Hartford Care (4) Limited

Hartford Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 20 and 21 April 2017. Hartford Court is registered to provide accommodation and care for up to 60 people. During the inspection 32 people were being accommodated, with one person in hospital. The home opened 11 months prior to the inspection and was slowly filling. The provider recognised this needed to be done gradually.

The service had 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 2008 and associated Regulations about how the service is run. However in the week prior to our inspection the registered manger had left the service. The brand director for the provider was providing the management support until a manager was appointed.

This was the first inspection the service had received since it registered on 16 May 2016.

People told us they felt safe living at Hartford Court. Staff understood the principle of keeping people safe. However, risk assessments were in not always in place to ensure staff were aware of how to minimise the risks facing people. There were some errors with the medicines administration and recordings.

People felt the staffing levels met their needs in a timely way. Staff told us they felt well supported by each other and the management team. They received support and had a good programme of training. Recruitment checks had been completed before staff started work to ensure the safety of people.

Staff had knowledge of the Mental Capacity Act but people's records around best interests decisions needed to be improved. People enjoyed their meals and the chef was keen to ensure people received a positive dining experience. People were supported to access a range of health professionals.

People had their needs assessed before they moved into the service and efforts were made to ensure there was a good overall picture of the person. Care plans had been completed but these were basic in nature and had not been updated as necessary. People felt confident they could make a complaint and it would be responded to. Complaints were logged and there were recordings of investigations into complaints.

People felt the staff were caring, kind and compassionate. The home had an open culture where staff felt if they raised concerns they would be listened to. Staff felt supported by the management team and were clear about their roles and the values of the home. The management team had, during our inspection also noted some of the areas where we had identified a breach. They were disappointed their own quality assurance processes had not identified these breaches and were keen to look at where their processes had gone wrong.

We found 3 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can

see what action we told the provider to take at the back of the full version of the report.

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 always safe.

Risks regarding individuals care had not always been identified and updated to ensure the risk could be mitigated. Medicine procedures were not always safe.

Staff were aware of what constituted abuse and of safeguarding policies and procedures.
Recruitment procedures were in place to ensure staff were suitable to work with people at risk.

Staffing levels were planned to ensure the needs of people could be met.

Is the service effective?

Good

The service was effective.

Staff had received training and supervision, to ensure they had the knowledge and support to meet people's needs.

Staff had knowledge of the Mental Capacity Act 2005, but records relating to best interest's decisions and meetings could be improved.

People enjoyed their meals and ate a balanced diet, where choices were always available.

People were supported to access a range of healthcare professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were, kind and compassionate.

People were supported by caring staff who respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had not been updated and there was a lack of personalisation in the support needs recorded for people.

People felt they could complain and complaints were investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance process was not effective at identifying areas which needed to improve to ensure people received a good quality service.

The service supported an open door policy and staff were encouraged to share concerns and make suggestions for improvements.

Hartford Court

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 comprehensive inspection took place on 20 and 21 April 2017 and was unannounced. One inspector and a specialist advisor in nursing carried out the inspection. The specialist advisor inspected on one day of the inspection.

Before the inspection, we reviewed previous inspection reports, action plans from the provider, any other information we had received and notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spent time talking to ten people, three visitors, eight members of care staff and the chef. We also spent time talking to the provider's brand director who was working in the home following the registered manager leaving in the week prior to the inspection. We looked at the care records of seven people and staffing records of three members of staff. We saw and were sent minutes of staff briefings, policies and procedures, compliments and the complaints log and records. We were given copies of the duty rota for a month, which included the week of the inspection, and a copy of the training matrix.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed interactions between people and staff. We received written feedback from two health and one social care professionals.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Hartford Court. People's relatives told us they were confident their relatives were in safe hands.

