Hawthorn Manor Limited

Hawthorn Manor Residential Home

Inspection report

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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

The inspection was carried out on the 11 October 2018. The inspection was unannounced.

Hawthorn Manor Residential Home is a 'care home'. People in care home services receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The accommodation was modern and spanned two floors. A stair lift was available for people to travel between floors. Staff provided residential care for up to 37 older people. There were 33 older people living at the service when we inspected.

At our last inspection on 10 February 2016, we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

Since our last inspection the registered manager and provider had been consistent in auditing the risks associated with providing care and the quality of people's experiences.

The outcomes promoted in the provider's policies and procedures were monitored by the registered manager to make sure they were in line with current legislation and practice. The policies included equality and human rights. There were multiple audits being undertaken to support learning and improve quality.

Staff consistently demonstrated they shared the provider's vision and values when delivering care. People were supported to maintain friendships and contacts with those they chose. Activities were planned to assist people to their purpose and pleasure in life.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People's needs continued to be assessed and their needs were recorded. People's right to lead a fulfilling life and to a dignified death was understood and respected at all levels. People, their relatives and health care professionals had the opportunity to share their views about the service either face-to-face, by using feedback forums or by responding to formal bi-annual provider quality surveys.

We observed that staff were friendly and caring. Staff understood the risks to people's individual health and

wellbeing and risks were clearly recorded in their care plans. Incidents and accidents were reported and appropriately investigated.

Risks to people from poor nutrition and hydration were minimised because people were offered meals that were suitable for their individual dietary needs and met their preferences. People were supported to eat and drink according to their needs, staff supported people to maintain a balanced diet.

There continued to be enough staff on duty to meet people's physical and social needs. The registered manager checked staffs' suitability to deliver personal care during the recruitment process.

Staff received training and supervision and continued to be that matched to people's needs effectively.

The premises and equipment were regularly maintained and checked to minimise risks. People's medicines were managed, stored and administered safely. The service was clean and odour free. Staff followed the provider's infection control policy. Staff understood their responsibilities to protect people from harm and were encouraged and supported to raise concerns by the registered manager. Emergency response contingency plans were in place.

The registered manager had sent statutory notifications to CQC when required. The CQC rating from our last inspection had been displayed.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Hawthorn Manor Residential 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 11 October 2018 and was unannounced. The inspection team consisted of one inspector, and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

We used information we held about the service and the provider to assist us to plan the inspection. This included notifications the provider had sent to us about significant events at the service. We also used 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.

During our inspection we spoke with seven people about what it was like to live at the service. We spoke with one relative. We spoke with seven staff members which included the provider's group home manager, the registered manager, a senior carer, three care staff and the cook. We asked for feedback about the service from three external organisations involved in contracting and monitoring the service.

We looked at risk and quality audit records, policies and procedures, complaint and incident and accident monitoring systems. We looked at four people's care files, five staff recruitment files, the staff training programme and medicine records.

Good

Is the service safe?

Our findings

We observed safe care. People we spoke with told us the service was safe. One person said, "We get looked after, even at night. They check on us every two hours. If I'm up for the toilet, they ask me if I am alright." Another person said, "Once I had to push the [emergency] buzzer in my room and carers were there straight away."

People continued to receive their medicines safely and as prescribed to protect their health and wellbeing. One person said, "They stand and watch me take it [medicine]." The policy on the administration of medicines followed published guidance and best practice. Senior staff were trained to administer medicines and their competence was checked by the registered manager to check safe practices were maintained. Medicines were stored safely in temperature controlled rooms within lockable storage containers. Storage temperatures were recorded within recommended ranges to maintain the effectiveness of medicines. Medicines were audited and stocks tallied with administration records. Staff described how they kept people safe when administering medicines. 'As and when' required medicines (PRN) were administered in line with the provider's PRN policies.

The provider's recruitment policy and processes continued to minimise the potential for new staff being employed who may not be suitable to work with people who needed safeguarding. Applicants were interviewed, had references, work histories were recorded and they had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding. The numbers of staff deployed was based on people's assessed care needs.

People continued to be protected from the risks and from potential abuse. Staff told us they could recognise poor practice and report it appropriately. Training about this had continued for staff. Staff had read and told us they knew how they could use the provider's whistleblowing policy to report concerns. Records showed the registered manager took steps to reduce risk and notified the CQC when they referred concerns to the local safeguarding authority.

