# P S P Health Care Limited

# Hatherleigh

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Inadequate |
| Is the service well-led? | Requires Improvement |

## Overall summary

The unannounced inspection took place on 9 and 18 December 2014 and included an evening visit.

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

Hatherleigh provides residential and nursing care for a maximum of 53 people. There were 52 people resident the day of our first visit.

We previously inspected this service on 4 and 12 June 2014 and found the home was meeting the required standards.

People's hygiene needs were not always met. This included the changing of soiled continence pads and washing/bathing to a standard acceptable to people.

# Summary of findings

Staff had been told that where they needed to prioritise their work people could stay in bed, or be dressed and put back to bed, to give staff time to ensure people received other care, such as receiving enough fluids.

The staffing arrangements did not ensure people's needs were met in a timely manner, such as receiving personal care or meals at a reasonable time. Inadequate staffing numbers put people at risk; one to one support was not always available when planned and sometimes there were no staff in the area which left some people without physical and emotional support.

Some aspects of medicine management put people at risk. For example, an inhaler was in use which was out of date.

People were not protected by the principles which underline the Mental Capacity Act 2005. There was no evidence of supporting people to make decisions or that people's capacity to make time and decision specific decisions was assessed. There was little evidence that people had been involved in planning their care although some families said they were consulted on people's behalf.

Most staff were unaware of the local authority safeguarding adult's team or the legislation which protects staff if they whistle blow concerns although they were informed on their pay slip they could contact the local authority if they had concerns about abuse. Less than half of the staff had received training in the safeguarding of adults, in the last two years. Some staff were worried about talking to the CQC.

Some people were isolated from company, stimulation and activities of interest to them, such as watching the television or listening to music. Activities staff were requested to direct their efforts to people who showed most need, which sometimes meant meeting their everyday routine support needs.

There was diverse opinion of the helpfulness of the registered manager and senior staff in responding to concerns people raised. Some people were very satisfied and some were very dissatisfied. Formal complaints were responded to and improvements made where possible. There was insufficient overview of the organisation to ensure policies were adhered to, risks managed and the safety and welfare of people promoted.

Staff showed a commitment to providing care which was kind, patient and individual to the person. Staff had good knowledge of people's individual needs although this detail was not always reflected in the plan of how their care was to be delivered.

There was a range of opinions about the quality of the meals provided, but people's nutritional needs were met.

People's health care needs were well met. People were supported to receive treatment and health care advice and support. Staff received training and support in their work although induction training was taking considerably longer than the home's policy said it should. Staff recruitment was robust.

We found breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

# 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?**

Requires Improvement 

The service was not safe.

Staffing arrangements did not ensure people's individual needs were met in a timely way or that people's safety was optimised.

Medicine's were not always stored, administered or destroyed in a safe way.

There were some unsafe practices in use, such as propping open both fire doors of the laundry.

The arrangements for safeguarding adults from abuse were not robust as staff knowledge was weak.

There were comprehensive recruitment processes in place and individual risks to people were assessed and regularly reviewed.

**Is the service effective?**

Requires Improvement 

The service was not always effective.

People's ability to make decisions was not maximised. People's capacity to make specific and time related decisions was not assessed. However, people were not deprived of their liberty unlawfully and decisions were made in people's best interest.

There was diverse opinion of the food provided but people were supported to eat, drink and maintain a balanced diet.

People's health care needs were met by staff who were trained and supported in their role.

**Is the service caring?**

Good 

The service was caring.

Staff understood people as individuals and were generally courteous and kind. Privacy and dignity were promoted.

People who were able to express their views had the opportunity to do so.

**Is the service responsive?**

Inadequate 

The service was not responsive.

People's personal hygiene needs were not always met in a timely manner.

Each person had a care plan but there was no set arrangement for ensuring they could contribute to the assessment and planning of their care.

People did not always receive enough stimulation for them to avoid social isolation.

# Summary of findings

Complaints were responded to and improvements made where possible.

