The Royal British Legion

Halsey House

Inspection report

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Date of inspection visit:
12 September 2018

Date of publication:
26 November 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This responsive inspection took place on 12 September 2018 and was unannounced. The last inspection of the service was 28 and 29 September 2016. The service was given a good rating with no breaches of regulations. The purpose of our inspection on 12 September 2018 was to focus on two key questions; safe and well-led, after a recent significant incident had occurred. We did not identify any immediate risks but found areas which could be improved upon.

Hasley House is a care home with nursing. People in care homes receive accommodation and nursing 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 can accommodate up to 89 people. At the time of our inspection there were 79 people using the service.

At the time of our inspection there was a registered manager 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 2008 and associated Regulations about how the service is run.

During our inspection we found the service had not always ensured people were safe and protected from hazards in line with their assessed needs. Following a serious incident, the service had reviewed their processes and had taken actions to safeguard people in their care. However significant shortfalls contributed to avoidable harm and this resulted in a breach of Regulation 12 of the Health and Social Care Act: Safe care and treatment.

People were safeguarded from abuse as far as reasonably possible because staff received the necessary training to help them recognise abuse. They had access to policies and procedures so they knew what actions to take. The service reported concerns to the safeguarding team but since the last inspection failed, on two occasions, to report these to the CQC. This resulted in a breach of Regulation 18: Notification of Incidents – CQC (Registration) Regulations 2009 (Part 4)

Care plans included a health profile which described people's physical, mental health and well-being and helped staff provide holistic care.

The environment provided people with comfortable accommodation which was flexible around their individual needs. The service promoted people's independence and right to positive risk taking and control over their lives.

We observed people received kind, considerate care by staff mostly familiar with their needs. Recently the service had been using regular agency staff to cover staff vacancies or to support existing staff whilst new staff were being inducted. Ongoing staff recruitment meant vacant posts were being filled and there was a gradual reduction in the use of agency staff.

People's needs were being reassessed to help ensure that the service could continue to meet their needs safely and in line with current staffing levels.

The service had a registered manager. They said they felt well supported but it was clear that the last year had been difficult in terms of staff recruitment and having effective deployment of staff to meet people's needs. The deputy manager had recently left which had left the registered manager short within the management team. A deputy and assistant deputy manager had been recruited in the last two months which had helped to improve the overall quality of the service people were receiving.

Recent audits had helped to clearly identify where the service needed to make improvements and audits identified timescales and who should carry out any necessary actions.

Medication audits were in place and the service identified where things needed to improve. Action plans were in place to help ensure people received their medicines safety and medicines were available as required.

The cleanliness and maintenance of the service was good and the environment was suited to people's individual needs.

We did not look at staff recruitment. At the last inspection to this service staff recruitment was good. We did however look at agency records to ensure agency staff had the right credential, skills and recruitment checks in place. We also looked at their onsite induction which was adequate.

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

Risks to people's safety had not always been well managed and records did not incorporate enough information about people's needs.

Staffing levels were good and adjusted to take account of people's assessed dependency and the environment.

Planned and routine maintenance and cleaning of the service was in place and the environment enabled people to be as independent as they could.

Audits were in place to help determine if people got their medicines as intended. Any errors were quickly identified to try and ensure people's safety and well- being.

We looked at staff recruitment only in relation to agency staff and this was satisfactory. We had no concerns about recruitment at the last inspection.

People were safeguarded from abuse as far as reasonably possible. Staff received training to help them recognise abuse and know what actions to take. The service reported concerns to the safeguarding team but had not on two occasions reported notifications to the Care Quality Commission.

Is the service well-led?

Requires Improvement

The service was not always well led.

Policies underpinning safe practice had not been clearly followed which exposed people to unnecessary risks.

Staff recruitment had been effective and vacant posts covered which had led to a reduction in agency staff and greater stability for the service.

The registered manager was competent and experienced but had found the last year difficult in terms of recruitment. They had been well-supported by the provider and additional support had been put in place to help ensure high standards of care were maintained.

People's experiences were considered when planning the service and feedback was acted upon.

Halsey 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 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.

Following a serious incident we carried out an inspection to follow up on a notification in which a person using the service died. The incident is subject to investigations by relevant bodies and as a result the inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls from a height. This inspection examined those risks.

This inspection took place on 12 September 2018 and was unannounced. The inspection was undertaken by two inspectors. Prior to our inspection, we looked at information already known about this service which included information from previous inspections, the provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Other information we looked at about the service included statutory notifications. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we looked round the service, spoke with the operational manager, the registered manager, the deputy manager, three care staff and ancillary staff, including maintenance staff. We carried out observations of care and the dining room experience. We looked at six care plans and records relating to the management and governance of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection to this service on 28 and 29 September 2016 the service was rated good in this key question and in all other areas. Our inspection on 12 September 2018 was undertaken because we received a notification of a serious incident at the service. The purpose of our inspection visit was to identify any current risks to people using the service. We also wanted to establish what the provider had put in place to reduce the likelihood of another serious incident.

