Bupa Care Homes (CFChomes) Limited

Hatfield Peverel Lodge Care Home

Inspection report

Crabbs Hill
Hatfield Peverel
Chelmsford
Essex
CM3 2NZ

Tel: 01245380750

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Hatfield Peverel Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service is set in large grounds in a rural location close to Hatfield Peveril. There are two units, Kingfisher House in the main building and Mallard House, which specialises in support for people with dementia. Since our last inspection the provider had reduced the number of people who could be supported at the service from 71 to 68. At the time of our visit there were 63 people using the service.

The inspection took place on 9 October and was unannounced.

At our last inspection in July 2017, the service was rated requires improvement overall. We had concerns staff did not have the necessary skills to meet people's needs, care plans were not person centred and people being cared for in bed lacked stimulation and access to activities. There had been some improvements however, the service was rated requires improvement overall. This was because previous inspections had highlighted that the provider struggled to maintain good care standards over time, with overall ratings of requires improvement in 2015 and 2016 and an inadequate rating in February 2017.

At this inspection we found the provider had addressed our concerns and improvements were being implemented in a positive and sustainable manner. As a result, the rating improved to good.

There was a new registered manager and deputy manager in place. 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.

The new management team worked very effectively together, with the deputy manager taking on the role of clinical lead. There was an open culture which focused on the people who lived there. Checks on the quality of the service were robust and improved the wellbeing of the people receiving care. The registered manager worked well with outside organisations to drive improvements.

People received the support they needed to remain safe. Staff demonstrated an enabling attitude to risk, ensuring people were not restricted unnecessarily. Learning from incidents and accidents was used to improve safety at the service.

Staff supported people to take their medicines safely and as prescribed. There were plans to improve the administration of medicines to ensure the task did not disrupt people's enjoyment at meal times. Staff worked hard to minimise the spread of infection, despite the challenges posed by the age of the property.

Staff across the service had been supported to improve their skills when working with people with dementia.

Care plans were being revised to provide more detailed guidance about people's needs. Staff continued to be well supported and functioned well as a team.

People received the necessary support to eat and drink enough, to ensure they maintained a balanced diet. People were supported to access health and social care professionals when necessary. There was a positive focus on enhancing people's quality of life through promoting their right to make choices about their daily routines. The registered manager ensured decisions were made in line with the Mental Capacity Act 2005.

There was a calm atmosphere at the service, which promoted a caring environment. Staff took time to support people in a dignified manner, encouraging their independence and respecting their right to privacy. Support to people being cared for in their rooms had become more person-centred. People engaged in varied activities, in line with their choice and preferences. Care plans were being adapted to become more person-centred and there was an effective system to make sure reviews of the support provided took place as required.

Support to people at the end of their lives was compassionate and caring. Care plans were being improved to ensure this support was consistent and in line with people's preferences. People felt able to raise concerns and be confident that these would be used to improve the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had a proportionate and respectful attitude to managing risk.

There were enough safely recruited staff to meet people's needs.

People received their medicines as prescribed and were protected from the risk of infection.

Is the service effective?

Good

The service was effective.

There had been marked improvements in the care of people living with dementia.

There was a good understanding of people's capacity and their right to make choices.

Staff promoted people's physical health and wellbeing, working well with outside professionals as required.

Is the service caring?

Good

The service was caring.

Staff took time when supporting people.

There were systems in place which promoted a caring approach.

Staff respected people's right to make choices and remain independent.

Is the service responsive?

Good

The service was responsive.

Care plans were now more person centred.

Staff supported people to remain stimulated, engaging in

activities of their choice.

Complaints were encouraged and used to improve the service.

Staff provided compassionate palliative care.

Is the service well-led?

Good

The service was well-led.

The new management team worked effectively to drive improvements.

People, families and staff told us they were well supported and listened to.

Checks took place on the quality of the service which made a difference to the people's wellbeing.

Hatfield Peverel Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 October 2018 and was unannounced.

