. It's a nice place to work."
•Staff respected people's diversity and treated people in a kind and caring way. They respected people's individual wishes regarding their lifestyle choices. Staff were understanding and knowledgeable about how they might need to adapt their support to best match an individual's cultural and religious traditions and preferences.
•Important life events were celebrated. On the second day of our visit staff took a decorated cake to a person who was celebrating their birthday.

Supporting people to express their views and be involved in making decisions about their care
•People could make choices about how they spent their day. At 9.30am on the first day of our inspection visit, some people were up having breakfast, but others had chosen to stay in bed. One staff member told us, "We let people stick to their own schedule. People get up at the times they want."
•People were supported to stay in their rooms or attend the home's communal areas if they wished to do so.
•We received mixed responses when we asked people if they had been asked their views about the care they

received. One person responded, "I have regular monthly reviews of my care." Other people could not remember, but typically responded, "If they did, I would tell them I am happy with the care."

Respecting and promoting people's privacy, dignity and independence
•People told us they felt respected by staff. One person told us, "Staff treat me with respect and observe my dignity, they always knock on my door before entering."
•All bedrooms were for single occupancy with en-suite facilities, which helped ensure privacy and dignity was maintained when personal care was provided.
•Staff spoke to people by name and listened to their views. Staff answered people's questions honestly and when one person became agitated, staff knew which topics of conversation would bring the person to a more contented frame of mind. They encouraged a less personal conversation by including another person; the two people then developed their own conversation.
•People had been asked if they preferred male or female support and their wishes were respected. One person said, "I like to have a female carer for my personal care, I would not like a bloke. I always have females here."
•Overall, staff encouraged independence. For example, at lunch time staff cut up two people's meals, so they could eat their meal unaided at their own pace.
•People's relationships with family and friends were encouraged and relatives could visit when they wished.
•The environment was supportive of maintaining 'family units'. For example, we were told how one person's young grandchild had found it difficult that their relative was no longer in their own home. The two had enjoyed using the cinema room together which had a positive effect on them both. One relative told us, "I went on my first holiday in six years as I know they are being well cared for."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•Staff were responsive to people's requests for assistance. For example, one person asked to go outside for some fresh air in their wheelchair. A staff member escorted them outside straightaway.
•People were involved in planning and reviewing their care needs, where possible. This ensured they received care and support in accordance with their preferences. For example, one person had a plan of care that showed how staff could enable them to be more independent and manage their time more effectively. This was an important part of the person's rehabilitation.
•However, we found there was sometimes a lack of consistency in the information within care plans. For example, one person could demonstrate specific behaviours towards certain staff which could place staff at risk. As this person lived with autism, a consistent approach was vital, but there was no care plan to advise staff how to respond to these behaviours. Daily records indicated staff responses could vary which meant there was a lack of consistency in supporting the person to manage their feelings.
•Staff kept records to monitor some people's behaviours when they became challenging. These were called 'ABC' charts. Sometimes the ABC charts did not contain information about what the person was doing when they became anxious or how they demonstrated their anxiety. Staff told us the management team did not analyse the ABC charts to identity the possible triggers for people's anxiety. This meant lessons could not be learnt on how to minimise the risks of a re-occurrence.
•Staff told us that working regularly with the same people was the best way to get to know and understand them, particularly if a person was not able to express themselves verbally. Throughout our inspection visit, permanently employed staff constantly directed and guided the agency staff to make sure people received a consistent approach, based on their knowledge. When there was a change in staff, relatives worried their family members might not obtain support in a consistent way, which was really important for their well-being. One relative told us, "The majority of staff are lovely but they are changing all the time. You just think someone starts to know [name], but then they go which is difficult. There are lots of agency workers, always has been, but more particularly now so you wonder how well they know people."
•The service had 'getting to know you' information about people in care plans, but this was not always used. For example, in one person's 'getting to know you' it informed staff the person did not like being referred to by their full name, but preferred the shortened version. Throughout the other records, the person was referred to by their full name.
•The provider had specific staff to arrange activities for people in the home. Together they arranged a programme of activities, taking into account people's interests and abilities. On the day of our second inspection visit people enjoyed a coffee morning and a game of skittles in the communal area between the three units on the first floor.
•However, improvements were required in understanding and responding to people's interests and need for occupation and engagement on the individual units. Staff told us they had little time to engage with people on a one-to-one basis, particularly in the mornings. A member of staff told us they sometimes sat and read

