Hallmark Care Homes (Brighton) Ltd

Maycroft Manor

Inspection report

2-8 Carden Avenue
Brighton
East Sussex
BN1 8NA

Tel: 01273799622
Website: www.hallmarkcarehomes.co.uk

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26 July 2016

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Ratings

Overall rating for this service	Good
Is the service safe?	Good

Summary of findings

Overall summary

We undertook this unannounced focused inspection on 26 July 2016, in light of information of concern we received. The service had been confirmed as having a serious infectious outbreak. Our inspection allowed us to confirm whether a breach of the health and social care act 2008 (HASC) had taken place, in respect to how people were protected by the prevention and control of infection. It also helped us to ensure that best practice requirements were being followed by the provider.

Maycroft Manor provides care and support to people with personal care and nursing needs, many of whom were living with dementia. The home was arranged over three floors and offered residential and nursing care based on people's particular needs and requirements. Individual units were referred to as 'communities'. One area was a specifically designed unit which provided an environment that supported people living with dementia. The home provided care and support for up to 99 people. There were 86 people living at the service on the day of our inspection. Maycroft Manor belongs to a large corporate organisation called Hallmark Care Homes. Hallmark Care Homes provide residential and nursing care across England.

A registered manager was not in post. 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. The registered manager had left the service approximately two months previously, and day to day management of the service was carried out by a peripatetic manager and clinical care manager. The provider was in the process of recruiting another registered manager.

The service was clean and well maintained, with clear guidance displayed for people and staff in relation to the prevention and control of the serious infectious outbreak. People told us they understood that the service had a serious infectious outbreak and that they had been provided with information about this. They told us they understood that visiting was restricted and that there may be some temporary changes to the way their care was provided. One person told us, "They told us all about it (the outbreak), they've been wonderful. They have done everything they can to sort it out. It seems like they've gone over the top, but they have to". The provider had also ensured that up to date and relevant information updates in relation to the outbreak were prepared and distributed to staff, visitors and people living at the service.

The provider had actively engaged with and followed guidance and protocols dictated by professional bodies such as Public Health England (PHE), Environmental Health (EH) and the local Clinical Commissioning Group (CCG) in order to contain the outbreak, and to obtain samples for screening people, staff and pets at the service.

The provider had sensitively and appropriately gathered stool samples for screening from everybody living and working at the service. Arrangements had also been made to provide specialist equipment and take isolation precautions for people who had been infected.

The provider had implemented appropriate refresher training for staff in relation to hand washing and infection control, and had also liaised with PHE to provide specific training around the effects of a serious infectious outbreak.

Effective management procedures had been put in place in light of the outbreak. A team of four managers had been put together to specifically deal with the issues in the service and to liaise with staff and external bodies. Staff told us that they felt well supported and listened to during the outbreak, and had clear lines of management and communication available to them. A member of staff told us, "Everything has been handled really well, especially around giving us good information about new guidance. I've been able to approach the manager about anything to do with it. It's really great that we've got such a good manager".

Changes had been made to the environment of the service and the way it was cleaned and maintained to limit the possibility of cross contamination. Staff practices and procedures had been amended in order to limit the risk of infection, and changes had been made in the way that waste was disposed of. The provider had relevant and up to date policies and procedures in relation to infection control and had updated them in light of this outbreak.

The provider undertook quality assurance reviews to measure and monitor the standard of infection control in the service and drive improvement. The provider was in the process of arranging meetings to establish learning and reflective practice, to put together protocols and tools to assist other services, both in the Hallmark Care group, and the local area that may be affected by an outbreak of this nature in the future.

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.

The provider had engaged and worked effectively with professional bodies in relation to the detecting, prevention and control of infection. The risk of further contamination had been managed and contained.

People, their relatives and staff had been given appropriate information, guidance and training with regard to the prevention and control of infection.

Robust management and quality monitoring procedures had been put in place, and improvements and changes to practice had been made at the service in light of the outbreak.