The risks to people's safety had not always been adequately monitored and recorded to show how the staff had taken sufficient actions to reduce the risk. We were unable to see how the service implemented its own policies to ensure the environment was fit for purpose and hazards had been identified and reduced.

Before the recent notification of a serious incident not all the windows were restricted and the risk from an unrestricted window had not been identified. There were no regular checks or audits on window restrictors to ensure they were in place, and remained effective and safe. The organisation's policy: Prevention of falls from height risk assessment dated 12 May 2018 stated that windows accessible to vulnerable residents and visitors should be fitted with window restrictors and checked regularly. By not doing this, the service had failed to protect vulnerable residents.

We noted other risks associated with the environment and equipment which had not been identified and could result in harm. For example, we noted the kitchen door on the nursing floor was held open by fire mechanism bolt despite a clear sign advising door should not be left open when room not in use due to the storage of chemicals. This remained open throughout our observation of over an hour and placed people at risk if they tried to drink the dangerous substances.

The service had not notified us of two incidents which had occurred since the last inspection which meant we could not respond appropriately or monitor the service in line with known risks. At the inspection we noted two people had been subject to emergency deprivation of liberty safeguards, (DoLS.) following separate incidents in which one person had left the service and another person remained on the premises but had entered the gardens of the service when it may have been unsafe for them to do so. The risks had not been assessed thoroughly prior to the incidents or lessons learnt from one incident to another.

This supports a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the incident which led to our inspection, all windows accessible to people using the service and where they might pose a risk had been restricted and regular monthly checks were in place at the time of the inspection visit.

The maintenance of the service was the responsibility of two maintenance staff who carried out routine checks, although some of the routine servicing was carried out by other contractors. It was not easy for us to audit the paper maintenance records because they were not indexed or stored in chronological order and

would take us a considerable amount of time to find the required documentation. However, records were also stored electronically and systematically reviewed and there was sufficient management oversight of them. There were no audits for wheelchairs to ensure they were well maintained and clean. The registered manager responded immediately by amending the weekly health and safety environmental checklist to include wheelchairs. There were no regular checks other than the service contract for call bell alarms to ensure these were all working effectively. This has since been added to the weekly health and safety environmental checklist. Whilst on inspection, call bells rang regularly and staff in the vicinity did not respond to these as a matter of priority which could result people not getting their care needs met in a timely way. We brought this up with the registered manager to address.

The maintenance person had been working on their own due to a second maintenance person being off for a number of weeks. The maintenance person was also required to do other duties which at times took them off site. The registered manager told us they were recruiting a third person to post. We found responsibility for maintenance was clearly established with well-developed relationships with outside contractors. The service was also supported by a facilities management contractor who attended the site twice weekly. There were record of minutes of Facilities Management and Health and Safety Regional Advisor meetings.

Regular environmental checks were in place to help ensure equipment was safe to use and the environment did not pose any immediate hazards to people. This had been assessed in line with regulation and considered people's right to take risks in a carefully assessed way. There were adequate systems in place for fire safety, the maintenance of equipment and water safety including regular checks on water temperatures. There were regular audits demonstrating how the premises and equipment were maintained and cleaned to ensure the environment was safe and reduced the risks of cross infection.

We found risks to people's safety were well documented which meant staff would be aware of the risks and be able to support people consistently with their needs. We found an exception to this. One person had advice from the occupational therapist that it was no longer safe for them to access the home's minibus as they could not maintain the correct seating position. The findings of the occupational therapist had not been recorded as being discussed with family, who regularly took their family member out in their chair and their own vehicle when it might not be safe to do so. The person's risks assessment and manual handling plan had not been updated.

We noted people had bespoke equipment to support their mobility and help them maintain a good position to promote good skin integrity. Mattress checks, bed rail checks and room safety checks were in place. Internal doors were alarmed which helped alert staff to people leaving the service. There was a moderate-sized fish pond in the gardens which was fenced off and covered with green safety netting creating a visible barrier for people and animals. This demonstrated that the provider had proactively taken risk mitigation measures based on the environment.

Care records viewed did not clearly demonstrate how staff were supporting people to settle into their new environment. The registered manager explained that information about people's health and care needs might not be completed in full when urgent admissions to the service took place. The service did not have an admissions policy and there was not a common understanding of how quickly care plans and risk assessments would be in place when a person first moved in. The registered manager agreed a clear admission process and clear documentation around how the person was settling in to their new environment would help the service respond more quickly to a person's changing or unmet needs.

