Hartford Care Limited

Stokeleigh

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?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 2 April 2015 and was unannounced. The service had no breaches of regulation at the last inspection in October 2013.

The home provides accommodation and personal care for up to 30 people, some of whom are living with dementia. There is a registered manager in place at the home. 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.

People did not always receive safe support with their medicines. For example, there was inconsistent information in one person's support plan about how their PRN medicine should be used. We also noted that best practice in infection control was not always followed during administration of medicines.

Summary of findings

The principles of the Mental Capacity Act 2005 were not yet embedded into practice where decisions needed to made on behalf of people who lacked capacity. A relative had been asked to give their consent to the use of bedrails for a person, which is not in line with the requirements of the Act. Not all staff were clear about the principles of the act which meant there was a risk that people's rights would not be fully protected.

People's healthcare needs were not all effectively met. For example, we found person who was at risk of malnutrition but there was no care plan in place to describe how this risk should be minimised. Where food and fluid charts were in use, amounts of fluid taken each day were not totalled which meant that people's intake was not being effectively monitored.

Feedback from people in the home was positive and this was reflected in the feedback from relatives also. There was a programme of activities in place and we observed people taking part in these during our inspection.

Staff were kind and caring in their approach and we observed staff offering kindness and reassurance when a person became upset. People had opportunity to be involved in care planning and gave their opinions and views when support was reviewed. Relatives told us they felt welcomed in the home and were kept informed of any important developments.

There were arrangements in place to meet people's individual needs and preferences. This included a document entitled 'this is me', which gave details about a person's life before they moved to the home. People confirmed they were able to follow their own routines, for example by choosing when they wanted to go to bed and to get up.

Staff were positive about the training and support they received. We reviewed the training matrix which showed the majority of staff were up to date with relevant training. Topics included moving and handling, safeguarding and dementia.

There was an open culture within the home and staff felt confident about raising any concerns or issues. Staff understood the term whistle blowing and their responsibility to use this procedure to protect people in the home if they needed to.

There were systems in place to monitor the quality and safety of the service and this included gathering the views of people in the home and their relatives.

We found three breaches of regulation during our inspection. You can see the action we have asked the provider to take at the end of the full version of this 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?
The service was not always safe.

People were not fully protected in relation to the use of medicines.

Infection control procedures were not always followed.

Staff were trained in and confident about identifying signs of abuse.

There were sufficient numbers of staff to ensure people's safety and meet their needs.

Requires improvement

Is the service effective?
The service was not always effective.

The Mental Capacity Act was not yet embedded into practice to protect people's rights.

People's healthcare needs were not always effectively met because clear records were not kept.

Staff were positive about the support and training they received and felt confident about approaching senior staff with any concerns.

People were able to see healthcare professionals when they needed to.

Requires improvement

Is the service caring?
The service was caring.

We saw positive interactions between staff and people in the home.

People had opportunity to be involved in planning and reviewing their own care.

Relatives were made welcome in the home and able to visit when they wished.

Good

Is the service responsive?
The service was responsive.

People's individual needs and preferences were acknowledged and met.

There were systems in place to respond to complaints in an open and transparent way.

Good

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

There was an open and transparent culture within the home with staff feeling able to raise issues and concerns.

Good

Summary of findings

There were systems in place to monitor the quality and safety of the service provided.	

Stokeleigh

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 2 April 2015 and was unannounced.

The inspection was undertaken by two inspectors. Prior to the inspection we reviewed information we held about the service, including notifications and information of concern. Notifications are information about specific events that need to be shared with the Commission in line with legislation.

We spoke with four people in the home, two relatives, five members of staff and the registered manager. We viewed the support plans for three people and other records relating to the running of the home such as audits and feedback questionnaires.

Requires improvement

Is the service safe?

Our findings

We found there were systems in place to help ensure that people were safe, however these were not always implemented to ensure that people were fully protected at all times. For example, during medicine administration, we noted that staff did not consistently wash their hands before and after administering eye drops to reduce the risk of cross infection. Staff did not wear an apron or gloves when changing a person's transdermal patch (a method of pain relief administered through the skin). This presented a risk of cross infection and was not consistent with the home's policy, which stated gloves and apron should be worn during this procedure.

