Hartwood Care Limited

Hartwood House

Inspection report

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Ratings

Overall rating for this service

Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service responsive?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 2 and 6 January 2015. Breaches of the legal requirements were found. This was because the provider had not maintained an accurate record of the care and treatment provided to people. The provider had not taken sufficient steps to ensure that there were enough suitably qualified staff deployed at all times to meet people's needs and the provider did not have suitable arrangements in place to ensure it was meeting the requirements of the Mental Capacity Act 2005. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm whether they now met the legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk

Hartwood House is arranged over three floors and consists of a new purpose built wing attached to an older existing property which has also been completely refurbished. The home can accommodate up to 50 people but at the time of our inspection there were 39 people living at the home.

The Emery Down nursing unit is on the lower ground floor and provides care for up to 10 people many of whom

Summary of findings

have complex nursing needs. A registered nurse is based on this unit and is available to provide some emergency clinical advice or support to the other two floors which are staffed by senior care workers and care workers.

The Limewood unit on the ground floor provides care for up to 20 people who require residential care. The people living on this floor are more independent and may need support with some daily living tasks such as personal care or support with their medicines management.

The Minstead unit is on the first floor and can provide care for up to 20 people who are living with dementia. Some of the people living on this floor could at times act in a manner which others could find challenging and which could place them or others at risk.

Following a review of records relating to people's care, we found that we had not been notified of two potential safeguarding incidents which had occurred within the service. The local authority had also not been informed. Whilst appropriate actions appear to have been taken, registered persons are required to notify the CQC without delay of such incidents. This had not happened.

The home 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 and associated Regulations about how the service is run.

People told us they felt safe living at Hartwood House and were cared for by kind, caring and compassionate staff. This was echoed by their relatives. Comments included, "He has special moments with staff", "They are caring with a capital C" and "Hartwood House is a little treasure".

Improvements had been made to the staffing levels within the service; however some people and staff felt that these could improve still further. Agency staff were required on a regular basis and recruitment and retention of staff remained a challenge, but we saw that the provider was taking action to address this.

The registered manager did not use a formal approach to assist in reaching judgements about staffing numbers and we have made a recommendation about this.

Overall we found that people's care plans were more detailed and were being reviewed regularly with the person, their relatives and where relevant with external professionals. It was evident that staff were working hard to personalise and improve the level of detail contained within people's care plans. Most people's care and monitoring records were being more consistently maintained and more accurately reflected the care and support they received.

We did find that some aspects of people's care records could be improved still further, for example, where people were living with dementia, they did not have a dementia care plan. Dementia care plans are important as they provide staff with Individually tailored guidance that supports them to promote and maintain the person's independence and adapt and develop their skills. We have made a recommendation about this.

Mental capacity assessments had been undertaken which were decision specific. Where people were deemed to lack capacity, appropriate consultation had been undertaken with relevant people such as GP's and relatives to ensure that decisions were being made in the person's best interests.

Improvements had been made to ensure that staff had training relevant to their role. Staff were receiving more regular supervision and had received an appraisal of their performance.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back 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?

Requires improvement

The service was not always safe

The registered manager had not notified the Care Quality Commission without delay of allegations of abuse.

Improvements had been made to the staffing levels within the service; however some people and staff felt that these could improve still further. Agency staff were required on a regular basis and recruitment and retention of staff remained a challenge, but we saw that the provider was taking action to address this.

We could not improve the rating for 'is the service safe' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Is the service effective?

Requires improvement

The service was effective.

The registered manager and staff knew how to support people in making decisions and had been trained in the Mental Capacity Act (MCA) 2005. Staff had a good understanding of the Act and their responsibilities in relation to this. Mental capacity assessments and best interests consultations had taken place with relevant professionals and relatives.

Staff were receiving more regular supervision and had had an appraisal. Additional training had been undertaken and further training was being rolled out which was helping to ensure that staff received all of the training relevant to their role.

We could not improve the rating for 'is the service effective' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Is the service responsive?

Requires improvement

Action was being taken to make the service more responsive.