Risks associated with people's needs were not always identified and therefore risk assessments were not in place to reduce risks and therefore ensure staff were aware of these risks. For example, where people had regular falls, their generic risk assessments had not been updated to reflect the increased risk. Care plans had not been developed to reduce any risks associated with falls. This meant staff may not be aware of the increased risk and may not take appropriate action to reduce the risks. It was also noted where people had sustained injuries, for example a skin tear there were no associated body maps or appropriate risk assessments to ensure staff were aware of the increased risks to people.

A failure to ensure risks associated with people's needs was assessed and plans were developed to mitigate these, and a failure to take effective action to address risks was a breach of Regulation 12 of the Health and Social Care Act 2014.

There were appropriate risk assessments for the environment of the home and policies and procedures to follow in the case of an emergency, for example in the event of a gas leak or flood.

People advised us they received their medicines on time and in a place of their choosing. Medical administration records (MAR) carried forward the total of the medicines, but we found these were not always an accurate recording. One person's medication had been changed on the pre-printed MAR charts, but this had not been countersigned. When asked a member of staff did not know who had changed this. We checked six people medicines against the MAR charts. We found three were accurate, but two people had more medication than expected and for one person this was less than expected. We could not be confident people received their medicines in line with their prescriptions. This demonstrated medicine practices were not always accurate and therefore safe.

A failure to ensure the medicines were safely managed was a breach of Regulation 12 of the Health and Social Care Act 2014.

Medicines were stored safely in medicine trolleys which were secured to the wall. Medicine rooms on each floor stored the medicines not put in the trolleys and had a fridge. The temperature of the room and fridges were checked and recorded daily.

People were protected by staff who knew how to recognise signs of possible abuse. Staff and records confirmed they had received training in how to recognise harm or abuse and knew where to access information if they needed it. Staff told us they felt confident the provider would respond and take appropriate action if they raised concerns. Staff had safeguarding training and part of this covered whistleblowing. Staff knew how to raise concerns outside of the service if required. People and staff were encouraged to speak about safeguarding and share any concerns they may have had.

There was enough qualified, skilled and experienced staff to meet people's needs. Staffing levels were planned and sufficient to meet the needs of people and duty rotas reflected this. People and relatives told us they had a good relationship with staff. Staff felt there was enough staff on duty to meet people's needs and they did not have to rush. The provider's brand director told us they were recruiting more staff to meet people's needs as the home became full. Staff were aware of this and believed staffing levels would increase as the home filled up.

Recruitment records showed relevant checks had been followed to keep people safe. Application forms had been completed and where available staff's qualifications and employment history including their last employer had been recorded. Photographic evidence had been obtained ensuring staff were safe to work with people. Staff were subject to a Disclosure and Barring Service (DBS) check before new staff started working. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. Staff confirmed they had been through a good recruitment process before they had started working in the home.

Good

Is the service effective?

Our findings

People told us the food was of a good quality and there was always a choice available. People told us the staff were helpful and always asked before supporting them if they wanted help or support.

People benefited from effective care because staff were trained and supported to meet their needs. The training matrix identified all training and when each member of staff had completed the area of training. This covered various areas including, first aid, fire, manual handling, dementia awareness, safeguarding and equality and diversity. New staff also undertook the Care Certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. There was a plan in place to ensure one to one formal supervisions, which included observations of practice with staff. Whilst this was in place it was noted some staff had fallen behind in having their induction period being assessed and signed off. However, during the inspection staff were booking these in with the provider's brand director. All staff spoken to stated they felt supported by members of the management team and each other.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff had knowledge of the Mental Capacity Act. People's records recorded if people had capacity or not. People's mental capacity had been assessed in the same three areas, which was not necessarily decision and time specific, in terms of the principles of the Act. People's records could have been improved regarding their capacity. For example, some people had pressure mats placed by their bed to alert staff to when they moved in order to keep them safe. However, whilst these were for people's safety they had not always been considered a possible restraint which would have been best practice. There was no evidence a best interests decision with relevant parties had always taken place with regard to these. We have addressed this in the well-led section of the report. However, there was no clear evidence of a negative impact on people and when talking with staff they were aware of the principles of the Act and advised they would support people appropriately. People also told us they were given choices and had as much freedom as they wanted. One person explained how they regularly went out of the home to visit local attractions and family members.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found applications had been made appropriately for people. Details of these applications and where decisions had been made these were recorded in people records.

