HC-One Limited

Hebburn Court Nursing Home

Inspection report

The Old Vicarage
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 4 February 2019 and was unannounced.

We last inspected Hebburn Court in March 2018. At that inspection we found the service was in breach of its legal requirements with regard to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because robust quality assurance systems were not in place to effectively monitor all aspects of care provision.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question good governance to at least good.

We found improvements had been made so the service was no longer in breach of its legal requirements.

Hebburn Court is a care home. People in care homes receive accommodation and 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.

Hebburn Court accommodates a maximum of 55 older people, including people who live with dementia or a dementia related condition, in one adapted building. At the time of inspection 34 people were using the service.

A manager was in post who had applied to become registered with the Care Quality Commission. At the time of writing the report the manager had become registered. 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.

Governance processes were more robust and any audits that identified areas of improvement were responded to. Parts of the building were showing signs of wear and tear. We received an action plan straight after the inspection with timescales to show how this would be addressed in a timely way. Improvements had been made to record keeping to help ensure people received person-centred care.

People said they felt safe and they could speak to staff as they were approachable. However, we have made a recommendation about keeping staffing levels and staff deployment under review as staff were busy during parts of the day and did not always have time to engage with people. Systems were in place for people to receive their medicines in a safe way.

People received a predominantly positive meal time experience and they received a choice of food. People said staff were kind and caring. Activities and entertainment were available to keep people stimulated.

Staff were aware of people's care and support needs. Care was provided with kindness and patience. People were involved in decisions about their daily care requirements but improvements could be made to make more information accessible to keep people informed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service supported this practice.

Appropriate training was provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves.

Communication was effective to ensure people, staff and relatives were kept up-to-date about any changes in people's care and support needs and the running of the service. There were opportunities for people to engage with the local community and all people were supported to maintain relationships that were important to them.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received a varied and balanced diet to meet their nutritional needs.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had the opportunity to give their views about the service. The provider undertook a range of audits to check on the quality of care provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe. We have made a recommendation that staffing levels and staff deployment are kept under review.

There were systems in place to manage risks, respond to safeguarding matters and ensure medicines were appropriately handled. Risks were assessed and managed.

Regular checks were carried out to ensure the building was safe and fit for purpose.

Is the service effective?

Good

The service was effective.

People were provided with good standards of care by staff who were well trained and supported in their roles.

Systems were in place to ensure people consented to their care.

The service assisted people, where required, in meeting their health care and nutritional needs.

Staff worked together, and with other professionals to ensure people's care and support needs were met.

Is the service caring?

Good

The service was caring.

Staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

People and their relatives said the staff team were compassionate, kind and caring.

Information was available to help ensure people received person-centred care.

Is the service responsive?

Good

The service was responsive.

There was a good standard of record keeping.

There were activities and entertainment available for people.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A newly registered manager was running the service. People were positive about their management.

Work had been done to make improvements and achieve compliance since the last inspection.

The registered manager and provider monitored the quality of the service provided and introduced improvements where identified.

Hebburn Court 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.

This inspection took place on 4 February 2019 and was unannounced. This meant the staff and provider did not know we would be visiting.

The inspection was carried out by one inspector and an Expert-by-Experience. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people.

Before the inspection we reviewed information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities who contracted people's care and other professionals who could comment about people's care.

During this inspection we carried out observations using 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 communicate with us.

We spoke with eight people who lived at Hebburn Court, the area quality director, the registered manager, the deputy manager, nine relatives, the cook, a nursing assistant, five support workers, the activities co-

ordinator and two visiting professionals. We observed care and support in communal areas and looked in the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for three staff, three people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

People and relatives expressed the view that they and their relatives were safe at the home. People's comments included, "I do feel safe, the care workers are good", "It's no different at night, it's just as good" and "Staff are around when I need them." Relative's comments included, "[Name] is safe because staff are always there to help them", "Staff are around when needed" and "Yes, [Name] is safe, staff come quickly if help is needed.

We received mixed comments from some relatives about staffing levels and staff deployment to ensure that people were looked after effectively. Relative's comments included, "Sometimes there are not enough staff. We think there are less staff upstairs", "I don't think there are enough staff", "Sometimes staff say you'll have to wait, but there is always someone in the lounge. Once or twice I've had to go and find someone", "Most of the time it's calm, it's like lunchtime they [staff] can be rushed but 90% of the time it is calm and staff are not rushed" and "Sometimes staff are very busy and rushed."