**Is the service well-led?**

**Requires Improvement**

The service did not have effective systems in place to ensure it was well led.

Although there were quality monitoring systems in place people's concerns were not always handled in a positive way and some staff were anxious about providing the CQC with information.

The provider lacked adequate overview of the service.

# 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 checked 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.

The unannounced inspection took place on 9 and 18 December 2014 and included an evening visit.

The inspection team consisted of three 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 service.

Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/complex needs. We therefore spent time observing the experience of some people.

Before the inspection, the provider completed 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. We contacted five health and social care professionals to obtain their views about the care provided in the home.

During our visit we spoke with 17 people who used the service, 13 people's families,11 staff, and the registered manager. We looked at records which related to six people's individual care, five staff files and policies which related to the running of the home such as fire safety checks, the menu, staff rota and servicing records.

Requires Improvement

# Is the service safe?

## Our findings

There were 52 people using the service the day of our first visit, one receiving end of life care. People were accommodated over three floors. The registered manager had recorded in the PIR: 'Our staff team of eight nurses, 37 care staff and 23 support staff allows us to ensure that we have the right skill mix in order to provide excellent outcomes for our residents. Staff have an average of three years' service, with 43 of our 68 staff having worked at Hatherleigh Care Village for over a year.'

Staffing arrangements did not ensure people's safety. For example, two of the 19 people on the first floor dementia unit were, according to staff, diary entries and the plan of care for one of the two people, to receive one to one care. This did not always happen. For example, during the lunch period two care workers were assisting people to eat and neither were able to observe the two people for whom the one to one care was in place. The day before our visit one of those two people had accessed a substance which had caused a physical reaction in their mouth at a time when they should have been receiving one to one observation for their safety.

People did not always receive support in a timely manner. At our first visit we were told the lunch was due at 1pm. Serving began from 1.30pm on the ground floor unit. At 2.40pm we asked a care worker why they were assisting a person with their lunch at that time. They said, "We are a bit late today and I still have two other people to feed."

During the late evening on the ground floor the two night shift care workers covering the ground and lower ground floors were assisting people who required two staff to assist them to bed. Each time they took a person to their room other people were left unattended. On one occasion, when the nurse had gone to the first floor and the two staff took a person to the lower ground floor there was no staff member on the ground floor. A visually impaired person was calling out to staff and one person was walking around; there were no staff to ensure their safety or respond to the calling.

Some people using the service and their families mentioned staff shortages, examples including, "They (the staff) do as much as they can do", "Sometimes they're dreadfully short staffed and it takes time for staff to come" and "The care is alright but they are short-staffed at the weekends…then things go downhill." Staff told us staff shortages were very difficult especially at weekends. A care worker described the times they had been called in to work on their days off and said they were "becoming exhausted".

The registered manager recorded in the PIR: 'We plan our rotas around staff skill mix to ensure consistent care delivery'. The staffing rota showed that staffing shortfalls at short notice were not always covered. For example, the afternoon of Friday 5 December 2014 staff had called in sick. Staff told us staffing that day on the dementia unit was reduced to two care workers and one nurse to care for 21 people, two who were to receive one to one care and the other who was receiving end of life care.

The registered manager said there was a continuous recruitment drive but the home was still unable to meet the staffing numbers they felt were necessary. She confirmed that agency staff were used to meet shortfalls when they were available, but this was not always so. She was reviewing the staffing skill mix, such as employing a dining room helper, to free up care staff from non-care activities. Steps had been taken to help with recruitment, such as transport to Okehampton and accommodation in the vicinity of the home. However, despite staffing difficulties the home took a day care client for 18 hours per week, from 10 December 2014. This would increase the tasks required of staff further although the provider did make clear that the person's needs were "minimal". This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the medicines kept on the first floor. The storage was not adequately secure in that non medicine items were stored with medicines. The home's medicine policy, reviewed on 3 November 2014, stated: 'On no account should anything other than medicines be stored in medicine cupboards'. Controlled drugs for disposal had not decomposed in the specialist jar as they should and were not stored in the controlled drugs cabinet but on the floor and so could be mishandled. Other medicines were correctly dealt with when they were being disposed of.

