Dr M J Sturgess

Hayes Court

Inspection report

50 Hayes Lane
Kenley
Surrey
CR8 5LA

Tel: 02086603432
Website: www.hayescourt.com

Date of inspection visit:
08 December 2016
09 December 2016

Date of publication:
16 February 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 8 and 9 December 2016 and was unannounced.

At our last inspection in August 2014 the provider met the regulations we inspected.

Hayes Court is registered to provide residential and nursing care for up to 56 elderly people, some of who are living with dementia. There were 49 people living in the home at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe from abuse. Staff had a good understanding of how to identify abuse and report any concerns.

People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to store and manage the administration of medicines.

Staff had not received training on the Mental Capacity Act and had little understanding of how it applied to people in their care. People were deemed to not have capacity to make decisions, although an assessment of their capacity had not been completed. This meant there was a risk of people having decisions made for them when they were able to make decisions for themselves, and that they were not as involved in day-to-day decisions about their care as they could be.

People's needs had been assessed and care plans were developed. People's care plans stated how their care should be delivered, but did not take account of people's individual preferences and social needs or interests. There was insufficient stimulation or activity for people living in the home. There were few if any opportunities for people to leave the home unless they had the support of their relatives.

People were satisfied with the quality of their meals and told us they had a sufficient amount to eat and drink. Staff supported people to maintain good health.

Staff were recruited using an effective procedure which was consistently applied. However, the provider did not employ a sufficient number of suitably qualified staff to meet people's needs. Staff received basic training in the areas relevant to their role but did not always have the training or skills to safely and effectively support people with more complex needs.

People were complimentary about the staff. Staff respected people's privacy and interacted with people in a caring and respectful manner. However, the care provided was task driven and not person-centred. People

told us staff did not have the time to have any meaningful conversations with them.

Improvements were required to ensure the service was well-led. The registered manager and provider did not have effective quality assurance systems in place to assess and monitor the quality of care people received.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to there being an insufficient number of staff to meet people's needs, the lack of appropriate systems to ensure people received their medicines safely, the failure to follow the requirements of the Mental Capacity Act 2005 and associated code of practice, the lack of person-centred care and the lack of effective systems to assess and monitor the quality of care people received. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Some aspects of the service were not safe.

Processes and procedures for ensuring people received their medicines safely were not always clear or followed by staff. There was not enough staff to meet people's needs.

People felt safe and staff knew about their responsibility to protect people from abuse. Staff were recruited using an appropriate recruitment procedure which was consistently applied. Appropriate checks were carried out on staff before they began to work with people.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff did not understand the main principles of the Mental Capacity Act 2005 and how it applied to people in their care.

The provider did not adequately support staff through relevant training.

People received a choice of meals and had sufficient to eat and drink. Staff supported people to maintain their health.

Is the service caring?

Good

The service was caring.

Staff were caring. People were treated with respect.

People were supported to plan their end of life care.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive to people's needs.

People did not feel in control of the care and support they received. People did not always receive personalised care.

People felt able to complain and that their complaints would be dealt with appropriately.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led

There was not always effective systems in place to assess and monitor the quality of care people received.

There was a clear management structure in place which people living in the home and staff understood. People using the service, their relatives and staff felt able to approach the management with their concerns.

Hayes Court

Detailed findings

Background to this inspection

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

The inspection took place on 8 and 9 December 2016 and was unannounced. The inspection was conducted by an inspector, an expert by experience with a special interest in elderly care and a specialist adviser with a specialism in medicine management.

As part of this inspection we reviewed the information we held about the service, including the last inspection report and the provider's information return (PIR). A PIR is a form that we ask providers to complete that tells us about the operation of the service, what they do to meet people's needs and any proposed improvement plans.

Some of the people living at the home were living with dementia and were not fully able to tell us their views and experiences. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support people received in the lounge, and in the dining room during lunchtime.

