GCH (HATFIELD) LIMITED

Hatfield Nursing Home

Inspection report

Tamblin Way
Hatfield
Hertfordshire
AL10 9EZ

Tel: 01895257010

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hatfield Nursing Home is a residential care home providing personal and nursing care to up to 118 people. The service provides support to older people, some of whom were living with dementia. At the time of our inspection there were 52 people using the service.

Hatfield Nursing Home accommodates up to 118 people in one purpose-built building.

People's experience of using this service and what we found
There were monitoring processes in place to help ensure a good standard of service. Quality assurance systems identified any areas that needed further development and any remedial actions were implemented. However, the overview of some elements of safety such as repositioning, oxygen management, record keeping was not robust. Also seeking people's views on their experience in the home needed to be more robust to help ensure any themes and trends were identified and if any additional actions were needed.

There were a high number of skin integrity issues and there was an indication there was a lack of repositioning and swift continence care which contributed to this. Storage cupboards containing cleaning products were not always secure which put people, particularly those living with dementia, at risk. There were areas of the home which needed further cleaning. There was a refurbishment programme in place to help address the areas needing repair making them difficult to clean.

Individual risks were assessed, and staff were aware of these. Reviews of events and accidents were carried out and any actions needed were undertaken. Medicines were managed in accordance with the prescribers' instructions.

People gave mixed views about if they always felt safe and supported by the service. People did say at night some staff were not helpful and rude. Safeguarding processes in the home needed to be more robust. The management team were providing training for staff. Staff told us they knew how to report any concerns about a person's safety or welfare.

People and relatives told us most of the day staff were kind and caring, they were happy living at Hatfield Nursing Home. Interactions observed were positive, staff responded to people in a way that anticipated their needs and demonstrated they knew people well. All observations found staff to be attentive and caring about the people they supported. However, on the nursing unit, engagement between staff and people was limited and this needed further development.

People gave mixed views about if there enough staff to meet their needs. Relatives and staff also gave mixed views. Our observations showed that this varied depending on the unit. The management team told us they had changed the allocation of staff on the nursing unit since our visit. Staff received appropriate training for their role and people felt they had good knowledge and skills. Staff felt supported by the new management

team.

Staff enjoyed working at Hatfield Nursing Home and wanted to ensure people were happy and well cared for. Care plans included all information needed to support people safely and in accordance with their wishes and preferences. These were being reviewed.

People and staff told us that the manager was often around the home and meetings were held. The home was being managed by a member of the provider's management team. There was additional support by a regional management team. After purchasing the home, the management team told us there was a significant of work to do. They prioritised safety, which they feel has improved but acknowledged there was further work and they would now be developing the remaining areas.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection This service was registered with us on 27 September 2022 and this is the first inspection. The last rating for the service under the previous provider was good published on 17 November 2018.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to safeguarding people, safe care and treatment, dignity and management. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service is requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, caring and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

The provider implemented actions following our feedback to improve standards in the home. This included further checks, training and sharing lessons learned with staff.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hatfield Residential and Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safety and governance at this inspection.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Hatfield Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 3 inspectors.

Service and service type
Hatfield Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hatfield Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. However, a member of the provider's management team was in post and managing the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection Notice of inspection

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 9 people and 4 relatives about their experience of the care provided to their family members. We spoke with 11 members of staff including the manager, supporting manager, regional manager, care and ancillary staff.

We reviewed a range of records. This included 8 people's care records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

● People gave mixed views about if they felt safe. Five people told us that at night, staff were rude and at times refused to support them or did not respond to their calls. One person said, "[Staff member] would not help me to go to the toilet. They were so rude (described staff member folding arms across their chest and waiting until they struggled to get to the toilet, then asked if they can go). They came in again (supper time) and I asked again to go to the toilet, but they didn't help me. I reported to the nurse and they said they knew who I was complaining about and I am not the only one." Another person said, "In the middle of the night is horrible here, I cannot sleep. It's a nightmare. They bang doors all night and they (staff) are horrible." People told us that staff during the day made them feel safe.