The majority of medicines were administered by registered nurses and some by trained senior care workers to residential clients. The registered provider recorded that medicine use was audited and the audit had identified eleven medicine errors in last 12 months and actions had been taken to reduce medicine errors. One person's family told us they found their family member when they visited

with tablet residue in their mouth which the person had not been assisted to swallow. We do not know if they reported this to the registered manager at the time this happened.

External medicines, such as ointment, had been signed for when administered. Tablets were generally administered from pre sealed packets which decreased the risk of mistakes. Boxed and bottled medicines in the locked cabinet were clearly and correctly labelled. Medicine administration records (MAR) were completed but included many hand written entries and referral to previous MAR records, which diminished the audit of continuity of the medicine's use. Transcribing a medicine and dosage is open to mistakes and the entries had not been checked by a second staff member for accuracy. The registered manager did not know why there were so many hand written entries and said they would contact the pharmacy about this.

Most medicines were delivered on a monthly basis but on checking other prescribed and medical stock we found some was stored although they were past the manufacturer's recommended use-by date. This included an inhaler which was in current use. The nurse also confirmed that blood glucose strips were being used by people to whom they had not been prescribed; these were not therefore those people's property and they had no right to use them. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Information from the provider stated just less than 50% of permanent staff at Hatherleigh had received training in safeguarding adults in the last 24 months. Most of the staff demonstrated a good understanding of what might constitute abuse and all said they would contact the nurse on duty or the registered manager if they had concerns which might indicate abuse. However, most did not know where they should go to report concerns externally, such as the local authority and police. When we asked for the home's whistle blowing policy we received two, one dated April 2008 and a second policy dated 14 October 2009. Neither informed staff that they were protected under the Public Interest Disclosure Act 1998, nor told them they should inform the local authority safeguarding team of any concerns they felt had not been dealt with adequately at the home. Neither was there contact details of external agencies included for staff use. The policy also contained information which was outdated, with regard to regulation of the service. However, the registered provider sent us a copy of staff's pay slip, which included the information that staff could contact the local authority if they had concerns that abuse might have occurred and we were told each staff had this information available in the employee handbook and electronically. The registered manager was able to demonstrate a good understanding of their role and responsibilities in protecting people from abuse. This is a breach of Regulation 11 (1) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People felt safe at Hatherleigh saying, "(The staff) would do no harm to anyone day or night" and "I feel safe and sound." Risks to individuals were assessed and measures put in place to reduce any identified risks. Assessments of people's needs, including protecting their skin from pressure damage, dietary intake and how to assist people to move safely, were regularly reviewed. However, a health care professional when visiting observed staff repositioning a person without using the equipment they felt was necessary for the task. They felt this put both the person using the service and the staff at risk of injury and fed this concern back to the registered manager.

Accidents were reviewed by the registered manager and provider organisation to look for trends and ways to mitigate risk and we saw that one person, who had a history of falls, was now falling less frequently.

Fire safety equipment had been serviced on a regular basis, as had lifts and the nurse call system. However, we found both laundry fire safety doors had been propped open which would pose an increased risk in the event of fire. We informed the registered manager about this concern.

There were comprehensive recruitment processes in place with each personnel file having an audit checklist to identify when each part of the procedure had been completed. Staff files included completed application forms. Pre-employment checks were done, which included references from previous employers, health screening and Disclosure and Barring Service (DBS) checks completed. These checks identified if prospective staff had a criminal record or were barred from working with children or people at risk. Nurse personal identification numbers (PIN) had been checked and we saw that where applicants were recruited from outside of the UK there was a migrant worker form to be completed. One file showed a copy of a new recruit's valid work permit had been obtained prior to

Requires Improvement

# Is the service safe?

employment. The registered manager told us they interviewed all prospective new staff but had at times selected staff that might not have been selected if recruitment in the local area was not so difficult.