All comments from people regarding the meals and choices were positive. The chef told us it was important people enjoyed a positive dining experience and spent time discussing menu's with people. Details of people's dietary needs were recorded in their care records and was also recorded in the kitchen. People's weight was recorded on a regular basis and if any concerns were noted appropriate action was taken. People had a choice where they ate their meals, in the large dining room, one of the smaller lounges or in their own room. People were offered a choice of beverages including red or white wine, non-alcoholic wine or a fruit juice to accompany their meal. The menus were displayed on the tables in the dining room and these recorded a varied choice of meals at all meal times. At lunch time people were supported in a positive way. We noted one person at lunch time had become anxious and did not want to sit and eat. Staff showed a good knowledge of the person and their needs. The person later sat with one staff member and enjoyed their meal.

People had access to a range of healthcare professionals including opticians, dentists, GP and nurses. Referrals to other health professionals were made when required. People were confident that medical attention would be sought and that a GP or emergency services would be called if needed. We did note some records did not record a person had access to a particular professional, for example a podiatrist, however we were assured this was just a recording issue.

Good

Is the service caring?

Our findings

People told us the staff were caring and kind. "I could not wish for anything else, the staff are wonderful, it is like a five staff hotel", was what one person told us.

Staff were knowledgeable and understood people's needs. Staff explained what they were doing when they supported people and gave them time to decide if they wanted staff involvement or support. Staff spoke clearly and repeated things so people understood what was being said to them. For example, at lunch time one person could not decide what they wanted to eat. Staff put two choices on each plate and supported the person to make a choice.

The environment of the home was designed so there were lots of choices for people in regards to where they spent their time and what they did. The home had main lounges but also smaller lounge areas where people gravitated to. For example, one gentleman spent time in the small 'captains quarters' where he read his paper daily. Two ladies enjoyed having their morning coffee in a small polka dot kitchen.

People were invited to attend 'residents meetings', where they could share their views on the home and any improvements they thought needed to be made. Minutes were made of these meetings and left in areas of the home so people could read them.

People's privacy and dignity was respected. Records for people were stored confidentially and only staff who needed these had access. Staff confirmed they understood and valued the need to respect people's privacy and dignity. They described the methods they used when supporting people with personal care. Staff knocked on people's doors and waited for a response before entering. Staff used people's preferred form of address, showing them kindness, patience and respect. When speaking to people staff got down to the same level as people and maintained eye contact. Relatives told us they were always made welcome and could visit at any time. There were areas in the home where people and relatives could make themselves hot and cold drinks. People had decorated their room with their own furniture and items which were personal to them and each room reflected the person's interests and character as much as possible. People had been consulted on their views on their care and privacy and dignity through resident's meetings and surveys.

Requires Improvement

Is the service responsive?

Our findings

People and families had been involved in the pre admission assessment and planning of coming into Hartford Court. Important information had been recorded regarding people's preferences and choices. For example, what time they wanted to get up and go to bed, or whether they wanted male of female staff to support them.

