Care UK Community Partnerships Limited

Hinton Grange

Inspection report

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Ratings

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

Overall summary

Hinton Grange is a two storey building located in a residential area of Cambridge. The home provides accommodation for up to 60 people who require nursing and personal care. At the time of our inspection there were 46 people living at the home accommodated in single occupancy rooms. The home is split into four main units where people are cared for according to their assessed care or nursing needs.

This unannounced inspection took place on 24 February 2015.

At our previous inspection on 31 July 2014 the provider was meeting all of the regulations that we assessed.

The home had a registered manager in post. They had been in post since December 2014. 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.

Summary of findings

The provider had a robust recruitment process in place. This ensured that only the right staff were recruited and offered employment.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that the registered manager and staff were knowledgeable about when a request for a DoLS would be required. We found that appropriate applications to lawfully deprive some people of their liberty had been submitted to, and authorised by, the local authority (Supervisory body). People's ability to make decisions based on their best interests were supported by records to demonstrate where this had been assessed as being lawful.

Staff did not always respect people's dignity at all times. Care was not always provided by staff in a caring and compassionate way. People's requests for assistance were responded to promptly.

People's care records were not always accurate or held securely and had not always been completed by staff at the time the person had been provided with their care. Support for some people to undertake their hobbies and hobbies and interests who lived upstairs was limited. This meant that people were at an increased risk of not being provided with stimulation that was meaningful to them.

People were supported to access a range of health care professionals. This included GP and community nursing services. Risks to people's health were assessed and acted upon according to each person's needs.

The majority of people were provided with a choice of meals based upon a range of options. However, people who required specialist diets such as pureed food had limited choices.

There was a sufficient quantity of food and drinks available for people.

People, relatives and staff were provided with information on how to make a complaint and staff knew how to respond to any reported concerns or suggestions. Action was taken to address people's concerns and to prevent any potential for recurrence. The availability and provision of information for Independent Mental Capacity Advocacy (IMCA) services in the home enabled people or their relatives to access these services if required.

The provider had quality assurance processes and procedures, such as audits, in place to improve, if needed, the quality and safety of people's support and care. However, although processes had identified areas for improvement, the actions taken had not always been effective. People were supported to raise concerns or comment on the quality of their care.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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 were supported by a sufficient number of staff who had been trained and were knowledgeable about safeguarding and medicines administration procedures.

Staff were recruited through a safe recruitment process and their suitability to work was established through appropriate checks.

Risk assessments had been completed to help ensure risk to people's health were minimized or eliminated.

Is the service effective?

Requires Improvement

The service was not always effective.
People's health needs were assessed and met in a way which ensured that these were met by the appropriate health care professional.

Applications and authorisations to lawfully deprive some people of their liberty showed us that staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards DoLS.

Sufficient quantities of food and drink were available to people living in the home but a choice of meals was not available for people who required a pureed diet.

Is the service caring?

Requires Improvement

The service not always caring.

People were not always provided with care and support with compassion. Not everyone's care was provided in a sensitive way.

Staff knew what was important to the people they supported. People could be visited at any time without restriction.

People were given every opportunity to maintain and improve their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's hobbies, interests and preferred social activities were not always supported.

Summary of findings

People and their relatives were involved as much as possible in their care assessments. Staff responded promptly to people's assessed needs.

Reviews of people's care helped ensure that changes and improvements were made to their care and support where this was required.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

Although the provider's audits had identified areas for improvement, the action taken had not always been effective.

People's care records were not accurate, were not held securely and could not be relied upon to ensure people's care was of the right standard.

People were supported by staff who shared the same beliefs and values of the home about always putting people first.

Hinton Grange

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 unannounced inspection took place on 24 February 2015 and was completed by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in caring for people with mental health needs and dementia care.

Before our inspection we looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also spoke with the service's commissioners, the local safeguarding authority and received information from the home's GP practice.

During the inspection we spoke with 11 people living in the home, eight relatives, the registered manager, the home's deputy manager, clinical nursing lead, three nursing staff, five care staff and three non care staff members. We also observed people's care to assist us in understanding the quality of care people received.