The inspection was carried out by two inspectors, a specialist professional advisor who was a qualified nurse 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. The Expert by Experience on the inspection had experience of caring for older people.

We spoke with eleven people who used the service and five visiting relatives to gain their views about the service. Some people who used the service were not able to speak with us about their care experiences so we used observation as a way of understanding the service they received. We also spoke with 12 members of care staff, three nurses, the chef and an activities coordinator. We spoke with the registered manager, the deputy manager, and the regional manager. We also had contact with five health and social care professionals who gave us feedback about the support provided at the service.

We reviewed all the information we had available about the service including notifications sent to us by the manager. Notifications are information about important events, which the registered manager is required to send us by law. We also looked at information sent to us from others, including family members and the local authority. The registered provider had completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the care records of eight people who used the service. We also looked at records relating to the management of the service. These included four staff files, training records, incident reports, medicines administration records and quality assurance records.

Good

Is the service safe?

Our findings

At our inspection in March 2017, we found people were being cared for safely and rated safe as good. At this inspection we found the service continued to improve in this area and retained a good rating.

People told us they felt safe at the service. One person said, "I feel relaxed and safe, it's nice and peaceful here." There was an open and pro-active culture in relation to promoting people's safety. Staff had a good understanding of the procedures in place to safeguard the people at the service, and who to speak to if they needed to raise an alert. A member of staff described how they had raised concerns when they found a person had an unexplained bruise. The incident was fully investigated, and the family informed. The incident was discussed with the whole team who were involved in the person's care so they could monitor and amend the support provided as necessary. Safeguarding incidents were fully recorded and logged so that the service could monitor ongoing themes.

Staff had carried out personalised assessments with each person which considered their safety and plans were put in place to minimise identified risk. This was done in a proportionate and appropriate manner. People described how staff had given them advice about smoking or about a healthy diet but had respected their right and capacity to make decisions about their daily lives.

Staff had the necessary guidance to support people safely, for example there were detailed plans where staff needed to use equipment to help people with their mobilising transfers. We observed staff supporting people to move and noted this was done safely, in line with the guidance. There were individual plans in place should there be an emergency which required people to be evacuated from the building.

The rear garden was not fully enclosed and it was possible to get to the front of the property and onto the road through a side passage. We discussed this with the registered manager who told us this was not a risk, given the current needs of the people at the service. We noted however that this placed a restriction on people who were at risk of leaving the service as they were not able to spend time in the garden unattended. The registered manager assured us they would review this identified risk in response to our feedback.

The registered manager ensured there were enough staff on duty. They described how they had increased staffing numbers recently at key times of the day following a recent review. Feedback from one member of staff and one person told us that there was sometimes a delay in responding to call bells. Whilst we observed one incident where there was a delay in responding to a call bell in the lounge, our observations throughout our inspection confirmed there were enough staff during our visit to meet people's needs. All the other people, families and staff we spoke to said there were enough staff. One person said, "I feel safe here there's plenty of carers around all the time" and a family member noted, "There's always a member of staff with our relative or around or within calling distance."

We found the service continued to recruit staff safely. Disclosure and Barring Service (DBS) checks had been undertaken to ensure new applicants did not have any criminal convictions that could prevent them from working in a care setting. There were effective checks of nursing staff qualifications, which helped the

registered manager ensure they had sufficiently qualified clinical staff. We noted checks had been carried out before staff started employment.

People were supported to receive their medicine as prescribed. Staff wore an identifiable red tabard indicating they were carrying out the drug administration round, which reduced the risk of them being disturbed. Staff had received the necessary training and their ongoing competence was checked to ensure they had the skills to support people safely with their medicines. The clinical lead ensured that staff had all the appropriate equipment where specialist equipment was needed and the nursing staff were trained in its use. Staff used the services of a local Hospice for advice and support and followed their palliative care guidelines on the use of end of life medication.