People's care plans were more detailed and were being reviewed regularly. Care plans contained information about the person's life, their interests and preferred daily routines along with information about the person's needs, abilities and the level of support they required. Further improvements could be made to some aspects of the records relating to people's care and treatment, for example, people living with dementia did not have a dementia care plan.

Summary of findings

We could not improve the rating for 'is the service responsive' from requires improvement because to do so requires consistent good practice over time. We will check this during our next planned Comprehensive inspection.

Hartwood House

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 done to check that improvements to meet legal requirements planned by the provider after our comprehensive in January 2015 had been made. The team inspected the service against three of the five questions we ask about services, is the service safe, effective and responsive. This was because the service was not meeting legal requirements in these areas.

This inspection took place on the 3 August 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor in the care of frail older people living with dementia, 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. Our expert had experience of supporting people living with dementia and of using health and social care services.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

As part of the inspection we spoke with eight people and 13 relatives. We also spoke with the registered manager, the operations manager, acting deputy manager, a visiting healthcare professional, ten care staff and the chef. We reviewed records relating to the management of the home such as staff training and supervision records, staff rotas and minutes of meetings with people and their relatives. We also reviewed records relating to eight people's care such as their care plans, risk assessments and incident and accident forms.

Where people were unable to tell us about their experiences due to complex needs, we used other methods to help us understand their experiences, including observation of their support. For example, we used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

Following the inspection we contacted two community health or social care professionals to obtain their views on the home and the quality of care people received.

Requires improvement

Is the service safe?

Our findings

The registered manager had not taken adequate steps to ensure their continued compliance with the regulations that govern their registration with the Care Quality Commission (CQC). The Regulations require that CQC are informed about any allegations of abuse, however, following a review of records relating to people's care, we found that we had not been notified of two potential safeguarding incidents which had occurred within the service. The local authority had also not been informed. Whilst appropriate actions appear to have been taken, registered persons are required to notify the CQC without delay of such incidents. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009 Notification of other Incidents.

At our comprehensive inspection in January 2015, we found that the provider had not ensured that there were sufficient numbers of staff deployed at all times to meet people's needs. At the focused inspection on 3 August 2015 we found that the provider had taken action to improve staffing levels, however, some people and some staff felt that staffing levels could improve further.

Most people told us there were sufficient numbers of staff available to meet their needs. One person said, "There are staff around all the time". Another said, "I can reach my call bell. They are very good at coming straight away on the whole. You can't blame them if there are many calls at once". Some people did, however, express some concerns about the staffing levels. One person told us that they felt the staff were "Frequently pushed". Another person said, "They sometimes say, I'll be back in a moment, but they don't come back". A number of people expressed concerns about the lack of continuity of staff and the number of agency staff that were being used. One person said, "They get a lot of outside staff". This person told us that this meant some staff did not always know their routine. Another person said, "The person you talk to one day isn't the person who is duty next day or the next week".

Relatives generally felt that the staffing levels had improved. One relative said, "The staffing level has definitely improved, there are enough now". Another said, "They [staff] are there when you need someone". A third relative said the staffing levels had improved. They explained that earlier in the year staff were often pushed, were very busy in the mornings and there was not enough time to sit with people. They explained that now, they felt staffing levels allowed the care workers to interact with their relative; they said nothing was too much trouble and their relative was always clean and comfortable when they visited. Some relatives also expressed concerns about the amount of agency staff providing care. A relative said, "The agency staff are not always briefed on [the person's] needs, they have to explain everything and this can be a niggle". Another relative said that the consistency of staff needed to improve, but that they felt confident the registered manager and provider were working hard to address this.

We received mixed feedback from staff about whether the staffing arrangements were appropriate. Some staff felt further improvements could be made. One staff member told us, "We are under so much pressure". Two staff told us that the deployment of staff could mean they were not always able to supervise the communal areas. They were concerned that this could impact on people's safety. They did acknowledge that staffing levels had now improved and hoped that this would help to address their concerns. Another said, "Staffing is a problem, its not because the manager is not trying, recruitment is a problem, we can have more agency staff that Hartwood House staff". They told us, "Everything gets done, the residents needs are our priority, the thing that goes by the way is being able to provide activities and spend time with people". Other staff felt that the staffing arrangements within the home were adequate. One staff member said, "The staffing levels are adequate, the people we are looking after are not quite so dependent now". They said, "We can provide good care, the team works really well together". Another staff member said, "The staff levels have improved, its good now, we have time to take people out in the garden, everyone supports everyone".

