

Hatherleigh Care Village Limited

Hatherleigh Care Village

Inspection report

Hatherleigh Care Village
Hawthorn Park, Hatherleigh
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Devon
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Tel: 0117287256

Date of inspection visit:
11 July 2018

Date of publication:
20 August 2018

Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This responsive focussed inspection took place on 11 July 2018. It was completed in response to a number of safeguarding alerts which indicated that people's needs may not be met in terms of their hydration, nutrition, personal care and safety. We found no evidence to support these concerns during our inspection, however we did find some areas of improvement. These included, an unpleasant and strong odour in the downstairs dining and communal areas, records not being stored confidentially and care records not always reflecting the care and support delivered.

At this focussed inspection we looked at two key questions safe and well-led. No risks, concerns or significant improvement were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection

When we last inspected this service in July 2017, we found the key area of safe as requires improvement. This was because the upstairs lounges and communal areas had a strong odour. This had been addressed by replacing all the carpet in these areas. We did not issue any requirements.

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

Hatherleigh accommodates up to 52 people in one adapted building. At the time of the inspection there was 51 people living at the service. It is set over three floors with bedrooms on all three floors and communal lounges, with dining areas on two. The service is in the process of making changes to the way people are accommodated. They are adapting the building into four distinct houses in order to allow them to follow a new model of care, which will mean people will be living in houses according to the stage of their dementia. The service mainly provides care and support for people living with dementia. It also provides nursing care.

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

At this inspection we found people were appropriately dressed, looked for the most part well groomed. We identified one person who looked unkempt. We spoke with staff and checked their care records. This showed staff had attempted to assist them with personal care but they had refused all help and appeared resistive to any interventions other than being assisted to eat their meal.

People were being assisted to eat and drink sufficiently to keep them healthy. It was a hot day when we visited and staff were offering people hot and cold drinks throughout the day. The lunchtime meal experience would benefit from improvements. There were no condiments on the tables and no menu for people to be able to make choices. Everyone we saw being served appeared to have the same meal. No choices were being offered. The cook said there was always a main meal and a vegetarian option.

We observed the nurse administering medicines being constantly interrupted by staff to request keys. Following feedback to the provider immediate action was taken to address this. This meant the nurse would not be constantly disturbed but it also meant medicines were only accessible to staff who were administering them.

Some improvements were needed in respect of infection control due to the strong odour in downstairs area and a lack of regular washing of soft toys. People would also benefit from improvements to their mealtime experience. The provider agreed to address these areas.

Risk assessments were in place for each person. These identified the correct action to take to reduce the risk as much as possible in the least restrictive way. People received their medicines safely and on time.

There were sufficient staff who mostly had the right skills and understanding of people's needs and wishes. The provider had recognised through their own quality assurance checks that there had been a significant staff team change. Some staff needed additional support to enable them to have the right skills and understand the ethos of their person-centred approach. They had a programme of support going into the home to mentor and model the care approach they were promoting. This was working well and staff felt supported and listened to.

There was a robust recruitment process and staff understood when and who to report any concerns about abuse. There had been good engagement with the local safeguarding team to ensure that where alerts had been raised, lessons had been learnt and practice improved, such as record keeping.

Risks were well managed and systems were in place to review and learn from any accident and incidents.

Quality assurance processes and audits helped to ensure that the quality of care and support as well as the environment were closely monitored. This included seeking the views of people and their relatives.

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 ●

Some aspects of the service were not always safe.

Malodorous smells in the upstairs communal areas had been addressed but there was a strong odour in the downstairs communal areas. This meant people could not be assured the environment was clean and hygienic.

People said they felt safe living at the service. Staff managed risk in positive ways to enable people to lead more fulfilling lives.

Staff knew about their responsibilities to safeguard people and to report suspected abuse.

People were supported by enough staff to receive appropriate care, although the provider had recognised some staff needed upskilling and had taken steps to address this.

Robust recruitment procedures were followed to ensure appropriate staff were recruited to work with vulnerable people.

People received their medicines on time and in a safe way.

Is the service well-led?

Good ●

The service was well-led.

The service was well-run by the registered manager and the provider who supported their staff team and promoted an open and inclusive culture.

People's views were considered in reviewing the service and in making any changes.

Systems were in place to ensure the records; training, environment and equipment were all monitored on a regular basis.

Hatherleigh Care Village

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.

This inspection took place on 11 July 2018 and was unannounced. It was completed by one adult social care inspector and a specialist advisor who is a nurse specialist in dementia care.

The provider had completed a Provider Information Return (PIR) prior to the last inspection. This is a form we ask the provider to complete at least once a year. It gives us some key information about the service, what the service does well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. We contacted the local authority commissioning team, who has responsibility for monitoring the quality and safety of the service provided to local authority funded people. We received feedback from two health care professionals about their experiences of the service provided.

