Inspection Report

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

Hazeldene House

Romford Road, Pembury, Tunbridge Wells, TN2 4AY

Tel: 01892823018

Date of Inspection: 04 March 2014

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

Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Hazeldene House Ltd
Registered Manager	Ms Lorraine Cousins
Overview of the service	Hazeldene House is registered to provide residential and nursing care for up to 30 people.
Type of services	Community health care services - Nurses Agency only Care home service with nursing Care home service without nursing Domiciliary care service Supported living service
Regulated activities	Accommodation for persons who require nursing or personal care Nursing care Personal care Treatment of disease, disorder or injury

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 inspection was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people's experiences of moving between care homes and hospital.

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 March 2014, 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, talked with staff and received feedback from people using comment cards.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

At the time of the inspection there were sixty two people using the service all of whom had a diagnosis of dementia at varying stages.

We spoke with 18 people that used the service and three visitors to the service. We also received six completed comment cards. People told us they were happy with the care provided and felt that their needs were met. We found that people had their needs fully assessed and planned for and they were involved in the planning of their care. Staff knew people well and knew how to meet their needs. We saw that staff provided the care people's plans said they needed and did so in a way that promoted their independence and rights. One person using the service told us "This is a lovely home, I have no complaints". We saw that staff were responsive to people's needs and people were treated with dignity and respect.

we found that the service worked effectively with other health and social care providers to ensure that people's needs were met. People were supported to access the services they needed.

The provider had effective systems in place for monitoring the quality of the service provided to people with dementia. Risks were assessed and managed and people's views were taken into account in the ongoing improvement of the service.

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.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

How are the needs of people with dementia assessed?

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People told us that they had an assessment of their needs before they moved to the service. A relative told us "we were involved in the assessment and the manager asked lots of questions about X and the care they needed". We saw that people had a detailed assessment of their needs included in their care plan file. This included their physical health needs, their emotional needs, mental health needs and their social needs. The assessments took into account how people's diagnosis of dementia affected them in their daily lives and whether they displayed any behaviours that may be challenging or require additional support.

People's experience of pain was assessed to establish how they expressed when they were in pain and if they required any pain relief. Where people were not able to verbally express pain we saw that nursing staff had used pain assessment tools to identify if they were experiencing pain. These had been completed daily until the cause of the pain was identified and managed.

We saw that people's written assessments included information about their life history. We saw examples that showed that staff knew people well and understood the importance of their life history in the support of the person. For example we heard a staff member talking with a person about their previous occupation as a nurse and their experience of the role. The assessment process also asked people about their preferences of social activities, for example whether they wished to join in group activities or have some 1-1 time allocated to them.

Each person had a very detailed life history book that had been developed with them when they moved to the service. Staff explained that the family were asked to help people fill in questionnaires about their lives and backgrounds and we saw examples of completed questionnaires. We looked at the life history books for three people and saw that they

included a scrap book of photographs of the person from their younger years, photos of family members and of significant events. These were all dated to help staff use them with people in conversation. The life history books included information about important events in the person's life, for example their wedding day or the birth of their children. Records in people's care plan files showed that they had been involved in developing the books as part of an ongoing project and that they were used in discussion with them regularly by staff.

How is the care of people with dementia planned?

The environment of the service had been planned with the needs of people with dementia in mind. The corridors and shared spaces were large with plenty of light. There was clear signage around the service to help people find their way around and interesting pictures of the local area to promote conversation.

People's individual care was planned based on the outcome of the assessment of their needs. We looked at four people's plans and saw that they reflected the needs identified in the assessment, for example a person who required specific support at night had a care plan in place for this. People's care plans showed that they had been written by their allocated member of the nursing team and that the person's keyworker (their allocated care worker), the person themselves and their relative had contributed their views.