Where people and their relatives had expressed concerns about the staffing arrangements, they remained very positive about the kind, caring and compassionate nature of the staff team. One relative said, "[The staff] are always very good, even when under pressure". Another visitor told us that they did not feel the lack of regular staff unduly affected their relative, they said, "Mum still feels that they adore her and spoil her".

Our observations on the day of the inspection indicated that overall, people were having their needs met in a responsive manner by staff who were familiar with their wishes and preferences. We saw that people received

Requires improvement

Is the service safe?

sensitive and unhurried support when they were unable to feed themselves. We heard staff chatting freely with people discussing the food and how it had been prepared. Overall, our observations indicated that lunch time provided an opportunity for social interaction as well for providing nutrition. We saw that all staff including the housekeeping staff took time to speak with people when passing.

We spoke with the registered manager about the staffing arrangements within the home. The registered manager and provider told us they were very comfortable that the current staff numbers were adequate and allowed staff to meet people's needs in a safe and person centred way. The registered manager told us that staffing levels were monitored and reviewed in line with people's needs and fluctuating occupancy although they did not use any specific tool or formal approach to calculate optimum staffing numbers.

We recommend that the provider adopt a more systematic approach to determining the number of staff and the range of skills required in order to meet the needs of people using the service.

The registered manager told us that the recruitment and retention of staff was a challenge. Records showed that since our last inspection twenty one staff had left the service. The staff rosters showed that agency staff were required on most of the floors on almost a daily basis. On some days, there were more agency staff overseeing a floor that Hartwood House care staff. For example, on Minstead unit on the 20 and 21st July, three of the five staff were agency staff. On the 22 July 2015 Emery Down unit was staffed by an agency registered nurse, two agency care workers and one Hartwood House care worker. The registered manager told us that where agency staff were used, they tried to ensure these were workers who had been to the service before and were therefore familiar with the home and the people living there. The registered manager told us that the organisation was working hard to recruit new staff and were offering improved terms and conditions in order to try and attract new staff. We were told that as of September they would be fully staffed in terms of registered nurses and a new deputy manager would be starting. Four new care staff were also starting shortly. However they were still recruiting to fill a further eight care worker vacancies. The provider is taking action to make improvements to the staffing arrangements within the service. However the programme of recruitment needs to be embedded and sustained to ensure that people are at all times supported by enough staff who are familiar with their needs and who have the right mix of skills and experience.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection in January 2015, we found that the provider was not acting in accordance with the requirements of the Mental Capacity Act 2005. People who lacked the mental capacity to make decisions around their care and support did not have a decision specific mental capacity assessment and a record of the best interest's consultation which supported staff to act and make decisions on their behalf. At the focused inspection on 3 August 2015 we found that the provider was now meeting this legal requirement.

Staff demonstrated a good understanding of the Mental Capacity Act (MCA) 2005 and their responsibilities in relation to this. We observed people being asked for consent before any care and support was provided. One care worker told us, "I always ask for people's permission before I do anything, even if the person can't communicate verbally, you can tell by their expression or reaction… we always talk people through care, for example, I tell them what I intend to do before I do it, if they refuse I leave them if it does need to be done right now and then return later…..its about trying to give people as much choice and control as possible". Another care worker said, "Mental capacity is about people being able to make the decisions they are capable of making…we always talk people through what we are doing, if they are adamant that they don't want care, that is their choice…if they needed essential care, I would report it to senior…we would try and use tactics, for example, getting another member of staff".

