Mallands Care Limited

Mallands Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection was unannounced and took place on 10 February 2015 and 20 February 2015. The home was closed to visitors due to an outbreak of influenza on our first visit, so we returned for a second day to speak with the people who lived at the service and any visitors.

Mallands Residential Care Home provides accommodation and personal care for a maximum of 38 older people. People who use the service include people with dementia and people with physical needs, as well as people staying for a short while for respite or convalescence. Mallands also provides personal care to people who wish to retain their independence and live in their own home through a small domiciliary care service operated out of the home. At the time of our inspection this was providing care to seven people in the locality.

At our last inspection of the home on 28 July 2014 we had identified concerns about the operation of the home. These were related to people's care and welfare, management of medicines, staffing levels, and how the service assured the quality of the services provided. The

Summary of findings

provider sent us an action plan telling us what they were going to do to put this right. They told us they would have completed this by November 2014. On this inspection we saw the necessary improvements had been made and sustained across these areas.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risks to people's health and welfare were assessed and management plans put in place to address concerns and reduce risks. People were protected from abuse, discrimination and their rights to make decisions were upheld by staff who understood their responsibilities. Staff asked people for their consent before delivering care, and where people lacked capacity appropriate steps were taken to protect people's welfare in accordance with the Mental Capacity Act 2005.

Improvements had been made to ensure that sufficient staff were available to ensure people were cared for in a safe way, both at the home and in the domiciliary care service. This had included the recruitment of new senior staff, and a new deputy manager post, and ensuring that there was an additional person on night duty each night. This meant that there were enough staff available to respond to people's needs.

There were robust recruitment arrangements in place so staff recruited were suitable to care for vulnerable people. This included the taking up of disclosure and barring checks and references. Improvements had been made to staff training and staffing structures to ensure that decisions about people's care were being made by staff with the appropriate skills, knowledge and experience.

Staff received the training they needed to care for people effectively, including induction and ongoing support. Staff were regularly updated on care issues with a rolling programme of training, and were not allowed to deliver care unsupervised until they had been assessed as being competent.

Improvements had been made to the medication systems at Mallands since the last inspection, and medication was being managed well. People received the correct medication at the correct time, and storage was secure. Medications were reviewed regularly both by the home and the supplying pharmacist.

Staff had an understanding of the Deprivation of Liberty safeguards and their responsibilities under the Mental Capacity Act 2005 for obtaining consent for care. Appropriate applications had been submitted for authorisations to deprive people of their liberty to maintain their safety.

People living at the home received a balanced diet with choices at each meal. People at risk of poor nutrition or hydration were assessed and records kept of all of their intake. Where significant risks were identified action plans were put in place to support the person with enhanced meals and snacks. Snacks and drinks were offered regularly but were also available for people to select from at any time.

We saw that staff and management were positive about providing good quality care. People who used the service were supported by staff who had built caring relationships with them. They were treated with respect and their privacy and dignity were promoted. We saw staff engaging in affectionate and good humoured interactions, and ensuring people's communication was understood even if this was not verbal. People were involved in decisions about their care. We saw good relationships in place and an understanding of people's emotional needs and well-being.

People's needs were assessed and care plans identified how to support them with their care needs. These plans were tailored to the individual and reviewed as people's needs changed. We saw that people had access to community healthcare to meet their needs, including access to medical, nursing and physiotherapy services.

Mallands had moved towards making activities more 'person centred' for people who lived there, and work was being undertaken to further identify areas from people's social and personal history to support them with interests and lifestyle choices.

We saw that there was an open culture at the home. Staff told us the management team were approachable. They had also developed a clear management structure, which had been significantly strengthened since the last inspection. This meant that decisions about people's care

Summary of findings

could be made by staff with the correct skills, knowledge and experience in a timely way. Complaints or concerns were managed well and learning took place as a result. People who used the domiciliary care service told us they were satisfied with the care they received.

Quality assurance systems drove improvements and raised standards of care. The service learned from incidents and regular audits highlighted potential for improvement.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe. Risks to people's health and welfare were assessed and management plans were put in place to address concerns or reduce risks.

Staff were knowledgeable and had been trained to identify and keep people safe from abuse and discrimination. People's legal rights were upheld by staff who understood their responsibilities.