During medicine administration, we saw that one person was prescribed a PRN (as required) medicine for anxiety. The Medicine Administration Record showed that the medicine had been given every morning. We discussed this with the registered manager who told us that the person was given the medicine every morning because they would become tearful otherwise. The person's care plan suggested that staff spent quiet time with the person to help alleviate any anxiety and that the medicine should be administered if this didn't work. The last entry in the care record of the person demonstrating any signs of distress that we saw was recorded on 18 March 2015. This meant there was conflicting information about how and when the medicine should be administered and therefore the individual was not fully protected from the risks associated with medicines.

This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection we were notified of an accident at the home. The registered manager was awaiting a report from the Health and Safety Executive in relation to this. They were aware from feedback from the visiting officer, that there would be recommendations arising from this report. The recommendations included placing coloured strips at the edge of all steps on the stairs to ensure that they were easily distinguishable for people and to help prevent falls. The registered manager confirmed that this would be done but wasn't able to give an exact date for when this would be completed to reduce the risks to people in this area.

Checks on the environment took place. For example, we viewed records of weekly fire alarm tests to ensure that these were working efficiently. Other checks, such as regularly reviewing bedrails and wheelchairs also took place.

There were risk assessments in place which identified the risks associated with people's care and the measures required to minimise them. However we found that for one person, risks assessments in relation to their mobility needs were dated 2012. There was a form on file to record when care plans and risk assessments had been reviewed and there was a note on file recording there had been 'no change'. However this wasn't sufficient to demonstrate that the person's needs had been comprehensively reviewed since first being assessed in 2012. This person had experienced a recent change in their mobility needs and there was therefore a risk that assessments were not fully reflective of the measures required to keep this person safe.

Although we found some inconsistencies in relation to hand hygiene, overall cleanliness in the home was of a good standard. We viewed all shared areas of the home and found they were kept clean and the home was free from odours. Staff confirmed they had received training in infection control and demonstrated good knowledge in this area. We saw staff carried gloves and aprons around with them in a bag so they were always accessible.

We observed the morning medicines round. The staff member administering the medicines told us they had recently commenced doing this following completion of a distance learning course and an online course provided by the dispensing pharmacy. They knew the people they were giving medicines to well, and demonstrated this during the medicines round. For example, one person had recently fractured their arm and the staff member asked whether they were in pain and whether they required any pain relief. They told us they would return to the person later and check to see if the pain relief had worked or if they needed extra.

We observed that people received their medicines as prescribed and that a thorough checking process was carried out by the staff member. Where required, assistance was given and people were asked before they were given their medicine. We saw that the Medicine Administration

Requires improvement

Is the service safe?

Record (MAR) chart was only signed once the staff member was certain that the medicines had been swallowed. When people declined medicines, we saw this had been correctly documented so it could be monitored.

Staff had been trained in and were knowledgeable about the signs of potential abuse. Staff told us they would feel able to report concerns and understood the term 'whistleblowing'. Whistleblowing is the term used to describe the action taken when a member of staff reports concerning practices in the workplace.

We found that staffing levels were sufficient to ensure people's safety. There were 28 people in the home with four care staff on duty during the morning and three in the afternoon. In addition to this there was a registered manager on site and a deputy manager. However, staff consistently reported that their ability to carry out their roles was affected by the need to carry out duties such as laundry and food preparation. Comments included; "It's difficult when we have the other things to do, like the laundry. It's a lot of pressure". The registered manager agreed that there were times in the day when staff were under pressure. The registered manager told us they were requesting extra staff to support at these times.

There were systems in place to support safe recruitment decisions and suitable checks were made. We viewed the files of three recently recruited staff and saw that (Disclosure and Barring System) DBS checks had been completed. DBS checks provide information about a person's criminal convictions and whether they are barred from working with vulnerable adults.

Requires improvement

Is the service effective?

Our findings

Staff knowledge in relation to the Mental Capacity Act 2005 (MCA) was not yet embedded in to practice. For example, we found an example of a relative signing their consent for the use of bedrails. This is not in line with the requirements of the Act, which states that where a person is unable to make a decision about their care or treatment independently, then a best interest's decision should be made. A next of kin does not have an automatic right to make decisions on their relative's behalf.

