Hatfield Haven Limited

Hatfield Haven

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

Summary of findings

Overall summary

The inspection took place on 28 July 2016 and was unannounced.

Hatfield Haven provides accommodation and personal care for up to 22 older people some who may be living with dementia. Care is provided on two floors. At the time of our visit there were 19 people living in the service.

Since the last inspection a new manager has been appointed and has taken up post. They told us that they had applied to CQC to be registered. 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 spoke positively about the service and the care that was provided. They told us they were listened to and staff were kind.

People told us that they felt safe. Staff were clear about what was abuse and the steps that they should take to protect people. The likelihood of harm was reduced as risks to people's health and welfare was assessed. Risk assessments guided staff in how to reduce the risks and keep people safe but could be more detailed.

Checks were undertaken on staff suitability for the role and there were sufficient numbers of staff available to meet the needs of the people living in the service.

Medication was generally managed safely but did not always follow the recommended professional guidance.

Staff received an induction to prepare them for their role and additional training was provided to support their learning and development. Staff had limited understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff supervisions and competencies had not been carried out on a regular basis.

People who lived in the home were positive about the quality of the food and our observations were that people enjoyed their meals.

The environment did not promote people's independence.

Care plans documented people's needs but varied in quality which meant that some people were at risk of receiving inconsistent care.

The manager was approachable and promoted an open culture.

Complaints were taken seriously and investigated. Staff knew what was expected of them.

There was no formal way of gaining people's views.

There were systems in place to drive improvement but these would benefit from a greater focus on people's experiences.

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 consistently safe.

Medication was safely stored but documentation did not always follow professional guidance.

Staff understood their responsibilities to safeguard people from the risk of abuse.

The provider had systems in place to manage risks. Staff understood how to recognise, respond and report abuse or any concerns they had about safe care practices.

Staff were only employed after all essential pre-employment checks had been satisfactorily completed.

Is the service effective?

Requires Improvement

The service was not consistently effective

Consent and the Mental Capacity Act was not consistently well understood by staff.

Staff supervisions were not undertaken on a regular basis.

People were supported to have a balanced diet and to make choices about the food and drink on offer.

People were supported to maintain their health by visiting professionals such as chiropodist, dentists and GP's.

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy and dignity was maintained.

Staff were kind and considerate in the way that they provided care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The information in people's care plans did not give enough detail and gave inconsistent information.

People's complaints were investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although systems were in place to assess and monitor the quality of the service provided, they were ineffective as they had not highlighted the areas of concern we had identified.

Systems were not in place to gain people's views.

The manager was visible and enthusiastic about their role.

Hatfield Haven

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 28 July 2016. It was unannounced and was carried out by one inspector 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.

We reviewed all the information we had available about the service, including notifications sent to us by the provider. A notification is information about important events which the provider is required to send us by law. We used this information to plan what areas we were going to focus on during our inspection. During the inspection we spoke with six people that used the service, four relatives, three staff and the manager.

We used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care during the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed how staff interacted with people who lived at the home. We observed how people were supported during meal times and during individual tasks and activities.

We reviewed six people's care records, six staff recruitment records, medication charts, staffing rotas and records which related to how the service monitored staffing levels and the quality of the service. We also looked at information which related to the management of the service such as health and safety records, quality monitoring audits and records of complaints.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they and their family members felt safe living at Hatfield Haven. One person told us, "We are well looked after." A relative told us, "[Name of relative] is safe here I see the way they let you in and she is happy."

Risks to individuals were identified and management plans were in place to reduce the likelihood of harm. However, although the risk assessments had been dated to say they had been reviewed on a regular basis they had not been updated to incorporate any changes in people's needs. For example, one person's risk assessment spoke about him walking yet he no longer walked without the use of walking aids. Most of the staff team had worked at the service for a long time and therefore they knew people's needs and were able to support them. However, new staff would not have the necessary information in the care plans to be able to support people in order to keep them safe.

Care records showed that each person had been assessed for risks before they moved into the home and again on admission. Any potential risks to people's safety were identified. Assessments included the risk of falls, skin damage, and nutritional risks, including the risk of choking and moving and handling.
We observed staff supporting someone to transfer from a chair to a wheelchair. The staff did not appear confident. We discussed this with the manager who told us staff had been trained in manual handling. However, there were no assessments of staff's competencies carried out.