We also 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 looked at seven people's care records, people who use the service (residents') and relatives' and staff meeting minutes and medicine administration records. We looked at records in relation to the management of the service. We also looked at staff recruitment, supervision and appraisal processes and training, complaint and quality assurance records.

Good

Is the service safe?

Our findings

People told us that they were safe and would speak to staff, nurses or management if they had concerns about their safety. One person said, "I feel safe because I am very well looked after." People, relatives and visitors told us that there was always sufficient staff on duty. A staff member said, "It does get busy at times but not to the point where people's care is affected."

People told us that they were supported to take risks including going out alone, going to the shops, pubs and other local amenities. One person said, "I go out but the staff make sure I have all my equipment with me in case I need help." Another person said, "I am due to get some equipment to help me get myself out of bed." We found that staff completed risk assessments to ensure that equipment was suitable and safe for the person's use. One relative said, "[Family member] has been here for some time now and I have no concerns that the staff look after them properly.

All staff we spoke with, including non care staff, had received safeguarding training and demonstrated a good understanding of what protecting people from harm meant. They were able tell us about the signs of potential abuse and who they could report these to. Access to information about protecting people from harm was displayed in the home for people and staff to access if required. This showed us that the provider took steps to help ensure people were kept as safe as possible.

The provider had notified the CQC of incidents involving people's safety and had taken appropriate steps to ensure people's safety. Examples of this included the introduction of additional observations of people to ensure they were being observed more regularly to help avoid conflict between people.

We found that all medicines and drugs were stored correctly and securely. Staff's competency to administer people's medicines was assessed after they had been trained. This was to ensure staff had a good understanding of what safe medicines administration was. Records of the quantities of medicines held matched the records we looked at. Staff had access to, and used, clear guidance and instructions to ensure people were administered their prescribed medicines at the time they needed. We saw that the morning medicines administration round was still in progress at 11.45am. This put people at risk of not receiving their prescribed medicines in a timely manner. The registered manager was aware of this matter and was offering additional supervision to some staff.

Staff told us about their recruitment and induction to the service and records showed us there was an effective recruitment process in place. This was to ensure that the provider only offered staff permanent employment after appropriate checks had been completed. Checks included references from staff's previous employers, explanations for any gaps in employment history and evidence that nursing staff had maintained their professional registration with the Nursing and Midwifery Council (NMC).

People, relatives and staff told us that there were sufficient staff working at the home. During our inspection we noted that people's request for assistance were attended to promptly by staff who had the right skills. The registered and deputy manager explained how people's care and support needs were assessed before they moved into the home. This assessment was then used to determine the staffing levels required to keep people safe. A person told us, "I never have to wait long if I ask for anything."

Where people exhibited health risks and had been identified as being at an increased risk we found appropriate steps had been taken. Examples included regular turns to prevent a pressure area developing and monitoring of people's fluid intake and output. Other examples of action taken included falls protection mats, additional checks of people's well-being and the provision and use of pressure area equipment. This was to help ensure that people's health risks were effectively and safely managed.

Regular and up-to-date checks had been completed on the home's utility systems and equipment, environmental health and fire safety. Staff told us about various fire evacuation drills and also when the lighting and emergency equipment was checked. People's care plans contained information how each person was to be supported in the event of an emergency including a fire. People were assured that the provider had appropriate checks to help ensure their safety.

Requires Improvement

Is the service effective?

Our findings

All of the people we spoke with told us that they rarely had to ask for specific help with their care as staff knew their needs well. One person said, “I have been here a few months and the food is good. I can choose from the two meal options but they will make me an alternative if I want.” People told us that they had snacks and drinks during the day and that there was never a shortage of food.

During the lunch time people were supported to eat in the dining area, in their room or a place of their choice. We saw that food was served promptly and staff told people that it was hot. A relative told us, “[Family member] always has a drink on their table and staff regularly ask if they have had sufficient. One person said, “The stew was gorgeous.” We later saw that their request for more food had been met.

Food and fluid charts had been completed for those people at risk of malnutrition or dehydration. This was to help ensure that people had eaten and drunk sufficient quantities.