● A relative who visited often said they had not seen anything that gave them cause for concern. However, another relative told us, "I have witnessed carers shouting at other, more challenging residents and sighing impatiently at them."

● We raised a concern regarding a staff member's approach to a person which was reported to us during our visit. We shared this with the management team. While they reported back to the agency about the staff member, no safeguarding referral was made by the provider to ensure the issue and staff member was investigated.

●There had been recent safeguarding concerns raised at the home. While training and guidance had been provided, people were still experiencing the negative approach of some staff.

Due to the lack of ability to recognise and report safeguarding concerns, this was a breach of regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff had received training in relation to safeguarding people from abuse and were able to tell us what abuse may look like and what they would do in response to concerns.

Assessing risk, safety monitoring and management

● People had their individual risks assessed and staff were familiar with these. They told us they felt most staff supported them safely. However, a relative said, "I feel confident some of the care workers provide safety for my relative, there are a few longstanding carers that I trust. Other carers do not seem to have the best interests of my relative at heart. I have visited after personal care has been carried out, requiring rearranging of the room, and my relative's emergency call bell has been left out of their reach."

● Some people told us their call bells were not in reach and they needed to shout for assistance until

someone came, this was normally at night. We asked the management team to review if there were gaps in records for some people's rooms.

● We found that where people were assessed as needing to be repositioned, this did not always happen. For example, we observed 2 people who needed 2 hourly positioning during the day to promote their skin integrity. During our observation period of 4 hours, they remained in the same position. One person's records had been updated inaccurately stating they had been positioned, the other had no record of positioning.

● From December to present 12 different people had been recorded with some type of wounds. The types of wounds included skin tears, moisture lesions, rashes, and category 1-2 pressure ulcers, inflammation and blanching on skin. On reviewing repositioning charts there were frequent gaps in positions being recorded. Staff were logged as giving care but no entry about the position was recorded. This indicated the care was not given and did not ensure staff knew which position the person should be in next.

● At times continence care was missed. People told us at night sometimes staff did not assist them which meant they were in soiled pads or bedding. On the morning of the visit a staff member told us they were assisting a person who it appeared had not received the continence care they required through the night and they were reporting this to their manager. We checked with the manager at the end of the inspection visit. They were not aware of the concern. The person who needed the support told us the night staff did not return to them as requested.

● People used oxygen and oxygen in use signage was in place. One person used an oxygenator (a machine that produces oxygen instead of using a cylinder) and this was kept in the corridor as the person did not like the noise. However, the risk assessment for this did not include how staff ensured it was not tampered with by others, did not include fire safety consideration as this was opposite a fire exit. In addition, it did not include that the avoidance of flammable products such as aerosols, emollient and alcohol gels should be maintained. The use of oxygen was also not included on the fire risk assessment

● On the unit supporting people living with dementia, there were cleaning products stored in an unlocked store cupboard. This placed people at risk of harm should they ingest them.

● Following our visit, automatic locking systems were installed to the storage areas.

Using medicines safely

● People's medicines were mainly managed safely, and people received them in accordance with the provider's instructions. However, we did observe one instance where they had not been. For example, one person who was to be supervised when swallowing tablets, was seen to spit out tablets and hand them to another person. We needed to intervene to ensure the person did not take them.

Due to safety not being consistently promoted, this was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Medicines audits were carried out and these identified any areas needing action.

● People had individual risks assessed and they told us they felt most staff supported them safely.

● Staff were able to tell us about people's individual risks and how they helped reduce these. For example, falls and how to manage these. Care plans were detailed to offer guidance. There were plans for managing behaviours that may challenge detailing triggers and strategies to support people in these scenarios.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment

● People gave mixed views about if there were enough staff to meet people's needs. One person said, "They don't have enough staff. My bath days are [named days]. Last week they had to move them to different days I think because they were too busy and not enough staff." One person said, "If I ring my bell, I usually wait for 10 minutes sometimes longer if staff are having their breaks or feeding someone."

● A relative told us, "Staff are lovely but so busy. If night staff get [person] up they have no dentures, no socks and they're not shaved."