We found that medication was in the main safely managed but the arrangements could be further strengthened. We observed the medication round as part of our inspection, and noted it was undertaken safely. The senior carer ensured people had a drink, and gave them time to take their medicines. People were protected by safe systems for the storage, administration and recording of medicines. Medications were kept securely and at the right temperatures so that they did not spoil. Medications entering the home from the pharmacy were recorded when received and when administered or refused.

The medicine trolley was kept locked when unattended, and the member of staff signed the medication administration charts after the medicines had been taken. We checked samples of medication as well as Controlled Drugs and saw that they were appropriately signed for and the quantities in stock tallied with the controlled drugs register. Staff recorded when they administered PRN medication such a pain relief. Some of the medication administration sheets had handwritten medication on them and these additions should have been signed by staff and checked for accuracy. We saw forms which should have been completed to say that the medication had been audited on a regular basis but the audits had not been carried out. We discussed our findings with the manager who told us they would ensure that regular audits were carried out in future.

There were policies and procedures regarding the safeguarding of people. Staff knew how to keep people safe and understood their roles and responsibilities to recognise respond to and report any incidents or allegations of abuse, harm or neglect. It was evident from our discussions with them staff had a good awareness of what constituted abuse or poor practice, and knew the processes for making safeguarding

referrals to the local authority. One staff member told us, "If I had any concerns I would go straight to the manager", and "We do our best to keep people safe." Our records showed that the manager was aware of their responsibilities with regards to keeping people safe, and reported concerns appropriately

We saw that there were processes in place to manage risks related to the operation of the service. For example, the manager arranged for the maintenance of equipment used including hoists, fire equipment and electrical appliances and held certificates to demonstrate these had been completed. There were appropriate plans in place in case of emergencies, for example evacuation procedures in the event of a fire.

There were sufficient staff to meet people's needs. Our observations showed the service was well staffed and in addition to care staff the service employed, housekeeping staff, a cook and an activities coordinator. Staffing rotas showed the home had sufficient skilled staff to meet people's needs, as did our general observations. For example, people received prompt support and staff were unhurried. We saw that people's buzzers were answered without delay.

Staff recruitment files demonstrated that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, the provision of previous employer references, proof of identity and a check under the Disclosure and Barring Scheme (DBS). This scheme enables the provider to check that candidates are suitable for employment. People could be assured that their needs were being met by staff that had been assessed as safe and competent, with the necessary skills for the job role they had been employed for.

Requires Improvement

Is the service effective?

Our findings

People were cared for by staff that had done some training to enable them to provide care that met people's needs. Staff told us they had received regular training opportunities in a range of subjects and this provided them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs. The training plan showed that the majority of staff's compulsory training was up to date. However, our observations and discussions with staff showed us that staff did not have enough knowledge on how to work with people who were living with dementia. For example, people were not offered any stimulating activities to do items were not placed on people's tables in easy reach of them that could occupy them and offer stimulation. We discussed our findings with the manager who agreed to look into further training for the staff.

Staff confirmed that when they commenced employment at the service they had received an induction. Records showed that the staff's induction was in line with the 'Care Certificate' this consists of industry best practice standards to support staff working in adult social care to gain good basic care skills. These are designed to enable staff to demonstrate their understanding of how to provide high quality care and support; this is gained over several weeks. Staff confirmed that opportunities were given whereby they had shadowed a more experienced member of staff for several shifts before they were deemed competent to work on their own.

Members of staff told us they felt supported by the manager. However, records we looked at of formal 1:1 supervisions showed they were not being undertaken on a regular basis. We discussed this with the manager who assured us they would amend this. A member of staff told us, "We have regular team meetings and also have shift handovers where we update other staff about each person." Records we looked at confirmed this. Staff also told us the manager supported them in their professional development to promote and continually improve their support of people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager had made the appropriate referrals to professionals for assessment when people lacked capacity and needed constant supervision to keep them safe. This met the requirements of Deprivation of Liberty Safeguards (DOLs). People told us that they had a say in how they were supported and we saw people being offered choices. However, staff were not consistently able to demonstrate and explain their understanding of the Mental Capacity Act 2005 (MCA).