Requires Improvement

# Is the service effective?

## Our findings

The registered manager and nursing staff had an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. Care workers demonstrated some understanding. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. The staff used a generic system for assessing a person's capacity. Although the system looked at different aspects of the person's care, such as whether they could consent to having bed rails, there was no evidence of people's ability to make decisions being maximised. For example, identifying a particular time of day when people were more receptive to weighing up the information. There was no evidence that the five statutory principles relating to decision making had been applied.

When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Some people's families felt they were consulted about people's care appropriately but we found this was not recorded. End of life care decisions were in place, such as whether the person wanted active intervention in the event of collapse, and GPs had discussed this with people.

Where people lacked capacity for involvement in their care, we asked family if they were involved on their behalf. Some said not, one saying "I am not at all involved. I have not sat down and gone through the care plan." One person said, "From day one there were sessions with (the registered manager) about likes, history. For decisions they phone the family."

We asked the deputy manager about the review of a person's mental capacity in relation to covert medication, and about consent to administration of medicines in general. They said that the question of the decision to self-medicate upon admission or thereafter was not actually asked. This meant the people were not given that choice and control. This is a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The home had made applications to deprive people of their liberty following a Supreme Court judgement on 19 March 2014 which had widened and clarified the definition of deprivation of liberty. Those applications had not yet been assessed by the local authority and in the meantime the staff continued to make decisions in people's best interest. This included coded doors to restrict the areas within the home in which people could move without staff support. The home had also been authorised to restrict the liberty of four people for their protection. The registered manager monitored the use of those authorisations. When we enquired about a staff practice with regard to one of the people we found the authorisation was being followed correctly.

There was varied opinion of the food provided. Comments included: "We're pretty satisfied…nice food…we get a choice"; "I could choose if I didn't like chicken", "Quite average but today no flavour. It would be so nice if the veg were on the table to help yourself and avoid waste" and "He hates the food." One person said their main meal preference was spiced food but they rarely got this and they did not like the gravy, which was always poured over their meal. One person's family said, "She eats everything she is given." Another person wanted the vegetarian menu to be enlarged, adding "Going to the dining room is not worth the candle".

The chef told us "At lunch there are mains, jacket potatoes, omelette, sandwich and veggie option." Lunch on the ground floor the first day was served from a trolley. It did not look appetising but appeared to be hot. Some people ate everything and some food was scraped away. One person ate all the gravy and the nurse refilled his meat. Our second visit there was a minced meat meal with pastry, potatoes and two vegetables.

The winter menu, week six, offered a vegetarian meal at each sitting or a meat with potato based meal, except for Fridays. The high tea menu included daily soup, and other options, including pasta, burgers, ploughman's and pilchards on toast for more variety. We saw people had drinks available to them and hot drinks were taken round routinely. However, meals might not always be appropriately spaced. We saw examples of where lunch was not served until 2.40pm.

Where there were concerns about a person's eating or drinking this was monitored, for example, through the use

# Is the service effective?

of fluid charts. However, according to the home's records, staff had not received training in malnutrition care and assistance, or with eating or swallowing (when choking was a risk).

Health and social care professionals were generally complimentary about the care provided at Hatherleigh. Their comments included, "They meet nursing needs", "Staff have a good understanding of dementia" and "Staff appeared knowledgeable about client's needs and, on advice given by health, were very quick to act and request necessary services deemed appropriate." A GP who attended people at Hatherleigh said they had no concerns about the care people received. There was a weekly GP review of people whom staff felt needed a visit and health care professionals were contacted as and when necessary.

Staff received regular supervision of their work by a registered nurse or a senior care worker and were able to ask questions. However, staff delivering supervision did not always feel confident where there were issues of performance to be addressed. They confirmed they did not receive training in staff supervision and the support they needed for the role was not always available. The provider recorded that each member of staff had received a regular supervision of their work.