with people in the afternoon, but we saw few people were engaged in activities that might interest them or give them something to look forward to.
•People felt the activities could be planned more around their own particular interests and hobbies. Comments included: "I don't like anything by the way of activities, but I keep myself busy" and, "There is not too much to do during the day, they do take me out sometimes." Another person said, "No-one has asked what my interests are. I have asked for painting equipment, but was refused." The mental health lead was aware of this and acknowledged that they needed to increase engagement and interaction.
•On the units for people living with dementia, there was little of interest in the décor, such as pictures, photos or tactile objects people could touch and hold to stimulate their minds. There was a lack of materials, such as board games or interactive artefacts to capture people's interest, which meant they were mostly reliant on staff for intellectual stimulation. Staff told us all the 'activities equipment' was kept on another floor which meant it was not easily accessible to people or staff. During our second visit, we saw that people were walking up and down the corridor with no obvious destination. In the afternoon, one person was falling asleep at the dining table until staff came in with some folders to write up records. The person then engaged the staff in conversation.

End of life care and support
•Where people needed end of life support, the provider had policies and procedures in place to meet people's health needs and their wishes.
•People's choices for their end of life were recorded in their care plan, when they wished to share this with the provider. One member of staff told us of a person who had recently died who followed the Muslim faith. They told us, "The family requested a north facing room so they could pray which we did accommodate – it was important to them so we did it."

Improving care quality in response to complaints or concerns
•There was a complaints procedure which was available in an easy read format so it was accessible to people.
•People told us they could raise concerns without feeling they would be discriminated against. Comments included: "I have no need to make a complaint. I would complain to the staff here if I need to" and, "I would go to whoever is in charge of the unit if I need to complain, never had to complain."
•We viewed records of recent complaints. These had been investigated thoroughly and responded to promptly in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Planning and promoting person-centred, high-quality care and support; Continuous learning and improving care

•We found improvements were required in the recording, management and analysis of accidents and incidents to drive improvement within the home. For example, one person could have feelings of anxiety and distress which could manifest as behaviour that challenged. Audit checks had not identified that staff were not recording incidents of those behaviours consistently. Sometimes those behaviours impacted on staff and other people and staff had not always completed incident forms in relation to those episodes. Whilst we were assured the person was receiving appropriate input from other health and social care professionals, a lack of incident reporting meant the management team did not have oversight of incidents that may need to be referred to the safeguarding authority. There was also the potential that risks associated with the person's care may not be managed.

•There was a process for staff to record unexplained marks or bruises on people's bodies, but further action was not always taken to identify the cause. For example, one person showed us an injury to their lower shoulder. A member of staff had recorded the injury on a body map, but no further action had been taken. The person disclosed to us that it had been caused by another person, which we shared with the registered manager.

•The provider had systems to identify where there were problems in the service, but communication between the units meant that sometimes the management team were not aware of issues staff had to face. A dual system of paper and electronic recording systems working in tandem, meant all information was not captured by management. For example, in December 2018, one person's behaviour had become extremely challenging and this resulted in a member of staff being hurt. This incident had not been identified as part of the management reporting structures, and the managers were not aware of the severity of the incident.

•Some falls people experienced had not been identified as part of the management analysis to give the provider an accurate overview to identify any trends or patterns.

•Communication was not always effective in the home. During our visit in January 2019 we were told by the registered manager that because of one person's behaviours towards female staff, two male care workers provided personal care. However, when we went on the unit, two female care staff told us they had provided this person with personal care that morning. They were not aware of the 'male only' directive, and there was nothing in the person's care plan stating this instruction. When we shared our concerns with the management team, the deputy manager told us that it was acceptable for care to be provided by a female care worker if they were supported by a male member of staff. A lack of communication and written care records meant that female care staff had been placed at risk of harm.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; how the provider understands and acts on duty of candour responsibility
•Registered providers and registered managers have a legal responsibility to inform us (CQC) about any significant events that occur in the home including any serious injuries or safeguarding events.
•The provider had a system of checks and audits to identify where improvements were needed. However, the audits and checks had not identified all the issues we found during our inspection visit. We also found there needed to be clearer lines of accountability to ensure important information was not lost between units and managers.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance

