Care Quality Commission

Sanctuary Care Limited

Hawthorn Green Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 28, 29 May and 2 June 2015 and was unannounced. At the last inspection on 14 and 15 July 2014 we asked the provider to take action to make improvements about the number of staff and promoting people's welfare by providing activities based on their interests. At this inspection we found these improvements had been made.

Hawthorn Green Nursing Home provides nursing care for up to 90 people. The home is organised into six units, three of which specialise in caring for people with dementia. Five of the units provide nursing care and the remainder provides residential care. There were 72 people living at the service at the time of our inspection.

A new manager had been in post since the end of 2014 and has a pending application to register as the registered manager of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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 were not always protected from risks to their health and wellbeing because risk assessment did not provide enough detail to guide staff about how to minimise risks. People who were at risk of developing pressure sores were not protected from the risk of potential harm because turning charts were not completed accurately.

The control and prevention of infections was not always well managed because linens were not washed at the right temperature.

Medicines were administered, stored and disposed of safely. However, the provider did not use pain charts to assess levels of pain experienced by people who could not express themselves fully.

People were protected from the risk of unsafe and inappropriate care by staff who had a good understanding of safeguarding adults.

Sufficient numbers of day staff had been deployed throughout the service to meet people's needs.

The provider supported people whose behaviour may have challenged others.

A thorough recruitment system meant people were supported by care staff and volunteers who were suitable for work in the caring profession.

People were supported to maintain good health because they had good access to healthcare services for ongoing support. However, the provider could not be assured people had adequate nutritional intake because records were not up to date.

The provider did not always support people adequately around their end of life care because people's requests were not being met.

Staff had developed caring and compassionate relationships with people using the service and supported them to make decisions about daily tasks where possible. Staff maintained people's privacy but more could be done to support people's diversity.

Care planning and subsequent reviews did not always provide written guidance that was tailored to the individual's changing needs.

The activity coordinator was implementing a series of improvements to tie activities into people's backgrounds and interests.

The provider did not manage complaints consistently.

There was an open culture at the service, however, formal communication methods were not entrenched. There was confusion amongst relatives about who held ultimate responsibility for the running of the service.

We found two breaches of the regulations relating to safe care and treatment, complaints, person centred care and nutritional and hydration needs. You can see what action we told the provider to take at the back of the full version of the report. We have made a recommendation about activities and infection control.

Summary of findings

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. People were not protected from the risk of harm.

The control and prevention of infections was not always well managed and the recruitment process was not always robust.

Staffing levels were adequate.

Medicines were administered, stored and disposed of safely. However, the provider did not use pain charts to assess levels of pain experienced by people who could not express themselves fully.

Is the service effective?

Requires improvement

The service was not always effective. The provider could not be assured people had adequate nutritional intake because records were not up to date.

People were supported to maintain good health because they had good access to healthcare services for ongoing support.

Staff had a good basic understanding of the principles of the Mental Capacity Act 2005.

Is the service caring?

Requires improvement

The service was not always caring because they did not adequately support people who required end of life care.

People's diversity was not always promoted.

Staff had developed caring and compassionate relationships with people who use the service.

Is the service responsive?

Requires improvement

The service was not always responsive because written guidance for staff was not always updated following a change in people's needs.

Complaints were not always dealt with satisfactorily.

People were supported to take part in activities that were tailored to their interests.

Is the service well-led?

Requires improvement

The service was not always well led. There was misunderstanding from stakeholders about who had ultimate responsibility for the home. Formal communication methods were under used.

The provider had implemented effective quality monitoring systems which were driving the improvements that were being made at the service.

Hawthorn Green Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 28, 29 May and 2 June 2015 and was unannounced.

The inspection was conducted by two inspectors, and two specialist professional advisors. Before the inspection we reviewed the information we held about the service and statutory notifications received. During the inspection we used a number of different methods to help us understand the experiences of people supported by the service. We spoke with 12 people using the service and nine relatives. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three visiting healthcare professionals.