Staff induction was not always completed according to the home's timescale. There was a 24 hour induction checklist, which emphasised that it must be completed on day one of their induction. In four files the completion date exceeded 24 hours, from 48 hours to over a month.

Staff felt their training had improved with comments including, "A lot better about (qualifications in care). In house training is better managed" and "Everybody is pretty much up to date (with mandatory training)." The staff practice we observed gave us no cause for concern. The provider recorded that a new training provider will be rolled out from January 2015. The registered provider recorded that all staff were actively encouraged to complete training to give the staff team confidence.

Two people's families expressed concerns around the seating and available space on the first floor dementia unit saying they felt this negatively affected their family member. One said their father would sometimes watch the television if seated so they could view it but they were mostly found sitting in the dining area or outside the view of the television. We saw them in the dining area on a dining room chair twice when we visited. People were able to use their bedroom for private visiting but most were unable to take themselves to their room or express the desire to go there and so remained in the communal spaces available. There was also seating in a quieter area outside of the lounge/dining room but this would only accommodate a few people at a time. Bedrooms we visited on that floor did not have a second chair available for visitors. One person's family had said some peoples pillows were "lumpy". That person's pillow had been replaced but we found other lumpy and sparsely filled pillows were in use, as we had been informed.

Good

# Is the service caring?

## Our findings

Care workers were courteous, kind and generally attended people with respect and patience when providing care and support. They were seen to be offering choices, providing information and ensuring the people they supported felt safe and involved during the different aspects of the care provided. This included assisting people to eat and assisting people to move using a hoist. One person needed assistance to be repositioned. The care worker was calm and explained what they were doing; giving the person the opportunity to understand what was happening. A person told us "They are so kind to (the person)."

Staff showed concern for the people they were caring for. For example, one person was asleep in a lounge chair and a care worker covered them with a blanket.

The registered provider recorded, 'A key feature that the team has developed is protecting our resident's privacy and dignity. We treat our residents as people, placing their needs first. Whilst our policies and procedures and training materials advocate this approach, our staff team have worked hard to put their learning into practice'. Personal care was delivered behind closed doors for privacy and dignity. One person's style of clothing had been adapted to ensure their dignity when in the lounge with other people.

A nurse told us "Our staff know clients really well, know how to adjust to mood and state of mind". They said agency staff usually worked with the same people so they tended to know those people well also. Nursing and care staff were able to describe people's needs and idiosyncrasies. They told us how people preferred to receive their care and how staff would respond if care was refused or the person was upset. For example, one person liked to rise late morning and retire late evening and this was respected and supported. Another person preferred to remain in a quiet room with no stimulation or visitors.

Most visitors felt very welcomed at the home with comments including, "Relatives can come any time." People visited throughout the day and evening. There were a lot of visitors to the home throughout our inspection.

The registered provider recorded that it was of 'paramount importance to the team at Hatherleigh that residents have a positive experience. Staff work to develop open and honest relationships with residents and their families. Residents are allocated key care assistants who have a detailed understanding of their needs'. People spoke positively about the staff at Hatherleigh. Comments included. "(Staff) are patient and kind", "100% staff are excellent", "The staff are fantastic" and "Staff are good."

People who were able to express their views had the opportunity to do so. For example, results from people's feedback about the home was displayed and one person's family told us they had completed "two or three" feedback surveys that year. The registered manager was very visible at the home and available to people using the service and visiting. One person's family said, "(The registered manager) is very amendable and accessible. Just knock on the door." Examples of advocacy from specialist organisations included that of a Parkinson's Disease specialist nurse.

The registered provider recorded, 'As a team we have developed and refined the service that we are able to offer our residents and their families at their end of life'. People appeared to be comfortable when receiving end of life care; rooms were warm, fresh, personalised and equipment required for comfort and safety was in place. GP visits ensured medicine use was adapted in the person's best interest and comfort taken into account. A GP told us they had no concerns about the care delivered at Hatherleigh or nursing staff knowledge. The registered provider recorded that 44 staff had received training in end of life care.