There were enough staff to meet people's needs. Staffing levels at the service were provided in line with

people's assessed needs and kept under review to ensure they remained appropriate. The service used a dependency tool to assess and plan for individual need. The organisation had responded to staff vacancies by using regular agency staff, this ensured the service did not run short. Agency staff were also used to support new staff who were on induction and shadowing existing staff. The service had effective recruitment and staff retention strategies and processes in place. They had actively recruited new staff and had looked to recruit over the numbers of staff they needed to help reduce the numbers of agency staff. They had recently recruited to additional posts which had been put in place to support the registered manager. There were now two deputy mangers posts instead of one and team leader posts to help ensure adequate oversight of the different units in the service. The service had also recently suspended new admissions until it had the staff in post it said it needed. This demonstrated the services commitment to ensure staffing levels reflected the assessed needs and staffing input required by each person.

Accidents and incident records were collated by the service. These showed what had happened and the actions taken by staff. These were reviewed by the registered manager as part of their overarching governance system. There were policies in place and increased monitoring and recording of a person's well-being following a fall or accident. This helped to ensure that the person had not suffered any injury or ill-health because of an accident or incident.

We did not look specifically at staff recruitment. At the last inspection there were no concerns about staff recruitment. We looked at the use of agency staff in terms of their recruitment and initial induction to the service. This was good and helped ensure people received continuity of care.

We did not look specifically at medication administration and the competencies of staff to do this safely. At the last inspection there were no concerns about medicine management. We did look at the service audits which showed how they were identifying poor practice around medication management and what steps they had taken to rectify this. This included missed signatures on medication records and creams not being dated when opened. It also considered whether prescribed when necessary protocols were in place and made it clear of the medicines intended use. There had been two medication errors not resulting in any harm to people using the service. There were processes in place to ensure staff were sufficiently trained and competent to give medicines. There were also processes in place to support people to take their own medicines when they had been assessed as safe to do so.

Requires Improvement

Is the service well-led?

Our findings

The last inspection to this service was 28 and 29 September 2016. The service was rated as good and there has been no change in management since that time. However, there have been changes in the regional support and the long-standing deputy manager also left the service giving a short period of notice. Although recruitment and retention had been challenging the service had a comprehensive recruitment strategy. Furthermore, the service benefitted from strong senior management support and oversight and increased management capacity. The registered manager was a competent, experienced manager. Both the registered manager and operations manager outlined the leadership support for Halsey House. The operations manager has visited the service on 10 occasions from October 17 – September 18, each visit was a minimum of two days. A full audit of the service has completed by the operations manager and the quality and Innovation Manager has also undertaken many visits.

We inspected the service on 12 September 2018 as a serious incident had occurred and resulted in a fatality. The incident is currently being investigated. The provider had failed to comply with health and safety legislation. The service had not been safe for its intended use. Window restrictors had not been in place for all windows where there was a risk of harm to vulnerable people and visitors. Quality assurance checks were not in place for window restrictors so this had not been identified prior to the incident. Processes to assess, monitor and improve the quality and safety of the service had not been sufficiently robust in this area which meant risks had not been adequately mitigated. Window restrictors and monthly audits of the window restrictors have since been introduced.

The service did not have an admissions policy and records regarding admission did not clearly explore all areas of risk to the person's safety and well -being. This information was gathered over time as staff got to know people well and people were happy to share information.

People were supported to stay hydrated but there was poor recording of this. Care staff were supported by catering staff to encourage people to drink enough for their needs. However, there was not a clear understanding of how staff would communicate with each other regarding the fluid intake of those at risk. Information was passed to care staff verbally and was not recorded contemporaneously. The registered manager said people did not have individually agreed targets and there was no clear monitoring of how much fluid people had over a number of consecutive days although when someone was not drinking much this would be passed on to the next shift as part of the shift handover. This meant the service had not assessed how much people usually drank and did not have a clear overview of actions they should take if people did not drink enough for their needs over a period of a few days. This meant processes and oversight around adequate hydration were not robust enough.