Sufficient staff were available to ensure people were cared for in a safe way.

There were robust recruitment arrangements in place, which helped to ensure that staff recruited were suitable to work with vulnerable people.

People's medication was administered safely. Improvements had been made to the safety of the medication systems since the last inspection.

Is the service effective?

Good

The service was effective.

People were looked after by staff who were well trained and could meet their needs.

People's health needs were met. People received the medical support they needed to promote their health and well-being.

Staff had received the training they needed to deliver good care to people. Staff training and staffing structures ensured decisions about people's care were being made by staff with the appropriate skills, knowledge and experience.

People were asked to consent to their care, and had their capacity to consent was assessed. Staff understood their responsibilities under the Deprivation of Liberty safeguards and Mental Capacity Act 2005.

People received an adequate and nutritious diet which took into account their specific health needs and preferences.

Is the service caring?

Good

The service was caring.

People were supported by staff who had built caring relationships with them. People were treated with respect and their dignity was promoted.

People, or their representatives, were involved in decisions about their care. We saw staff treating people with kindness and respect. We saw evidence of good relationships in place and an understanding of people's emotional needs and well-being.

End of life care was delivered based on best practice and care for the person and their family in a partnership where possible.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans identified how to support people with their care needs. These plans were tailored to the individual and reviewed as people's needs changed.

Staff were making activities more person centred for people who lived there. Work was being undertaken to further identify areas from people's social and personal history to support them with interests and lifestyle choices.

Complaints were managed well and learning took place as a result.

Is the service well-led?

Good

The service was well-led.

There was an open culture. The management team were approachable and defined by a clear structure, which had been significantly strengthened since the last inspection.

Staff and management were positive about providing good quality care.

The registered manager ensured that they monitored the quality of the service. The service learned from incidents and regular audits highlighted potential for improvement.

Mallands Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 February 2015 and 20 February 2015 and was unannounced. It was carried out by two adult social care inspectors on the first visit and one on the second.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We, the Care Quality Commission (CQC) looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

On the inspection we spoke with or spent time with six people who used the service, seven staff and four visitors to the home. We also spent time observing the care of people who were not able to communicate with us verbally about their experiences in depth. This included observations over a mealtime, of medication administration and moving and handling practices. We looked at five people's care plans in detail and other plans to check details of the care they received. We sat in on a staff handover between shifts so that we could see how staff were organised and duties delegated. We looked at two staff files, and other records held by the service such as medication administration records (MAR), quality assurance action plans and reports and policies.

Prior to the inspection we had contacted the local community teams who supported or commissioned placements at the home for their views on the service. We also took into account and followed up information we had received about the home since our last inspection, including reviewing safeguarding concerns.

We also spoke with five people who received a service from the domiciliary care support team operated by the home.

Good

Is the service safe?

Our findings

People told us they felt safe at the home and with the staff who supported them. One person told us "They are all lovely here – why wouldn't I feel safe? They (staff) all know what they are doing".

People's care plans contained risks assessments which outlined measures in place to reduce risks to themselves and others. We looked at some of these in detail with the manager. The plans in use identified risks to individuals, for example from tissue damage, poor nutrition or falls. Where concerns were identified the plans detailed the actions to be taken by staff to reduce the risks, for example with the use of pressure relieving equipment and regular turning and repositioning. We saw records that showed us how, when and by whom this had been carried out on a daily basis. Risk assessments were also being regularly reviewed to ensure they were reducing risks to people without being overly restrictive.

The home had arrangements in place to manage emergencies. People had emergency evacuation plans in place in case of fire. Staff we spoke with told us about fire training they had undertaken the day before our first visit. They told us they had been taught about emergency evacuation procedures and how to move frail people using equipment in an emergency. Risk assessments were available for the environment of the home and for safe working practices for staff. Reasonable adjustments had been made to staff duties to support them carry out their duties in ways that protected their own health and welfare. Staff we spoke with clear about the location of fire alarm points and first aid equipment for use in an emergency.

Mallands had policies available for staff in relation to safeguarding people from abuse. Risks of abuse to people were minimised because staff had received training in recognising and reporting abuse. Staff we spoke with had a clear understanding of what constituted abuse and how to report it through the home's management structures. The staff we spoke with told us they would have no concerns about reporting things that concerned them. One told us "We have information on the staff room notice board about how to report concerns. If I couldn't find that I would look it up on the internet. I would report anything I was worried about."