Inadequate

# Is the service responsive?

## Our findings

People's care needs were not always responded to in a timely manner. During our day time visits the home was generally fresh and odour free. During our evening visit there was a strong odour of faeces when we sat with people. Care workers confirmed some of those people had required personal care to return to a fresh state when they had been assisted to bed. It was recorded at a nurse and senior care meeting, "No resident is to be left sat in a pad for more than 6 hours without it being checked." Records of pad checks showed that people did not always have assistance with personal care until they were put to bed by the night staff. Examples included some people not changed since 9am,10am and 11am; periods of 10 to 12 hours. One person's care plan stated the person should be offered a change of clothes when the clothes were stained from food. We visited that person late morning and again during the evening and their clothes were stained and remained stained and covered in food debris throughout. The registered manager said the person was sometimes resistive to having care and had sometimes to be persuaded. A person's family said their loved one was able to say when they wanted to visit a toilet, but staff would have to go up to them and start that conversation. They said family had visited on one occasion and spent three hours with the person with their pad smelling of faeces.

Staff said decisions on what care and support people would need to be omitted were made. An example was that staff would prioritise who would be got up for the day based on whether there was enough staff to support them or not. We were told everybody was washed and put into a clean pad at the beginning of the day but the pad change round would be omitted if it was felt that people's fluid intake needed to be prioritised. The registered manager confirmed that she had told staff that they would need to prioritise people's basic needs if short staffed and make the necessary decisions of which part of their care and support to omit in order to meet these. This meant that people's needs were not fully responded to.

Care workers were frustrated at being unable to provide the care they felt people wanted, such as regular showers, finger nail clipping and hair washing. During our first visit one person with long nails told us they had asked for them to be cut "two or three times" adding "everything is put off." By our second visit they had been cut. Some people had greasy hair. Records showed infrequent bathing/showering and hair washing. Some people's families were happy with the standards of personal care provided, one saying "Mum is always clean and tidy." Other people's families were not happy with the standards of personal care.

Most people who were able to tell us their experience of living at Hatherleigh were happy with their care. Comments ranged from "Superb care" and "I've been well cared for" to "The (staff) are alright but they have not grasped my needs" and "The care is alright." We saw evidence of one person thriving since admission to the home and the family of another said "Staff are good. (Mum) is eating really well and now maintaining her weight." They said their mother had settled into the home really quickly. Some people's families were not happy with the care provided and cited inconsistencies in what staff had told them. One said, "They tell you so many different things. They all tell you differently."

There were examples of staff not responding to people's changing needs. For example, one person's family said they found their family member sitting in front of cold fish and chips, which they felt their family member was unable to manage. This was three days after the person had damaged their mouth, the result of which we observed during our visit. The family said, "It all seems a bit hit and miss." This is a breach of Regulation 9 (1) (b) (i) (ii) HSCA 2008 (Regulated Activities) Regulations 2010.

The provider recorded: 'Each resident has an individual care plan that records the choices that individuals have made. This information is gathered from the resident, their family and any external professionals that provide input to their care.' We saw that each person had a care plan in place. However, people were unaware they had been involved in their care planning one person saying, "I don't remember talking with matron about my care." The registered manager was insistent that people's care was discussed with them when at all possible, or with their family representatives when necessary. Some people's families confirmed this and some said they were never consulted. Only one recorded reference was found of a person having been involved in a discussion about their care plan.

Care plans described the care each person required and most provided the detail of how to deliver that care. For example, one described the person's preferred type of drinks, hot and cold, likes and dislikes and what type of the

Inadequate

# Is the service responsive?

cup the person preferred. However, where a person was known to exhibit aggressive behaviour, the plan stated staff should distract them, but did not include how that particular person was best distracted. Care plans had been regularly reviewed so the information available to staff described their needs at that time. A health care professional told us they had observed a person with challenging behaviour struggling to eat and the care worker assisted and understood the person's needs well. The registered provider had recorded that 48 staff had received training in how to deliver personalised care.