We spoke with the manager, the deputy manager, the clinical lead, the regional manager, eight care workers, eight nurses, and six auxiliary staff members. We looked at 10 people's care records, 12 staff files, as well as records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

The provider had taken action to address the concerns identified at our previous inspection in regard to staffing levels. Sufficient numbers of day staff had been deployed throughout the service to meet people's needs. People told us, "There are enough staff." A relative said, "There are always staff about, the ratio seems alright to me". The rota we reviewed demonstrated that staffing numbers were adequate to support people. There was one nurse and three care staff available on each unit where up to 15 people were living. At the time of our inspection 7 beds were unoccupied. The regional manager stated his commitment to maintain the level of staff even during periods where occupancy levels were not at 100 per cent to always ensure people were kept safe.

During this inspection we found that people were not always protected from risks to their health and wellbeing. We saw risk assessments relating to nutrition, continence, falls, moving and handling, and Waterlow in people's care files. However, the quality of the care records was inconsistent and did not always provide sufficient detail for staff about how to manage specific risks. For example, the risk assessment for a diabetic person did not inform staff about what to specifically look out for if the individual became hypo or hyper glycaemic or what action must be taken to minimise the risk to that individual.

Furthermore, people who were at risk of developing pressure sores were not protected from the risk of potential harm. Staff were unaware of one person who required support to change position. Repositioning charts to guide staff were inaccurate. We observed that by 16.00 on the first day of the inspection, these charts had not been filled in since 07.00 that morning. Not accurately completing these charts meant staff could not be aware of when or into what position a person should be supported to turn. We observed that one person had not been turned throughout our visit on the first day. Staff informed us that they did not fill in the charts accurately because they were not kept in people's rooms where they could be easily filled in as they went and, instead, completed them at the end of the day. The charts did not always specify to what position someone had been moved, which potentially meant that staff would not be able to accurately follow the people's agreed positioning regime.

We discussed the ongoing assessment of one person's wound as no documentation had been made for almost a month. We were informed that the wound had healed; however, an entry to that effect had not been documented.

Staff were not always aware of how to protect people during emergencies. For example, during a fire; one staff member asked, "If it's a real fire what do people do?"

The issues above relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The control and prevention of infections was not always well managed. We observed that linen was washed at 60 degrees Celsius which was confirmed by staff. This is a lower temperature than required in the guidance in the Prevention and Control of Infection in Care Homes (Department of Health 18th February 2013). Therefore the provider's practice put people at risk of cross-infection in the event of infective diarrhoea and vomiting. However, staff were seen to be wearing gloves and following good practice around hand washing.

A thorough recruitment system was in place for care staff; the staff files we reviewed contained application forms, interview records, proof of their right to work in the UK, criminal record checks and two references.

Medicines were administered, stored and disposed of safely. The administration of medicines was recorded accurately in the medicines administration records. Audits and nurse competency assessments ensured people's medicines were administered safely. Disposal of medicines records were accurately maintained. Controlled drugs were locked in a secure cupboard appropriately. This protected people from unsafe administration of medicines, and the potential misuse of medicines. However, the provider did not use pain charts to assess levels experienced by people who could not express themselves verbally although spare copies were available at the service.

People were protected from the risk of unsafe and inappropriate care by staff who had a good understanding about how to safeguard adults from abuse. People told us, "People are nice and looked after… The safety is very good." Staff were able to identify the different types of potential abuse and stated that they would report any instances of abuse to the manager. Staff had received safeguarding training which they felt was beneficial. The

Requires improvement

Is the service safe?

management team were aware of their duty to report instances of suspected abuse to the local authority and the Care Quality Commission and we saw evidence of this having been done.

However, the safeguarding and whistleblowing policies did not provide contact details for the appropriate local authority safeguarding teams. The management team agreed that this was an inappropriate omission and stated they would amend the oversight.

The provider supported people whose behaviour may have challenged others. People told us, "Here we try to be kind to each other. If there are quarrels people are taken aside by a member of staff and peace is usually restored". Relatives were satisfied with the approach of the service stating, "I see when people are challenging and staff treat them very nicely." Staff had a good understanding of individuals' needs and we observed staff defusing situations using distraction techniques. The policy available to guide staff provided a clear procedure for them to follow.

