Hayes Court

Hayes Court

Inspection report

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Date of inspection visit: 1 August 2014
Date of publication: 29/01/2015

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

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, and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

Hayes Court is a care home which provides nursing and personal care for elderly people many of whom have complex needs and/ or are living with dementia. At the time of our inspection there were 45 people living at the home. The home had a registered manager. A registered manager is a person who is registered with the CQC to manage the service and shares the legal responsibility for meeting the requirements of the law; as does the provider.

We previously carried out an inspection of Hayes Court in March 2014. During that inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found that people were not adequately protected against the risk of abuse because care workers did not have good knowledge about how to recognise abuse or know the action they should take if they suspected someone was at risk of abuse. We saw that people's needs were regularly assessed but where a

Summary of findings

change in their needs or risk was identified, care plans and risk assessments were not always updated accordingly. We were concerned that the systems in place to monitor the quality of care people received were inadequate.

This inspection was carried out to check whether the provider had made the required improvements. The inspection was unannounced and carried out on 1 August 2014. We found the provider had made improvements to minimise people's risk of abuse. People's care plans and risk assessments reflected their current need and there were better systems in place to monitor the quality of care people received.

We found there were procedures and risk assessments in place that staff implemented to reduce the risk of harm to people. The manager and staff understood the main principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS). People received their medicines safely and were adequately protected against the risk and spread of infection. The home was well maintained as was the equipment people required.

People were cared for by staff who were recruited through a thorough recruitment process. Appropriate checks were carried out on applicants before they began to work with people. The majority of staff were experienced care workers who had the skills, knowledge and experience to care for people safely. There was a sufficient number of staff on duty to care for people safely and effectively. Staff understood their roles and responsibilities and were supported by the management through relevant training, supervision and performance reviews.

People were satisfied with the care they received and told us they were treated with respect and kindness. People and their relatives felt involved in their care planning and in control of the care they received. There were a variety of activities for people to participate in within the home but some people felt that more could be done to support people to participate in activities outside the home. Staff ensured people received a nutritious, balanced diet and people who required it were supported to eat their meals. People were happy with the quality of their meals and said they were given enough to eat and drink.

People's healthcare needs were met by suitably qualified staff. Regular checks were carried out to maintain people's health and well-being. People also had access to healthcare professionals and staff liaised well with external healthcare providers. People were supported to plan their end of life care which staff delivered in accordance with their wishes.

There were systems in place to assess and monitor the quality of care people received. People felt able to express their views and told us the management and staff were responsive to their complaints and comments.

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 knew how to recognise abuse and how to report any concerns. There was a sufficient number of staff during the day and night with the right skills and experience to care for people safely.

The manager and staff understood the main principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS).

Medicines were safely stored, administered and recorded. The home was well maintained and equipment was regularly checked. The service had an infection control policy which staff understood and applied in the course of carrying out their duties.

Good

Is the service effective?
The service was effective.

People were satisfied with the care they received. People were cared for by staff who knew and understood their needs. Staff had the knowledge and skills required to carry out their roles.

People were supported to have sufficient amounts to eat and drink and to maintain a balanced diet. People's health was regularly monitored and they had access to a variety of external healthcare professionals and services.

Good

Is the service caring?
The service was caring.

People said the staff were kind and caring. People were supported by staff to express their views.

We observed that people were treated with dignity and respect and this was confirmed by people we spoke with. The process for planning end of life care was thorough. Some staff had been trained in end of life care and people's wishes were well implemented by staff.

Good

Is the service responsive?
The service was responsive.

People and their relatives were involved in their care planning and felt in control of the care and support they received. The care people received met their needs.

People knew how to make suggestions and complaints about the care they received and felt their comments would be acted on. People received co-ordinated care when they used or moved between different healthcare services.

Good

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

Good

Summary of findings

There was a clear management structure in place at the home which people living in the home and staff understood. Staff knew their roles and accountabilities within the structure.

There were systems in place to monitor and assess the quality of care people received. There was evidence of learning from concerns raised at our previous inspection and internal audits. We saw that changes had been implemented as a consequence of these.