We looked at all areas of the home and at equipment. We spoke with six people living in the home, six care workers, the cook, a nurse and the registered manager. We also spent time looking at records including eight people's care files, five staff files and records relating to the management of the home. We spoke with members of the commissioning team from a local authority that commissions the service.

Inadequate

Is the service safe?

Our findings

People did not have any concerns about the way their medicines were managed and told us they received their prescribed medicines when they should. However, we found the arrangements in place for ordering, storing, administering and recording people's medicines were not safe.

The provider's policies and procedures in place for managing people's medicines when they first moved into the home were not always followed by staff. We saw evidence that a person had been regularly administered insulin based on information received from the hospital when the person was discharged, without a discharge note in place for the nurses to refer to.

There was one medication room on the ground floor used to store and prepare people's medicines. There was not an appropriate level of cleanliness and hygiene in the medication room. The floor was stained and sticky indicating that it had not been properly cleaned recently. Bottles of liquid medication had not been wiped after use leaving the bottles stuck in their boxes and some of the bottles stuck to the shelves. Non-medicinal products were stored alongside medicines. People's cigarettes and lighters were stored in a shelving unit next to people's spirometers, inhalers and nebulisers.

The clinical lead told us that several people required their medicines to be crushed in order for them to be administered. There was also a single small metal pestle and mortar. The clinical lead told us people did not have separate, named pill crushers but the pestle and mortar were cleaned between use. The pestle and mortar had substantial white powder residue. The fact that the same pestle and mortar was being used to crush several people's medicines meant there was a risk of the medicines interacting which could lead to unexpected side-effects..

There were inadequate arrangements in place to ensure people's creams and emollients including steroid creams, were stored and applied safely. Some creams were kept in people's rooms. In one person's room we saw a cream which was in use had been dispensed in March 2016 and there was no date of opening recorded. There were also two other creams which had no opening date and no information regarding the date it had been dispensed. This meant there was a risk of people using creams which were past there use by date which could lead to reduced effectiveness, skin irritation and/or bacterial infection.

People who required steroid creams were at risk of having the wrong amount of cream applied. These medicines are not meant to treat large areas of skin. They have a dose the manufacturers recommend but staff were unaware of these recommendations and therefore were not following them. There was not an effective system in place for staff to record when creams had been applied to people. We asked staff about the arrangements for recording when people's creams had been administered. One staff member told us that there was "a cream's book" but this could not be found when we asked to look at it. The clinical lead was not sure whether any records were completed of the creams applied to people.

We found that fluid/food thickener was stored in people's rooms which meant there was a risk of people accidentally ingesting it and choking. There were inadequate arrangements in place to help ensure that

people who required fluid or food thickener received it safely. People's care plans did not have sufficient information to enable staff to use thickeners appropriately. For example, the care plans of people who required the use of thickeners did not state how they should be prepared. We spoke to two staff members about how they prepare the thickener they use for a person who required it and both gave us different answers. We were unable to clarify how the thickener should be prepared as there was not any information relating to this in the person's care plan. We raised our concerns about the arrangements in place for the use of thickeners with the manager and clinical lead. Both were unaware of the risks associated with the use of thickeners or of recent guidance issued by the Department of Health on the safe use of thickeners

People's medicines profile did not always contain details of their allergies. Two people's care files had details of their allergies but this information was not contain in their medicine profile. This meant there was a risk of people being given medicines they might be allergic to.

The clinical lead nurse told us that only nurses administered medicines. On speaking to care staff it became clear that whilst nurses prepared people's medicines, the function of administering medicines was delegated to care staff. This was confirmed when we checked the medicine administration records.. Care staff had not been trained in administering medicines and the provider could not provide evidence that their competency to administer medicines safely had been assessed.

Since the inspection we have seen confirmation that major steps have been taken to address many of the deficiencies we found in relation to the management of medicines. However, we remain concerned that until the new systems are embedded and audited, staff have been trained and/or their competency to administer medicines checked, there is a risk that people will not receive their medicines safely.