Care plans were developed from the initial assessments and background information. However these were not personalised and contained very little information. Standard sentences had been used in people's care plans giving the same information. Care plans were not detailed and did not give enough information for staff to be able to know an individual's needs. Where people were on medication for pain, there were no pain assessments or care plans to inform staff how they would identify if a person was in pain. One person had a diagnosis of a medical condition which affected most of their activities but this was not detailed in the sections of their care plan. We found information in daily notes of incidents or accidents, but these had not been detailed, or followed up in terms of updating people's care plans. For example, daily notes made reference to a skin flap, but there was no body map, but there was a body map for a separate incident. However people's care plans and reviews made no reference to these incidents. Plans of people's care were not updated. Care plans were reviewed on a monthly basis; however these appeared to be more of a paperwork exercise only. Where people's needs had changed or there had been incidents for example falls, this information was not included in the monthly review. The relevant sections of the care plan were not changed or updated as necessary. For example, if someone had frequent falls, the risk assessment and mobility care plan had not been updated to reflect people's needs had been changed. We noted where people were on fluid charts good records were maintained. However when the records showed the person's fluid intake had fallen well below the target no recorded action was taken and the care plan was not amended. Good records were maintained where people were on a pressure turning chart. However, the recordings showed whilst people were checked according to the time frame in the care plan, they were not responsive to people's needs: as people were left in the same position for longer periods than their care plan indicated.

The care and treatment of people was not always demonstrably person centred and care plans did not reflect people's changing needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home employed activities co-ordinators who covered seven days of the week. They provided activities both on an individual and group basis. All activities were recorded and the programme was given to each person and left around areas of the home for people to pick up. Activities were arranged all over the home and in the garden and offered a wide range of activities.

There was a complaints procedure in place, which was displayed in the home. We saw resident meetings encouraged people to provide feedback and reinforced they could raise concerns with staff at any time. People knew how to raise a complaint but said they had not needed to. We reviewed the complaints records and saw complaints had been dealt with in line with the provider's policy and the satisfaction of the

complainant with the outcome was recorded. People were encouraged to share their feedback through resident meetings and surveys.

Requires Improvement

Is the service well-led?

Our findings

People reported to us they thought of Hartford Court as their home. They believed there was an open culture where they could have their say and influence how the home was run. Staff told us they really enjoyed working at the service. Staff repeatedly told us it was the best place they had ever worked and they believed people received a really good service. Staff were aware of the values and vision of the service. They felt they could make suggestions to the provider's brand director and they would consider any suggestions they made.

The home did have a registered manager but they had left the week before the inspection. The first day of the inspection was also the deputy managers last day. The home had already recruited a deputy manager who had started work in the home. The deputy manager and the home were being supported by the provider's brand director. People and staff spoke very positively of the provider's brand director and her positive impact on the morale of the home.

A range of audits were carried out on a regular basis. This included monthly and quarterly audits which covered areas such as record keeping, environmental safety, staff training and supervision, care plan reviews and people's views, management of medicines and incident recordings. However, the quality assurance system had not identified the shortfalls in risk assessment and medicines we identified in the safe section of this report, nor a need to consider mental capacity assessments for the use of bed mats and record best interest decisions. Care plan audits were carried out regularly but these had not identified the areas of concerns we found as reported in the responsive section of this report. However when we discussed these areas with the brand director and deputy manager they could identify the gaps too. We noted in some staff's supervision sessions areas of frustrations had been recorded but there was no evidence these had been addressed or followed up. Incidents and accidents were recorded and looked at on a monthly basis. However it was noted there was no analysis of this information. The collation at the end of the month was a report rather than analysis, so no learning was possible from the information and no changes were again made to people's care plans and associated risk assessments.

This failure to ensure there was effective systems to monitor the service to drive improvement was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Surveys were completed to gain the views of staff and people who used the service to establish if they thought a good service was being delivered. The results of audits and surveys were compared to the other homes of the provider, to see if there were any common themes or areas where a particular home was failing or excelling. The information from these surveys and audits was used to ensure improvements were being made. For example a staff member had commented in the survey they would like to undertake a particular training course. This had been identified and it was recorded the issue would be discussed with the member of staff.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always demonstrably person centred and care plans did not reflect people's changing needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had not had their risks identified and there was therefore no plan in place to mitigate the risk facing some people. Medicines management were not safe for all people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective quality assurance system to ensure people received a good level of care.