We recommend that the provider seek advice and guidance from reputable sources about the prevention and control of infection.

Requires improvement

Is the service effective?

Our findings

The provider could not be assured people had adequate nutritional intake because records were not up to date. Staff told us they were not always filling in the charts at the time food and drinks were given, therefore there was a risk they would not remember accurately. The auditing tool was not effective because people were reported to have had such low amounts of fluids; it should have prompted the unit nurse to query the amount, or the unit nurse should have been asked to explain the situation to the manager but this had not occurred. This meant there was a risk that people may not have always been referred promptly to healthcare professionals to look into their nutritional needs. Appropriate written guidance was not always available to staff in people's care records. For example, we were told by a nurse that a person should have an acute care plan to address their recent weight loss, however, this was not in the care record and staff were using the existing care plan for eating and drinking.

People told us, "the food is enjoyable enough, I wasn't brought up fussy." One relative said, "We worry [they] are not eating properly… There is no quality or meal variety." Menus and condiments were not available on the table.

The issues above relate to a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Positively, we observed lunch in two units where music was played and people were singing along to it and enjoying their meals. Staff assisted people to eat their food at their own pace and extra helpings were available. A soft diet was available to those who required it and we noted that referrals had been made to a dietitian as appropriate.

People were supported to maintain good health because they had good access to healthcare services for ongoing support. A good working partnership had been developed with the local GP, dietitians and occupational therapists. This was confirmed by the GP who visited during our inspection and by people's care records.

The Mental Capacity Act 2005 (MCA) provides the legal framework to protect and support people who do not have the capacity to make specific decisions. We noted that the provider had carried out mental capacity assessments when required under the MCA.

Care staff had had a basic understanding of the principles of the Act. For example, staff understood people's right to make their own decisions whenever possible.

The Deprivation of Liberty Safeguards (DoLS) ensure that, where a person cannot provide consent, any restriction on their liberty is in their best interests. The management team understood the legal framework and recent Case Law and had submitted DoLS applications for people who could not consent to restrictions on their liberty, such as not leaving the service without support. The relevant paper work was held in people's care files.

Care staff understood that they were able to provide care in certain situations but that they could not force people to do things. Most staff we spoke with were aware of the people who were subject to DoLS. However, two staff members were not, therefore people were at risk of being supported inappropriately. One member of care staff spoke extensively about who to involve in decisions about care such as the person who has lasting power of attorney for health and welfare. Staff used hand signals to obtain people's consent who could not verbally communicate about day to day tasks and to understand what they liked to do.

The provider was undertaking an ongoing piece of work to ensure staff had the necessary skills and knowledge to meet peoples' needs. We noted that during the most recent audit in May 2015 the completion rate of mandatory training was at 81 per cent as opposed to 63 per cent in March 2015. Disciplinary action had been taken where people had not completed training as required to ensure competency. We found a number of staff had a national vocational qualification in health and social care and they were able to speak knowledgeably about the courses they had taken. Staff felt supported to undertake further training. Care staff discussed their professional development in one to one supervision meetings and annual appraisals that had recommenced on a regular basis this year 2015. The sessions were designed to support staff to carry out their roles effectively in line with the provider's policies and procedures.

Requires improvement

Is the service caring?

Our findings

The provider did not always support people adequately around their end of life care because psychological needs assessments were not in place and people's requests were not being followed. For example, one person's requests about their environment were not being complied with. Furthermore, their repositioning was not being carried out as per the care plan and there was not a care plan to manage an ongoing wound and associated pain was not being assessed. There was a lack of clarity amongst staff as to whether this person was on end of life care and the management team agreed that this should have been made clear from their records, which it was not.

The issues above relate to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's diversity was not always considered by the provider. For example, Holy Communion was offered at the service monthly; however, people from other religions were not catered for. A person had asked for regular visits to their place of worship during a meeting but this had not been arranged. Positively, there was a commitment from the provider to ensure that people from a particular cultural background were supported by staff who shared that background or spoke their first language. One staff member also discussed how they supported a person to undertake religious rituals, "One person likes to do the Rosary, I start it and [they] finish it." Staff spoke respectfully about people's different values and traditions.