Since our last inspection there had been three safeguarding referrals concerning the home. We saw that the home had acted appropriately to report concerns to the appropriate external agencies where they had been identified and had taken immediate action to protect people who used the service. Further actions had been taken to prevent a recurrence of the concern and we saw that this had been sustained.

We saw that there were sufficient staff on duty to keep people safe and meet their needs. We saw that Mallands had recruited additional senior staff and a new deputy manager who were delegating and leading staff teams working directly with people.

The manager showed us the tools that the home used to assess the levels of staffing needed throughout a 24 hour period at the care home. This identified people with high needs who might need two staff to support them with their care needs. On this inspection, we arrived early in the morning so that we could speak with the night staff. We found that since our last inspection the number of night staff had been increased from two to three. The night staff we spoke with told us that there were now always three staff on at night. This meant they were able to respond better to people's changing needs. People told us there were usually enough staff now to meet their needs. One person said "Yes there are enough staff now I think. I get attended to when I need help – I couldn't ask for more. They ask me what I want. I know I have to fit in with other people and sometimes they can be a bit demanding but we all get on OK".

The registered manager told us in their PIR they had a robust recruitment procedure for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults. We looked at two staff files and found these checks had been carried out. Staff we spoke with told us that the recruitment procedures they had followed had given them the support they needed to do their job. Improvements had been made to this system including a staff "Buddy" role for the first 4 weeks of employment and a clear system for the reviewing of skills and monitoring of competencies.

Mallands had systems in place for addressing poor performance or safeguarding concerns over staff. We saw evidence that disciplinary action was taken against staff

Good

Is the service safe?

where concerns were identified, which included referral to the disclosure and barring service where appropriate. This helped to ensure that where there were concerns staff could not just move to another job.

At our last inspection we had identified concerns over the management of medicines at the home. We identified concerns in relation to overstocking and stock control, recording and staff knowledge about the medicines they were administering. We saw that improvements had been made.

Medication was being stored and administered safely. People's medicines were administered by senior staff who had received appropriate training to carry out the role. We observed staff giving people their medication. People were given time to take their medicines and explained to them what they were taking where this was appropriate. We saw people being asked if they wished to take 'as required' medication, and it was recorded if they refused this. Staff who were administering medicines told us that their competency had been assessed when they started to give out medication.

The local pharmacist had carried out individual reviews of people's medicines to ensure that the prescriptions were clear and there were no drug interactions. We saw one prescription that was not clearly written, but this was amended while we were still at the home to ensure that it was clearly in accordance with the prescribing instructions. Records clearly indicated where people received varying prescriptions what dose was due.

People who received a service from the domiciliary care service told us that the staff who came to them cared for them safely, understood how any equipment the person needed was used and were consistent.

Good

Is the service effective?

Our findings

People received effective care and support from staff who had the skills and knowledge to meet their needs. The home had developed the staffing structures to include more senior staff and was developing a system of 'champions' for different areas of care to help staff develop their roles further. Staff teams were well organised and had individual allocated duties for the shift along with a group of people whose care they were responsible for.

The registered manager told us in their PIR that there was a comprehensive training programme for all staff, and we saw that this was the case, with a 12 month training plan for staff in place. In addition to this, regular sessions were set up for staff to undertake group and individual learning, with training sessions and scenarios about care and questions for staff to complete. Staff we spoke with told us they enjoyed this style of learning. Training was delivered via DVDs and both internal and external trainers. The staff we spoke with told us that they felt the training at the home was good and met their needs. One told us they had appreciated the training they had received about moving and handling as it demonstrated the equipment that was used in the home. Another told us they had "learned a lot" and that they had been encouraged to use it to care for the people living at the home better.

Staff told us that they were shadowed and senior staff ensured they were competent before delivering care unsupervised. People who used the domiciliary care service told us that the staff understood what support was required. One told us "we have two carers at a time and they are familiar with what is needed. If there is a new person they come with a senior to make sure they are confident in using the equipment needed."