Maycroft Manor

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. The inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

We undertook this unannounced focused inspection in light of information of concern we received. The service had been confirmed as having a serious infectious outbreak. Our inspection allowed us to confirm whether a breach of the health and social care act (HASC) had taken place in respect to how well people were protected by the prevention and control of infection. It also helped us to ensure that best practice requirements were being followed by the provider.

This visit was unannounced, which meant the provider and staff did not know we were coming. The inspection team consisted of one inspector. Before our inspection we reviewed the information we held about the service. We considered information which had been shared with us by the Local Authority, Clinical Commissioning Group (CCG) and Public Health England (PHE) and looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the Local Authority and Clinical Commissioning Group (CCG) and Public Health England (PHE) to obtain their views about the care provided in the service.

During the inspection we spoke with four people who lived at the service, the peripatetic manager, the clinical care manager, the hospitality services manager, the head housekeeper, three care workers and three ancillary/housekeeping staff.

We looked at areas of the building, including people's bedrooms, bathrooms, dining rooms and lounges. We spent time observing care and reviewed records of the service, which included quality assurance audits, information briefings for staff, visitors and people using the service, and policies and procedures, along with other relevant documentation to support our findings.

Good

Is the service safe?

Our findings

When we arrived at the service, we saw clear signage on the entrance doors that informed visitors that the service was closed to all non-essential visitors. Clear guidance was also displayed in the reception area and throughout the service for people and staff in relation to the prevention and control of the serious infectious outbreak.

We spoke with the management team at the service, who gave us a detailed account of events leading up to the confirmation of the outbreak, and also the subsequent measures and arrangements they had put in place. The manager told us, "We had already started monitoring the number of residents who had loose bowels and we were mindful of the numbers". The manager explained that they had not raised the alert of a possible outbreak, as the number of people affected was not disproportionate to the size of the service. However, the manager told us that once a positive case of infection had been confirmed, they had actively engaged with and followed guidance and protocols dictated by professional bodies such as Public Health England (PHE), Environmental Health (EH) and the local Clinical Commissioning Group (CCG) in order to manage and contain the outbreak. We saw this was the case and viewed documentation and received feedback from the relevant professional bodies to confirm this. The manager added, "The moment we were aware we went into 'lock down' and have been in daily communication with PHE and EH ever since".

People told us they understood that the service had a serious infectious outbreak and that they had been provided with information about this. They told us they understood that visiting was restricted and that there may be some temporary changes to the way their care was provided. One person told us, "They told us all about it (the outbreak), they've been wonderful. They have done everything they can to sort it out. It seems like they've gone over the top, but they have to". Another person said, "Yes they told me about the outbreak. They are doing their very best I suspect. They are making sure we wash our hands. They are doing very well". The provider had also ensured that up to date and relevant information updates in relation to the outbreak were prepared and distributed to staff, visitors and people living at the service. The manager told us, "We have given regular written updates to everybody, either in person, through the post or via email".

At the request of PHE, EH and the CCG changes had been made to the environment of the service and the way it was cleaned and maintained to limit the possibility of cross contamination. For example, a designated toilet had been put in place for staff on each floor, which was not accessible for people living at the service. The way that food, such as fruit, biscuits and cakes were presented had been changed to ensure they were in individual wrappers. Additionally, single use towels had been placed in all bathrooms. The service was clean and well maintained, and we were told that the tasks on the cleaning rota had been increased, and that a stronger detergent was being used to ensure that bacteria were killed. One member of staff told us, "Everything to do with cleaning has gone up a notch, and we are maintaining it". Another member of staff said, "We are using chlorine on all handrails and contact areas. The cleaning rota has been added to and we sign to say it has been done". We saw that changes had also been made to the way that waste was disposed of. This ensured that any potentially contaminated waste was labelled appropriately and removed from the service immediately.