The registered manager told us during the day on the top floor 16 people were supported by one registered nurse, one nursing assistant and one support worker. On the ground floor 18 people were supported by one nursing assistant and three support workers. Overnight staffing levels included one registered nurse, a nursing assistant and two support workers, an additional support worker also worked from 6pm until midnight to supplement staffing levels. Our observations during the inspection showed that staffing levels and staff deployment were not well-managed to ensure timely and person-centred care to people on the top floor during certain times of the day such as in the morning.

A staffing tool was used to calculate the number of staffing hours required. Each person was assessed for their dependency in a number of daily activities of living. The dependency formula was then used to work out the required staffing numbers. The registered manager told us this was kept under review as people's dependency changed.

We recommend that the provider keeps staffing levels and staff deployment under review to ensure people receive timely and person-centred care.

At the last inspection we had considered improvements were required to infection control in certain parts of the home due to a malodour. At this inspection we found improvements had been made however, there was still a malodour to the top floor. We discussed this with the registered manager. Straight after the inspection we were informed this had been addressed, as the lounge carpet, which was marked and stained and some chair cushions had been replaced. Staff received training in infection control and plastic gloves and aprons were available for use by staff as required.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the person in charge. The staff training matrix and staff confirmed they had completed safeguarding training. A safeguarding log was kept which showed prompt referrals had been made to the local authority safeguarding team, and investigations had been undertaken where necessary.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary.

Care plans were in place for people that provided some guidance for staff for the management of behaviours that challenged when a person may become agitated. Care plans included information about triggers to help staff recognise when a person may become upset. They did not document what staff needed to do, to de-escalate the situation and help calm and reassure the person. Staff we spoke with could describe how they de-escalated a situation with a person. For example, one person could be distracted with chocolate. For another person, if they were given a particular item it calmed them. We discussed this lack of detail in some people's care plans with the registered manager who told us it would be addressed

Risk assessments and their evaluations were in place and reflected current risks to people. They were regularly evaluated to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for choking, losing weight, falls and pressure area care. The assessments were also part of the person's care plan and there was a clear link between care plans and risk assessments.

Regular analysis of incidents and accidents took place. The registered manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls.

People received their medicines in a safe way. Staff had completed medicines training and had access to policies and procedures to guide their practice. All medicines were appropriately stored and secured. Medicines records were accurate and supported the safe administration of medicines. One relative said, "Staff try to ensure [Name] takes their medicine, they watch while [Name] takes it."

Records showed that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors were contracted to carry out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. Records were also available to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Robust recruitment processes were in place which included appropriate vetting procedures to ensure only suitable staff were recruited. Recruitment files showed appropriate checks were completed before staff started employment. This included proof of identity, criminal history checks, references from previous employers, job histories and health declarations.

Good

Is the service effective?

Our findings

At the last inspection areas of improvement were identified as the home was showing signs of wear and tear and some areas were in need of refurbishment. At this inspection we saw some improvements had been made as communal areas of the home had been redecorated and some flooring and furniture had been replaced.

However, some hallways and bedrooms were still in need of refurbishment as paintwork to walls, doors and skirting boards were marked and damaged. We discussed with the area quality director and registered manager that refurbishment, although it was ongoing, should be carried out in a timely way as it had been identified at the last inspection. Immediately after the site visit we received an action plan with realistic timescales for completion of the refurbishment and evidence to show the changes that had taken place since the site visit. Relative's comments included, "Improvements have been made", "[Name] has been promised a room that has just been done or going to get done" and "The bedroom is lovely, I'm happy with it."

We saw there was appropriate signage around the building to help maintain people's orientation. As part of the refurbishment the top floor environment was being further developed to promote the independence and orientation of people who lived with dementia. Themed seating areas had been provided on corridors for people to sit and look at as they walked around, bedroom doors had been painted different colours to help people identify their rooms and a 1950s room was available for people and visitors. The registered manager and deputy manager, described other plans such as the dementia friendly café to help ensure people who lived with dementia were stimulated and kept aware.

Staff were positive about the training they received. Their training records showed they received training to meet people's care and treatment needs and they kept up-to-date with safe working practices. Staff received supervision and support to carry out their role. Staff comments included "Training and induction are really good", "Very much supported", "Loads of opportunities for training"," We do on-line and face-to-face training", "Supervisions are three monthly or earlier if needed" and "There are opportunities for career development."