● We reviewed the call bell logs and found they were typically answered in 5 minutes or less. This included during the night. There were times when the bell rang for longer. We asked the manager about this who told us, "The acceptable time to answer bells is 4 minutes. We run reports monthly and discuss them with the team as part of staff meetings, if the team consistently took over 4 minutes to answer the bells, we would then move on to completing supervisions with staff/performance management and discuss lessons learnt. As part of our daily walkaround and bi-monthly night visits we spot check this, recently we haven't identified this as an issue at Hatfield Nursing Home."

● On the unit that typically provided nursing care, we found staff were not visible on the corridors other than when they prepared their trolley between going between people. Staff members were working in a task orientated way going from room to room.

● Staff gave mixed views about staffing levels. A staff member told us, "No, we don't have enough staff." Another staff member said, "Staffing, could do with another (staff member) but they (management) say it's enough on here." A third staff member said, "Staffing is ok."

● Work had been ongoing to recruit permanent staff and the agency staff usage had reduced. They felt this had made improvements. There was ongoing monitoring to assess the suitability of staffing. Following our visit, the management team told us that they have reviewed and amended staffing allocation on the nursing care unit.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely. However, while the guidance had changed and the staff were no longer required to wear masks, the provider policy was to wear masks. We noted several staff not wearing their masks correctly. Following the inspection visit the provider informed us they were reviewing their policy and staff no longer needed to wear masks, unless in an outbreak, or it was the staff member's or people's choice for them to wear one.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. However, there were some areas of the home that needed deep cleaning, for example, chairs, carpets and overlap tables, and some woodwork that needed to be repainted to enable effective cleaning. A relative told us cleanliness in the environment could be improved as an ongoing issue. They showed us their

family member's carpet which had food debris. The management team informed us that there had been a need for significant cleaning and refurbishing since they purchased the home and there was ongoing work to address these areas.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● People told us that their family and friends could visit freely. We saw visitors in the home on the day of our visit.

Learning lessons when things go wrong

● The management team shared findings from audits, complaints and events with staff to help ensure there was learning from them.

● The management team were providing training as part of their learning from recent events.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us in most cases they were treated well. One person said, "Staff are nice but busy, sometimes people wait. Care is good, feel I am treated well, respected." A relative told us, "No concerns, quite happy. Staff are lovely, know [person] well, they answer all my questions." However, most people we spoke with told us at times, mainly at night, this needed to be improved. One person said, "Staff here are nice with the exception of one." Another person said, "Some staff lovely, some are great. Some are rude, tell you off like you're 5 if you press bell." A relative told us, "I have witnessed very rushed personal care, tea and snacks being brought into the room and put down on the table without a word spoken to my relative."
- We observed staff supporting people in a kind and attentive way. For example, one person had painful feet and a staff member set about finding ways to relieve this and staff were seen to hold people's hands or put their arm around someone.
- A person whose first language was not English was trying to communicate with staff. One staff member had been learning key phrases in the person's first language. A member of the management team told us there was a pictorial communication booklet for staff use. Staff did not use the booklet, nor were they aware of the booklet, which was only found after a search in the office.
- However, on the unit mainly supporting people who were cared for in bed, staff were busy and there was a lack of engagement between people and staff. For example, we asked staff to support a person in bed who told us they were uncomfortable. Staff went in the room and it was total silence and a staff member who supported a person to eat in the dining room with little interaction other than from time to time asking if the person wanted a drink. No other interaction or keeping the person interested was attempted and the person only ate half of their meal.
- We spoke with the management team about this feedback and the observations. They told us they were working with staff providing mentorship and showing staff what was expected. They told us this had started to improve. A breakfast club had been started, people across units could meet on one unit to spend time chatting with different people and staff were engaging better.

Respecting and promoting people's privacy, dignity and independence

- We noted staff closed doors when supporting people with personal care. However, we also noted that all bedroom doors were open the rest of the time and some people were seen in a state of undress. The management team told us the care plans were a work in progress, but their aim was to ensure they included the level of detail about preferences such as if people wanted their doors open.
- Some people told us they didn't like it when other people wandered into their rooms. One person said, "I

feel safe except when [other person living at the home] comes in my room. I woke up the other night and they were in my room staring at me." We asked the management team to speak with people about how they could prevent this. The management team told us they had implemented gates on people's doors where this was requested.