The plans were clear and easy for staff to follow. They stated the objective, for example to support a person if they became distressed, and detailed how this should be done to ensure a consistent approach, for example providing comfort and using discussion about a family member to calm them. The plans had been reviewed each month and we saw that changes were incorporated into the plans. Staff we spoke with told us that they were informed about changes to people's plans at the daily shift handover and were required to read the updated version.

Are people with dementia Involved in making decisions about their care?

We saw that, where people were able to, they had signed their care plan to show that they had been involved and agreed with the plan. If they were not able to sign their relative or appointed person had signed on their behalf. People's plans showed that they had been asked their views about their care, for example their preference of night time routine had been recorded. The way people preferred to be addressed had been agreed and recorded.

People told us that they were able to make choices about their everyday lives and routines, for example when to get up, what to eat and how to spend their time. During the inspection we saw people being offered a choice of where to eat their meal and what activities they wished to participate in. Staff respected their decisions.

Where people required additional support to make day to day decisions staff provided information in alternative ways, for example we saw that some people were offered a choice of meals by being shown the actual dish available rather than being offered a choice verbally or by picture. This helped them to make an informed choice. Where people were unable to make decisions about their care or treatment the service followed the appropriate procedures to ensure assessments were carried out under the Mental Capacity Act and decisions made on their behalf that were in their best interests.

Some people had made advance decisions about their future care, for example how they wished to be cared for at the end of their life. These had been recorded in the care plan and staff had been made aware. Some people had 'Do not resuscitate' orders in place. These had been signed by the person themselves or their appointed power of attorney and had been counter signed by the person's GP and/or mental health professional involved in their care.

Are people with dementia provided with information about their care?

People were provided with an information brochure about the service when they moved to the home. This gave them information about the range of services available to them and the type and standard of care they should expect to receive. The brochure included details of the complaints procedure for the service.

The manager of the service ran a two monthly dementia support group in the service for people and their relatives to attend. This was also open to members of the public. The support group provided people with an opportunity to discuss fears and questions about dementia and how to access further support for relatives who may have been diagnosed with dementia. The manager arranged for professionals to visit the group and provide information, for example there had been a recent session on communication for people with dementia provided by a speech and language therapist.

Records showed that people were given information about the care they were being provided with along with any risks. We saw that one person was required to wear a piece of surgical equipment and was at risk of harm if this was not worn. The risks had been clearly explained to the person so that they understood the need to use the equipment. This was recorded in their care plan.

How is care delivered to people with dementia?

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Staff were assigned to a regular team on each floor of the service to provide continuity of care to people. There was some movement of staff between floors to ensure they knew the needs of other people using the service should they be required to work with them.

We spoke with staff about care they were providing to people. Staff understood what was written in people's care plans and how to provide the care. We saw that staff knew people well and knew about their family life and life history. We saw that staff provided the care that was written in people's plans, for example providing people with the equipment they needed to move safely around the service and ensuring that people had the personal items they needed such as glasses and hearing aids. Staff were able to describe people's current needs, for example they knew what hospital clinics a person had recently attended and what the next steps were in relation to their health needs.

We saw that staff were responsive to people's needs, for example they immediately noticed when a person attempted to stand without their walking frame and they went quickly to their assistance. People told us that they liked the staff and that there were enough staff available to meet their needs. One person told us "There are always staff around, you don't have to wait long".

People's care and treatment reflected relevant research and guidance. We saw that

people's care plans contained information for staff about how to respond to the symptoms of their dementia such as confusion about time and reality. This reflected current recommended practice. we saw that staff were patient when asking people questions and offering choices and gave them plenty of time to respond. We saw one person was upset and a care staff was providing comfort. The person wanted to speak to their relative on the phone and the care staff made frequent attempts to call the relative and kept the person informed until they were able to reach the relative. Staff were able to describe specific techniques they used to help people feel reassured if they became distressed. For example staff said that they sang to one person during personal care and this helped the person to remain calm. This was reflected in the person's care plan.