Hayes Court

Detailed findings

Background to this inspection

Our inspection team was made up of an inspector and an expert by experience with a special interest in end of life care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

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

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

We looked at all areas of the home and at equipment. We spoke with five people living in the home, five people's relatives, five care workers, the cook, the cleaner and the manager. We also spent time looking at records including eight people's care files, five staff files and records relating to the management of the home.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People told us they felt safe. Comments included, "I am safe here and happy outside", "I do feel safe here" and "they do look out for me, I feel very safe". People knew the type of behaviour that was unacceptable and what to do if they had any concerns about their safety. One person told us, "Any nonsense from any of the staff and I'll be straight on to (the person) but I've never had any trouble here" and "I can always speak to (the manager) if I have any problems".

At our last inspection we were concerned that staff did not know how to recognise abuse or the steps they needed to take if they were concerned a person was at risk of abuse. During this inspection, we found that staff had been trained in safeguarding adults and their understanding of the training had been checked by members of the management team. Staff we spoke with knew the different types and signs of abuse.

The home had safeguarding and whistle-blowing policies and procedures for staff to follow if they had concerns that a person living at the home was at risk of abuse. Staff we spoke with were familiar with the procedure and how to report their concerns. We saw evidence the whistle-blowing procedure had been followed on one occasion. This meant the home had appropriate arrangements in place to protect people from abuse.

People living at the home had personalised risk assessments which identified a variety of risks and gave detailed information to staff on how to manage the risks. The risk assessments balanced protecting people with respecting their freedom. Where people were at risk of falls the least restrictive mobility equipment was recommended. The new risks people faced were shared with staff when there was a change of shift and care plans were updated in a timely manner, which minimised the risk of people receiving inappropriate care.

The manager and staff understood the main principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS). Although no DOLS applications had needed to be made, staff were able to describe the circumstances when an application should be made and how to submit one. At the time of our visit nobody living at the home was subject to DOLS but the manager was considering making applications for two people living in the home.

Most people felt there was enough staff to care for people safely. People told us "there are always staff around", "I think there are enough staff to look after everybody here", and "when I need something, there is usually someone not too far away". However, we also received the following comment, "at weekends it seems the care levels are not as during the week". In all areas of the home there appeared to be a sufficient number of staff to meet people's needs, including senior staff. We observed that staff attended promptly to assist people when called.

The manager told us staffing levels were checked on an ongoing basis, but particularly when there was a change in a person's dependency, during pre-admission assessments and if staff or people living in the home raised concerns. We saw the staffing levels had been increased recently in response to an increase in the number of people living in the home and an increased number of people being at risk of falls.

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

People received their medicines safely because the home had appropriate arrangements in place to order, store, administer and record medicines. People we spoke with knew the medicines they were taking and what they were for. People told us they received their medicines at the right time and in the correct dosage. We saw confirmation of this in the care records we reviewed. This meant people were protected against the risks associated with the unsafe use and management of medicines. People had clear records of the medicines they were required to take, as well as how and when these should be administered. Staff handling medicines were registered nurses and there was at least one registered nurse working on every shift.

The building and surrounding gardens were adequately maintained to keep people safe. The water tanks and utilities were regularly inspected and tested. The home was fully accessible and of a suitable design and layout to meet

Good

Is the service safe?

the needs of people living there. The home had procedures in place which aimed to keep people safe and provide a continuity of care in the event of an unexpected emergency such as, a fire or boiler breakdown.

We saw confirmation there were arrangements in place to test and service essential equipment such as lifts, call bells and hoists. Staff had been trained in how to use the equipment people needed. We saw that the right number of staff were involved in using equipment such as hoists and that they were used correctly. There was sufficient equipment in the home to assist people and staff.

People were well protected against the risk and spread of infection. People told us the standard of cleanliness was always good. All areas of the home and the equipment we saw were clean. We saw the provider carried out comprehensive infection control risk assessments. Staff had received training in infection control and were able to tell us how they applied their training day-to-day. We observed that staff followed the home's infection control policy. Staff practised good hand hygiene, put on personal protective equipment such as disposable gloves and aprons before delivering personal care and disposed of clinical and non-clinical waste appropriately.