We spoke with staff about the MCA and found their knowledge was limited. For example, one person told us that staff would decide if a person required bedrails, rather than acknowledging that the person had a right to consent. This meant there was a risk that people's rights would not be fully protected in line with the MCA.

This was a breach of regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's healthcare needs were not always effectively met. For example, one person had been visited by the district nurse in relation to reviewing a pressure ulcer. They had advised that the person should be repositioned every two hours to prevent skin damage. We viewed the charts in place for recording repositioning and found at least three occasions when the gaps between repositioning were longer than two hours. On one occasion the gap was as long as five hours.

We also looked at the fluid recording charts for those people who had been identified as requiring one in place. No information was recorded about the total amount of fluids a person should be drinking. We also noted that individual drinks were recorded on the charts but no totals for the day were recorded, which meant that people's fluid intake could not be effectively monitored.

In another person's care files, we saw they had been assessed as being at high risk of malnutrition and had recently been prescribed food supplements. However, there was no care plan in place describing how this person's nutritional needs were being met, or what measures were needed to reduce the risks of malnutrition. This meant that there was no clear guidance for staff and a risk that the person's needs would not be effectively met.

This was a breach of regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Although we found some concerns in relation to how people's nutrition and hydration needs were met, people were positive about the meals provided. Comments included; "The food is quite good" and "The food is good, but sometimes the plate is too full and it puts you off". We observed a lunchtime meal and saw people enjoyed their food and told us it was nice. People were offered drinks both at the mealtime and throughout the day. However people were asked to make their choices of meal, the day before and many people had forgotten what they had ordered and weren't immediately aware of what they had been served. Although we were told that changes could be made on the day if requested. The member of staff responsible for meal preparation confirmed they were made aware of any particular dietary needs of people in the home.

People were supported to see health care professionals when required. For example, we saw notes in people's care files made by the chiropodist and GP. We also noted there were records of contact with the GP when people had experienced a fall or ill health.

Staff were positive about the support they received from the registered manager. We saw from records that supervision sessions didn't always take place at the expected frequency of every two months; however staff told us they felt able to approach the manager and discuss concerns at any time.

Staff confirmed they had all received appropriate training. Training topics included infection control, moving and handling, fire safety, safeguarding adults and dementia. There was a training matrix in place to record the training staff had received and when it was due to be refreshed. This reflected that the majority of staff were up to date with the training topics.

Good

Is the service caring?

Our findings

People in the home benefitted from being supported by staff who were kind and caring in their approach. Relatives told us they felt staff were kind and this was reflected in our observations. For example, we observed one person become tearful and upset. Staff spent considerable time with the person, holding their hand to reassure them and talking about their concerns. The person responded positively to this interaction and became visibly less distressed. We saw staff interact with people by first name and people knew staff names too. There was lots of laughter and friendly interaction. For example, we saw staff complimenting people on their hair.

We observed that staff knocked on people's doors before entering their rooms. All personal care was carried out in private. Staff told us; "We are caring here and the residents are like our extended family" and "I like being there for people and helping improve their quality of life". Another staff member said; "Getting to know about the person is so important so that we can maintain their dignity".

People's support plans identified where they were able to carry out aspects of their own care independently. For example in one plan we read that a person was able to wash and dry themselves, but staff were required to supervise in order to ensure their safety by checking water temperatures. This guidance helped to ensure staff supported people to maintain their independence.

However, we did also observe occasions when staff interactions did not fully take account of people's needs. At the lunchtime meal we saw staff gave people their plates of food without comment or explaining to people what was on their plate. We asked people what they had chosen for their meal and people weren't able to tell us. Although people did not appear upset by this; at this time staff were focused on the task of serving meals rather than the needs of people.

We saw documentation to show that people and their representatives had been given opportunity to provider their views and opinions about the care they received. For example, we saw that people's opinions had been recorded as part of their care review process and that relatives had been contacted with a view to attending care meetings. Relatives confirmed that they had been invited to care review meetings.

People were able to maintain relationships that were important to them. We saw friends and relatives visiting people during our inspection. Relatives confirmed that they were welcomed in the home and able to visit as they wished. Family members confirmed that they were kept informed of any concerns about their relative. Contact with relatives was recorded in people's care files.

Good

Is the service responsive?