There were not appropriate arrangements in place in relation to the ordering, storing, administration and recording of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

There was not a sufficient number of nursing staff to meet people's needs and help keep people safe. On the first day of our inspection there was one nurse on duty. The nurse who was also the clinical lead was responsible for assessing people's needs; providing nursing care; managing and administering medicines and monitoring and influencing the standard of clinical care provided by nursing and care staff. It was clear from speaking to the nurse that they were overwhelmed by their responsibilities and that this had impacted the quality of care people received for example, in relation to the safe administration of medicines. Staff told us there was usually one nurse working at night.

There were also insufficient care staff to meet people's needs. On two occasions we saw one member of staff using a hoist to move a person, when the hoist could only be safely used by two staff members. We spoke with people who required the assistance of a hoist to move from one place to another. One person told us, "I have two staff most of the time but sometimes there is one because they are short staffed." Another person told us, "I usually have two and I've had one [staff member]." We observed there was insufficient staff in the dining room at lunchtime to support people who required assistance to eat. Four people had to wait to be assisted by staff and fell asleep before staff were free to support them to eat lunch.

This amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

People told us they felt safe from abuse and knew what to do if they felt at risk of abuse. People commented, "There's always someone around 24 hours a day" and "I fee safe enough. If I didn't I'd tell my

family." The provider had taken reasonable steps to protect people from abuse. The home had safeguarding and whistle-blowing policies and procedures for staff to follow if they had concerns that a person living in the home was at risk of abuse. Staff we spoke with were familiar with these policies and procedures. They also knew how to identify abuse and how to report their concerns internally and externally.

Staff were recruited using a safe recruitment practice which was consistently applied. This included appropriate checks before staff began to work with people. Records we reviewed demonstrated that professional references, confirmation of applicant's right to work in the United Kingdom and that they were physically and mentally fit to do the job were obtained. Criminal record checks were also carried out. This minimised the risk of people being cared for by staff who were inappropriate for the role.

The building and surrounding gardens were adequately maintained to keep people safe. The water tanks and utilities were regularly inspected and tested. The home was fully accessible. The home had procedures in place which aimed to keep people safe and provide a continuity of care in the event of an unexpected emergency such as, a fire or boiler breakdown. We saw confirmation there were arrangements in place to test and service essential equipment such as lifts, call bells and hoists. Staff had been trained in how to use the equipment people needed.

With the exception of the medicines room, the home was clean and well maintained. People told us the standard of cleanliness was always good. Staff practised good hand hygiene, put on personal protective equipment such as disposable gloves and aprons before delivering personal care. There were appropriate arrangements in place for the disposal of clinical and non-clinical waste. These measures helped to protect people from the risk and spread of infection.

Requires Improvement

Is the service effective?

Our findings

People had mixed views on whether staff had the necessary skills and training to provide effective care. People commented, "'Most them 80/20 know what they are doing', "I believe so", "Yes" and "Not all the time some are good some are not."

Once appointed, staff were required to complete an induction. This covered the main policies and procedures of the service and basic training in the essential skills required for their role. Newly appointed staff were required to shadow an experienced staff member and observe care being delivered before they were allowed to work alone with people.

Staff received training in areas relevant to their work such as safeguarding adults and infection control. However, staff did not have training to provide effective care to people with complex needs. This meant that people were at risk of receiving care that was inappropriate or unsafe. For example, people who required PEG feeding - a procedure in which a tube is passed into a person's stomach - were supported by some staff who had not had any training on the risks associated with PEG feeding or aftercare once the tube was in place. We raised this with the registered manager who showed us documentary evidence that staff had been booked on a training course for the week following our inspection. However, we remain concerned that some people were being supported by staff who did not have the relevant training to meet their needs.

Staff received regular supervision, although one member of staff had not had a supervision meeting since they started to work at the service and another staff member supervision was overdue. During supervision meetings staff had the opportunity to discuss issues of concern, their training needs and their performance was reviewed. We saw evidence that staff attended staff meetings where they were able to discuss concerns about and the progress of people living in the home, receive guidance on good practice and discuss issues affecting their role..