We observed in the Kingfisher unit that the timing of the administration of the medication coincided with lunch. A nurse was administering the medication on both floors of the unit. This involved the nurse having to go up and down between the two floors using three different medication trollies, and the process did not function effectively. Although the process of administrating the drugs were safe and correct it did interrupt the flow of persons enjoying their lunch. The trolley was also in the way of staff trying the serve the meals and we witnessed two persons refusing to take their medication because they were eating their lunch. We discussed this with the manager who already had plans in place to improve the timing of the lunch time medicines.

There was detailed advice in care plans outlining the support each person needed to take their medicines. Where appropriate people were enabled to remain independent and to have a choice about the medicine they took. For example, on person's care plan stated they could, "Advise if they want extra pain relief." Staff accurately recorded the support they provided. Regular checks were carried out to ensure the correct stock was in place and staff were administering medicines as prescribed. Medicines were stored safely when not in use and there were safe processes in place for the ordering and disposal of medicines.

We found the registered manager was minimising the risk of infection. The age of the property posed a challenge in terms of upkeep and maintenance. There was an odour in one of the corridors, however, we noticed staff were vigilant about cleanliness. There was a deep cleaning plan for all the rooms. Checks carried out by the registered manager were driving improvement in infection control. For instance, staff had been prompted recently to ensure they washed their hands.

Staff recorded the logging of incidents and accidents and we could see since the new registered manager had arrived this process was more robust. The registered manager had improved oversight of what was happening and was using this information to learn about the service and take action to make things better, for example to review the risk assessment in place after a person had a fall.

Good

Is the service effective?

Our findings

At our last inspection we found improvements were required to ensure staff developed the required skills to meet people's needs. At this inspection we found the registered manager had addressed our concerns and we rated effective as good.

Care staff spoke positively about the training they received. A member of staff stated, "I felt supported to go off and do additional training to help me to my job." There was a comprehensive plan in place for the induction of new staff. Senior staff ensured care staff were aware of the standards expected of them and provided guidance to develop their skills. We observed a member of staff being shown in a supportive way how to work with a person who had become agitated. The senior staff handled the incident in a calm manner and care staff and the person responded well.

The clinical lead was responsible for staff skills and visited the units daily to observe staff delivering care, getting involved where if staff needed additional clinical support. There was an effective system in place to check gaps in staff training. People and their families told us staff were skilled in their job. A relative told us, "They are very good at encouraging [Person] to get out of their room and into the lounge, they have to use a hoist but are really good."

When we had last visited the service, we found staff did not always have the skills to support people with dementia or other mental health needs. At this return visit we found staff training had been refreshed and senior staff had attended a course which promoted the principle, "Person first – Dementia second." They had then shared their learning with the rest of the team. We saw this had resulted in a tangible improvement in the way staff interacted with people. For example, when a person became distressed staff used distraction techniques to help reduce their anxiety.

Staff now had a greater understanding of the impact of dementia in people's life. A person's care plan gave guidance to staff about how someone with memory loss experienced bereavement anew when they continually found out their parents had died. This advice helped staff chose what subjects to chat to people about and also to understand why they might become distressed.

Staff had completed assessments and care plans to provide staff with information to meet people's individual needs. There were risk assessments in place with additional assessments depending on care needs, such as wound care, nutritional assessments and moving and handling. On reviewing the care plans some had always been updated and did not represent the current care being provided. One person's care plan stated that their weight was to be recorded monthly, but this was not recorded according to the care plan. Improvement plans for the service demonstrated that action plans were in place to address this and the registered manager confirmed care plans were still being amended.

When people came for a respite stay, the care plans were appropriate and focused on providing staff with relevant information. Specific health needs were outlined to ensure tasks such as blood pressured checks were carried out. The care plans also provided enough information to help the person adjust to their

temporary home, with advice to staff such as, "What does a normal day look like."