The registered manager continued assessing risks to individual people, for example, they assessed people's mobility, nutrition and health needs. The registered manager assessed risks from the premises and equipment. Staff followed recognised infection control practice. The premises and grounds were well maintained, cleaned and odour free. Records showed a system of regular checks of the premises, the fire alarm and essential services such as the water, gas and electricity took place. Equipment, such as hoists, profiling beds and wheelchairs, were serviced. Staff understood how to report accidents and incidents to the registered manager and these were recorded, investigated and responded to reduce future incidents. For example, after a fall, one person had been assessed for a different walking aid to minimise continued risks.

The risks to people from foreseeable emergencies was minimised. Contingency plans were in place. Staff had training in fire safety and practised the routine. Evacuation policies were based on moving people most at risk from away from the area of danger until they could be rescued. Signage advised the 'fire plan' for

everyone to see and people's personal evacuation plans (PEEPs) were kept with the emergency pack.

Good

Is the service effective?

Our findings

People and their relatives told us that staff were helpful and friendly and had the skills and knowledge to provide effective support. One person said, "The care is very, very consistent the staff put safety first." Another person said, "I wasn't drinking very much, but staff encourage you to drink. There's plenty to drink during the day and I have water in my room." People told us the liked the food provided.

People's health and wellbeing continued to be maintained and reviewed in partnership with external health services. Referrals had been made as necessary to community healthcare teams, for example to GP's, and mental health teams. There were records of contacts and advice given by health care professionals. People continued to be supported to have enough to eat and drink and were given choices. Staff were aware of people's individual dietary needs and their likes and dislikes and any risks there may be to people's health such as choking. We observed people being supported and encouraged to eat and drink at lunchtime and throughout the inspection.

The premises continued to meet the needs of people living with poor mobility. The internal and external parts of the premises were accessible with ramps and flat surfaces. Decoration was clean and fresh, with people's bedrooms were personalised if people chose to do this. Equipment was provided and used to monitor people's wellbeing, such as alarms to alert staff if people were out of bed at night. This meant that staff knew to check on people, for example to prevent falls.

The Mental Capacity Act 2005 (MCA 2005) 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 people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager continued to have a good understanding of the Mental Capacity Act (MCA) 2005. One person was subject to a current DoLS authorisation. There was an up to date policy in place covering mental capacity. Staff had received training in relation to protecting people's rights.

The registered manager continued to train and support staff to develop the right skills for their role. Training was planned and monitored so that staff were kept updated. This included mandatory training in, infection prevention and control, first aid and moving and handling people. Care staff understood when to report concerns they may have about people's health. This protected people's health and wellbeing. The training staff received included equality, diversity and human rights. The provider had a policy about equality and the protection of human rights that staff could access. Staff understood how to manage behaviours that may challenge.

The registered manager continued meeting with staff for supervisions and an annual appraisal. This gave staff the opportunity to discuss what had gone well for them over the previous year, where they had weaknesses in their skills and enabled them to plan their training and development.

Good

Is the service caring?

Our findings

People described and we observed a caring service being delivered for people. One person said, "The care staff are so good." Another person told us that staff always speak to her and ask if she is alright. Another person said, "They [staff] really look after you and you can have a laugh with them. Sometimes they come and sit with me and we have a chat and a laugh."

We observed that people continued to be treated kindness, compassion and respect. For example, we saw that staff sat with people, listened and joined in the conversation. Staff asked people for their permission before providing support and explained clearly to people what they were going to do before they did it. When speaking to people, staff got down to eye level with the person so that the person could clearly see them and staff used eye contact and caring gestures, like a gentle touch on the arm or back to reassure people. Staff used people's preferred names when addressing them.

People told us that staff continued to respect their privacy and that staff supported them to maintain their dignity. People's care plans were stored securely. We observed people eating lunch and saw that staff actively supported people to maintain their dignity whilst eating.

Choice and independence were respected. People told us they were involved in day to day decisions about their care. One person said, "They don't worry you if you'd like to stay in your room. They let you do it your way and you're not made to do things." People told us that they continued to be supported to remain as independent as possible. One person said, "I wash myself and the carer [staff] checks I've done it."

We observed that people's relatives were free to visit people when they wanted to do so. Visitors came and went freely during the inspection. A person said, "My daughter and sister are able to visit regularly and I go out in the car sometimes." A relative said, "The carers are really perfect and very good."

Staff appropriately communicated information to others about people's care. The registered manager kept records of relatives with a lasting power of attorney. [A lasting power of attorney is a written authorisation to represent or act on another's behalf for health and welfare and/or financial matters]. During the inspection we observed the registered manager meeting with relatives who had power of attorney to discuss people's care. The registered manager confirmed advocacy service's were available, but these were not required at the time we inspected.