We saw that people were provided with the support they needed to eat their meals. Some staff sat at the table eating lunch with people which they said encouraged them to eat more. The provider might like to note that we found that people were seated at the table approximately half an hour before their meal was served. Several people were heard to frequently ask where their meal was.

We found that there was a varied programme of social activities for people to choose from. Two social care coordinators were employed full time and a third was being appointed to allow one staff to be allocated to each floor. The social care coordinators were responsible for arranging group activities and outings and for assessing people's social needs when they moved to the home to find out what they enjoyed doing and what support they needed.

During the inspection we saw people joining in with a painting session and people were offered opportunity to go into the grounds for a walk before lunch. Staff told us that a group of people had been supported to visit the local museum in Tunbridge Wells the previous day, where they enjoyed looking at local history and talking about their memories of the past.

People had their religious and cultural needs identified in their care plan and those that wished to were supported to take holy communion weekly. Staff were aware of people's cultural needs, for example we saw staff from another country spending time talking with person who had family there about their last visit.

People were encouraged to be as independent as they could be. Each bedroom included a kitchenette to enable people to prepare their own drinks and snacks if they wished to. The service had a large day centre room downstairs that people could use to host meals for their family and friends if they wished to. We saw that people were free to move around the service as they wished to and could choose to spend time in their room or one of the shared areas.

Is the privacy and dignity of people with dementia respected?

People told us that the staff treated them well and with respect. One person commented "I have nothing but praise for the care provided. Good quality, passionate and respectful." Another person said "The staff are very kind and nice here". We saw that staff were patient in providing support to people. One person frequently asked the time and staff were heard to answer the person's question respectfully and in the same way each time. A relative visiting the service told us "I have only seen kindness and courtesy by the staff here and I am very happy with X's care. X always smiles when the staff come up and speak to [them]".

We saw that the privacy and dignity of people was respected, for example staff ensured that residents were moved from their chair to wheelchair in a dignified way. Those that required physical assistance to eat their meals were supported in a discreet manner.

The building provided people with their own bedrooms with their own front doors and letterboxes for their personal post. This gave people a sense of privacy and mirrored home life. All bedrooms had ensuite bathroom facilities for people's privacy and comfort.

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

How does the provider work with others when providing care to people with dementia?

The service worked closely with the local community mental health team. The manager told us that recently a number of people using the service had been diagnosed with dementia with Lewy Bodies, which presents similar symptoms to Parkinson's disease. We saw records that showed that referrals had been made to a Parkinson's nurse who had been visiting people to carry out further assessments and provide advice. The provider was in the process of working with the Local NHS trust to offer a unit of bedrooms in the service for use as rehabilitative placements for people with dementia requiring to be discharged from hospital, but not yet ready to go home.

We saw that people's care plans and records reflected the involvement of relevant health care professionals such as the community mental health team, GP and other specialists. Where advice had been given this had been incorporated into the care plan, for example advice about the use of surgical equipment. We saw that where a person's behaviour had changed recently a referral had been made to the community mental health team for further advice.

There had been no recent admissions to hospital from the care service. Staff knew what information to send with a person if they had to go into hospital. This included a profile of their health needs, communication needs and their current care plan. The manager told us that staff always accompanied people to hospital until their relatives could arrive and gave examples of where this had happened. We spoke with a relative of a person who had recently been admitted to the service from hospital. They told us that they had been given support from the hospital to find a residential placement and that the move to the home had been smooth because the staff had communicated well with the hospital and asked lots of questions about the person's needs.

Are people with dementia able to obtain appropriate health and social care support?

People told us that they were supported to see health professionals when they needed to,

for example their doctor or their dentist, and could arrange for routine check-ups. Records showed that staff were quick to recognise and respond to people's changing health needs and to seek advice from the person's doctor. A relative told us that "X's medical needs are seen to immediately".