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes such as Hayes Court are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had not trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general or the specific requirements of the DoLS.

Records demonstrated that people were deemed to lack the capacity to make decisions although their capacity had not been assessed. There were no records of decision specific mental capacity assessments in

place, for example, when do not attempt resuscitation (DNAR) decisions had been made by a GP. When we looked at people's care records in these examples, there was either none or very little recorded information in place explaining whether a capacity assessment had been undertaken, why the decision was made in each person's best interests and little recorded evidence of best interest meetings being held or reviewed. This meant there was a risk of people having a decision made for them when they were capable of making the decision themselves.

This was a breach under Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risk of poor nutrition and dehydration. People's dietary needs were identified when they first moved into the home and this was recorded in their care plans. A cook was employed and people's meals were freshly prepared daily. The menus we looked at were designed to offer healthy, balanced meals. People were given sufficient amounts to eat and drink. People were satisfied with the quality and choice of food available.

People were supported to maintain good health because a variety of checks were regularly carried out and recorded. We saw that people were regularly weighed and where appropriate their skin regularly checked for the existence of pressure sores. Everybody living at the home was registered with a local GP surgery which had a good working relationship with the home. People were appropriately referred to specialists and had access to a range of external healthcare professionals.

Good

Is the service caring?

Our findings

People told us the staff were caring and respectful. Comments about the care provided included, "I can't fault the staff" and "They are very nice." Another person described staff as "dedicated."

Our observation showed staff responded to people in a kind, caring and respectful manner and we saw examples of staff using touch to reassure people, holding their hands when they were upset. However, this interaction was mainly when staff were in the process of carrying out a task. We did not see staff spending time sitting and talking with people. This meant that people had limited opportunities for meaningful interaction with staff.

Many of the staff had worked at the service a long time. They a had a positive attitude to their work and the people they supported. Staff spoke about people in a caring and respectful manner. One staff member told us, "I love my job. I love the people I look after and the people I work with." and "I treat them like I would my own family but I don't get to spend as much time talking to them as I would like."

We observed staff interacting with people and found the staff approach was friendly and respectful. Staff were patient, polite and encouraging. They supported people at a pace that suited people and addressed them in the way they preferred.

People's rooms offered them privacy and comfort. Staff respected people's need for privacy as some people preferred to remain in their own rooms and not participate in planned activities. People told us staff respected their privacy. We observed, and people confirmed, that staff knocked on the door and asked for permission before entering people's rooms. Bedroom doors remained closed while people received personal care. Staff were able to describe how they ensured people were not unnecessarily exposed while they were receiving personal care.

The home had an effective approach to end of life care. People felt they were in control of the decisions relating to their end of life care and that the issue was dealt with sensitively. The care files we reviewed had clear, detailed information on people's preferences for their end of life care. There was an on-going process of training staff in end of life care. They were able to tell us how they put their training into practice.

Requires Improvement

Is the service responsive?

Our findings

People had mixed views on whether the care they received met their needs. People told us their health needs were met but they were not supported to live fulfilling lives and spend their time day to day in the way they preferred. One person told us, "I spend every day in the lounge in front of the television. I'm not even watching it. There are activities but nothing I'm interested in." We observed that person was in a lounge sitting in a wheelchair with a call bell attached to it for the whole day on the first day of our inspection apart from when they were moved to the dining room to have lunch. Another person told us, "I haven't been out since 22 July."

People's needs were assessed before they began to use the service and reviewed regularly thereafter. People were not as involved in the care planning process as they were able or wanted to be and this was evident from looking at their care plans. Four of the six people we spoke with told us they did not feel involved in making decisions about their care. As a consequence, the care people received was not always personalised. People commented, "We fit into their schedule", "With personal care you never know what time of the day they are coming to you", "If you are going out they don't come earlier you just have to wait and then go out" and "They decide when I go to bed which I don't like, 8.30 to 9, I like to go up much later." We observed that there very little interaction between staff and people other than when they were supporting them.

