Alexis Care Limited

Hatherleigh

Inspection report

Hawthorn Park
Holsworthy Road
Hatherleigh
Devon
EX20 3GZ
Tel: 01837 810602
Website:

Date of inspection visit: 21, 23 and 29 December 2015
Date of publication: 29/01/2016

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

Overall summary

This inspection took place on 21, 23 and 29 December 2015. The first two visits were unannounced.

Hatherleigh provides personal and nursing care to a maximum of 53 people in the rural community. The home has one unit providing care for people with dementia and one unit, over two floors, providing general nursing care. There were 50 people resident at the time of this inspection.

Our inspection in December 2014 found six breaches of the regulations. These related to care and welfare, staffing, medicine management, safeguarding people from abuse, consent and quality monitoring. The provider sent us a comprehensive action plan. We inspected the service again in December 2015, specifically to check whether people's care and welfare needs were being met, and found that they were.

The home is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Medicine management was well organised and there were checks in place to make sure people's medicines were provided in a safe way.

People's needs were met by sufficient numbers of staff, who were recruited following checks on their background and suitability to work in a care home environment. Staff received training, supervision and support in their roles.

The premises was well maintained and upgrading improvements had increased people's comfort.

Risk to individuals was assessed and any identified risk was managed for their safety.

Staff had a good understanding of how to protect people from abuse and respond should they had any concerns. People's legal rights were upheld.

There was a varied menu and people's dietary needs were met. One said, "Food is quite nice. I get enough to eat, it is tasty and well cooked".

Health care needs were met through consultation with community professionals and support to attend hospital and other health care visits.

People received kind and compassionate care. One person said, "Nothing is too much trouble for them. I am very lucky." Staff engaged with people in a respectful way, promoting their dignity.

People received care which was individual to them, taking into account their needs, preferences and wishes. There were regular activities for people should they wish to be involved and the home environment had benefitted from adaptations, such as raised vegetable beds and posters to trigger memories from people's past.

Complaints were used as a way to improve the service. Where necessary staff had received additional training and an apology had been given where things could have been done better.

There were comprehensive systems in place to ensure the service was well run, such as audits, staff meetings, and consulting with people about how the home is run.

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?
The service was safe.

Staff understood how to protect people from abuse.

There were enough staff to meet people's needs.

Medicines were managed so as to protect people and promote their health.

The premises were safe and well maintained.

Individual risks to people were assessed and managed to promote their safety and welfare.

Good

Is the service effective?
The service was effective.

People's legal rights were upheld.

Staff received training, supervision and support in their roles.

People received nutrious food from a varied menu. Dietary needs were met.

People's health was promoted through staff knowledge and the involvement of community and hospital professionals.

Good

Is the service caring?
The service was caring.

People received kindness and caring from the staff, who treated them with respect.

Dignity and privacy were promoted.

Good

Is the service responsive?
The service was responsive.

People received care and support in accordance with their individual needs, preferences and wishes.

Regular activities helped to provide people with interest and prevent isolation.

Complaints were used as a way to improve the service.

Good

Is the service well-led?
The service was well-led.

The registered manager knew people well and was able to make changes to improve people's lives.

There were arrangements in place to listen to peoples' and staff views and audits to check the home was running as it should for people's health and safety.

Resources and support from the provider were available to help the home run well.

Good

Hatherleigh

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 21, 23 and 29 December 2015. The first two visits were unannounced.

The inspection team consisted of two adult social care inspectors 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; in this case the person was a member of Age UK.

Before the inspection the we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information in the PIR along with information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law.

A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. 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, who could not comment directly on their experience.

We spoke to 14 people who lived in Hatherleigh Nursing Home, five people's visitors, 11 staff members, the deputy and registered managers and the organisation's training and quality assurance manager. We looked at four people's care records, daily handover information about people's needs and medicines administration records (MARs).

We looked at three staff recruitment records, the records of staff meetings and at staff training arrangements. We also looked at the staffing rota, a range of quality monitoring information such as survey results and received information from four community professionals about the service.

Good

Is the service safe?

Our findings

Our inspection of December 2014 found that the staffing arrangements did not ensure people's needs could always be met in a safe way.