We saw a member of staff giving a person who they told us was a vegetarian some meat to eat. When we asked this staff member if they were a vegetarian they said, “I don’t know. Their [family member] doesn’t visit very often. They then said, “They need protein.” In addition, nursing staff told us that the person was vegetarian. When we checked this person's nutritional plan there was no record if the person was or was not a vegetarian. The chef had a good knowledge of people’s likes, dislikes, and food allergies. Although there was a choice of meals available, people who required a pureed diet were not given any choice. In addition, some people were given food and were not asked if the quantity served met their needs. This meant that people were not involved in the decisions about what they wanted to eat.

The registered manager and staff we spoke with told us that they received regular supervision and training to ensure they were kept up-to-date with current care practices. One staff member said, “I had a really good induction and I continue to have support since I started my employment.” Another member of staff told us, “I have just done moving and handling, safeguarding and fire safety training.” The registered manager, senior care and nursing staff told us that they also regularly offered and gave day to day support. The registered manager was aware of the training needs for staff and was taking formal action and implementing measures to address staff’s non-attendance at refresher training.

The registered manager explained how people were supported in the least restrictive way possible and all possible options were considered. Examples included mattresses on the floor and hospital type beds which could be lowered to almost floor level. This meant that people were able to safely get out of bed and were not unnecessarily restricted. We saw that staff understood people’s needs well. This was by ensuring they always received a verbal, written or implied consent from each person before providing any care or support.

People’s care plans included advanced directives including do not attempt cardio pulmonary resuscitation (DNACPR) records which had been signed by a health care professional and discussed with the person or their families. Staff told us and explained when this decision was to be respected. This showed us that DNACPR current guidance was followed.

We found that the registered manager had sought and gained authorisation from the appropriate authorities (Supervisory body) to lawfully deprive people of their liberty. This was to ensure people were cared for in a safe way without exposing people to unnecessary risks that were not in their best interests. This showed us that staff, appropriate to their role, had a good understanding about what the implications of the MCA and DoLS meant for each person. We found that where people required care that was in their best interests but they did not have capacity to agree, the necessary steps had been taken to ensure that this was done in a lawful way.

Requires Improvement

Is the service effective?

People told us, and we saw, that access to a range of health care professionals including opticians, audiometrists and GP services were available and provided when needed. One person said, “I saw a doctor last week as I was due a check.” People’s health conditions were monitored regularly and where health care support was required we saw that referrals were made in a timely way. A relative said, “I met the new assistant manager who was very helpful and is organising a hearing and eye test for my family member.” This showed us that people’s health care needs were attended to.

People and their relatives we spoke with told us that the management and nursing staff were very good at keeping them informed about any changes to people’s care and support needs. One relative said, “[Family member] has several health conditions which require support and care from the staff, community nurses and a GP.” Another relative said, “I’m happy with the home, some staff are excellent” We saw and found that where people had been identified as being at risk of malnutrition that timely health care professional advice had been sought and implemented. This meant that people, their relatives and staff were involved in their care and any treatment options and outcomes.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that the staff were caring and would do anything for them. One person said, “The staff are busy but if I need any help they ask what this is and then help me.” A relative said, “They’re all good at caring for [family member]. Staff told us, “We have a laugh with people and it is not just about getting the job done. People come first.”

However, we saw inconsistencies with people being supported with their meals at lunchtime. One person who was not able to sit close to the table was eating independently but their food was falling onto their tabard. They then proceeded to eat their food from their tabard. On two occasions staff walked straight past this person. We asked staff if they could position this person in a more dignified way but we were told. “All the tables are the same and they can’t get any closer.”

We observed two members of staff on two occasions shout across the dining room about another person’s care needs. The staff then proceeded to ask the person if they wanted gravy, brought the gravy to them and asked if they wanted this. The staff poured the gravy on the person’s food without giving them the chance to pour their own gravy.

On another occasion we saw a person eating independently had food on their face. Over one hour later we saw the person had eaten their lunch and staff had removed their plate but the staff had not assisted the person to clean their face. We saw two members of staff walk into the room, ignore the person and walk straight back out.

People’s care plans contained information regarding the personalised way they wanted their care to be provided. This included their personal life history and their personal care preferences such as whether people preferred a bath or shower. However, some of the information was limited. Words used to support people included, “To be fed at lunchtime” and “Can be resistive”. No further explanation was provided for staff to determine the level of support and what this actually meant. We saw that one person’s care plan stated that they ate and drank independently but during our inspection we saw that staff were supporting this person to eat and drink. When we suggested that staff gave the person cutlery to eat they then went on to eat independently. Staff told us that they sometimes ate independently. However, the care plan did not state this. This meant that people were at risk of receiving care that was inappropriate.