Staff practices and procedures had also been amended in order to limit the risk of infection. We saw that tables were only set for mealtimes when the food was ready, so that they could be cleaned and that tablecloths were not being used. The manager told us how it had proved difficult to get some people to wash their hands prior to eating, so they had implemented a 'hot towel service' before every meal. This had proved popular and people enjoyed using the hot towels, one person told us, "We get lovely hot towels before food for our hands". The manager told us that this service would continue once the outbreak was over. Staff were positive in respect to the changes. One member of staff told us, "We clean the tables and the arms of the chairs between each meal, everything has improved". Another member of staff said, "We've got our hand gels and we really know about infection control now".

The provider had implemented appropriate refresher training in relation to hand washing and infection control for staff. They had also liaised with PHE to provide specific training around the effects of a serious infectious outbreak. The clinical care manager explained how a 'light box' was used to demonstrate to staff how they should wash their hands to ensure they were clean. Staff were complimentary of the training. One member of staff told us, "I was given hand washing training and was given an information pack. I've read up on it". Another member of staff added, "The refresher training on hand washing was really good and the presentation from PHE was really useful. As long as we keep washing our hands and following the guidance, we'll be fine". We saw documentation that confirmed all staff had received updated training in relation to hand washing and infection control.

Part of the process to safeguard people and contain the outbreak, was to obtain stool samples for screening people, staff and pets at the service, to determine if they were infected. This had proved challenging for some people at the service living with dementia, who were not able consent to providing a sample. However, the provider had adopted innovative and non-intrusive ways to gather samples where required. Appropriate information had been made readily available to people and staff, and the provider had sensitively and appropriately gathered stool samples for screening from everybody living and working at the service. One person told us, "They were very tactful about the sample, they explained it all, as it was a bit embarrassing". A member of staff added, "The stool sample issue was explained to us and managed ok". We saw documentation that was updated daily in respect to the results of the screening and this information was shared with PHE and staff.

Arrangements had also been made to provide specialist equipment and take isolation precautions for people who had been infected. For example, we saw that specific infection control trolleys had been purchased and implemented. These trolleys contained personal protective equipment (PPE), which could be stored separately from other PPE and used solely for people who had been infected. Additionally, we saw that where possible specific members of staff were allocated to care for people who had been infected, so that continuity could be maintained, which limited the risk of infection being transferred to others. The manager told us when somebody had tested positive for infection, they had explained isolation precautions to them and their families. One person told us, "It gets lonely, it is horrible missing your friends, but it has to happen though until this horrible bug goes away. They come and visit me every day in my room, but they did that anyway". We were given examples of how activities staff visited infected people in their rooms regularly to help prevent social isolation.

Effective management procedures had been put in place in light of the outbreak. A team of four managers had been put together to specifically deal with the issues in the service and to liaise with staff and external bodies. The manager told us, "Setting up the management group has been a godsend. We have daily updates with the operations director and weekly updates with the executive management team. Just having the four of us has allowed us to liaise effectively with PHE and EH and we have worked very closely with them. We have supported each other daily". Staff told us that they felt well supported and listened to during

the outbreak, and had clear lines of management and communication available to them. A member of staff told us, "Everything has been handled really well, especially around giving us good information about new guidance. I've been able to approach the manager about anything to do with it. It's really great that we've got such a good manager". Another member of staff added, "It's been really good actually, how much they have supported us". Feedback from professional bodies such as PHE and the CCG stated that the service had engaged transparently and effectively with them. We were informed by the manager that there had been no new cases of infection reported at the service in the past two weeks. Furthermore, we saw that a 'position statement' had been provided by PHE to staff, people using the service and their relatives which stated, 'We are hopeful that we will shortly be able to declare the outbreak over and the home will be able to return to normality'.

The provider had relevant and up to date policies and procedures in relation to infection control and had updated them in light of this outbreak. They also undertook quality assurance reviews to measure and monitor the standard of infection control in the service and drive improvement. The provider was in the process of arranging meetings to establish learning and reflective practice, to put together protocols and tools to assist other services, both in the Hallmark Care group, and the local area that may be affected by an outbreak of this nature in the future. The manager told us, "We want to develop a pack or toolkit that can be used by other homes. We will be holding 'lessons learned' sessions with a view to giving training to other homes".