Good

Is the service effective?

Our findings

People felt the care they received met their needs and that they were cared for by staff who knew how to do their job. People told us, “The staff do seem to be qualified to carry out the care needed”, “they know what they are doing”, and “they are skilled at giving care”. Many of the staff we spoke with were experienced care workers who had worked at the home for many years. They knew the people living in the home well, understood their needs and how they preferred their care to be delivered.

Staff had received training in the areas relevant to their work and there was a system in place to check staff competency in areas of their training. We saw confirmation that staff member’s understanding of the types and signs of abuse and how to report any concerns was tested. Staff received regular supervision where performance was reviewed and their training needs discussed. This meant people received care from staff who had the necessary skills, knowledge and experience to carry out their roles effectively.

People were supported to have sufficient amounts to eat and drink and maintain a balanced diet. People had a choice of nutritious food and were offered enough to drink. Staff responsible for preparing meals knew what constituted a balanced diet and the menus we looked at were designed to offer a healthy, balanced diet. People living in the home and their relatives told us the quality of food was good. People commented, “I enjoy the food”, “I have water and the food is the best part”, and “the food is always good. I eat better now than I did at home”.

People who were at risk of poor nutrition and dehydration were identified when they first moved into the home and this was recorded in their care plans. Where appropriate, their food and drink intake was monitored. People also had access to dieticians where their needs required it. We observed that people were given a choice of meals.

People who required assistance to eat and drink were supported to do so. Staff enabled people to eat and drink as independently as possible. The interaction we saw between staff and people at lunchtime was positive. Relatives told us, “they are encouraging (the person) to eat”, “(the person) needs pureed meals and always has liquid available and they check (the person) has enough to drink”, and “(the person) eats well sometimes but tends to refuse so they try and encourage (the person) to eat”.

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

Some additions had been made to the home for the benefit of people living with dementia such as a “Memory Lane” wall to encourage people living with dementia to reminisce, which has been found to have a beneficial effect on their well-being. People’s rooms were also personalised and filled with their mementoes. We observed that staff were patient and communicated in a positive way with those affected by dementia.

Good

Is the service caring?

Our findings

People told us they were treated with kindness and respect. People commented, “They are really good to me”, “the carers are very caring”, “they (staff members) are always popping in to check that I’m alright”, “they are always courteous and respectful”, and “when I’m in pain, they are very quick to act”.

The interaction we observed between staff and people using the service was meaningful and compassionate. Staff knew the people they were caring for well and how they preferred to be supported. People were supported at a pace that suited them. People were enabled to spend their day as they pleased and told us they were given choice in their day-to-day decisions. One person told us, “I’m not one for socialising so I spend most of the time in my room but the staff are lovely and are always checking up on me.”

People and their families were involved in their care planning. The care plans we reviewed considered all aspects of a person’s individual circumstances and reflected their specific needs and preferences. People’s care files included details of their life history, family relationships and individual wishes. We saw that staff used this information and their knowledge of people living in the home as a starting point for conversations and to aid communication. People told us their care was delivered according to their care plan and generally felt in control of the care they received and the way it was delivered.

People told us their privacy and dignity was respected at all times. We observed, and people confirmed, that staff knocked on the door and asked for permission before entering people’s rooms. Bedroom doors remained closed while people received personal care. Staff were able to describe how they ensured people were not unnecessarily exposed while they were receiving personal care. People were encouraged to be independent. One person told us, “I like to do my own thing and they let me get on with it.” A relative told us, “(the person) likes to wander around and they don’t mind at all.”

The home had an effective approach to end of life care. This meant that people were consulted and their wishes for their end of life care was clearly recorded, reviewed and acted on. People and their relatives felt they were in control of the decisions relating to their end of life care and that the issue was dealt with sensitively. The care files we reviewed had clear, detailed information on people’s preferences for their end of life care and demonstrated that a range of people including healthcare professionals were involved in the planning process. There was an ongoing process of training staff in end of life care. They were able to tell us how they put their training into practice. We saw evidence that people’s choices for end of life care were respected and acted on by staff.