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Risk assessments highlighted people at highest risk of poor nutrition and hydration and staff actions required to help address this. We observed people at the home over two mealtimes, one lunch time and one evening meal. We saw people being supported to eat by staff in a relaxed and comfortable manner. Each person had an allocated care worker to help them eat, which helped ensure that their meal was hot and that they received the staff attention they needed to eat well. We saw that meals including soft diets were presented well. We saw that people were able to exercise choice over what they ate.

On our second visit we looked at a care monitoring and recording system that the home had installed. This meant that entries were completed by staff onto a mobile handheld electronic recording system throughout the day each time they had an interaction with a person at the home. This then automatically informed the manager and other staff on duty for example if a person had not had fluids or food at the optimum level within a two hour period, and gave print outs of the overall food or fluid intake for the person for the day. This helped ensure that staff had a high awareness of monitoring food and fluid consumption for people at potential risk of poor hydration or nutrition. Staff we spoke with told us the system worked well as it was completed while they were with the person rather than having to remember to complete paper records later about food or fluids taken.

Staff had a clear understanding of the Mental Capacity Act 2005 (MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. Staff had received training in the principles and application of the MCA. Most people who lived in the home were able to make decisions about what care or treatment they received. We saw that people were asked for their consent before staff assisted them with any tasks. We spoke with staff about how they understood the wishes and needs of people who were unable to communicate verbally. A staff member told us about one person they supported. They said "she communicates in other ways – you can tell with her eyes and her body language. For example if she is uncomfortable and wriggling then she needs to go to the toilet".

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Care plans that we saw recorded where best interest decisions were being made on people's behalf for day to day care as they lacked the capacity to consent.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by

Good

Is the service effective?

which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The registered manager was familiar with the Deprivation of Liberty Safeguards and we saw that five applications for DoLS had been submitted for authorisation to the appropriate authorities. These were awaiting decisions. This told us that the home understood how people's rights should be protected.

Good

Is the service caring?

Our findings

People said they were supported by kind and caring staff. They told us "The staff are very caring towards me. I don't ring the bell unless I really need something, so when I do they come quickly." A relative of a person who used the domiciliary care service told us "The staff are very respectful, but can still enjoy having a laugh with him. They jolly him along and it cheers him up". Another told us "The girls who come to me are lovely".

People's privacy was respected and all personal care was provided in private. Staff supported people in public areas in a discreet manner, respecting their dignity, and at the person's own pace.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. Staff knocked on people's doors before entering. When we heard staff discussing people's needs either in the handover or during the day the discussions were respectful and compassionate. For example on the first day we saw that a person who lived at the home had suffered a bereavement. We heard staff discussing how they had supported the person in their distress and supported their emotional well-being. We also heard them speaking with relatives and heard them discussing the impact of the bereavement and working with the family to help support the person in their loss.

We saw that people made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. We heard people being offered choices and staff offering them choices in ways they could understand with simplified information on which to make a decision.

People were offered ways to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received. Records in the notes told us who participated in the reviews and the outcomes of the consultation. We saw a file of compliments and letters of thanks on display in the hallway.

People were offered care and support sensitively and with care. Staff sat with people and laughed with them about shared experiences. Staff were good humoured and positive in their approach with people. Staff understood and interpreted people's behaviours appropriately as way of understanding and attending to their needs. Staff understood people's behaviours as a sign of communication or frustration, for example.

Visitors who had come to view Mallands as a potential placement for their relative told us they had been impressed by what they had seen, and by the openness and approach of the management and staff.

The service provided end of life care for people. Where possible people had been consulted with about their wishes and these were recorded in people's care plans in detail. For example one plan included information of photographs the person wanted near them at the end of life and jewellery they wanted to be wearing. Where appropriate medicines had been prescribed and obtained in advance of the person needing this in a 'just in case' bag. This meant that if the person deteriorated suddenly then prescribed medicines would be immediately available for example to manage increased pain or dry secretions that the person might find distressing. This told us that staff tried to support the person to have a pain free and calm end to their life in accordance with their wishes.

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. Plans clearly identified the actions to be taken for people, such as regular position changes and these were monitored and actions taken recorded throughout the day using the care monitoring systems carried by staff.

People were able to make choices about all aspects of their day to day lives, and we saw that their choices were listened to.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. For example we saw that a person was being admitted to the home from hospital with a specific health condition around the time of the inspection. The registered manager had held a meeting with the local nursing team to identify care needs and carry out joint care planning. Where people were receiving support from the domiciliary are service this had been identified and documented in care plans. People told us "My care plan is here in my home and the staff write in it every time. The specialist nurse I see also looks at it and writes in it so everyone understands what needs to be done".