We observed caring and compassionate relationships were developed by staff with people living at the service. People were happy with staff treatment, "I've been at the home for two to three years and I find the staff good and that I know them well." Another told us, "We have a laugh and have a joke with staff." Relatives found staff to be "gentle". One told us, "The staff are caring, they know people's little foibles. I admire the staff." There were instances of interaction between the people using the service .One person told us that during a recent hospital admission both staff and people from the service came to visit him, which he was pleased about. However, this was not widespread throughout the service and people were often sitting alone and not engaged with each other.

Staff supported people to express their views and sought consent to carry out daily care tasks. A person told us, "I can get a bath or shower when I want and I go to the hairdresser once a fortnight." We observed staff members lowering themselves to people's eye level, maintaining eye contact and using hand signals alongside verbal questions. Staff asked people about whether they wanted to do something before they assisted them, for example when moving someone to the lunch table. We saw that a brief personal history was included in care records and staff told us that they used these to understand people's preferences.

People's privacy and dignity was respected. People told us, "Staff always knock on my door before entering." Staff informed us they maintained people's privacy by closing the door during care tasks and we observed this being done.

Requires improvement

Is the service responsive?

Our findings

The provider had taken action to make improvements to the concerns identified at our previous inspection regarding promoting people's welfare and wellbeing by taking into account people's hobbies and individual interests. An activities leader and an activities assistant had been recruited since our last inspection who had begun a series of improvements. Activities were provided seven days a week. The provider had sought guidance from the local authority and had worked with an occupational therapist (OT) to develop activities appropriate to people's needs and preferences. The OT spoke positively about the improvements the service had made. Activities were planned to include people who were unable to participate in group activities. We found that staff made time to sit with people if they preferred to stay in their rooms and a hand washing and massage activity had been set up for them. We also observed that a sensory machine had been set up in a person's room. Staff were aware of the type of music people liked and sang it with them or put it on in their rooms and pictures of where people had grown up had been printed to be used as discussion starters. The people using the service wanted a home cat and the provider bought one for the service. Two group activities took place each day on a unit, such as using a parachute or musical entertainment.

However, the provider told us they were not able to offer a large group activity on each unit every day meaning that some people were left sedentary for extended periods of time. One person reported, "I would like to do more things like making stuff out of plasticine." This is an area that would benefit from further improvement.

People were supported to maintain links with the local community. Relatives told us that they had been invited to informal events such as gardening and cocktail evenings. People had been on trips such as to a show and the Imperial War Museum. Links with a local school had been developed and children visited regularly. The coordinator was in the process of arranging for people living at the service to go to the school and use their facilities such as the art room.

During this inspection we found that people did not always receive care that was responsive to their needs and preferences. Relative's informed us that they had been involved in planning their family member's care and staff took the time to ask them about their relative's preferences. However, people were not fully involved in planning their own care. For example, there was no evidence that a person who had capacity to make decisions about their care had been involved in their care planning since they signed their care plan in 2013. We saw that care plans were reviewed monthly by staff members, but there was no evidence that people who used the service had been invited to participate in reviewing these documents. Involvement in care planning can help some people to feel more in control of their care arrangements and it can also help staff to understand an individual's priorities.

Care planning and subsequent reviews did not always provide written guidance that was tailored to the individual's needs. We saw evidence that one had been updated following a person's fall. However, care records did not always reflect people's changing needs where they were more complex. For example, the assessment of a person whose behaviour may have challenged the service had not been updated since 2013 and the manager stated that he was no longer presenting the types of behaviour that it specified. This meant that staff may not be able to respond to this person's behaviour and support them adequately. A member of staff told us how they supported someone when they became anxious by saying, 'I will arrange for your mum to come and visit on the weekend' which calmed them, however this technique was not included in the care plan meaning agency staff would not be able to respond to the person's needs effectively.