At this inspection people and their family members told us people's needs were being met. Their comments included, "Sometimes (the staff) are rushed but the care is brilliant", "I could not have better care" and "I have visited the home on many occasions - morning, afternoon and evening and there are always staff on hand dealing with the residents in a kind and sensitive fashion, and my mother is relaxed and at peace."

Staff said that on the whole, with current arrangements, there were enough staff to meet people's needs and perform their roles. The registered manager had the authority to make staffing decisions based on assessment of people's changing needs and they had changed how staff were deployed at the home. For example, the recruitment of additional activities workers and the new role of dining room assistant. We saw how this enabled care and nursing staff to concentrate solely on their caring role.

Vulnerable people were not left without a staff member available to ensure their safety. For example, during our December 2014 inspection people with dementia were left unsupervised in a lounge. Staff said the new staffing arrangements ensured this could not happen. However, one community professional said that on rare occasions no care staff was visible in the ground floor lounge. Another said, "The home always seems to be well staffed." In the PIR the registered manager reported that current staff had an average of three years' service, with 43 of the 68 staff having worked at Hatherleigh for more than one year, providing continuity.

Our inspection of December 2014 found the arrangements for safeguarding adults from abuse were not robust as staff knowledge was weak. This inspection found staff received training in the safeguarding of adults and they knew how to respond to concerns. One told us they would check that any concern they might raise was responded to, adding "I wouldn't take anything for granted." With the exception of one person, who said when wheeled on a commode they sometimes had pain going over the threshold to the toilet, all said they felt safe at the home. One said, "I feel safe and sound, definitely."

The registered manager was aware of the types of abuse and their responsibility to protect people from abuse and harm, including where people presented with challenging behaviour. For example, they had reported an altercation between two people using the service to the local authority, which is required in order to protect vulnerable adults. The safeguarding and whistle blowing policies at the home set out types of abuse, how to recognise abuse and the steps which should be followed to safeguard vulnerable adults, such as working in partnership with the local authority.

There was a well organised recruitment and selection process in place. Staff files included completed application forms and interviews had been undertaken. Pre-employment checks were done, which included references and telephone calls to previous employers to check information. Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. A recently recruited staff member confirmed they had not started work at the home before the recruitment checks had been completed.

Our inspection of December 2014 found medicines were not always stored, administered or destroyed in a safe way. This inspection found that medicine management was well organised, which reduced the possibility of mistakes. There were arrangements for monitoring each medicine, from its delivery to the home, administration and, where necessary, disposal. However, one person, left alone to take a liquid medicine, had not taken it 20 minutes later although it had been signed for as taken.

The auditing of medicines provided checks on the safety of the arrangements and staff practice. Information for staff administering medicines was available and comprehensive. For example, the use of covert medicines and in what circumstance 'as required' medicines could be used.

The premises was kept in a safe state. The maintenance worker said "The response is quick" when they contact the head office with regard to maintenance needs, for example,

Good

Is the service safe?

to arrange a repair. One person told us a light had not been mended as quickly as they expected. We found the repair had been initiated but a piece of necessary equipment for the mend had not yet arrived.

People were benefiting from improvements to the premises, including new boilers which had increased the temperature in a part of the home previously difficult to keep warm. Also the reliability of hot water. People commented on how much they liked the home environment, one saying "I'm not going anywhere except Hatherleigh…my room is very lovely." One person said, "They keep (the home) nice and clean."

Community professionals told us risks to the people they were involved with were well managed. Staff used tools to assess risks to people's welfare, such as weight loss, falls and pressure damage. Where risk was identified this was followed up, for example, requesting a choking assessment, build-up drinks or specialist equipment, such as a pressure relieving mattress. The use of bed sides was risk assessed and where a risk existed floor mattresses were used as an alternative, for safety.

Staff had a written record, updated daily, of people's current needs, including risks. For example, for one person staff were informed: 'Anxious at times and does not tolerate too much noise'. In addition to people's main care plan and the daily record a summarised sheet ensured staff could quickly check information when with the person to whom they were providing care.