Heads of department meetings were held weekly and the registered manager said they did a daily walk around. These were not recorded so it was not clear how the registered manager and other heads of department would be alerted to any immediate or ongoing risk. Handovers took place at each shift changeover. We observed handover between the staff leading the floor and the staff who would take over the lead. Notes were taken by the nurse at the time of the handover and there was a communication book

and diary in situ. However other care staff leaving and coming on shift were not involved in the handover. Nurses told us the information was on a white board and care staff were allocated specific room and were responsible for the care of those people. The white board gave details of anyone requiring regular turns/monitoring or assistance with food/fluids which were then recorded in the folder in their rooms. There were detailed sheets of everyone's basic needs for the use of agency staff, which would have been helpful for other staff. These were only updated weekly so important information and, or changes could be missed. People's dietary needs/allergies were on a list in the kitchen and in different units, one only included room numbers and not people's initials which was a concern as a number of people had recently moved rooms. This meant that people may be at risk of receiving the wrong food and be at risk of choking or other risks associated with their diets.

The registered manager, when asked, said that relative meetings were not routinely held and when they had been planned relatives had not attended. This meant the opportunities for relatives and people using the service to influence the service were reduced. The service did have annual surveys it sent out to ascertain people's feedback and identify where service improvements were required.

The service had not always ensured the risks to people's health and safety had been fully taken into account when planning and delivering a service and there had been insufficient oversight of this. This supports a breach of Regulation (17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the recent serious notification leading us to inspect the service, the service had taken robust measures to ensure the future and continued safety of people using the service. We found the building was safe and fit for purpose and enabled people to live safety according to their assessed needs. The provider put an emphasis on promoting people's choice and enabling people to choose how they lived.

The service had not notified us of two incidents which meant we could not respond appropriately or monitor the service in line with known risks. This is a breach of Regulation 18: Notification of other incidents. Care Quality Commission (Registration) Regulations 2009.

The service had notified the local authority safeguarding team of these incidents and had previously notified CQC as per regulation.

The service took into account people's feedback in planning the service. For example, the service told us because of feedback they had: Introduced an accessible, safe garden footpath which enabled people to enjoy the grounds including their visitors who would accompany them; The entrance to Halsey House, curb had been lowered at the request of a person using the service to improve the access and safety of the environment. The service told us resident meetings were scheduled monthly. However, the last two planned meetings had not taken place during the summer months. This was due to annual leave of the registered manager and resignation of the Deputy Manager. People spoken with told us the meetings had been cancelled and said they did have concerns mostly about the quality of the food. Comments about the food included, "The chef lacks imagination or choice." Another person said, "One day the menu had fish for breakfast, lunch and supper." Another said, "we want fresh veg – all the veg is frozen, not seasonal – we get sprouts in the summer." Another said, "The meat is tough" "meat is overcooked and dry." This had not been identified and acted upon by the provider.

We noted on arriving to the service we asked if anything was planned for the day that we needed to be aware of. The registered manager said no but we found out later that fire alarms were tested on a Wednesday. We were not informed of this or told where the fire exit points were. We would expect all visitors

to be given this information to help ensure their safety.

We received good feedback from people about the care they received and this supported our observations. We found staff were attentive throughout the day and provided various opportunities for people to join in different activities and clearly knew people well.

The service benefitted from additional staff with lead roles to support the registered manager. For example, there was a full- time training and development officer who was supporting the launch of a personal development plan for all staff. This helped to identify and support staff's personal development and growth. The training and development officer was also carrying out observations of staff practice and promoting across the staff team values and behaviours they wished to see. Registered managers across the group of homes were meeting regularly to share best practice and lessons learnt. A new peripatetic manager's role had been put in place to support new managers or managers who were struggling with any aspect of the service.

The service also had an occupational therapist based on site. Management staff and heads of department had clearly defined management hours. Staffing hours had been reviewed and there had been a revision in pay scales to help attract and retain staff. A staff board would help show who was on duty in each of the units and who was in charge which would help people and relatives know who they could refer any questions to.

The dependency levels of people had been reviewed in line with their needs, accommodation and staffing levels. The service had introduced 'resident of the day,' which meant each day a named person's needs were reviewed on each unit. This review looked at the person's needs but also considered the cleanliness of their room, any maintenance concerns or issues with the meal time experience.

The service offered personalised support with peoples' records and medication kept within their rooms unless there was a specific reason not to keep medicines in the person's bedroom. There was lots of information around the service to act as a reminder for staff to promote people's well- being, such as reminding people to drink enough. There was also information around the service about different activities and events people could choose to participate in. The main lounges had televisions in which people could choose and download films of their choice and there was a library area and other smaller dining and lounge areas should people want to sit quietly.

Care plans included a one-page profile, information about people's choices and preferences and care plans for each of their identified needs. There was a separate section describing people's health needs and management of long term conditions.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The service failed to notify us of two incidents which would help us determine any actions we must take to ensure the service is safe for people that use it.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not take sufficient action to assess and reduce the risk of avoidable harm when considering people's safety in relation to the environment. There was insufficient management oversight of this.