● We observed a person who walked in and out of people's rooms. We queried this with a staff member who told us it was okay as the person who lived in the room was in the lounge. This approach did not respect people's private spaces and belongings. We were aware there were instances of people's belongings going missing. We also noted that all bedroom doors were open even though people were not in their rooms.

● Not all doors had names or memory boxes completed to help orientate people to their correct rooms.

● We also noted at lunchtime, people were in the lounge with the TV on. A staff member walked into the room and said, "Turn the TV off, it's lunchtime." People were not asked if it was ok or if it was their preference to leave the lounge for their meal.

Supporting people to express their views and be involved in making decisions about their care

● People were not sure if they had been involved in decisions about their care. One person said, "I am involved in my care planning and I was asked to interview a carer to know what a carer needs to be like,"

● A project manager was in the process of updating care plans. They told us this included speaking with people about their care. However, there was not yet a facility on the electronic plans to record that people had taken part.

● A relative had recently had a care plan sent to them to review but said it identified their family member by the wrong gender in several places, included information not relevant and the author appeared not to know their family member well. The management team told us care plans were in a poor state when they purchased the home and they were continuing to improve them.

● We observed staff asking people before supporting them and listening to what they had to say.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- People gave mixed views about their experience at the home. Most people told us during the day they felt well cared for but at night it was a different experience. We shared this with the management team who were not aware of the widespread concerns from people about nights, even though there had been some safeguarding concerns raised.
- There had been monthly audits of key areas such as medicines and care plans. A management team were in post to carry these out and complete the actions.
- However, these checks had not identified or resolved the issues we found as part of this inspection. For example, the inability to consistently recognise safeguarding concerns, injuries not robustly recorded, poor management of safety in relation to oxygen and cleaning products, gaps in recording and repositioning, and people's experience, particularly at night. Also there needed to be more focus on promoting people's privacy and dignity and ensure everyone was treated with respect.

The oversight and management of the areas identified had not been robust. Therefore, this was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- The management team were providing training and guidance to help ensure staff had the correct skills and knowledge to provide person centred care.
- Staff told us that the management team were making progress and they were enjoying the support and training being provided. One staff member said, "I'm enjoying the training, things are better here now, these guys (people living at the home) are happy. [Interim manager] is nice, they all are, [project manager] too." We asked staff if they would have a relative of theirs living at the home. One staff member said, "Nothing is perfect, 90% yes I would from what I see, the 10% is because I don't see everything."
- People and their relatives said the management team was approachable, friendly and they were happy living at the home. Relatives also told us in general they were happy. They said there were some 'niggles' such as missing clothes etc but overall, they were satisfied.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The management team held meetings for relatives to keep them informed. They contacted relatives when issues arose. A relative told us, "The contact with the home is good."

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Following recent concerns raised, the management team had not spent time speaking with people to assess if the concerns had also impacted on them. As part of our inspection people raised concerns with us.

● However, there had been a focus on training and guidance for staff to help raise awareness and prevent a reoccurrence.

● Since purchasing the home, the provider's management team had been carrying out checks and audits. This helped them understand areas that needed developing and implement an improvement plan. There had been some significant actions needed on taking over the home to ensure everything was at the required standard. Work had been ongoing to drive safety and further improvements were in progress.

● Staff feedback was sought through meetings, supervisions and observed practice with the manager or a member of the management team. One staff member said, "Lots of training and support, management all go round checking, I feel they listen."

● There were meetings for people and relatives so they could learn about changes and updates in the home and share general views.

Working in partnership with others

● The management and staff team worked with other professionals to ensure support and the right care for people. This included mental health teams, speech and language therapists and physiotherapists.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's safety was not consistently promoted

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Further work was needed to ensure that the provider and staff could swiftly recognise and report potential safeguarding concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems needed to be developed further to ensure they could recognise and resolve all shortfalls in the home.