Hawkhurst House Limited

Hawkhurst House

Inspection report

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Date of inspection visit:
15 December 2020

Date of publication:
24 February 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hawkhurst House is registered as a care home with nursing and a supported living service, it provides personal and nursing care for up to 85 people. Both aspects of the service are provided in the same building. A person using the care home service may have their bedroom next door to a person using the supported living service and everyone may use the same communal facilities. At the time of our inspection 55 people were living at the home.

Where people use the supported living element of the service, they have a tenancy agreement with the home's provider for their accommodation. As such, we may only include them in the inspection if they also receive the regulated activity of personal care. Staff confirmed everyone living at the service received personal care, we have therefore included everyone living at the service in our inspection. People using the service were older people, some of whom were living with dementia and nursing care needs.

In addition, Hawkhurst House is identified by the Local Authority as a 'designated service provider', as described in the Government's Winter Plan for adult social care. This means the service can deliver care and accommodation for people leaving hospital, who have tested positive for COVID-19 and who will be transferring to another care home at the end of their required isolation period.

The designated area is on a separate floor, with a separate entrance and exit. Staff working in this area do not work in other parts of the home. Specific policies, procedures, equipment and training are in place to maintain infection control and support the care needs of people during their isolation period. This enables the provider to deliver this service without increasing the risk of infection to staff, visitors or people using other parts of the home.

People's experience of using this service and what we found
People using the home were positive about their experiences and told us they felt safe living there. However, we found some interactions between staff and the people they supported were poor and visibly did not meet people's expectations or social needs.

There had been a significant turnover of staff in recent months and while there were sufficient numbers of staff to meet people's needs, some staff were not familiar with the people they supported. We saw newer staff being prompted by more experienced staff about how to best support people. Conversely, experienced staff supported people positively. They engaged easily and confidently, often to the visible and verbal contentment of the people they were supporting.

Medicines were usually safely managed, there were effective checks that enabled any mistakes to be quickly identified and addressed.

Although training was continually reviewed and mostly up to date, a lack of competency assessments, other

than in giving medicines, meant the provider could not validate staff practice when interacting with the people they supported. This created difficulty in ensuring there were sufficiently experienced staff to support people. The provider had created a new post for an experienced member of staff to coach, mentor and competency assess new staff to address this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Where some people were unable to make some decisions for themselves, decisions made in their best interests were clearly recorded.

Staff understood their responsibilities in relation to safeguarding people. However, on one occasion processes within the service failed to ensure a notification about a safeguarding was sent to CQC as needed. Internal quality assurance processes identified and rectified this oversight.

Assessments had been made about risks to people and actions had been taken to minimise these. Accidents and incidents were recorded and monitored; actions were taken to minimise risks of reoccurrence.

Staff worked closely with other professionals to meet people's needs. People and families were invited to give their views on their care and they were listened to.

Oversight of the service was robust, there were effective audits in place which sought to address the concerns found during this inspection. However, some initiatives had not been in place long enough to understand if they were wholly effective. We will review the effectiveness of these initiatives at our next inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 18 November 2019).

Why we inspected
We received concerns in relation to safeguarding, staffing mix and experience, medicines and oversight of the service. A decision was made to inspect and examine those risks.

As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well Led. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hawkhurst House on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information 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? The service was safe. Details are in our safe findings below.	**Good**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Hawkhurst 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 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Hawkhurst House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Hawkhurst House also provides a supported living service to people who have a tenancy for their suite. In this case we only regulate the personal care people received.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. An interim manager was overseeing the day to day running of the service; the provider was actively seeking to recruit a permanent manager and selection processes were underway.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with the provider, the interim manager, the Clinical Care Consultant, the Designated Service unit manager, the compliance manager and three nursing staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. We also looked at a variety of records relating to the management of the service. We also spoke with one domestic cleaner as well as two care staff.

Good

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question remained the same. This meant people were safe and protected from avoidable harm.

Staffing and recruitment

● There were enough staff to meet people's needs. People told us they felt there were enough staff and our observations found staff were available to respond to people as needed, such as when they needed assistance to eat or reassurance. People looked clean and cared for, and care records reflected that people received the support they required. The provider used a dependency tool to calculate the numbers of staff needed based on people's support requirements.

● However, retention of staff had been problematic; there had been a high turnover of staff in the last few months. This had left some people feeling that they did not know who would be supporting them. One person told us, "It's always new faces".

● We discussed barriers to staff recruitment with the manager. They partially attributed this to factors such as transport difficulties and the COVID-19 pandemic. The provider had sought to address this by providing staff with free transport to and from Hawkhurst House. However, while we found the home operated with adequate staff in terms of meeting people's needs, it was unstable. The manager acknowledged recruitment and retention of staff was an area requiring improvement. They were actively seeking to recruit permanent staff and conducting exit interviews to understand why people were leaving.