Good

Is the service effective?

Our findings

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 a far as possible people make their own decisions and are helped to do so when needed. When they lack capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible.

People were involved in day to day decisions about their care with examples including the time people chose to rise or retire, what activities they wishes to be involved in and food preferences.

Each person whose capacity was uncertain, had which decisions they could, or could not make, recorded. For example, whether they were able to make informed consent about a treatment. Senior staff understood which steps to take to check whether a person could make informed consent and gave examples of doing so. However, there were no records of what practical steps had been taken to help the person make each decision. A community professional gave an example of where a meeting had been held to come to a decision for a person lacking capacity and in their best interest. However, they said this was without a formal capacity assessment in place to demonstrate the person could not make that decision themselves. Another community professional said the registered and deputy managers had shown a good level of understanding of how to protect people under the MCA. This is what we found, but records did not always support this.

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 are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were upheld. The registered manager had documentary evidence of where people had authorised others to act on their behalf if they lacked capacity for a decision. They understood people's right to leave the home if there was no legal authorisation to prevent them. They had submitted applications to the local authority to deprive people of their liberty where the person would be unsafe without those restrictions. At the time of the inspection those authorisations were not in place but the home was protecting people in the meantime.

Most comments about the food were positive. They included, "Food is quite nice. I get enough to eat; it is tasty and well cooked"; "Food is terrific" and "No grumbles." People confirmed that there was always enough food.

The menu was very varied. For example, some people had a cooked breakfast; the choices included fried bacon and eggs, scrambled eggs and porridge. There was a choice at each meal sitting, including a vegetarian option. Alternatives were also available should the choices on offer not be acceptable.

The cook understood and provided specialist diets. For example, there were 'smoothies' for people who needed additional calories but found eating difficult. Staff had lists of the people at risk of choking. There were dedicated staff to serve and assist people with their meals but only care workers trained how to protect people from choking assisted people where this was a risk.

Throughout the inspection people were continually offered drinks and where people required assistance with their meal this was provided in a calm and unhurried manner. There was a lot of socialising amongst people over the lunch period although the dining room was barely able to accommodate people's individual wheelchairs. The registered manager said they had tried in the past to change the arrangements for the tables but people had not liked this and so it was changed back.

Community professionals said that the staff at Hatherleigh appeared competent. One said, "I have had positive feedback from several visitors about their satisfaction with the staff team." People and their families commented positively about the care they received. Comments included, "I would be quite happy to send a relative and know they would be well looked after here", "The care is brilliant" and "They know what they are doing." Staff expressed satisfaction with the training they received, which they said included computerised training in 12 subjects.

Newly appointed staff received the nationally recognised Care Certificate and some core senior staff were being trained to assist with this. The training and quality assurance manager was visiting during our second visit,

Good

Is the service effective?

with the intention of delivering Care Certificate training, also training specific for nursing procedures. A system was in place to ensure no required training was missed and any specific training requested would be made available if possible. For example, the maintenance worker had been trained in how to test portable electrical equipment.

Staff received supervision of their work. This included face to face meetings with their line manager where any training needs were discussed and they had the opportunity to raise any queries or suggestions. Supervision also included observation of staff work and workbooks, which we were shown. Staff meetings were held on a regular basis. However, the last care worker meeting had not been well attended but the minutes of the meeting were available to them.

A recent decision had been made to change GP surgery due to difficulties regarding prescriptions. Records showed that external professional advice was readily sought for routine care, such as foot, eye and dental, and any health care concerns. This included mental health and risks from choking. The registered manager said that people living with dementia, and other vulnerable people, never attended hospital without a care worker for support.

During the 2015 inspection some people commented negatively about the available space and furniture. This inspection found only positive comments about the environment. In addition, plans were being progressed to improve the environment, including the garden. In addition, the PIR included that current research into dementia friendly environments was to be taken into account when reviewing the dining area décor.

Good

Is the service caring?

Our findings

People spoke positively about the caring attitude of the staff. Comments included, “The staff are very tolerant; generally extremely good” and “Nothing is too much trouble for them. I am very lucky.” One community professional said, “I have observed several staff interacting with residents in a very caring and compassionate manner.”