The registered provider recorded, 'Our activities and stimulation program forms a major part of our planning for care delivery. We have dedicated activities co-ordinators who work with our residents in groups and one to one to ensure that we are able to reduce the risk of isolation and loneliness'. The provider organisation's instructions for covering staffing shortfalls included cancelling activities so that activities coordinators could help with the delivery of care and staff providing care confirmed this happened. One person told us they were "lonely" and we saw many people had spent the morning in their rooms where there was no stimulation. We saw how some people, having been freshened early morning, had been placed in their day clothes and returned to bed, where we found them late morning. The registered manager confirmed this was not part of their planned care and the people had not agreed to it. It was, she said, sometimes to protect them from pressure damage. She said she also had to prioritise people getting their fluids over the time taken to get people up.

People's families said there was not enough stimulation for people. Comments included: "They have tea and then just sit about", "There is not enough seating for the TV" and "(The person) would respond if (the person) could hear the music". There were some regular activities arranged by the home, such as men's lunch on a Friday with fish and chips and a beer. However, some people told us they had employed a private activities worker and bingo and skittles was available due to the input of one person's family who chose to volunteer their assistance. We were told there was a programme of completing 'This is me' information which provides details about an individual in an easy to access format for staff reference. The minutes from a staff meeting dated 3 November 2014 stated that 10 of the 21 had been completed for people on the first floor. The registered manager said they would then be completed for other people at the home.

The home had a complaints procedure in place and displayed at the home's entrance. The registered provider recorded there had been 13 complaints in the last 12 months, eight from one person's family, and each had been resolved. One person's family told us: "I have no concerns about the care home, a year ago when my mum moved there, I did complain, as I was not at all happy. I now would like to report that my mum is getting first class care, and I would recommend the home. It has greatly improved, and the staff are excellent." Most people felt issues raised were followed up. For example, one person visited early afternoon and found their relative still in bed. They said that when they had spoken to the registered manager it was sorted out very quickly and it had never been repeated. Where a person's family was not happy with the response to a complaint a representative of the organisation had personally visited the complainant to try to resolve the complaint.

Requires Improvement

# Is the service well-led?

## Our findings

An open, inclusive and empowering culture was not fully achieved at Hatherleigh. The CQC is aware of one person's family representative who did not feel their views were listened to by the registered or deputy managers. However, the registered manager and provider had gone to considerable lengths to resolve the issues raised and the person's GP had no concerns about the person's care. A care manager told us of a second family where disagreement about the care provided "Became a battle." They said, "A more open approach, looking at risk and client choice in a positive way may have improved outcomes." Two care workers said they were anxious about speaking with us, saying they did not want to get into "Any trouble". One also felt the trust between the nurses, managers and support staff had been lost. An example given was being "Told off" and the feeling that assumptions were made that they were not doing their job when there might be a good explanation for what had happened.

A visitor's opinion was that the organisation prevented the registered manager from achieving what they felt was necessary but the registered manager strongly denied this saying, "What I have asked for has been provided." One person said, "(The registered manager) leads a good team" and another person's family said, "(The registered manager) is really good. Always there when you walk in." A health care professional said, "(The registered manager) is a warm and empathetic person." The registered provider recorded, "The culture of our team has always been to 'silently' support residents providing a safety net for them (and their loved ones). We are careful not to take over their lives and make decisions for them."

Some staff commented favourably about working for the organisation, their comments including, "I love it here" and "The manager is lovely." Staff said they were able to ask questions and share ideas "most of the time." The general feeling from staff, as with some visitors, was that the registered manager did not have the autonomy to make necessary changes at the home. One confirmed they could knock on the registered manager's door at any time. However, they did not always feel they received the answers they needed and had sought information on-line or from other people they felt might know the answers they sought.