Care plans contained a 'personal history' of each person including personal information such as their family life. They were written in a person-centred manner and included preferences such as what time they like to get up.

The provider did not manage complaints consistently. People told us they would tell staff if they were unhappy. One person had made a complaint and felt the staff handled it well. Relatives we spoke with had mixed views about how their concerns were dealt with. There were those who reported that staff on the units dealt with their concerns satisfactorily. Records demonstrated formal complaints were kept computerised and had been dealt with following the provider's complaints procedure. However, a relative told us about a complaint they had made but we could not find a record of it on the system. Day-to-day concerns were not recorded in an appropriate monitoring system and a relative told us about a repeated

Requires improvement

Is the service responsive?

request for certain food to be provided which was not complied with. Furthermore, it is best practice for an easy read complaints procedure to be discussed with people living at the service. This was not in place meaning the provider had not done all it could to support people to feedback about the service.

The issues above relate to a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We recommend that the service seek advice from a reputable source about how to increase resources to increase the activities that can be offered to people using the service.

Requires improvement

Is the service well-led?

Our findings

In recent years there had been a succession of managers who had worked at the service for a short period of time. The current manager had been in post since the end of 2014 and was in the process of applying for registration with the Care Quality Commission. Despite the manager's efforts to make himself visible at the service such as moving the office to the centre of the home, walking around the building and chairing relative's meetings, this disruption in the management of the service had led to some confusion amongst relatives about who was responsible for running the service. Three relatives we spoke with were not aware of who the new manager of the service was and relatives viewed nurses as their main contact within the service, "We know the head nurse but don't know the manager. They introduce themselves and then they change."

People, relatives and staff reported an open culture at the service. One person told us, "The manager is frequently available and listens to what we have to say." There were regular 'resident meetings' however, the views of those who could not communicate fully were not recorded in the minutes. A relative told us, "I get the impression that the main nurse would be open to listening to any concerns or comments." The provider was working to establish relatives meetings but had found attendance was low and had produced monthly newsletters as an alternative way to disseminate information. Staff felt the manager was approachable and friendly and reported they could speak to him about different issues.

Staff felt accountable to people and their relatives and discussed the feedback they received from line managers during their shifts, "The nurses feed back to us at the end of a shift if we have done a good job, the senior nurse will tell us if we could have done something better, relatives also give us feedback." Staff expressed they felt supported by the provider and were able to raise queries or concerns to the registered manager directly on a day-to-day basis and at supervision sessions. However, staff were not always supported to feedback using formal communication methods. This could benefit from improvement in order to discuss people's care and the running of the service, such as more detailed handovers.

The management team comprised of a home manager, deputy manager and clinical lead. They felt well supported by the regional manager who visited the service often and told us that an open relationship had been developed where they would work together to find solutions to problems.

The service was organised in a way that promoted safe care through effective quality monitoring. A number of audits had been completed, such as monthly inspections by the regional manager and medicine audits. The home manager completed a daily round of the units each day. The regional manager completed a daily walk around the service. These audits had identified problems in the service and 'service improvement plans' had been drafted to address the shortfalls within a certain timeframe. For example, mental capacity assessments had been completed where they were previously missing. However, not all the areas for improvement we found had been identified by the audits.

All accidents and incidents were compiled by time and location on a monthly basis and the manager monitored these reports to identify if accidents were increasing at a particular time or area. However, the accidents we reviewed had not been investigated which meant that the root cause may not have been known and the provider could not be assured they were improving the service for those individuals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not assess all risks to the safety of service users and did not do all that was reasonably practicable to mitigate all risks. Regulation 12(2)(a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The provider could not be assured that the nutritional and hydration needs of service users were being met. Regulation 14(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The provider did not ensure the care and treatment was appropriate, met people's needs and reflected their preferences in end of life care. Regulation 9(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The provider did not ensure any complaints received were investigated and necessary and proportionate action taken in response to any failure identified by the complaint or investigation. The provider had not established and was not operating effectively an accessible system for identifying, receiving,**

This section is primarily information for the provider

Action we have told the provider to take

recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16(1) and (2)