Care plans contained information which focused mainly on people's health care needs and provided little information about people's preferences or personal history. They were mainly task orientated and lacked personalisation. Sections for life story and lifestyle in three of the care plans we looked at were blank and there was only brief information about individual backgrounds recorded in the admission assessment completed for each person. In relation to people's social needs, we saw the same information recorded in several people's care files, "Encourage participation in activity sessions."

The provider employed a part-time activity co-ordinator who worked at the service 2-3 days per week. There was no evidence that the activities on offer had been arranged in consultation with people living in the home. People told us that there were some activities on offer but these did not happen very often and were not the type of things they were interested in. People commented," I sit here and watch them all go to sleep", "I'd like to go out", "I'm not interested in anything they do here. My family take me out once in a while, otherwise I just sit here in front of the television all day" and "It [activities] bores us silly."

Staff told us, "They [people] are looked after but there's nothing for them to do", "Those who are able should have the chance to go out. There's a party today but there isn't generally enough going on" and "There could be more for them to do."

The lack of person centred care amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had the opportunity to give their feedback on the care and support they received. These included surveys as well as residents' meetings. Records indicated that a variety of issues were discussed by people such as, whether they were happy with the food, the standard of cleanliness in the home and the arrangements regarding laundry. The registered manager used the feedback received from people to address the issues raised.

The service gave people and their relatives information on how to make a complaint. People told us they knew how to make a complaint and would do so if the need arose. One person told us, "[If there is something I'm not happy with I speak to [the manager] he is always ready to listen and tries his best."

Requires Improvement

Is the service well-led?

Our findings

There were insufficient and ineffective systems in place for checking the quality of the care people received. There was not a system in place to ensure that staff had the training and skills required to care for people safely and meet their needs. For example, there was not a system to check staff competency to administer people's medicines safely. Audits were conducted in areas such as staff supervision however where the audits identified areas which required, improvement these improvements were not always made. For example, there was a system in place to check that staff supervision was up to date. The registered manager was aware that some staff were not getting regular supervision but this remained unchanged month after month.

The manager was aware of many of the shortfalls we identified but had been unable to work towards improving these areas because of a shortage of administrative support.

The provider did not establish and operate effective systems or processes to assess, monitor and improve the quality and safety of the service provided. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views on whether the home was well organised. People commented, "I think it's organised except when short of staff appears to be no contingency for that", "I don't think it's as good as when I first came", "It's too big, too many people or they need more staff" and "Yes I do think it's well organised." People felt the manager was approachable and interested in their welfare.

Staff felt able to express their views on the management of the home and the way care was provided. Staff told us there was open communication between them and management. One staff member told us, "We don't hold back in staff meetings." Another staff member told us "I can go to the manager any time." Staff worked well as a team.

There was a clear staff and management structure at the home which people living in the home and staff understood. People knew who to speak to if they needed to escalate any concerns. Staff knew their roles and responsibilities within the structure and what was expected of them by the management and people living in the home.

There was a system in place to record, monitor and review accidents, incidents and complaints. Where appropriate accidents, incidents and complaints were discussed at staff handovers so that staff were immediately aware of what had happened and were given guidance on how to minimise the risk of similar events occurring.

There were appropriate arrangements in place for storing records. We asked to see a variety of records, policies and procedures relating to people, staff, management of the service and maintenance of the premises. These were promptly located and well organised.

Registered providers must notify us about certain changes, events or incidents. A review of our records confirmed that appropriate notifications were sent to us in a timely manner. There were effective systems in place to ensure that the standard of maintenance of the home and equipment used was routinely monitored. Where repairs or servicing was required prompt action was taken.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment people received did not meet their needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The care and treatment of people was not always provided with their consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way through the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and operated effectively to assess, monitor and improve the quality and safety of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not deploy a suitable number

of suitably qualified, competent, skilled and experienced staff to meet the needs of people.