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. Staff undertook the Skills for Care, Care Certificate to further increase their skills and knowledge in how to support people with their care needs. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through Mental Capacity Act application procedures called the Deprivation of Liberty Safeguarding (DoLS). The registered manager had submitted DoLS authorisations appropriately.

Records showed that assessments were carried out to check people's capacity and understanding with regard to specific decisions. They also recorded who was involved in the decision-making process where decisions were made in people's best interests. For example, with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink).

People were supported to maintain their healthcare needs. One person told us, "I haven't seen the doctor, I'm alright." Relative's comments included, "[Name] has their own GP. I got them set up with a podiatrist", "Staff take [Name] to all their appointments" and "The chiropodist comes in." The registered manager told us they wanted to establish a regular clinic at the home, if possible, with a link GP. They were aware that in other some other homes this had been set up with the Clinical Commissioning Group as part of a Vanguard model of care to reduce people's admission to hospital.

People's care records showed they had regular input from a range of health professionals. For example, for people who were at risk of poor nutrition, referrals were made to relevant health care professionals such as dieticians and speech and language therapists for advice and guidance.

Systems were in place to ensure people received varied meals at regular times. People received drinks and snacks in between meals. Records showed people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately.

We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. One relative told us, "It is much better since [Name] went onto fork mashed foods. Previously they were left to do it themselves. Their weight is now staying stable."

We observed the lunch time meal. Tables were well-set as table cloths, napkins, condiments and flowers were available on tables. Some people remained in their bedrooms or lounges to eat. Staff provided full assistance or prompts to some people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. No person was rushed and people could eat their meal at their own pace However, the lunch time organisation was not always well-managed. For example, some people waited at the tables for over 30 minutes before the meal was served to them as staff were busy with other people. Some people on the top floor, who required some prompting or encouragement to eat, did not receive these prompts as staff were busy and did not have time until much later. The registered manager told us this would be addressed.

Good

Is the service caring?

Our findings

During the inspection there was a pleasant and relaxed atmosphere in the home. Staff appeared to have a good relationship with people. Several compliments had been received by the home thanking staff for the care. At inspection relative's comments included, "Staff keep their patience", "I chose this home for [Name] because it's homely", "The staff are lovely with [Name]", "Staff are very kind", "Staff are really good" and "The staff are fine, the staff who have been here a long time are really good with [Name]."

People's privacy and dignity were respected. People told us staff were respectful. We observed that people looked clean, tidy and well-presented. A relative said, "[Name] wears a skirt and staff cover them up when [Name] is being hoisted." The language used within people's care records was informative and respectful.

The registered manager promoted amongst staff an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Staff received training in equality and diversity and person-centred approaches to help them recognise the importance of treating people as unique individuals with different and diverse needs.

People were supported to maintain their independence whenever possible and personal preferences were respected. One person told us, "I can do what I want. I have clean clothes on every morning that I choose myself." Another person said, "I don't go to bed late and like to get up early." We saw that some people liked to spend time in their own rooms to follow their own daily routines. One person told us, "I like to spend time in my room and watch television." Staff understood the importance of people maintaining their independence and the benefits it had for their well-being.

Care plans provided information to inform staff how a person communicated or made decisions. For example, one care plan stated, "Staff to give eye contact and use hand gestures to help with communication." Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing and two plates of food. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

Some information was in an accessible form for people who no longer read. A pictorial orientation board advertised the weather and days of the week. An activities programme was in pictorial format to advertise activities. We advised the registered manager that pictures could be bigger to help people see them. Written menus were available to inform people but pictorial menus with photographs, pictures of food were not available to help some people choose their meal. We discussed with the registered manager about making information more accessible and they told us this would be addressed. We observed at the lunch time meal staff showed people two plates of food to help them make a choice.

Written information was available about people's likes, dislikes and preferred routines. One relative told us, "I did fill in a form about [Name]'s likes and dislikes." Records documented information about people's

hobbies and interests to help ensure staff provided person-centred care when the person was unable to tell staff about their routines and how they wanted their care to be delivered.

The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Good

Is the service responsive?

Our findings

People and relatives confirmed there was a choice of activities available. Their comments included, "If singing is going on, [Name] will join in", "The activities person really tries", "[Name] loves music", "We keep chickens and we get eggs", "There's a list of things on the walls they're going to do" and "On Tuesday I go out for lunch with the activities person" and "There is a caravan to visit." An activities programme advertised parachute games, arts and crafts, cinema experience, ball games, jigsaws, musical memories, bar afternoon, bingo, baking crazy golf, armchair exercises, musical bingo, singing, pamper days and hairdresser. People said regular weekly entertainment and seasonal parties took place. A coffee morning took place each week. A weekly bar experience afternoon also took place where people enjoyed an alcoholic drink sometimes with a family member.