Nursing staff were employed at the service and made regular assessments of people's health needs, such as blood pressure, skin condition and dietary needs to alert them to any changes. Where a person had required advice from a dietician this had been arranged on their behalf and the staff had recorded the advice that had been given within the care plan.

People were supported to access their care manager or social worker from their funding authority for advice and to invite them to attend meetings to review their care. Social care professionals were made available to people through the dementia support group meetings, for example to provide advice about available services and accessing funding.

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.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

How is the quality of dementia care monitored?

The manager of the service carried out regular checks of the quality of care provided by checking people's care plans were up to date and that the records showed that the correct care was being provided. The manager and senior staff carried out observations of staff practice to identify areas of improvement as part of the programme of staff supervisions. An independent consultant was used to complete a monthly audit of the quality of the service. This included producing an action plan for any improvements required. We saw that the manager met with the registered provider of the service to discuss the audit and action plan each month.

Records showed that staff undertook training in dementia care and managing behaviours that challenge. The manager also completed dementia awareness sessions with staff as part of their programme of induction. Staff told us that they found the training useful in their roles and gave examples of how it had helped change their practice. One care staff said "I understand now the importance of knowing about people's life history in providing their care".

We saw records that showed that the social coordinator regularly monitored people's levels of social engagement and identified any person appeared not be responding to what was provided so that alternatives could be offered. They provided collated information to the lead nurse for each person each month to demonstrate how people's social needs were being met.

How are the risks and benefits to people with dementia receiving care managed?

Decisions about care and treatment were made by the appropriate staff at the appropriate level. There was a nurse in charge of each floor of the service. Staff told us that they received a handover each day at the start of the shift where they were given an update on

people's well-being and the running of the shift was planned. Staff told us that they reported any concerns about people's well-being to the nurse in charge who would assess the person and decide if further medical advice was required.

There was evidence that learning from incidents took place and appropriate changes were implemented. We saw that there was an effective system in place for monitoring accidents and incidents in the service. The manager collated information about incidents to identify patterns and trends and to implement actions to reduce risks. Records showed that where a person had regularly fallen during the night they had been provided with a lowered bed and an alarm system to alert staff if they got up and required assistance. People who used the service and their relatives felt that it was a safe place to be. One relative commented "I am glad X is in a safe environment".

Individual risks to people were identified at the assessment stage. This included the risk of poor nutrition, dehydration, pressure sores or behaviours that may challenge the service. The risk was assessed and steps agreed for staff to follow to reduce the risk. Risk assessments had been reviewed every month and updated as needed. New risks were identified when the care plan was reviewed each month or as they arose. Systems in place to monitor risks to individuals included keeping a record of their fluid intake, monitoring people's weight, repositioning people in their beds and armchairs and using equipment such as pressure relieving mattresses. We saw records that showed that staff completed these checks consistently and used the necessary equipment as described in people's care plans. The nurses checked the completion of monitoring charts for accuracy and any problems at the end of each shift.

Are the views of people with dementia taken into account?

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted upon. People told us that they felt listened to and could talk to the manager or any of the staff about their care and any concerns they had. One person told us "Any comments I have made have been listened to and acted upon".

The provider took account of complaints and comments to improve the service. The service had a clear complaints procedure that was displayed in the service and was issued to people as part of their welcome pack when they moved in. We saw that a record of complaints made about the service was maintained and where complaints had been made they had been responded to appropriately and timely feedback given to the complainant. There had been no recent complaints recorded.

Meetings were held with relatives and people using the service at regular intervals to share information with them and seek feedback. Questionnaires were sent out to relatives annually with the results collated and published and an action plan developed to make any improvements. We saw that staff had a good understanding of the communication needs of each person they were supporting and were regularly checking with them whether they were happy with their care throughout the day of our visit. The manager gave examples of how different members of staff were involved in discussions about the service with people and their relatives, for example the chef met with relatives to discuss matters relating to the menu.

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. 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. We monitor the implementation of action plans in these reports and, if necessary, take further action. 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:

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.

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