● We reviewed recruitment practices. Checks on permanent new staff included obtaining a person's work references, identity, employment history and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable staff from working with people who use care and support services.

Systems and processes to safeguard people from the risk of abuse

● While potential safeguarding matters were raised with the local authority safeguarding team as needed, they were not always brought to the attention of the manager in line with the service's policy. On one occasion, this resulted in a delayed statutory notification to CQC and could have delayed the manager taking required action to reduce risk. This omission was identified by internal quality assurance processes and rectified.

● Staff had received training in safeguarding people and the whistleblowing policy. This had been discussed at a recent staff meeting to reiterate the need to inform the manager of any suspected abuse.

● The local authority safeguarding team were reviewing several safeguarding concerns raised by staff, people using the service and visiting health care professional. At the time of the inspection, the local authority review remained ongoing.

● Staff told us how they were able to recognise potential signs of abuse and felt comfortable reporting safeguarding issues. There were systems and processes to help safeguard people from abuse.

Using medicines safely

● Medicines were usually safely managed and administered. Effective checking systems allowed any errors or omissions to be quickly identified. When this occurred, staff followed policy to ensure risk was minimised.
● Where people were prescribed medicines 'as and when necessary', such as for pain relief or when they were anxious, information was available for staff about how to administer the medicines safely and consistently. Guidance included, why the medicine was prescribed, when the person may need to take it and maximum number to be taken in a 24-hour period.
● Where some people received medicines via their Percutaneous Endoscopic Gastrostomy (PEG), there were detailed instructions about how it should be given. This included information about the flushing of the PEG with water pre and post administration.
● There were safe procedures to check in medicines, dispose of unwanted medicines and maintain appropriate stock.

Assessing risk, safety monitoring and management
● Risk assessments were detailed and guided staff about what to do to minimise each identified risk and keep people safe. Individual risk assessments included risks related to falls, nutrition and hydration, health, activities and mobility.
● The manager assessed risks to individual people, their risk assessments clearly identified the areas of risk and what action to take to keep these to a minimum. Where people had specific health care needs, for example in relation to diabetes, catheter or stoma care, specific risk assessments were in place.
● Care plans explained the actions staff should take to promote people's safety while maintaining their independence and ensuring their needs were met appropriately.
● If people's skin was at risk of becoming sore or damaged, staff used pressure reducing equipment, such as, air mattresses, air cushions and creams as well as closely monitoring the condition of people's skin.
● Environmental risks and potential hazards in the premises were assessed. Gas, electricity and fire systems were tested. People had individual emergency evacuation plans. Regular fire drills were practiced and staff knew how to evacuate people safely from the building. We found some safety checks had lapsed in the months before our inspection. This was partly due to awaiting the recruitment of a new maintenance person and partly due to the need to limit the number of trades people on site during the Covid-19 pandemic. Checks had since been reinstated and an action plan provided oversight and timescales for those awaiting completion.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● Accidents and incidents were reviewed and analysed for learning and to identify themes, for example the online care planning system could be used to review the times and locations of falls. This information was used to identify any times or places where additional staff could be required.
● When things when wrong they were used as learning opportunities. The senior management team

discussed what improvements could be made to minimise reoccurrence and these formed the basis of action plans which were regularly reviewed.

Requires Improvement

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.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

● Staff were not always suitably experienced to provide the support people needed. For example, one person tried to speak with a member of staff as they walked past with another person, they asked for food and the staff member replied, "No" and walked away. The person continued shouting for something to eat and appeared distressed, staff ignored them, then shouted an acknowledgement from some distance away. A staff member arrived to support them to eat, however, there was very little engagement and they just gave them their food.

● While more experienced staff engaged very positively with people, some newer staff appeared aimless until directed by other staff.

● We raised our concerns with the manager and compliance manager about staff interactions and the quality of the induction training provided. We found, other than for nursing staff and staff trained to give medicines, there were no competency assessments of staff. This meant the provider could not validate staff practice when interacting with the people they supported.

● We received assurances the provider recognised induction training was an area requiring improvement. To facilitate this they had, the day before the inspection, created a new post whereby new staff would receive coaching and mentoring following completion of their induction training. Competency assessments would also take place to ensure learning was consolidated and evident in staff practice. We will review the effectiveness of these measures at our next inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed prior to moving into the service, this enabled staff to ensure they could meet people's needs. When it was felt that the person's needs could not be met effectively then they were not admitted.

● People's assessments were completed using recognised assessment tools such as the Waterlow score relating to skin integrity and a MUST score relating to the risks of dehydration and malnutrition. These assessments were then used as the basis for people's care plans and risk assessments.