•The registered persons had failed to inform us of some significant events that had occurred in the home in accordance with their regulatory requirements. For example, we were told of a serious injury that had occurred in December 2018 and records showed another person had sustained a serious injury requiring hospital treatment in November 2018. We had not been notified of either of these injuries. We also identified at least five safeguarding incidents that had been referred to the local authority which we had not been notified of.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

•Since the service opened in July 2017 there had been three managers at Hawthorne House. The manager at the time of our inspection visit had been in post since August 2018 and had been registered with us since September 2018. The registered manager was very experienced and understood what needed to be done to improve the service and was working towards that goal.
•The registered manager was supported by a deputy manager, a head nurse and departmental managers.
•People and their relatives knew the management team. Comments included: "I know the (deputy) manager and I see him pretty often and he always asks how I am", "I know the manager and I see her on the unit quite often, she is approachable" and, "[Name] is the manager, I spoke to her this morning."
•People and relatives were confident in the management of the units and the service. Typical comments were: "I think the unit is run fairly well" and, "I can't find anything wrong with the running of the unit." However, some people did share concerns about their safety, particularly at night.
•Staff felt motivated by the new registered manager. One staff member told us, "Since the new manager came here, I have had more opportunities to take part in things and develop my knowledge, for example in the management of medicines." One member of staff told us how the registered manager was supportive during difficult times. They told us that following a death at 2.00am in the morning, the registered manager was informed and arrived at the home at 4.00am to provide support.
•At our visit in January 2019 we found the supervision and appraisal system for staff had improved and there was a strong emphasis on encouraging staff to develop their skills. Staff understood their roles and responsibilities and were committed to delivering high quality care.
•There had been high sickness levels, and staff leaving the service. New sickness procedures were reducing sickness levels, and new recruitment procedures were being trialled to provide prospective staff with a greater understanding of the complexity of people they would be working with before they started their training.
•Staff said there was an open culture where they felt confident to raise or report any concerns. Comments included: "The provider has a whistleblowing policy, I am familiar with it and would be confident to use it" and, "I am confident to be honest and open and share any concerns or issues with my manager."
•The provider's in-house trainer explained that the responsibility to challenge poor practice was embedded

within the training staff received. They explained, "We make sure staff are comfortable to challenge, even their superiors. Just because they are superiors it doesn't mean that they are right."
•The registered manager was aware of their duties under the new general data protection regulations. However, on one unit we found people's information was not kept secure so confidentiality was maintained. In full view of the corridor, there was a large whiteboard listing everyone by name, and showing some of their personal information.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
•The registered manager had introduced meetings for people and their relatives. We received mixed comments about the effectiveness of these meetings. One relative told us, "We have had two relatives' meetings. The activity staff do those which is a shame as it would be better if the management team attended. Staffing levels has been discussed at both but nothing really seems to be done." However, another relative felt more positive about their voice being heard and said, "The
relatives and patients' forum went very well. Everyone is given their say. Agency staff, we didn't know their names, they now have name tags so that was a good result."
•Information was being shared so people and relatives had a better understanding of the service. The provider's in-house trainer explained, "We welcome families to attend the training so they can understand the way we work with people with conditions like dementia. It helps us all work together so families aren't confused about why we might be doing something. Relatives told us they knew there was a meeting planned about the use of physical interventions to explain when and why it might be used in a person's best interests.
•Staff were given opportunities to share their views of the service and the support they received. For example, staff were asked to complete evaluation forms of their training courses so the provider could ensure they remained relevant and added value to staff practice.

Working in partnership with others
• The registered manager worked with external organisations to develop the service they provided. These included local authority social work teams, NHS services and teams of health and social care professionals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us of significant event that had occurred in the service in accordance with their regulatory responsibilities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's systems and processes for safeguarding people from abuse were not always operated effectively so they could immediately investigate any allegations or evidence of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems were not always effective in assessing, monitoring and mitigating the risks to people who used the service.