During the inspection we spoke with six people. However, some other people were not able to comment specifically about their care experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia. We also spoke with two relatives, six care staff, the cook, administrator, maintenance person, quality assurance lead, clinical director and the registered manager.

We looked at four people's care files including risk assessments, care plans and daily records. We reviewed three medicines records, three recruitment records and a variety of records relating to the auditing of the environment and quality of care.

Is the service safe?

Our findings

When we last completed a comprehensive inspection on 25 July 2017, we rated this key question as requires improvement. This was because there was a strong malourous smell in the upstairs lounge. We also found a sluice room left open and cleaning products left in one bathroom. We fed all this back to the provider. They took immediate actions to ensure the sluice room was locked and staff were reminded to keep cleaning products locked. Since the last inspection, the provider had revised their policies and procedures around cleaning products. Each housekeeper was supplied with a trolley with a locked box to ensure cleaning products were kept away from people living at the service. They also replaced the upstairs carpet within a few months of the inspection being completed. We did not therefore issue any requirements in relation to these areas.

At this most recent inspection, we found a strong odour in the downstairs communal areas. One staff member said, "Some of our family members do sometimes urinate in this area so this has contributed to the odour." We also found some soft toys were in need of washing. Some looked grubby and had an odour about them. The provider did not have a system for ensuring these soft toys were regularly cleaned. One of the laundry staff said, "We don't have a system as such, staff do pop them into the laundry basket and we wash them as needed." On the day of the inspection, we saw three soft toys drying on top of the drying machines. Following this feedback, the provider agreed to look at further deep cleaning and refurbishment of carpets. They also agreed to look at a system of regular cleaning of soft toys.

This inspection was triggered as a result of a number of safeguarding alerts which had been raised by relatives and healthcare professionals. Their concerns centred on

- ☐ Care needs not being met
- ☐ People not getting their hydration and nutritional needs met
- ☐ Poor standards of care for some individuals
- ☐ Unexplained injury resulting in serious injury for one person.

At this inspection, we did not investigate any of these individual concerns, this is a matter for the safeguarding and commissioning teams. However, we wanted to assure ourselves that people were not at risk and that people were in receipt of safe care which met their needs in a timely way.

We did not find any evidence to support people's care needs not being met. People were appropriately dressed, looked for the most part well groomed. We identified one person who looked unkempt. We spoke with staff and checked their care records. This showed staff had attempted to assist them with personal care but they had refused all help and appeared resistive to any interventions other than being assisted to eat their meal. Staff were instructed to try again at different times.

Through the safeguarding processes and via their own clinical audits the provider had recognised that staff needed further support in ensuring record keeping was well maintained and accurately reflected the actions taken by staff. This included when staff had attempted to offer support with personal hygiene or with meals, but this help had been refused. Safeguarding meetings confirmed this was an area for improvement. The provider had set up a person within their quality assurance team to provide face to face and on line

mentoring in recording keeping. This staff member had been spending three days per week at the service assisting staff to improve their practice both in records and in actual care delivery. They were planning to offer more sessions face to face and via phone calls to as many staff as required.

People received appropriate hydration and nutrition. Reviewed care records showed what amounts were offered and what had been consumed. On the day of our inspection, it was hot and staff ensured people had a plentiful supply of hot and cold drinks throughout the day. The lunchtime meal experience would benefit from improvements. There were no condiments on the tables and no menu for people to be able to make choices. Everyone we saw being served appeared to have the same meal. No choices were being offered. The cook said there was always a main meal and a vegetarian option. One person refused their main meal and so was offered a sandwich as an alternative, which they ate a small amount of. The quality assurance lead said that staff would and should be offering people a range of choices of food throughout the day, not just at mealtimes. We did see snacks of fruit; homemade cakes being offered mid-morning and afternoons.

We checked incidents and accidents against those being notified to CQC. There was a good correlation and it was clear actions were taken when trends were picked up. For example, on 26 June and 8 July 2018 there had been six falls which were all unwitnessed. One person fell twice on the same day. The system enabled the reviewer to update the care plan, the mobility care plan was reviewed in this case on the same day as the two falls. There were potential underlining health reasons why this resident may have been at greater risk of falls e.g. they were registered blind and had a diagnosis of Alzheimer's. This was identified within their care plan.

The registered manager was required to review all incidents and accidents each day as part of their daily checks. These were also monitored by the provider's quality assurance team. One incident of a person who sustained a serious injury was part of an ongoing safeguarding process. This incident was unwitnessed and had been fully investigated by the provider and lessons learnt shared within the staff team and the wider provider network. The safeguarding process identified that the service had acted appropriately following the incident in obtaining medical intervention once an injury was noted. However they identified that records could have been better. As stated above, this area was being addressed.

People's medicines were being managed safely. However we identified that the nurse was prone to lots of interruptions as the medicines key was being held on a main bunch of keys. This meant staff were repeatedly asking to have access to these keys. When we fed this back to the provider they agreed this was not the normal process, and would be addressed immediately.