We found the whole team communicated and worked effectively. The activity coordinator and chef joined senior staff and care staff at daily meetings which helped ensure a consistent service. When we spoke with them, we noted the whole team were able to describe people's care needs in detail, demonstrating a shared knowledge of the people they cared for.

People were supported to eat and drink in line with their preferences. A family member told us, "We've had lunch here. The food is delicious, smells good and is presented really well." In the dementia unit, lunch was a positive occasion and unrushed. People received the support they required. We saw a variety of drinking utensils, such as beakers with lids and glasses, which encouraged independence and dignity in line with each individual's personalised needs. In the Kingfisher unit we found the lunchtime was a less positive experience, as described in the safe section of this report, however there were already plans in place to address this.

People had a nutrition assessment and information from this assessment was shared with kitchen staff. Documentation of food and fluid intake was captured where staff were concerned they were at risk of malnutrition or dehydration. They had access to an NHS dietician, if there was a need. A member of staff told us, "[Person] is not able to decide how much to eat so we need to make sure they have eaten enough each day."

There was a hostess who was responsible for supporting people with their nutritional and hydration needs. We observed them in the Kingfisher unit, encouraging drinks and snacks, including fresh fruit throughout the day. We did not see them supporting people in the Mallard unit, where this role was carried out by care staff. We found people did not have the same access to fresh fruit. We fed back to the registered manager who told us they sometimes sent across platters of fresh fruit to the unit and agreed to prompt staff to offer fruit every day.

The chef was a central part of the service and regularly asked for feedback on the meals. We observed them interacting positively with people. They knew people well, and said, "[Person] is often hungry at four o'clock so that's a good time for them to eat as they are losing weight." They had attended workshops help by the provider, which gave them new ideas, for example about creating attractive pureed meals. They had brought samples to residents meetings which gave people an opportunity to have a say about food choices. The chef had benefited from the improvements in dementia care across the service. They told us, "If someone is losing weight we don't just feed them up but first talk to the head of care to see if there are concerns about their dementia or other health issues."

Staff supported people to access health and social care professionals and organisations as required. Any contact was recorded so that staff could make sure people attended appointments as necessary. We also found varied examples where staff had worked well with outside professionals. During the inspection a specialist nurse was visiting a person who had recently been discharged from hospital. They told us the nurse on duty was knowledgeable about the person's condition and responsive to their care needs. Care plans recorded emergency contact details where a person might require urgent care due to their mental health needs.

The physical environment had been enhanced to promote people's wellbeing. There were sensory objects mounted on the walls and memory boxes outside people's rooms, which contained special items and information about a person, such as photos of a family pet. These measures helped stimulate memory and acted as a visual prompt. A member of staff said, "Things have improved, like different coloured doors so

people can identify their bedrooms easily."

We checked whether people were being supported in line with the Mental Capacity Act 2005 (MCA). People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff had a good understanding of people's capacity. Senior staff had carried out assessments into people's capacity and the registered manager ensured the necessary procedures were being followed when people's freedom was restricted.

We found the registered manager promoted people's rights to have a say on decisions about their life even when they had fluctuating capacity. We noted a person had been enabled to make a choice which increased the quality of their life even though it was the less safe choice. This decision had been made following appropriate risk assessments and discussions with interested parties.

Good

Is the service caring?

Our findings

At our last inspection we found staff to be caring. At this visit we found people continued to receive a caring service and the rating remained good.

There was a warm and peaceful atmosphere at the service. We observed that people presented as being relaxed and at ease with staff. A person told us, "There are good caring members of staff, who all seem to chip in and be helpful." We observed staff engaging with people in a friendly personalised manner. Staff had time to speak to people and made eye contact when listening to them. The guidance to staff in care plans promoted this caring approach. One person's care plan stated a person benefitted from human touch and informed staff that this person like it if staff held their hand and offered reassurance when they became distressed.

We observed that support was not rushed. When staff carried out a support task with people they chatted with them and were focussed on the person rather than the job being completed. For example, we observed two members of staff supporting a person to mobilise with a hoist. Staff kept reassuring them and talking about subjects which were of interest to the person being moved.