Staff interaction with people was skilled and respectful. For example, providing them with constant information when delivering care. Staff always asked what the person wanted, gave eye to eye contact to help the person understood, and kindly gestures, such as rubbing a person’s hand. One person’s behaviour was known to become aggressive if they felt overwhelmed. The staff understood this and did not encroach on the person’s space more than the person could tolerate. One staff member gave the person some information. The person smiled at them in response. The person’s community psychiatric nurse said, “They (the staff) manage his needs very well. They explain every step before they do something.” Staff gave us a detailed explanation of how they knew when the person needed to be left alone.

One person needed a stool to rest their leg. The care worker fetched a pillow to make this more comfortable. Another person was struggling with their electric wheelchair and a nurse noticed and assisted.

People’s dignity was promoted. For example, one person said, “The night staff are good, both male and female. A male care worker came to help with showering but asked first if this was acceptable.” People were supported to present in a dignified way. For example, consideration was given to people’s clothing to help them maintain their dignity.

Personal care was provided discreetly and people were addressed in appropriately respectful terms. Privacy was provided. One person chose to go to their room to receive a visitor. Where people wanted to spend time alone in their room this was accepted, although they were encouraged to join other people rather than remain isolated. However, one person, returning from a hospital visit, was not offered privacy to describe the outcome of the visit in the corridor where many people could overhear the conversation. This was fed back to the registered manager who said they recognised this could have been handled better.

A nurse told us how differently care was provided at Hatherleigh compared to their native country. We asked the registered manager how they ensured cultural differences were understood and did not impact on people using the service. They explained that new nursing staff from abroad were asked to work as care workers before undertaking nursing duties. This was so they could work along side care staff to help them understand people’s needs fully, including any cultural differences.

People were asked their views as their care was provided and kept informed of what was happening and why. People were unable to confirm they were consulted about their care plan but those plans included records of who had been involved in decisions about care and treatment.

There were many thank you cards from grateful families. For example, one said, “Whilst we will say that the staff who cared for mum in her last hours were amazing, and acted with welcome dignity and respect, we would say also that we encountered that same high standard throughout mum’s stay with you.”

People receiving their care in bed appeared comfortable and their welfare was promoted through regular position changes and checking their diet met their needs. Staff had received training in specialist equipment, specific to providing end of life pain relief.

Staff showed concern and compassion where one person had no family. An IPad had been purchased so they could see pictures of dolphins, which they loved. Following their recent death an arrangement was being completed for a religious service to be held in the home’s garden. This was so people who knew them could attend and a tree was to be planted in their memory.

Good

Is the service responsive?

Our findings

The inspection of December 2014 found people's personal hygiene needs were not always met in a timely manner. This inspection found personal hygiene needs were being met in a timely manner.

Staff had very detailed understanding of the people in their care. For example, they were able to describe one person's previous employment, hobbies and nature and how their behaviour had changed since their illness. People's records included their personal histories and the information was reflected in the plans of how to provide their care. For example, 'Mr. (person) will stay in bed until between 10.30am to 2.30pm'. One community professional, asked if people received person centred care said, "In my experience, very much so."

Each person had received an assessment of their needs prior to admission to the home, usually by the registered manager. The registered manager was asked to take an emergency admission during our inspection. They said they would only take that admission once the person were assessed, and they left to make that assessment.

The inspection of December 2014 found that each person had a care plan but there was no set arrangement for ensuring people could contribute to the assessment and planning of their care. During this inspection one person told us, "The manager came and did a care plan and asked me what my preferences are." Each person had a care plan in place and these recorded who had been involved in producing the plan.

Care plans are a tool used to inform and direct staff about people's health and social care needs. Those care plans were being transferred to a computerised system. This had led to some inaccurate plans, with conflicting information, because not all staff understood how to change from a draft plan to a completed plan. Additional training was being provided. Although there were inaccurate plans; the care plans in paper form were still in use, in addition to information in people's rooms and paper daily care needs updates. This meant staff did have accurate information to support them to provide appropriate care for people.