Care plans and assessments were being reviewed regularly and staff understood people's needs. For example, one person had a medical condition which staff understood. They knew what actions they needed to take to support the person to remain healthy. People's healthcare need were identified and addressed by staff, including contact with district nursing teams and GPs. For example we saw that one person had received emergency care for a blocked catheter from district nurses the night of our first visit. Community healthcare professionals we spoke with prior to the inspection did not express any concerns about the home and told us they felt it had improved since our last inspection.

The registered manager gathered information from families about people's previous life history. This was to help staff support people with memory loss in the knowledge of the lifestyle choices the person had made prior to losing their memory. Staff had a clear understanding of how people liked their care to be delivered.

Staff responded to people's needs quickly. For example one person was eating their meal with staff support. Halfway through the meal they told staff they wanted to go to the toilet. We saw that the staff member immediately responded to this and went to get a hoist to help them move, rather than having them wait until their meal was finished.

People were able to take part in a range of activities according to their interests. The activities organiser told us about how they were moving towards delivering a more person centred focus on activities and stimulation for people. We saw evidence of activities being carried out including recent events to celebrate Valentine's day. On the day of our visit there was a newspaper reading group and discussion occurring. One person was doing some art work and others were singing or listening to music.

The registered manager told us in their PIR that they were looking at ways to ensure people who did not wish to mix or could not engage with other people did not become socially isolated. We spoke with the activities organiser about this. They discussed one person with us who had significant memory loss and physical health issues. However the person had a history involving music and still responded to music, even though they were not able to say so verbally. The activities organiser told us "I am not sure if they are smiling because I have a beautiful voice or if I am amusing her with my rubbish singing".

The registered manager sought people's feedback and took action to address issues raised. Meetings were held bi-monthly for people to share their views on the home and suggest improvements formally, however people we spoke with told us that the manager's door was 'always open' if they wanted to discuss anything. The next meeting was due the week following the inspection.

Each person received a copy of the complaints policy when they moved into the home. We looked at the way Mallands responded to concerns or complaints. We saw that complaints had been acted upon promptly and a response sent to the person with an apology or an indication of actions to be taken to prevent a re-occurrence. People we spoke with told us they would feel free to raise any

Good

Is the service responsive?

concerns with the management or would tell their families if they were unhappy about anything. People living in the community also had clear information about how to raise concerns about the domiciliary care service they received. One told us “I had an issue when we first started. I called (the registered manager) and it was sorted straight away”.

Good

Is the service well-led?

Our findings

On the inspection we met with the registered manager, newly appointed deputy manager and one of the directors of the provider company. We found that substantial changes had been made since the last inspection. For example the strengthening of the management team had freed the manager with time to undertake more managerial tasks and have a clearer oversight of the home.

There was a clear vision for the development of Mallands which was shared among the management team, who were enthusiastic and positive about the changes being made. Staff told us that the vision and values of the service were shared with them at learning events, through their Induction and staff meetings. They were also positive about the investments being made in the home. They told us the manager was very approachable and consulted with them to identify any issues with the home as well as ideas for improvement. A staff member told us "management is really good, help when you need it, complaints are dealt with quickly and maintenance issues always dealt with as soon as possible"

The service monitored the quality of the care delivered through robust quality assurance systems. Audits and checks were in place to monitor safety, falls, risks and quality of care issues. Accidents and incidents which occurred in the home were recorded and analysed on a monthly basis. Any actions identified that could prevent a re-occurrence were then actioned, for example improved lighting.

Mallands management team were in the process of sending out questionnaires to relatives, visiting professionals and people who lived at the home to formally gather their views about the home and any improvements people feel could be of benefit. We saw the analysis of the last questionnaires at our last inspection in July 2014. We saw that suggestions made in previous questionnaires had been acted upon.

Mallands is a member of a local quality improvement initiative for care homes for people with dementia. We saw that they had also taken advice and received training on best practice and developments in dementia care. This had led to the development of the sensory garden, and development of activities. The home also had links to the Newton Abbot community nurse forum and staff were registered as dementia champions.