Supporting people to eat and drink enough to maintain a balanced diet

● People's care plans contained details of their preferred food and drink. They also gave staff guidance about the consistency of food required and the level of support needed. For example, some people required their food to be in a soft consistency to minimise the risk of choking.

● Staff encouraged people to eat and drink enough to stay well. Staff offered people seconds of their meals or an additional pudding if they preferred sweet food. People were offered regular hot and cold drinks by

staff.
● Where people needed to have their food and fluid intake monitored to ensure they ate and drank enough, records were up to date and guided staff about recommended daily intakes and what to do if these were not met. This helped to monitor people's nutrition and reduced the risk of dehydration.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's care plans gave staff the guidance needed to support their health needs. For example, when people were living with diabetes, their care plan stated their acceptable blood sugar levels and the action to take if they were too high or too low. There was also information about the signs staff may see if the person's blood sugar was not in the acceptable range.
● Staff had made referrals to other agencies as required. For example, when people had a number of falls, they had been referred to the falls team. When people's mobility deteriorated advice was sought from physiotherapists or occupational therapists about the best way to support people.
● When people were living with dementia or another mental health condition staff were given information about how this affected them and the support they needed. For example, how to reassure people who were anxious and how to communicate with those whose dementia had become advanced.

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 when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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 had the appropriate legal authority and were being met.

● People were given choices by staff throughout the inspection. People were asked for their consent before staff helped them to move or offered help.
● When required, DoLS were in place and there was a system to ensure that they were applied for prior to their end date.
● When people lacked capacity, decisions had been made in their best interest. For example, about living at the service and receiving some medicines covertly. These decisions were made by the people who knew the person best including their loved ones and medical professionals.
● When people's loved ones had lasting power of attorney (LPA), this had been recorded in their care plan and proof had been seen. The person with LPA was then kept up to date about their loved ones needs and consulted about any changes in their care. A lasting power of attorney (LPA) is a way of giving someone you trust, your attorney, the legal authority to make decisions on your behalf if you lose the mental capacity to do so in the future, or if you no longer want to make decisions for yourself.

Adapting service, design, decoration to meet people's needs

● The service provided accommodation for people over three floors and was purpose built. Corridors and communal areas were spacious, enabling people who used wheelchairs to navigate easily. A passenger lift provided step free access to each floor. The home was light, well-furnished and presented a welcoming environment. Bathrooms were well proportioned and well equipped, there were specialist baths and showers and enough room for staff to support people safely.

● Rooms were personalised with people's belongings and tailored to meet their needs. For example, some people's en-suite bathrooms were equipped with hand grab rails to help people navigate safely and use them independently.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements, Continuous learning and improving care

- The service had failed to meet one of the requirements of their registration, whereby a registered manager must be in post. Discussion with the provider found the previous registered manager had left unexpectedly and, although interviews were taking place for a new manager, an application had not been submitted. The failure to meet this registration requirement is a factor limiting the rating for the Well-Led key question to Requires Improvement. An interim manager was in place overseeing the day to day running of the service.
- Our observation found some staff were unclear of their roles, they required prompting from more experienced staff about how best to support people. Competency assessments were not routinely in place. The provider and compliance manager recognised this and had created a new role for an experienced member of staff to address this concern. The effectiveness of this measure will be reviewed at our next inspection.
- Audits were comprehensive and effective; they had identified the concerns found at this inspection. Measures had been put in place to address the concerns which reinforced a culture of learning and improvement. The effectiveness of these measures will be reviewed at our next inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were asked their views through meetings and surveys, although not everyone we spoke with was aware that this happened. We reviewed some surveys people had completed and found the results were positive.
- Staff had worked hard to ensure people were not unsettled by the measures in place to protect them from the risk of contracting COVID-19. They had spoken with people about the need to restrict visitors and why PPE was in use. The service had adapted their approach when working with families to follow the guidelines in the current pandemic, whilst continuing to offer support.
- The manager held staff meetings where staff could raise issues and information could be shared. They had also introduced responsive meetings to communicate important messages to staff.

Working in partnership with others

- The manager worked with other professionals to support people to stay as safe and well as possible. For example, they had ordered a stock of COVID-19 test kits, so they could test staff and people regularly. Where

people needed support from other health care professionals, referrals had been made. These included, for example, occupational therapists, tissue viability nurses and the community mental health team.

● The service worked closely with the local hospice team when people neared end of life to ensure they were comfortable and their wishes were known.

● Staff had built strong relationships with social services and discharge teams at local hospitals to support a smooth transition for people into the service. The manager knew who they could contact for support with issues or concerns, including CCG staff and the local authority safeguarding team.

● People were referred to advocacy services when they needed to make important decisions about their lives.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager understood their responsibility under the duty of candour.

● People, their families and stakeholders were informed when things went wrong and about the actions taken to minimise the risk of issues reoccurring.