The morning medicines were taking from 8 am up to 11 am, although the nurses were aware of those who required their medicines within time periods, such as people with Parkinson's.

The records relating to medicine administration were well maintained and there were protocols for when staff should consider as needed (PRN) medicines. There were clear audits showing these and medicine amounts were checked regularly both by those administering and by the quality assurance team.

There were sufficient staff available during the inspection. The registered manager and provider said that they had been let down by some staff persistently calling in sick. This had impacted on staff morale. They did not believe it had impacted on the delivery of care, but may be a reason some other areas had not been completed to satisfaction, such as record keeping. They also acknowledged that the skill level of staff needed some further work as some more experienced staff had left. To this end the provider had ensured either the quality assurance team or another manager from one of their other services were spending whole days sharing best practice and modelling good care. For example, a registered manager from one of the

providers other homes was at the service during our inspection. She confirmed she was intending to be there for several days working alongside care staff.

We noted that some of the nursing team would also benefit from updated training in diabetes care. We looked at the medicines in relation to one person with diabetes. Their care plan showed they were being treated with medication for diabetes, stated that their risk was low, was having an annual blood test but having twice daily (at approximately the same time each day) capillary blood sugars (cbs) taken by the staff, this appeared to be rather frequent and invasive, if indeed the risks are low. It was also mentioned that the person enjoyed a high calorie diet. The member of staff didn't appear confident when asked what they would do if the capillary blood sugars were outside the pre-arranged range of 5-15mmols. Good practice is to have cbs taken at random times during the day.

The home was kept clean although some areas had a strong odour. The housekeeping team had a cleaning schedule, which including ensured the home was kept clean and free from infections. Staff understood infection control processes and there was a plentiful supply of gloves, aprons and hand sanitizer gel. Staff followed infection control processes with hand washing and the wearing of protective clothing. Some floors were noticeably sticky but the provider said this was an issue with the amounts of cleaning fluid used leaving a sticky residue rather than the floors not being kept clean.

Staff understood abuse and what to watch for and who to report any concerns to. There had been at least six safeguarding alerts raised within the last 12 months. There was clear evidence of the provider and registered manager actively working with commission and safeguarding teams to review practice and improve the service where issues were identified. Such as improvements in record keeping as mentioned earlier in the report.

People were protected by safe recruitment practice which ensured only staff who were suitable to work with vulnerable adults were recruited. This was because the provider ensured the right checks and references were in place before the staff member started working for them.

Is the service well-led?

Our findings

The service was well led by the registered manager and quality assurance team, plus the provider. The provider had recognised that as a newly appointed manager, the registered manager needed some support and guidance around their role and responsibilities. To this end they had developed a programme of support for the registered manager and staff team. This included support from other registered managers from the provider's other locations. Also some of the quality assurance team spending time with staff on key aspects of record keeping and the right approach to care for people with complex dementia care. This showed the provider was being responsive and working proactively to ensure the registered manager and staff team had support and guidance to meet their roles.

The registered manager was new to this role. A registered manager is a person who has registered with the CQC 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.

The service had a range of audits to review the safety and suitability of the building, the medicines management and the care plan documentation. Prompt actions were taken where audits identified issues. With the introduction of electronic care plans and risk assessments, the provider's quality team were able to access records remotely. This meant they had daily access to records and could audit and advise on care plans and risk assessments on a more frequent basis. Additionally the clinical director had provided some detailed "to do" sheets for the registered manager to ensure they did not miss key aspects of their role. This included daily checking of all accident and incident reports, looking at trends and only signing these off once actions had been followed up.

The provider had a clear vision and credible strategy to improve the quality of care and support being delivered. Their aim was to have a truly person-centred approach following best practice and guidance. They had begun this process with bespoke training to all staff covering the four main domains of safe, effective, caring and responsive. This was work in progress. The provider and quality team agreed that out of their five services, Hatherleigh was the last to be worked on in ensuring their model of care was embedded. Staff were enthusiastic about the move to a different model of care. One said "We have started our training and I am excited about the changes to the way we work. I am looking forward to seeing the refurbishments so people have the right environment to live in."

There had been good partnership working with commission teams, allied healthcare professionals and the local safeguarding team. The provider and registered manager had been open and transparent about where things had gone wrong, for example where someone had sustained a serious injury. They had provided detailed investigation analysis to us and the safeguarding team. They had recognised that some people with complex needs were not appropriately placed at the service and were working with commissioners to find alternative placements.

The provider used various ways to gain the views of people and their families. This included annual surveys,

meetings and one to one discussions. We did not look at this in detail during this inspection as it had been fully covered during the comprehensive inspection.

The last inspection report was prominently displayed for people and visitors to see, together with the full report. The rating was displayed on the provider's website.