The home environment was not 'dementia friendly' for example; we did not see any pictures or sensory

objects or memorabilia for stimulating conversation and memory. There was some appropriate signage but there was no arrow signage thought-out the building or colour coding to help people living with dementia to be less confused or anxious. There was a small garden area with some plants but despite the morning part of the day being warm and sunny no one was encouraged or supported to go outside. The communal areas of the home were quite small for example, the dining room only seated twelve people, and some people sat in the lounge areas with a small table to eat their meals and although staff ate with people at mealtimes they had to stand up. We discussed this with the manager and they told us they were looking into new furnishings for the lounge and dining area to enable more people to sit at the tables if they chose to.

People had a choice of two meals for lunch and one person had fish and chips because they did not want either of the choice that were on offer. We observed that staff encouraged people to eat, and accepted people's decisions not to have anything if they chose not to. For example, one person had been sleeping and when asked did not feel like anything to eat at the present moment. Staff told us this person had eaten a large breakfast therefore they probably were not hungry at the moment and would be offered something later. The dining room during the lunchtime period had a relaxed atmosphere and none of the staff rushed or hurried people. People told us, "The food is excellent I am never hungry or thirsty." One relative told us, "[Relative] obviously likes the food they have put on weight since they moved in which is great."

We did not observe the use of 'show plates' these are used when people need a visual prompt to understand the choice of food they are being offered. Pictures or 'show plates' enable people to make an informed choice. We discussed this with the chef who told us they were in the process of sourcing some new pictures. The manager told us they would also start to use 'show plates' to help people make a choice.

The chef told us they have details of any nutritional needs for people. We were told that there were no individuals with allergies but there was support for people with diabetes.

The service had appropriately assessed people's nutritional needs and the Malnutrition Universal Screening Tool (MUST) had been used to identify anyone who needed additional support with their diet. Support from Speech and Language Therapist (SALT) had been sought where a risk of malnutrition had been identified as well as swallowing difficulties. Staff had received some guidance within support plans and associated risk assessments in supporting people identified to be at risk but although these had been reviewed they needed updating with relevant current information.

People's day to day health needs were being met and they had access to healthcare professionals according to their specific needs. People told us that staff took appropriate action to contact health care professionals when it was needed. One relative told us, "They get the GP out if necessary." We saw in people's records details of appointments.

Good

Is the service caring?

Our findings

People were generally happy with their care and told us that staff were caring. One person told that, "The girls are lovely they are like my friends", and "It is very nice here and the people are kind."

Staff interactions with people were considerate and the atmosphere within the service was welcoming, relaxed and calm. Staff demonstrated affection, warmth and compassion, for the people they were supporting. For example, people made eye contact by kneeling or sitting next to them and listened to what people were saying, and responded accordingly. People were not rushed and they were given time to respond to a question. We observed staff being tactile and placing an arm around someone and holding another person's hand when talking to them. People were comfortable with staff interactions.

We looked at six people's care plans and saw that they contained some information about people's likes and dislikes and their personal history but they did not consistently give enough detailed information for staff to have the tools to open up a discussion with people or to know at a glance what people's preferences were. We discussed our findings with the manager who informed us they would review the care plans. Staff understood people's care needs and the things that were important to them in their lives because they had worked with them for a long time, for example members of their family, key events and their individual preferences.

People were encouraged to make day to day choices, and their independence was promoted and encouraged where appropriate according to their abilities. We saw that staff knocked on bathroom doors and waited for a response before entering, this showed us that people were treated with respect. We observed people being spoken to discreetly about personal care issues so as not to cause any embarrassment.

People and their relatives were actively involved in making decisions about their care and their independence was promoted. One person told us, "I get up early and I go to bed anytime when I am tired, I definitely have enough independence. When I go to the bathroom they come and check on me. I choose my own clothes and they help me to dress." One relative told us, "The manager was very good at doing the initial assessment and asking me for information to put in the care plan."

