# Inspection Report

***We are the regulator:*** *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

# The Hawthorns

29 Rotton Park Road, Edgbaston, Birmingham, B16 9JH

Tel: 01214559024

Date of Inspection: 04 November 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

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|---|---|
| **Care and welfare of people who use services** | ✓ Met this standard |
| **Cooperating with other providers** | ✓ Met this standard |
| **Safety, availability and suitability of equipment** | ✓ Met this standard |
| **Staffing** | ✓ Met this standard |
| **Assessing and monitoring the quality of service provision** | ✓ Met this standard |

## Details about this location

| | |
|---|---|
| Registered Provider | Mr John Holcroft Jnr |
| Registered Manager | Mrs. Linda Smith |
| Overview of the service | The Hawthorns is a 22 bedded residential home. The service caters for elderly people requiring more support that can be offered within the community. |
| Type of service | Care home service without nursing |
| Regulated activity | Accommodation for persons who require nursing or personal care |

# Contents

*When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.*

## Summary of this inspection

### Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

### How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 November 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

### What people told us and what we found

On the day of our inspection we saw there were 20 people living at The Hawthorns. We spoke with five members of staff, three people who used the service and four relatives. We looked at policies and processes, three care records and three staff records, to gain an insight into the care provided.

We saw that people were involved in decisions about their care. Care plans and risk assessments were in place and were updated regularly to ensure people received the care they needed.

We saw that staff co-operated effectively with external health providers to ensure people who lived at The Hawthorns received co-ordinated care.

We saw that the equipment used was maintained regularly. This was to ensure people who lived at The Hawthorns were safe.

There were adequate numbers of staff on duty and staff received appropriate support and training to enable them to care for the people who lived at the service. Staff told us they really liked working there and that the provider was very supportive. One person told us, "The staff are lovely and help me if I need it."

People experienced good quality care and effective systems for monitoring were in place. There was evidence that people and their families knew how to complain if things were not right. There were a variety of activities designed to meet people's needs and maintain their independence. People told us they liked living at The Hawthorns. One person told us, "They (the staff) always ask me what I want."

You can see our judgements on the front page of this report.

## More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

## Our judgements for each standard inspected

**Care and welfare of people who use services** ✓ Met this standard

**People should get safe and appropriate care that meets their needs and supports their rights**

### Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

### Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at three people's care records and saw that care plans had been carried out and used to inform the care plans. We saw that pre-assessments were carried out in preparation for moving to The Hawthorns. The assessments contained details about the person and their wishes. These helped staff to understand their needs. We saw that families had been involved in providing information to support the person moving into the service. We saw that once a person moved to The Hawthorns care plans were reviewed regularly and staff were informed of any changes. There was also evidence of advanced care planning which helped staff to meet people's needs as their needs and abilities changed. This meant that people experienced care that was relevant to their needs.

Care and treatment was planned and delivered in a way that minimised risks to people's safety and welfare. The care plans we looked at showed that risk assessments for people's mobility, emotional wellbeing and health needs were completed. Risk assessments were in place for use of the four stair lifts within the home to ensure people could access the upper floors in safety. The risk assessments were reviewed annually or more frequently when the person's needs or abilities changed. This meant that systems were in place to minimise risk and keep people safe.

Staff we spoke with showed a good knowledge of the people who lived at the service and were able to give examples of care that had changed. They told us one person was at increased risk of developing pressure sores. Risk assessments had been reviewed to monitor their skin and specialist advice implemented appropriately to prevent pressure sores developing. We saw that risks, such as weight loss and poor appetite, were documented in people's care records. Appropriate action was taken to minimise the risks to people, such as changing their diet and monitoring their weight. This meant that people received care on a daily basis that was relevant to their needs and kept them safe.

Care was also planned to meet people's social needs. The manager told us about a recent activity where staff took a person who lived at the service to a local international food festival so they could experience food linked to their culture. There were pictures around The Hawthorns of staff and people who lived there taking part in various activities. There were pictures of a trip to the Botanical Gardens and activities based on public events such as Wimbledon. Both staff and people we spoke with told us the activities were very varied and were a positive experience for people living at The Hawthorns. People we spoke with said they enjoyed the activities provided. One person told us, "I like to go out shopping." Another told us, "I can go out whenever I want." This meant that people were supported to live in a way that enhanced their sense of wellbeing.

The service used expert advice to meet people's care and welfare needs. We saw evidence in the care records that regular GP visits took place and people received flu vaccinations appropriately. We saw that appointments with chiropody, dental and ophthalmic services were recorded and specialist services such as occupational therapy were used when needed. This meant that people's health needs were monitored and managed as required.

There were arrangements in place to deal with foreseeable emergencies, such as staff cover in the event of staff sickness, or if adverse weather hindered travel. We saw that The Hawthorns had a call system with a wireless call-bell in each person's room and at certain points around the service. We witnessed that when people called for assistance, staff responded appropriately. This meant that people who lived there could call when they needed assistance or help in an emergency.