Our findings

person using the service told us; "There's not enough to do". They were sitting in one of the lounges with several other people and the TV was on. We asked what they were watching and they told us "No idea". However, other people appeared to enjoy the organised activities. During musical bingo we saw that people were singing along to the music and appeared to be enjoying themselves. They were tapping their feet and clapping their hands. Another person told us; "There's enough to do most of the time. I just go along with what's happening. I don't always want to do things though, so sometimes it's just nice to sit here and relax".

There was a member of staff with responsibility for activities who worked Monday to Friday. They told us they based activities on people's needs and took into consideration people's life history. They told us; "Talking to the relatives helps us find out what people like to do. For example we do quizzes, card games, musical bingo and we have outside entertainers come in". They told us magicians, actors and musicians visited once a month.

We asked staff how they prevented people from being isolated. They told us about one person who preferred to stay in their room and they made an effort to go and see them every day, even if it was just for "a quick chat".

Staff told us that people who were able to would occasionally walk up to the local downs area. They told us that during warmer months people spent more time outdoors, and that a gardening club was planned for the near future.

We saw information was included in people's care files about their lives prior to arriving at the home. This included important events and relationships to help staff understand people as individuals. Staff referred to this information when we asked them how they got to know people's likes and preferences. On one occasion, in general conversation, we heard a staff member refer to the place where a person was born. The person showed enjoyment in the fact that staff knew this information.

Consideration was given to people's spiritual needs. Information about a person's faith was recorded in their support plan. It was Good Friday the day after our inspection and we were told that Holy Communion would be available to those who wanted it. We were told there were no particular cultural considerations in terms of people's dietary needs at the present time; however we were given examples of how these had been met for people in the past.

People had clear support plans in place and these were evaluated on a monthly basis and any changes noted. For example in one plan, there was an additional entry to describe a change in a person's continence needs. Support plans covered a range of areas of care required, such as a person's mobility needs, eating and drinking and their personal care.

We saw there were processes in place to respond to complaints. Relatives we spoke with said they had not had reason to complain but would feel able to approach the registered manager if they had any concerns or complaints.

We viewed examples of formal complaints that had been made in the last year and saw that a response had been made in each case. The responses were transparent, acknowledging where mistakes had been made and what action was being taken in response to them to improve the service provided. This meant that people could be assured that their complaints would be listened to and a full response provided.

Good

Is the service well-led?

Our findings

Staff told us they felt well supported by the registered manager and felt able to report any concerns. They told us the registered manager was approachable and they felt they were listened to. Team meetings took place and staff told us they were able to speak up at them. This feeling was reflected by people and their relatives who told us they felt able to approach staff and the registered manager with any concerns. This showed that there was an open and transparent culture within the home.

During our inspection we observed that the registered manager was visible in all areas of the home and interacted with people and staff throughout the day. They helped with key times during the day such as mealtimes, by helping people find a table for example. This helped to ensure that the registered manager was able to monitor the day to day running of the home.

The provider was taking action to ensure that the company visions and values were embedded across the staff team. One member of staff told us they were aware of the provider's values and they felt part of a group of homes. All of the other staff told us; "I just think of myself as working for Stokeleigh". We saw the provider was running a session on "Brand Training" during April. The notice read that the training would cover "a history of Hartford Care, who we are, our ethos and our vision and where you and your home fits in".

There were systems in place for monitoring the quality and safety of the service provided. These were in the process of being updated by the provider to reflect recent changes in how the Commission inspects services. Systems included gathering the views of people who use the service and their relatives. Six people had responded to the last survey and comments included; "I don't think it could be better". Positive comments were also reflected in the survey given to relatives. One person commented that; "the empathy between my mother and staff is very good" and "provides loving attentive care to the residents"

Other audits included a care plan audit which had identified issues such as weights not being recorded. A note had been made next to these findings to confirm that they had been actioned. The service was supported by the wider organisation through visits from the regional manager. We viewed report from January 2015 with an associated action plan.

There were systems in place to record and report accidents in the home. The reports recorded that action had been taken in response to these incidents, for example in one accident report we saw that the person's GP had been informed and the incident notified to CQC.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 2 (h) Procedures for preventing the risk of cross infection were not always followed. 12 2 (g) People were not always protected from the risks associated with medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's rights were not fully protected in line with the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People's healthcare needs were not always effectively met.