People were supported to access their mobility equipment including walking frames and wheelchairs. Support was given by staff in a sensitive way. Staff provided people with encouragement and support to ensure the person understood where they were going and why. For example, to the toilet or for their lunch.

People, their relatives or friends were involved in the reviews of the care provided. One person said, “I am asked regularly if there is anything I want changing. It took me a while to settle in but the staff have been great. They joke which is what you need in a place like this.” Relatives told us how they felt involved in their family members care, and were kept informed about any health changes, doctors’ visits or hospital appointments and the results of any tests.

Information regarding Independent Mental Capacity Advocacy (IMCA) services were displayed in the home for people who lacked capacity. Staff told us that people or their relatives were able to request general advocacy services if this was required. This meant that people were supported to access advocacy services where they needed someone to ‘speak up’ for them.

People were able to receive visitors at any time. One person told us, “I have family visitors every day. I can go into the garden area and my [family member] also takes me out in my wheelchair. It’s my choice.” A relative said, “I can visit when I want which is most days.”

People’s privacy was respected. People who wanted to lock their door were able to do this or

Requires Improvement

Is the service caring?

they could leave it open if they preferred. One person said, “I am very happy here. The staff look after me well as it’s like home.” We saw that staff knocked on people’s doors and awaited permission before entering and that doors were kept closed when people were receiving personal care. People told us that they could choose male or female care staff to assist them with the personal care. One person said, “I was a bit nervous at first but now they just get on with it in a very caring way.”

Requires Improvement

Is the service responsive?

Our findings

People who lived at the home told us, and we found from records viewed, that prior to people living in the home, a comprehensive assessment of their needs had been undertaken. This was to ensure that staff were able to meet people's needs. A relative told us, "When [family member] first came to live here they were reluctant to drink but now staff they know well are accepted by [family member] to help them drink."

One person told us, "I go to seated exercise classes, watch films and play board games. They [staff] ask me what I want to do and then support me with my choices." We saw people living downstairs had a variety of hobbies and interests to take part in but that the variety available to people living on the first floor were very limited. The registered manager told us that people were always asked if they wanted to attend activities downstairs. One person said, "There are two activities staff but they spend all their time downstairs. Staff said, "Only occasionally we do one to one support." Another member of staff said, "We are supposed to spend one to one time with people who are unable to go downstairs but we don't have time." For those people cared for in bed or unable to access the downstairs lounges there was limited activities and meaningful stimulation.

We found that equipment including wheelchairs and beds adapted to each person's individual situation had been provided. One person said, "Now I have the right equipment it is much easier for me to get around." We saw this person go outside on their own as this was what they liked to do.

Relatives told us that staff regularly asked if they were happy or if there are things they wanted to change. One person said, "I asked for a bedside lamp and this provided." A relative told us, "I talked with [name of registered manager] about [family member] and other people and now they are in a room more suited to their situation."

One person said, "I like it here but if I was concerned about anything or if I wanted something I would ask the staff or the [registered] manager. I see them around most days and we chat about everything." A relative said, "If I had to complain I would just speak to [name of registered manager]. I have never had to complain." Staff told us, and we saw in meeting minutes we looked at, that they were able to voice their opinions at staff meetings and that any concerns were acted upon. Two relatives told us that the meetings they attended were well supported. Meeting minutes we looked at showed us that people who had raised concerns were supported to have their concerns addressed. This showed us that the provider listened to people's views and acted upon them if required.

The provider had up-to-date complaints policies and procedures on display and people were given information on how they could comment about the service, raise concerns or make compliments. People told us that staff gave them opportunities to raise concerns about their care and action was taken where required. For example, one person said, "The new [registered] manager is a breath of fresh air. They talk with me quite a bit." A relative said, "I have never had cause to complain but if I did I know who to speak with." A residents' meeting had recently been held and had been well attended. People were given several ways they could comment about the service and how it was run. This included a suggestions box, meetings and talking with staff.