Good

Is the service responsive?

Our findings

One person said, "I love to read and there are lots of books here for me to read." We observed there were several bookcases, full of books to borrow, around the service. Another person said, "There are sufficient activities going on in the home and that the manager is trying to think of other things to do." Another person said, "I was poorly when I moved into the home. The carers [Staff] got the GP in and I was quickly prescribed antibiotics. The carers [Staff] kept an eye on me. They looked after me."

Peoples care needs, preferences and choices continued to be discussed and agreed with people and recoded in a care plan about them for staff to follow. People could chose to share information about their beliefs and sexuality. Care plans were individualised and gave clear details about each person's needs and how they liked to be cared for. Sections included family, interest, health and wellbeing and independence. Care plans contained information on a range of aspects of people's needs including mobility, emotional wellbeing and specific physical and mental health support.

People's communication needs were assessed against accessible information standards 2016 to check if they required any specialised aids. For example, one person had a hearing loop fitted for their television. Care plans were reviewed regularity. People and their relatives, where appropriate met with staff to discuss and review their care. Where people were not able to be involved in these reviews records showed that care had been discussed with relatives and professionals where appropriate and decisions made were based on people's life history and previous preferences. Care plans were accurate and up to date.

People's health care was managed in line with their assessed needs. People were registered with a local GP practice of their choice. The care plans recorded people's progression with heath care professional interventions such as physiotherapy by measuring changes at intervals. For example, in response to falls, people were referred for specialist assessment and their falls had reduced.

To promote wellbeing and reduce isolation activities continued to be planned and coordinated. Activity participation was recorded so that it could be monitored. We could see which people had attended activities. Pictures and photographs displayed key events on the notice board. This included social, physical and one to one activities based on people's feedback. People told us that they enjoyed the activities. People who preferred to stay in their rooms were visited by staff. Activities assisted people to remain active. For example, we observed a darts session where people were holding and throwing darts. One person playing darts said, "I like to join in things."

People and their families were given information about how to complain and details of the complaints procedure were displayed in the service. People told us they knew how to raise a concern and they would be comfortable doing so. There had been one recent complaint. This related to a member of staff giving a relative incorrect information. As a result of the investigation the registered manager now attended all staff hand over meetings. We saw confirmation that the complaint had been resolved to people's satisfaction.

People's wishes for their end of life had been documented in care plans. People also had a section in their

care plan detailing how any pain they may be experiencing could be managed. Staff worked closely with a nearby GP to support people at the end of their life to make sure people receiving end of life care were supported with dignity.

Good

Is the service well-led?

Our findings

People told us the service was well managed. One person said, "The manager is lovely. You can talk to her. She's always busy, but if you want to ask her anything, she's always there." Another person said, "I think the manager is great." Another person said, "This was the best home I looked at."

There was a registered manager in post. 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. We observed the registered manager was well known by people and the staff. They knew people's names and assisted with care when needed.

The registered manager had notified external organisations such as the local authority safeguarding team about incidents or accidents at the service. Improvements to the quality of the service were driven by the provider's responses to risks and consistent audits. For example, a new fence had been ordered for the rear garden to reduce the risks to people from part of the garden. An action plan was in place to enhance the fire protection in the service. For example, by adding an extra fire door to a corridor. A computerised system was used to monitor all aspects of risks management and care planning. These included managing care plan reviews, staff training and risk assessment.

The registered provider continued to seek people's views about the service from a range of people including people using the service, relatives, staff and external healthcare professionals. There were resident and relative's meetings. People told us they were aware of when meetings were taking place. The provider's quality assurance system included an analysis of people's responses to measure their performance.

There were regular staff meetings at the service and hand over meetings between shifts. The staff meetings gave staff the opportunity to discuss people's care and issues they may want to discuss about the quality of the service. Staff continued to receive appropriate supervision and told us that the registered manager was supportive and that they were listened to. One member of staff said, "We get appraisals and supervision, we talk about organisational objectives." The registered manager met with other care home managers at regular meetings facilitated by the provider. This gave them the opportunity to keep up to date with changes and developments in social care. At the last meeting the provider discussed the organisational philosophy with the management.

Policies and procedures governing the standards of care in the service were kept up to date, taking into account new legislation. For example, medicines policies followed guidance issued by the National Institute for Health and Care Excellence. The registered manager referred to external published guidance when managing risk. For example, safety alerts from the Health and Safety Executive. The service worked with others including community mental health teams.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can

be informed of our judgements. We found the provider had clearly displayed their rating at the service and on their website.