We saw that there was an emergency and crisis recovery plan in place, in the event that The Hawthorns needed evacuation as a result of flooding or fire. There were details in the office regarding people's evacuation needs. There were business continuity arrangements in place to back up IT systems and to deal with failed utilities. This meant that people who used the service could be cared for and kept safe in the event of an emergency.

**Cooperating with other providers** ✓ Met this standard

**People should get safe and coordinated care when they move between different services**

## Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

## Reasons for our judgement

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

On the day of inspection we spoke with two health and social care professionals. Both had been involved with the home for some time. They told us that The Hawthorns was quick to contact them when a person who used the service health needs had changed. They told us that referrals from the service were appropriate and that changes to care or additional medication were implemented quickly. This meant that staff co-operated effectively with others to ensure people who lived at The Hawthorns received co-ordinated care.

The manager told us that a health professional visits the service every two weeks so that changes in medication or care can be reviewed. We saw evidence in the records we looked at that blood tests had been taken and medication for infections commenced. This meant that people's urgent health needs were managed as required.

The service ensured information was shared appropriately when people moved between providers. The three care records we looked at showed that emergency services were called appropriately when people fell or experienced pain. We saw that each set of records had an information pack that could accompany people to hospital with details of their medication and care needs. Staff we spoke to told us that staff would accompany residents to hospital so that transfer of care could be co-ordinated. This meant that The Hawthorns worked with other services to respond to emergency situations.

In the three risk assessments we looked at we saw that requests for specialist intervention were made when required. For example a person who used the service had experienced an increase in falls and was referred to the occupational therapist. The therapist suggested a change in walking equipment, which when provided had reduced the number of falls. This meant that the service supported people to access other health or social care support they needed.

**Safety, availability and suitability of equipment** ✓ Met this standard

**People should be safe from harm from unsafe or unsuitable equipment**

## Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

## Reasons for our judgement

People were protected from unsafe or unsuitable equipment because the provider had maintenance and checking procedures in place. In the maintenance records we looked at we saw that the two hoists in the home and the four stair lifts were checked twice yearly by a maintenance service. We saw staff aided people to use the stair lifts to gain access to their bedrooms on the upper floors. The manager informed us the hoists were not currently used for any of the people living at the home but staff still received training as part of moving and handling. We saw that staff had completed this training in September 2013. This meant that the provider had systems in place to ensure equipment was used safely.

Equipment was available to help people meet their personal care needs. There were a variety of styles of bath and shower rooms. The shower room and one bath had opening sides so that people could use the bath or shower easily. One bath had a seat device which could be raised and lowered to lift a person in and out of the bath. Another bath was low to the floor so that people who were more independent could step in or out. This meant there was appropriate equipment to allow people who used the service, to bathe easily and maintain their independence.

In the three care records we looked at we saw that risk assessments for equipment were in place for people who used the service. For instance we saw that one person had been provided with a walking aid to aid their mobility. Another person had a wheelchair used for outings outside the home. During the inspection we observed that staff provided foot rests for people with swollen ankles and people had recliner chairs in their rooms. This meant there was enough equipment to promote the independence and comfort of people who use the service.

**Staffing** ✓ Met this standard

**There should be enough members of staff to keep people safe and meet their health and welfare needs**

## Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

## Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs. On the day of our inspection staff were caring for 20 people who lived at The Hawthorns. The manager told us that staff rotas were planned a month in advance so that staff knew when they were on duty. Staff we spoke with confirmed this. The manager told us that there were four staff on duty in the mornings, three staff to cover the afternoon and evenings and two staff on at night. We saw that call bells were answered promptly and there were staff available to help with activities and at mealtimes. This meant that staffing numbers were adequate to meet people's needs.

The provider may wish to note that on the rota's we looked at, we saw that some of the staff were on duty for six or seven days without a break. This increased the risk that staff could be too tired to maintain the quality of care provided.

Systems were in place to monitor and review people's needs so that effective staffing levels were maintained. In the three care records we looked at there were comprehensive care plans and risk assessments in place. People's individual levels of independence were noted and we saw that care plans and risk assessments were reviewed regularly to see if someone's needs had changed. The manager and staff we spoke with told us that most people living at the service required minimal assistance with care and that more staff were rostered to be on duty when there were additional duties such as hospital appointments. On the rota we looked at there were more staff on duty on certain days, which confirmed what the manager had told us. This meant that staffing levels were adjusted to meet people's needs.

People were cared for by staff who were provided with an appropriate level of training and development in order to care for people who used the service. We spoke with five members of staff who told us that the provider was very supportive of training and that they were provided with relevant training to meet people's needs. We saw that staff received appropriate training to care for people who used the service such as, food hygiene, medication and health and safety. We also saw training linked directly to people's individual needs such as, training for diabetes and pressure area care. This meant that people were cared for by staff who were supported to deliver care to an appropriate standard.