Care plans described how people wanted to be supported during the end stages of their life and their wishes were recorded. Where people had made a decision about resuscitation a completed 'Do Not Attempt Resuscitation' (DNAR) directive was in place. Where possible people had been involved in their care plan and when this had not been possible a family member had been consulted about the care their relative needed.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf visited at any time. Relatives confirmed this and told us they were able to visit their relative whenever they wanted and at a time of their choosing. One person said, "I come every day just pop in to say hello never a problem."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were involved in planning and reviewing their care needs. People were supported as individuals, including looking after their social interests and well-being. Relatives told us they were invited to a review every three months.

Before people came to live at the service the manager carried out a detailed assessment. Following this initial assessment, care plans were developed detailing the care, treatment and support needed for staff to provide support to people. Care plans were informative and contained some information about how best to support people. However, they did not contain enough detail to ensure people had adequate personalised care. For example, one care plan said a person would like a bath and would need support but did not go into detail on what that support should look like.

The service employed an activities co-ordinator to support people with social activities and hobbies. However, this person had no training in supporting people living with dementia and therefore although the activities offered outside the home were very good the activities in the home were limited and did always offer stimulation to people living with dementia.

A range of activities took place outside of the home and people told us they enjoyed going out comments included, "We went to the seaside yesterday and last week we went to the aquarium." The service had a face book page and it evidenced trips out for example, we saw people had visited a garden centre, zoo, and sea life centre. Relatives told us, "They have regular outings, schools visit and the local church does a service here." Staff told us, "We took some people fruit picking then made cakes and jam with the fruit and we went to the garden centre and bought some plants and planted them with those that were interested in gardening." The service had an 'American themed' party arranged and had bought decorations and dressing up clothes for people to wear if they chose to. The manager and staff spoke enthusiastically to people about this forthcoming event.

The vicar visited on a weekly basis and carried out a service for people wanting to take part.

People told us they had no complaints but would talk to the manager if they needed to. People's comments included, "I have no complaints but if I did I would go to the manager", and "I would tell the staff if I wasn't happy with something straight away." We saw in people's rooms they had details of how to complain in easy read format.
People told us that if they raised a minor issue it was always dealt with straight away. For example, one person lost their hearing aid and glasses, they had been accidently taken by another person living in the service they told they staff and they were found and returned straight away.

Staff told us they were aware of the complaints procedure and knew how to respond to people's complaints.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us that they felt the home was managed well and were complimentary about the manager. The manager was a visible presence in the home and on our arrival was helping out in the kitchen because of the cook being on annual leave. The manager told us their priority was to the people living in the home and ensuring things run smoothly despite staff being on annual leave and to lead by example.

The manager was enthusiastic about their role and spoke passionately about their vision and what they were trying to achieve at Hatfield Haven. At the time of our inspection they had only been in the management position for a few months and were in the process of becoming registered. We observed the manager interacting with people in a positive caring way. Staff told us they were a visible presence and supported them on shift if the need arose.

We saw minutes of recent staff meetings where the manager had set out their expectation regarding the care they wished to see delivered. However, although staff had queried the level of staffing on occasions and made suggestions in the meeting, the minutes did not reflect any action that had been taken to answer their question. We discussed this with the manager who informed us that although they had not put an action on the minutes they had spoken to the provider about the staff suggestion and in future would include this within the minutes of the meeting.

Staff we spoke with were clear as to their responsibilities and told us that they felt supported. One member of staff told us, "I love it here; it has a homely atmosphere and is small" and, "If I say I need new equipment, they are good and I get it, I feel fully supported by the manager she is coping fine she hasn't been doing the job long."
Staff training had been provided but there had been no staff competencies assessments carried out. Therefore the manager could not be confident that staff had the necessary skills to carry out their job role. We witnessed staff supporting a person with manual handling and they did not appear to be confident.

Actions were taken to learn from accidents and incidents. These were monitored and analysed to check if there were any emerging trends or patterns which could be addressed to reduce the likelihood of reoccurrence. Healthcare professionals told us that they had a good relationship with the manager and that communication between both parties was very good.

The manager carried out some audits to monitor quality within the service. However we did not feel that these were robust enough. For example, medication audits had not been carried out for some time and we did not see any audits about the quality of the care that was provided to people.

Relatives told us they would like to have the chance of meeting with the manager on a regular basis at a 'relatives' meeting as sometimes when they visited the manager was busy and they were unable to speak to them. However, we were told that if they had a complaint and spoke to the manager they were happy with the process and kept fully informed of the outcome.