The registered provider recorded that there was a quality monitoring system in place. They said the last resident survey was sent out in January 2014 and 17 families responded. 81% of those who responded marked quality of care as either 'Good' or 'Very Good'.

Staff had a number of mechanisms to raise concerns, both internally and externally, which included meetings, emails and anonymous suggestions box. Where concerns had been raised systems had been adapted to prevent similar concerns arising again. The registered provider had recorded, 'Where we have got it wrong we have readily apologised and tried to make up for the inconvenience'.

Overview of the service by the provider organisation was not always in line with its policies. For example, the policy and procedure on the management of fire safety at the home stated that the registered manager and operations director were both to check and sign off the safety checks on a monthly basis. This was not done. Another example, was storage of non-medicine items in a medicine cupboard, contrary to the home's policy.

The administrator said that the organisations policy was that the in-house maintenance person mended those things he could, and that any other larger jobs were referred up to the head office for action. Outstanding maintenance jobs referred to the head office were 25 in total dating from 16 May 2014 to August, September and October 2014 onwards. 16 of these sheets were marked as 'priority within 24 hours', six as 'priority', that being one week, and the remainder did not have a time indicated. These contained many issues about doors and particularly door closures, and some about electrics such as water coming through an extractor fan, failure of portable appliance testing, and closure of fire doors. We received evidence that replacement door closures had been received at the home and the registered manager gave us explanation for some of the entries, such as condensation being the cause of the water in the extractor fan. The registered manager felt the short timescales recorded had not been necessary. However, the urgency stated in the referral to head office had not been highlighted as a concern or the arrangements reviewed and amended in light of the fact that the timescales had not been met.

The registered manager, asked about visits from the operations director of the organisation, said they did not

Requires Improvement

# Is the service well-led?

know when the last one had been adding, “Months and months ago.” However, we are aware that there had been an early morning visit by a provider representative just prior to the inspection.

This is a breach of Regulation 10 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010.

The registered manager said they were in regular contact with the head office of the organisation, for example, about staffing levels, and that resources and support was always available. Examples included, additional moving and handling equipment and changes to the staff training arrangements. Aspects of the home were audited by the registered manager. Examples included an accident and audits database to help monitor trends and clinical audit tools, such as medicine errors. This showed that staff practice within the home was monitored. Staff meeting records indicated that the standards of care provided were monitored, such as completion of fluid charts. The home was also signed up to the ‘Gold Standards Framework’ good practice scheme and the ‘Devon provider engagement network’. The registered provider recorded, ‘(The registered manager) has developed a clear set of values for the home, both through formal models such as the "Golden Rules for Care Staff" and through setting expectations for care via more informal methods’.

The registered manager understood their legal responsibilities. For example, they submitted notifications to the CQC as they were required and were always knowledgeable and informed when information had been requested by the CQC.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br><br>**There was not suitable arrangements in place to obtain, and act in accordance with, the consent of people using the service. In particular, where it was believed people did not have the capacity to make specific decisions about their care and treatment.**<br><br>**Regulation 18** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing<br><br>**Appropriate steps had not been taken to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of people using the service.**<br><br>**Regulation 22** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse<br><br>**Suitable arrangements were not in place to ensure that people were safeguarded against the risk of abuse.**<br><br>**Regulation 11 (1) (a)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines |

This section is primarily information for the provider

# Action we have told the provider to take

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision<br><br>There were not effective operation systems in place to assess and monitor the quality of the service provided or identify, assess and manage risks relating to the health, welfare and safety of people using the service.<br><br>Regulation 10 (1) (a) (b) |
| | People were not appropriately protected against the risks associated with the unsafe use and management of medicines.<br><br>Regulation 13 |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br><br>Proper steps had not been taken to ensure that each person was protected against the risks of receiving inappropriate care in that individual personal care and hygiene needs were not always met or the welfare of people promoted.<br><br>Regulation 9 (1) (b) (i) (ii) |

**The enforcement action we took:**
We have served a warning notice which must be met by 28 February 2015.