Staff supported people to communicate their views and to make choices about their care. We observed that at lunch time a person told staff they wanted their meal later as they were not hungry yet. Staff respected people's right to make their own decisions. A member of staff discussed a choice a person had made and demonstrated a compassionate attitude saying, "What is life if not to enjoy it?"

Care plans were written to encourage staff to promote people's independence. For instance, a person's care plan gave details of exactly which part of their personal care they were able to complete independently, so they only needed prompting to brush their teeth but required more assistance when having a shower.

Family members told us how the service had been set up to support them when they came to visit. A visitor told us, "There's a place where we can make our own tea or coffee. Staff make us feel really welcome. We can visit at night when we're working which is great."

We observed staff respected people's privacy and always knocked on bedroom doors before entering. People and families told us staff dealt with personal care in a sensitive way, for example closing curtains and doors to maintain dignity. Where possible staff had asked people whether they agreed to being monitored which promoted people's dignity and rights. For instance, a person had agreed in their care plan to staff checking their bowel movements, as a way of managing a health risk.

Staff maintained people's information confidential. Care plans and individual files which were locked away in a cupboard on each unit. The staff member in charge held the key to this cupboard and no notes were observed left lying around.

Good

Is the service responsive?

Our findings

At our last inspection we rated responsive as requires improvement as we found care plans were not person centred. We also found people being cared for in bed lacked stimulation and access to activities. At this inspection we found the registered manager had addressed our concerns and we rated responsive as good.

Staff supported people to remain active and stimulated. We observed throughout our visit that people sat in small groups in lounges, engaged in varied activities of their choice, such as puzzles or art work. People told us they loved the beautiful garden and we observed a number of people chose to have their afternoon tea and cakes on the terrace. A person said, "I did not want to eat with the rest, so at the moment I can still have lunch out on the terrace, they (staff) accommodate me. Whilst it's still warm I can eat out here. We have deer in the garden which we like." People told us the quality of activities was maintained at weekends, "We like the weekend activities, we had ABBA here last week and we also have had music days."

On the day of our inspection one of the activity coordinators was away. We noted other staff stepped in to carry out activities, such as encouraging people to throw huge inflatable balls to each other. The activity was lively and we observed people became more alert and interacted more with each other and with staff. We were given examples where people had been supported to fulfil 'bucket-list' dreams, for example staff arranged for a person to ride on a Harley-Davidson motorbike for the first time. Some of the activities had been designed to promote fitness and overall wellbeing, such as playing with huge inflatable balls. We saw pictures of people sitting soaking their feet in a paddling pool during the hot weather.

The activity coordinator told us they had attended the new dementia training and described how this helped them understand better the needs of the people they supported. Purpose-built tactile activities had been attached to the walls of the corridors. An example of this was a piece of equipment made up of plastic pipes and connections which had been designed for a person with dementia who had been plumber. This was a personalised activity designed to promote stimulation.

There was an improved focus on the wellbeing of people being cared for in their rooms. The activity coordinator described how they would visit people in their rooms for a chat or to share a quiz which had taken place earlier in the lounge. They told us visiting singers had recently come to the service and staff had arranged for them to sing to people in their rooms.

During our visit we observed a person who was vision impaired tell a member of staff they were not able to join in an activity as they could not read the crossword puzzle which other people were doing. We noted no alternatives were offered, for example a larger print puzzle, so the person was not able to join in and went to sleep. We did not find this incident representative of the rest of the service as elsewhere we had seen some excellent resources in use, such as specialist tactile cushions being used by people with visual impairment. However, we raised this with the manager who assured us they would discuss this incident with the staff team to support continual improvement.

Care plans were gradually being revised as people's needs changed and we saw the new documentation

was more person centred. It provided improved guidance to staff as outlined in the effective section of this report. The service run a 'resident of the day' programme. This was used as an opportunity to ensure people's needs were reviewed on 'their day'. The reviews were comprehensive and as well as involving the person, staff consulted with family members, as appropriate. People had been asked who they wanted to be involved in their reviews to ensure the retained a choice about who was consulted about their care.