Good

Is the service responsive?

Our findings

People made positive comments about the care they received. People told us, “I get and have everything I need”, “the staff are wonderful”, “they look after me very well. I’ve no complaints”, and “the staff are very good”. Relatives told us, “(the person’s) health needs have been dealt with after coming here”, “the care (the person) gets is effective so far”, and “we have to be grateful”.

At our last inspection we were concerned that where a change of need or risk had been identified care plans were not always updated. The care plans we looked at demonstrated that people’s needs were assessed when they first moved into the home and reviewed on a regular basis thereafter or when there was a change in need. We saw that where a person’s risk of falls had increased, new risk assessments had been carried out and care plans updated accordingly.

People and their relatives knew how to raise concerns or make a complaint. People were able to express their views on the care they received because they said the staff were approachable and responded to their requests, concerns and suggestions. We saw confirmation that residents’ meetings were held and that people had the opportunity to voice their views at these meetings. People and their relatives told us that generally the issues raised were dealt with by staff.

An activities co-ordinator arranged a variety of activities within the home which were appropriate for people living with dementia and gave people the opportunity to socialise. People’s religious and spiritual needs were taken into account. The home had links with a local place of worship and clergy regularly attended the home to conduct a religious service. People were supported to maintain relationships with their friends and relatives. People’s visitors told us they were always made to feel welcome at the home. The majority of people we spoke with were satisfied with the opportunities available to socialise and with how they spent their time day-to-day.

However, some people felt that more could be done to support people to access the community. One person told us, “I would like to get out more.” Another person told us, “I would like to go out but I’m worried I’ll fall so I don’t go out.” Neither person had told staff of their wish to go out more. A staff member told us, “There are things for them to do here and some of them go out with their family but those who don’t have any visitors don’t really go out.” We raised this with the manager who told us that staff would support people to go out if they choose to and that they would remind people of this.

We saw that a variety of external healthcare professionals were involved in people’s care and that the communication between the home and external agencies was good. There were systems in place to ensure people attended their hospital and other healthcare appointments and to ensure that all staff were aware of the appointments. One person told us, “They make sure I attend my appointments and they always save my lunch.” We saw evidence that when people were admitted or discharged from hospital, staff liaised with the hospital so that both parties were aware of changes in people’s needs and medicines. This minimised the risk of people receiving inappropriate care.

Good

Is the service well-led?

Our findings

People told us the service was well organised and that the management were approachable. One person said of the management, “They are ever so good. I have no problem asking any of them if there is something I need.” Another person told us, “They know what they’re doing and they do their best.” There was a clear management structure in place at the home which people living in the home and staff understood. Staff knew their roles and responsibilities within the structure.

Staff told us the management of the home had improved since our last inspection because the manager spent more time out of the office and was more involved in delivering care. The manager had arranged his working pattern so that he could support staff during both the night and day shifts. Throughout our visit members of the management team were seen interacting with people living in the home.

Staff told us the home was a pleasant working environment and that they enjoyed working there. Many of the staff had worked at the home for several years. Staff felt supported by the management. . They told us, “they ask for our opinion on things and we tell them”, “If we are not happy about something we will tell them, we are very vocal and they do listen”. The manager told us the home’s core values included independence, dignity, respect, and kindness. Staff we spoke with had a good understanding of these values and we saw that they were put into practice.

There were appropriate arrangements in place for checking the quality of the care people received. The records we reviewed confirmed that managers and staff regularly checked care plan reviews, handling medicines, infection control and staff training and supervision. We saw confirmation that where issues were found, this was raised at staff handovers or at individual supervision meetings.

The manager sought to improve the quality of care people received by obtaining and acting on feedback from people and their relatives. We saw that after receiving negative feedback about the way people’s laundry was handled, a new system was put in place. We saw that since our last inspection where we reported some concerns about the quality of care, management had taken steps to address all of our concerns and the standard of care had improved as a result. The manager told us he regularly attended provider meetings to obtain and share information with staff on best practice. The local authority confirmed the management of the home were active participants in provider meetings.

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