Staff were kept well informed of people's changing needs. A daily record of people's needs was produced for staff and included, for example, 'Can be become anxious. Loves dancing and singing.'

The inspection of December 2014 found people did not always receive enough stimulation for them to avoid social isolation.

This inspection found there were two activities coordinators and a busy programme of indoor activities. One activities coordinator visited people's rooms to say hello and "for a catch up" as she had been away. People told us, "There are quite a lot of activities"; "I get a newspaper every day…there are plenty of activities and there is a list and it is at a height for people in wheelchairs to access" and "Every afternoon there is something on, quizzes, group crossword, all very good." Entertainment was advertised for over the Christmas period and carol singers performed during the inspection.

The registered manager was working hard to improve outside activities for people. Some had attended a music and dance session but the number able was limited because of the travelling. Having seen how much people appreciated the outing arrangements were being made for an 'on site' room to be made available. This was to include film of bands which people would be familiar with. The equipment for this had been purchased in preparation for the events.

A sensory room was nearly completed and staff named people who had enjoyed the relaxing space and others who did not like it.

Staff were responsive to people's changing physical and emotional needs. For example, we saw one person who became distressed whenever staff were not with them. Staff spent a lot of time supporting them. We were unable to understand the person's speech but each staff member who engaged with them was able to communicate with them effectively. This meant they could provide the care that person wanted.

Complaints were used as a way to improve the service. For example, one person's family had complained how long it had taken staff to answer the telephone and so a more conveniently placed telephone was provided for staff to use. The registered manager said staff used 'reflection' following any complaint so as to look at how things might have been done better. Records of complaints showed that an apology was offered where fault had been found and where necessary further staff training, or disciplinary action, had resulted.

Good

Is the service well-led?

Our findings

Our inspection of December 2014 found the service did not have effective systems in place to ensure the home was well led.

Community professionals, asked if the home was well-led said, "Yes. The atmosphere is always in my view welcoming and any staff I have encountered have been polite and welcoming"; "(The registered manager) is very good in her understanding and knowledge of the clients" and "Definitely, I found the manager to be very accommodating, person-centred in her approach, supportive of staff and knowledgeable. Communication with outside professionals was excellent."

Our inspection of December 2014 found the provider lacked adequate overview of the service. This inspection found there were comprehensive arrangements in place to monitor the standard of service provided. These included checks by the heads of department, the registered manager and the provider. Records showed how these led to action plans. These included what action was required and within what timescale. Checks included record keeping, accidents, training and environmental risks. The registered manager said, "The team at head office are now 100% better."

Toward monitoring the service and maintaining standards of care agency staff were asked to complete a questionnaire when they had completed a shift. This asked them, for example, 'Did you consider patients' dignity was considered when providing care?'

There was close and effective cooperation between the staff and the provider. For example, the administrator, cook, maintenance worker and housekeeper told us how quickly they received a response when they needed equipment, advice or other action from the provider.

The home was well resourced. For example, maintenance work was not delayed and additional money was provided to ensure people had additional festive foods, activities and people and staff had presents over the Christmas period.

Staff views were taken into account and acted on. For example, one staff said they had suggested moving a staff information board so it could be used for people's benefit. This was now planned. The registered manager had improved people's access to the garden area, which provided a safe walking space, raised vegetable beds (currently containing leeks), seating and ornaments. Plans were in place to provide an enclosed balcony for people on the first floor, with the expectation this will be in use by summer 2016.

There had been no formal surveys of people's views during 2015 but there had been resident meetings, for example to get people's views about changing GP practice. The registered manager was frequently seen around the home and clearly known to people using the service and their family. With the exception of one person where a complaint had not been resolved to their satisfaction, people spoke highly of the registered manager. Comments included, "In my opinion the home is being run very well and is a credit to the efforts of the manager who makes herself available and (from the observations made during discussion) obviously has a personal knowledge and interest in the well-being of my mother."

Staff said they felt well supported. One said, "(The registered manager) is very kind. She shows staff and leads by example…very big on communication." The registered manager spoke of the importance of staff feeling free to raise any issue. A care worker said, "I'm very well led and (the registered manager) always answers my questions".