We saw examples of fully completed and decision specific mental capacity assessments in people's care records. For example, we saw that one person had a mental capacity assessment in relation to the use of an alarm mat which alerted staff that they were mobilising so that they could check on their safety. Other people had mental capacity assessments in relation to the use of covert medicines, the use of bed rails and other aspects of their personal care. Where people had been deemed to lack capacity we saw that detailed best interests consultations had been undertaken with relevant professionals and relatives so that a shared decision could be reached about whether a particular course of action or aspect of the person's care and support was in their best interests.

At our inspection in January 2015, we found that the arrangements in place for staff to receive supervision and appraisal of their practice needed to improve. At this inspection we found that improvements had been made. Most staff were now having more regular supervision and had received an appraisal.. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. Most staff told us that their supervision was useful and helped them to feel supported in their role. One staff member said, "yes supervision is helpful, it shows up areas I need to improve on, but I don't have to wait for support, I can go to [the registered manager] at any time".

At our last inspection, we found that staff did not have all of the training relevant to their role. For example, a high proportion of staff had not completed training in the Mental Capacity Act 2005 or in nutrition and hydration. A review of the training records showed that most staff had now completed training in both of these areas. A number of staff told us that they felt they required training in the care of people living with dementia and in managing behaviour which challenged. To address this we saw that training in both of these areas was in the process of being rolled out for all staff. This will help to equip staff with the tools and resources they need to be able to respond to behaviours which challenge in a consistent and person centred manner. This meant that the provider had taken action to make the required improvements as detailed in their action plan following our inspection in January 2015.

Requires improvement

Is the service responsive?

Our findings

At our comprehensive inspection in January 2015, we found that people did not always have a detailed plan of care which helped to ensure that staff were able to deliver personalised and responsive care. We issued a requirement and asked the provider to send us a report telling us what action they were going to take to make improvements. At our inspection on 3 August 2015, we found that the provider had taken action to make the required improvements.

Overall we found that people's care plans were more detailed and were being reviewed regularly. Some staff had already completed additional training to develop their skills with writing care plans and over the coming months we saw there were plans to roll this out to all staff. It was evident that staff were working hard to personalise people's care plans which now included more information about the person's life, their interests and preferred daily routines. The care plans provided detailed information about the person's needs, abilities and the level of support they required. In each care record, there were risk assessments which were mostly reviewed on a monthly basis. These helped to identify if people were at risk of becoming malnourished or of developing skin damage. One person who was receiving their nutrition via artificial means had a detailed and personalised care plan regarding this. The plan provided clear instructions for staff about how they should provide the person's care. Another person who was living with diabetes had a comprehensive and detailed care plan which had specific and clear guidelines about how best to manage their diabetes. Most of the staff told us that the care plans were informative and provided clear guidance on how to support people.

However, we noted that further improvements could be made to some aspects of the records relating to people's care and treatment. One person's care plan contained conflicting information about how aspects of their care should be managed. We spoke with the nursing staff about this who took immediate action to update this person's records. Information about people's food allergies was not always clearly recorded in their care plans, although we did note that this information was accurately recorded within information held in the kitchen. One person who was at risk of choking did not have a specific dysphagia care plan. This was of concern as the person's daily records noted that the person 'often coughed when drinking'. However staff were informed about the person's choking risk and the nurse was able to describe the actions required in the event of the person experiencing a choking incident, however this is in an area for improvement.

People living with dementia did not have a dementia care plan. Dementia care plans are important as they provide staff with Individually tailored guidance that supports them to promote and maintain the person's independence and adapt and develop the person skills as the condition advances.

We recommend that the provider consider relevant guidance on dementia care planning.

Records relating to skin damage needed to be more detailed. For example, one person's skin care records, reported a number of bruises. The records did not always include information about the location of the bruise, measurements or where appropriate photographs of the skin damage. We spoke with the nurse about this. We found that they had a good level of knowledge in relation to skin care and a good understanding of the issues we raised. We are therefore confident that further improvements will be made to ensure that people's skin care records are suitably detailed and contain a robust investigation into the potential causes of these so that remedial actions can be put in place.