Requires Improvement

Is the service well-led?

Our findings

People and relatives we spoke with told us they knew who the manager was or who was in charge and that they saw them frequently around all areas of the home. One person said, "I see the person in charge and they always say hello and talk to me." Staff told us that the registered manager was always there for them whatever time of day or night. We saw the registered manager around the home, including talking to many people as they knew them well. They told us that this was also to make sure that staff cared for people and supported them to an acceptable standard.

Quality assurance checks completed by the provider in November 2014 had identified that staff were not accurately completing people's care records. However, we found, that despite reminders to staff to ensure they completed records in a timely manner, four people's care records had not been completed by staff. This was to confirm that people who required regular checks throughout the night had actually had these provided. This was from midnight until 08.00am on the day of our inspection. This meant that we could not be assured people had received all their care and support and whether people had been checked throughout the night.

In November 2014 the local safeguarding authority requested documentation for a person who had been admitted to hospital. It took the provider three days to locate the information which had been 'lost' due to the computer system 'crashing'. We found during our inspection where we had identified omissions in people's care that the electronic records system did not reliably maintain an accurate record despite observing staff entering these records. Although staff told us that the system would back this information up during the night, this was not the case at the time the records were created. This meant that for over eight hours people's care records were not accurate. Three staff confirmed to us that the system was not reliable. This put people at risk of receiving care or treatment that was unsafe or inappropriate.

We found that people's care records were not held securely and confidentially. We found people's care records left on tables in dining rooms and the nurse's office was found unsecured on three separate occasions when we checked this. People and visitors and non care staff were able to access this information. This meant that people's personal care records were accessible and not held securely to keep their information confidential.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All staff we spoke with confirmed that they liked working at the home and the reason for this was, "It's such a good team and we help each other out if we can." Another staff member said, "It does get busy but we can ask for extra (agency) staff if required. There is another senior carer starting next week."

Records we looked at and staff we spoke with confirmed that regular checks and audits were completed on people's medicines administration, care records, accidents and incidents and all areas covering the health and safety within the home. The provider's incident and accident recording system was used to determine the number and pattern of incidents. This information was then used to develop and put action plans in place to prevent or reduce the potential for recurrence. For example, we saw that if a person experienced several falls, equipment was introduced which helped ensure their safety.

The home had a registered manager in post. They had been in post since December 2014. They had notified the Care Quality Commission of incidents and events they are required to tell us about using notifications (A notification is information about important events the provider must tell us about, by law) submitted to the CQC. The manager had taken appropriate action and liaised with all authorities to ensure that action was taken to prevent the potential for recurrence. This showed that where poor practice had been identified or where there were opportunities to improve, prompt action was taken.

Staff meeting minutes we looked at showed us that staff had the opportunity to raise any suggestions to improve the service and that these were acted on. Staff were aware of their roles and responsibilities and how to escalate any issues to the manager or provider if required.

The registered and deputy manager told us the key challenges were ensuring the successful recruitment of a permanent staff team. They also showed us the steps they were taking and had plans to recruit staff in an area where

Requires Improvement

Is the service well-led?

there was a high demand for nursing staff. Other action taken had been to reduce staff sick absences where staff had not followed the provider's policies. This had resulted in less staff absence and a better staff team culture.

People and relatives were provided with a variety of ways that they could comment about the quality of the care provided. A relative told us, "There has been issues in the past and I continue to liaise with the [registered] manager. They support my suggestions and make changes." Another relative said "[Name of registered manager] has made a lot of changes including reducing agency staff which has improved the situation for my [family member]." During relatives and residents' meeting people had raised concerns that there had been a reduction in the quality of some foods provided. The provider was aware of this and had reverted to previous food suppliers.

The registered manager and staff we spoke with all told us that they would have no hesitation, if ever they identified or suspected poor care standards, in whistle blowing (whistle-blowing occurs when an employee raises a concern about a dangerous, illegal or improper activity that they become aware of through work) to the provider's management and the appropriate authorities including the CQC. One staff member said, "I have reported things in the past and action was taken to prevent the situation from happening again. I am confident that the registered manager would support me."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records.** **How the regulation was not being met: People's personal records were not held securely and were not always kept up to date.** **Regulation 20 (2) (a).**