An enthusiastic activities co-ordinator was recently employed. They told us about individual trips that had been arranged. For example, for a person who was interested in trains. They described a "Three wishes" file" which recorded things people particularly wanted to do, which the home would try to help them achieve. They described activities that were being planned or were available for people who lived with dementia. They described sensory bags where people had to feel and smelling pots to stimulate senses. A tabard people could wear with pockets and zips, a tool board and hand warmers people could wear with textured items sewn into them. This would also be helpful to keep people occupied, if they wanted, when staff were busy. We observed some people on the top floor sat sleeping or were unoccupied and dis-engaged in the morning. We discussed this with the registered manager who told us it would be addressed. A record of activities was maintained and people were offered the opportunity to be involved, if they wished.

There was a good standard of record keeping helping ensure people's needs were met individually. Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being. Reviews of peoples' care and support needs took place with relevant people. One relative told us, "I have been asked to sign the care plan." Other relative's comments included, "I've recently seen [Name]'s folder" and "There is a book, it has everything in about [Name]."

Care plans were in place that provided some details for staff about how the person's care needs were to be met. However, care plans did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. For example, for personal hygiene. We discussed this with the registered manager who told us it would be addressed.

Staff completed a daily accountability record for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's care plans. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people, when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs.

Records showed the relevant people were involved in decisions about a person's end-of-life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs.

People knew how to complain. People we spoke with said they had no complaints. One relative said, "I'd just tell the manager and he'd sort it out." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and seven had been received and investigated.

Good

Is the service well-led?

Our findings

At the last inspection we had concerns audits were not all effective to monitor all aspects of care provision. At this inspection we found improvements had been made during and after the inspection to satisfy legal requirements so the service was no longer in breach of Regulation 17.

Improvements had been made to the environment, there was a programme of refurbishment with an accepted date for completion in 2019. There was an improve standard of hygiene. Improvements had been made to care records and they contained more detail to enable person-centred care to be provided.

Auditing and governance processes were in place to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. They showed action that had been taken as a result of previous audits where deficits were identified and the follow up action that had been taken. Weekly checks included for the safe maintenance of the premises. Monthly audits included checks on staff training, health and safety, medicines management, dining experience, dementia care, accidents and incidents, infection control, nutrition, skin integrity and falls and mobility.

The registered manager told us visits were carried out by the area quality director to audit the standards of care in the home. They audited a sample of records, such as care plans, complaints, accidents and incidents, risk assessments, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required. Action plans were produced from visits with timescales for action where deficits were identified.

The provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were to be sent out annually to people who used the service and staff.

The registered manager had become registered with the Care Quality Commission in February 2019.

The registered manager was enthusiastic and had introduced ideas to promote the well-being of people who used the service. Staff, people and relatives we spoke with were all positive about their management and had respect for them. Comments included, "There have been improvements", "The manager is very approachable", "I can just go and talk to the manager", "The manager has been alright with us", "The manager will come and ask us if everything is okay."

Staff said they were well-supported. They told us they worked as a team and we observed they knew what they doing as they supported people. Staff member's comments included, "The manager is very approachable" and "The manager's door is always open and you can talk to them."

The atmosphere in the service was cheerful, welcoming and open. A variety of information with regard to the running of the service was displayed to keep people informed and aware. This included the complaints procedure, safeguarding, advocacy and forthcoming events.

People and their relatives were kept involved and consulted about the running of the service. Meetings took place with people and relatives and minutes were available for people who were unable to attend. Their comments included, "In the early days I went to meetings", "We have a resident and relative's meeting when the manager is on duty, it's useful" and "Resident meetings happen every two months." Meeting minutes showed items discussed related to the environment and people's care.

Staff told us, and meeting minutes showed, staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. One staff member commented, "We have regular staff meetings."

Staff told us communication was effective to keep them up-to-date with people's changing needs. Their comments included, "We have daily flash meetings with heads of department and manager to discuss what's happening in the home" and "We have a handover at the start of each shift." A handover session took place, between staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. This was to ensure staff were made aware of the current state of health and wellbeing of each person.