Most people's care and monitoring records were being more consistently maintained and more accurately reflected the care and support they received. However records relating to the administration of topical creams and ointments were not always completed and did not contain detail about where the creams should be applied. Where people were prescribed 'as required' or PRN medicines, the guidance in place did not contain sufficient information to inform staff as to when these medicines should be administered. PRN protocols are important as some people are not able to tell staff that they are in pain for example. One person's PRN protocol said, '[the person] is unable to express when they are in pain. Staff to look for non-verbal expressions'. However there was no record of what these non-verbal expressions might be. Whilst the Hartwood Care staff we spoke to were able to tell us in detail about the signs and behaviours which might indicate that the person needed their PRN Medicines, agency staff would not have the same level of knowledge and therefore detailed PRN protocols help to ensure that people receive their as

Is the service responsive?

required medicines in a manner that is responsive to their individual needs. The registered manager told us that the deputy manager was working on producing more detailed PRN protocols and so they anticipated that these would shortly be in place.

At our last inspection, we found that improvements were needed to ensure that people and their relatives were involved in making decisions about their care and support and that people had regular reviews of their care plan. At this inspection, we found that the required improvements had been made. Most people told us they were involved in reviews of their care plans and were able to talk with their key worker about the contents of this. Relatives also felt involved and told us they were usually kept well informed about changes or incidents and accidents. One relative said, "I am never worried about [the person] They would always inform us and update us on any changes in their needs". Another relative told us, "I am totally involved in reviews and have done an end of life plan". Another said, "We have gone through the care plan with [the key worker] we are always involved". One relative did say that they were not always informed in a timely manner should their relative be running out of toiletries for example. They felt this was an area which could improve. We observed that relatives were encouraged to be involved in delivering their loved ones care if this is what they wanted. One visitor told us how they liked to be involved in helping their relative to eat and drink. They said, "It is such an important thing to do and I feel more part of their life and can be close with them".

Overall we found evidence that people were receiving care that was responsive to their needs. People told us they were able to make choices about how they spent their day and when they received their care. One person told us, "They try to find out about what I want to do". Another person said, "I like to get up early and the staff always try to accommodate this". A third person said, "I was ill in bed for three days with a chest infection, the carers told me they would look after me and they did".

Relatives also felt that their loved one's received responsive and personalised care. Comments included, "They know my relative inside out now" and they "Work to people's routines". One relative said, "The chef's interaction with [their relative] was brilliant, he really gets to know people and their preferences". One relative told us how the registered manager and staff team had worked hard and 'stepped up the care' when their relative was poorly in order that they could remain at the home and not go into hospital. A relative told us "I asked for a profiling bed and they got one in here and an airflow mattress". Another relative described how staff had noticed how their relative often wandered to a certain location within the home and so made arrangements for a chair to be placed there so they could take a rest.

We saw that people took part in a range of activities both within the home and within the community. Most people told us they enjoyed the activities which were varied and of interest to them. People and their relatives told us there was often entertainment in the main lounge and trips had been arranged to local hotels and gardens for afternoon tea and to the theatre. On the day of our inspection, there was musical entertainment available for all on the Limewood unit and in the afternoons, we saw staff playing board games and doing puzzle books with people. Staff on Minstead unit told us that they tried to ensure that on nice days, people were provided with opportunities to sit or walk in the gardens. Some staff expressed regret that they were not always able to spend one to one time with people, particularly on the days when the two activities staff were not available. Two people told us that they wished the staff had more time to sit with them. One said, "I spend a lot of time in my room, I haven't got dementia so I find it difficult to talk to some of the people here". Activities records suggested that people did intermittently receive one to one time with the activities staff and were encouraged to take part in group activities such as watching DVD's, doing jigsaw puzzles, painting or attending a church service. A visitor told us that staff danced with their relative and another told us how they had arrived to find a staff member just sat with their relative holding their hand which they greatly valued.

Most people and their relatives said they would recommend the home. One person said, "Yes [they would recommend the home], it's very friendly and they put themselves out for you". A relative said, "I can't speak highly enough of the care, there is nothing I can think of that they could do better, everything I mention they take on board immediately".

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **How the regulation was not being met: The registered persons had not notified the Care Quality Commission without delay of allegations of abuse Regulation 18 (1) (e).**

This section is primarily information for the provider

Enforcement actions

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