**Assessing and monitoring the quality of service provision** ✓ Met this standard

**The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care**

## Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

## Reasons for our judgement

The provider took account of complaints and incidents to improve the service. We saw the provider's incident and complaint policies and two recent complaints with evidence that appropriate action had been taken. The manager told us that everyone received an information leaflet when they moved into The Hawthorns which contained details of the complaints process. There were comment cards at the front entrance that visitors could use if they wished. Relatives we spoke with told us they would complain if the need arose. One relative told us, "There is always someone available if needed". We spoke with three people who used the service and they told us they would speak with the manager if they were worried. This meant people who lived at The Hawthorns and their relatives knew how to complain if they were unhappy with the care provided.

There was evidence that learning from incidents or investigations took place and that appropriate changes were implemented. We saw records of incidents reported by staff, and the actions they had taken. The manager told us they reviewed incidents and complaints on a monthly basis to identify patterns and, where possible, minimise the risk of a reoccurrence. We saw records of these audits. We saw that the most common incident reported was falls. There was evidence that the manager had analysed the incidents to identify patterns and had taken appropriate actions to prevent a reoccurrence. For example, we read on one person's care records that, following a series of falls, action was taken to review risk factors, amend their medication and provide further support. We also saw evidence in the care records we looked at, that risk assessments were reviewed after incidents occurred.This meant that incidents were managed appropriately to minimise the risk of a reoccurrence in order to keep people safe.

The manager explained how they checked a national 'Central Alerting System' (CAS) for providers of health and social care. The CAS is a web-based cascading system that issues safety critical information and guidance to the NHS and others, including independent providers of health and social care. This includes patient safety alerts, important public health messages and other information. This meant that the provider used the most up to date information to minimise risks to people's health and wellbeing.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted upon. We saw that residents meetings were held monthly, chaired by a person who lived at the home and that written records were kept. The manager told us they arranged relatives' meetings on a regular basis, but attendance was poor. Relatives we spoke with said they were unable to attend the meetings so the manager sent them copies of the minutes and took account of suggestions they made. For instance, we saw that ideas for activities and changes to the menu were put in place. Also, that the service had developed an email and skype account to help people who lived at The Hawthorns keep in touch with family and friends. This meant that people who used the service and their families could suggest improvements or changes to the services provided.

We saw that staff meetings took place approximately every month. Staff told us they used the meetings to discuss changes for people that lived at the home, needs of new people moving into the home and ideas for training and activities. Quality issues, such as audits and assessments were discussed and training sessions were delivered. This meant that staff were supported to suggest changes to benefit people that used the service.

Arrangements were in place to monitor and assess the quality of the service provided. We saw records of monthly audits for 2013, which included audits of incidents, care plans and equipment in the home. We saw the annual pharmacy audits for medication which showed that medication had been given as directed and there were no concerns. We saw a fire safety folder, which recorded dates of audits and fire drills that had taken place, as well as checks of fire-fighting equipment. This meant that the provider had systems and processes in place to manage potential hazards within the home.  We saw a quarterly audits completed by the local authority that looked at the quality of services provided for the people living at the home. This meant that the provider used a variety of methods to assess and monitor the quality of the service.

## About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

| | |
|---|---|
| ✓ **Met this standard** | This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made. |
| ✖ **Action needed** | This means that the standard was not being met in that the provider was non-compliant with the regulation.<br>We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete. |
| ✖ **Enforcement action taken** | If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people. |

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact -** people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact -** people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact -** people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

## Glossary of terms we use in this report

### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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| Respecting and involving people who use services - Outcome 1 (Regulation 17) |
| Consent to care and treatment - Outcome 2 (Regulation 18) |
| Care and welfare of people who use services - Outcome 4 (Regulation 9) |
| Meeting Nutritional Needs - Outcome 5 (Regulation 14) |
| Cooperating with other providers - Outcome 6 (Regulation 24) |
| Safeguarding people who use services from abuse - Outcome 7 (Regulation 11) |
| Cleanliness and infection control - Outcome 8 (Regulation 12) |
| Management of medicines - Outcome 9 (Regulation 13) |
| Safety and suitability of premises - Outcome 10 (Regulation 15) |
| Safety, availability and suitability of equipment - Outcome 11 (Regulation 16) |
| Requirements relating to workers - Outcome 12 (Regulation 21) |
| Staffing - Outcome 13 (Regulation 22) |
| Supporting Staff - Outcome 14 (Regulation 23) |
| Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10) |
| Complaints - Outcome 17 (Regulation 19) |
| Records - Outcome 21 (Regulation 20) |

### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

## Glossary of terms we use in this report (continued)

**(Registered) Provider**

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

**Regulations**

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

**Responsive inspection**

This is carried out at any time in relation to identified concerns.

**Routine inspection**

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

**Themed inspection**

This is targeted to look at specific standards, sectors or types of care.

## Contact us

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|---|---|
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