People and families were able to complain and were confident that their concerns would be dealt with. This feedback was encouraged and used as a way to improve the service. For example, families had said access to the garden was difficult for people with mobility issues and the registered manager had asked the maintenance team to look into this. Complaints were recorded and investigated in detail.

Staff had started capturing people's end of life needs in care plans, for instance what they would like to achieve in the final year of their life, such as attending a special family event. We found the care plans did not reflect the positive support being provided in this area. A health professional told us they had visited a person receiving end of life care and although the care that was being delivered was good, a more detailed and updated care plan was needed to ensure consistency of care. The registered manager told us the care plans were being developed further and gave us examples of personalised support which staff had given to individuals and their families when they required palliative care.

Good

Is the service well-led?

Our findings

Previous inspections had found the service had a history of failing to sustain improvements. The service was rated requires improvement in 2015 and 2016, with an inadequate rating in February 2017. This failure to maintain improvements had contributed to the rating of requires improvement at our last inspection of July 2017.

At this inspection we found the provider and registered manager had put robust systems in place to maintain and continue building upon improvements.

Central to the improvements were the appointment of a new registered manager and deputy manager. The new senior management team worked well together, with clearly defined responsibilities and roles. The management team effectively prioritised the key areas which needed addressing and were committed to getting the service right for the people they supported. The deputy manager was also the clinical lead and had a vital role in developing staff skills and knowledge and improving standards of care. We observed during our visit that they had a good overview of the clinical decisions taking place at the service.

The provider and senior staff carried out regular quality audits. These were detailed and considered people's wellbeing as well as the quality of documentation. For example, the area manager had carried out a monthly review which included speaking with people and checking they were happy at the service. They also checked records such weight charts to monitor whether there had been any weight loss over a period of time.

We were assured the quality checks and audits were robust, and had helped the registered manager address any issues we had raised during our inspection. For instance, a recent audit of meals had noted that the meal service in the Kingfisher unit was disorganised, as outlined in the safe section of this report. The registered manager was able show us the actions they were already taking to resolve this concern prior to our visit.

Checks on the quality of the service were being used to address gaps in knowledge and skill and to enhance the support and clinical care people received. This was demonstrated in the updating of care plans which were being amended to provide improved guidance to staff. This was a gradual and thorough process, prioritising those people most at risk, which ensured the new style plans were consistently produced to a good standard.

The registered manager was not complacent about what they had achieved and was realistic about what still needed doing at the service. They told us they had turned down a referral for a person as they felt they were not able to meet their complex needs. They said. "We have to be realistic about what we can do at this time."

The staff we spoke to stated they felt well supported and told us the management team visited the units on a daily basis. One member of staff stated that senior staff were approachable and although there had

recently been changes to the senior management team it had been a positive experience. A member of staff said, "Management have been supportive and kept us all informed."

The registered manager attended resident and relative meetings and we saw these were used to encourage open communication and feedback about the service. A relative said "Management are very easy to access, they are always happy to talk to me. Their doors are always open, we've not had many occasions where we needed to talk to them though." The provider also run a comprehensive schedule of surveys and questionnaires which provided the registered manager with information to improve the service.

The service benefitted from access to the wider BUPA resources, which had helped drive improvements. There were good examples where staff had learnt about best practice, such as the workshops attended by the chef and the new dementia training.

The registered manager understood the importance of developing good relationships with external organisations, such as the GP surgery and the local authority. They had worked closely with the local authority and health professionals to improve the quality of the service, taking part in programmes and joining local networks which were designed to promote best practice. We spoke to two professionals who had visited the service since our last inspection to review the quality of the service. They told us they had observed a vast improvement and noted that the new registered manager and deputy manager had been a positive addition to the service.