

Barchester Healthcare Homes Limited

Middletown Grange

Inspection report

Middletown
Hailey
Witney
Oxfordshire
OX29 9UB

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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 ●

Summary of findings

Overall summary

We inspected this service on 21 March 2017. Middletown Grange nursing home is registered to provide accommodation for up to 60 older people some living with dementia who require personal or nursing care. At the time of the inspection there were 53 people living at the service.

There was 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. The registered manager worked closely with the deputy manager.

At the last inspection on 10 February 2016, we asked the provider to take action to make improvements and make sure people received activities, stimulation or engagement which met their needs and staff engaged with people and ensured care was person centred. Also to ensure the provider assessed, monitored and mitigated the risks relating to the health by managing accidents and incidents. At this inspection on 21 March 2017 we found the actions had been completed.

People had access to activities and stimulation from staff in the home. Activities were not always structured to people's interests, however, the variety had improved. Staff engaged meaningfully with people and ensured care was person centred.

The provider effectively assessed, monitored and mitigated risks relating to health, safety and welfare of the people. There were systems in place to record, investigate and manage accident and incidents.

People who were supported by the service felt safe. Staff had a clear understanding of how to safeguard the people and protect their health and well-being. People's medicines were stored and administered safely.

There were enough suitably qualified and experienced staff to meet people's needs. People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where required, staff involved a range of other professionals in people's care.

The registered manager and staff had a good understanding of the Mental Capacity Act 2005. Where people were thought to lack capacity, assessments in relation to their capacity had been completed in line with the principles of MCA. The registered manager and staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

People received care from staff who understood their needs. Staff received adequate training and support to carry out their roles effectively. People felt supported by competent staff who benefitted from regular supervision (one to one meetings with their line manager) and team meetings to help them meet the needs

of the people they cared for.

People's nutritional needs were met and people had a good dining experience. People were given choices and received their meals in timely manner. People were supported with meals in line with their care plans.

There was a calm, warm and friendly atmosphere at the service. Staff we spoke with were motivated and inspired to give kind and compassionate care. Staff knew the people they cared for and what was important to them. People's choices and wishes were respected and recorded in their care records.

Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

Leadership within the service was open and transparent. The provider had quality assurance systems in place. The provider had systems to enable people to provide feedback on the support they received.

The registered manager informed us of all notifiable incidents. The registered manager had a clear plan to develop and improve the home.

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.

Risks to people were assessed and risk management plans were in place to manage the risks and keep people safe.

There were sufficient numbers of suitably qualified staff to meet people's needs.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

Medicines were stored and administered safely.

Is the service effective?

Good ●

The service was effective.

Staff had the knowledge and skills to meet people's needs. Staff received training and support to enable them to meet people's needs.

People were supported to have their nutritional needs met.

Staff had good knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. People who were being deprived of their liberty were being cared for in the least restrictive way.

People were supported to access healthcare support when needed.

Is the service caring?

Good ●

The service was caring.

People were treated as individuals and were involved in their care.

People were supported by caring staff who treated them with dignity and respect.

Visitors to the service and visiting professionals spoke highly of the staff and the care delivered.

Is the service responsive?

Good ●

The service was responsive.

People received meaningful activities and stimulation. However, this could be improved.

People's needs were assessed and personalised care plans were written to identify how people's needs would be met.

People's care plans were current and reflected their needs.

Is the service well-led?

Good ●

The service was well led.

People, their relatives and staff had mixed views of the management team and the way the home was run.

The leadership created a culture of openness that made people feel supported.

There were systems in place to monitor the quality and safety of the service and drive improvement.

Middletown 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 inspection took place on 21 March 2017 and was unannounced. The inspection team consisted of 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.

Before the inspection we reviewed the information we held about the service and the service provider. The registered 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 looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We also obtained feedback from commissioners of the service.

We spoke with eight people and eight people's relatives. We looked at five people's care records including medicine administration records (MAR). During the inspection we spent time with people. Some of the people who used the service had communication and language difficulties and because of this we were unable to fully obtain their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements. We looked around the home and observed the way staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the registered manager, the deputy manager and six staff which included nurses, care staff, housekeeping, maintenance and catering staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. In addition we reviewed feedback from people who had used the service and their relatives.

Is the service safe?

Our findings

People told us they felt safe. Comments included; "I feel very safe. I have no complaints about the standard of care. I am very happy", "I feel safe and secure here definitely" and "I do feel safe, yes. It's alright here". People looked happy and appeared content.

People had risk assessments in place to enable staff to support them safely. These protected people and supported them to maintain their freedom. Some people had restricted mobility and information was provided to staff about how to support them when moving them around the home. Risk assessments included areas such as falls, fire and moving and handling. Risk assessments were reviewed and updated promptly when people's needs changed. People had personal evacuation emergency plans in place (PEEPs). These contained detailed information on people's mobility needs and additional support required in the event of a fire.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. Staff told us, "I would report it straight away to nurse. I would take it further if I had to" and "I would record the incident and report it to the manager and local authorities".

People benefited from staff who understood and were confident about using the whistleblowing procedure. There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. One member of staff told us, "I can whistleblow to CQC, safeguarding, police or social services".

People were supported by sufficient numbers of staff. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. Staff told us, "We have enough staff on shifts" and "We are well-staffed". The provider used a dependency assessment tool at the beginning of care provision to assess the staffing ratio required. The dependency assessment was also reviewed whenever people's needs changed.

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

People received their medicine as prescribed and the home had safe medicine administration systems in

place. The provider had a medicine policy in place which guided staff on how to give medicines safely. We observed staff administered medicines to people in line with their prescriptions. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why. Staff had completed medicines training. One member of staff told us, "We have yearly drug assessment and also whenever there has been an error".

Equipment used to support people's care, for example, weight scales, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. We observed staff using mobility equipment correctly to keep people safe. People's bedrooms and communal areas were clean. Staff were aware of the providers infection control policies and adhered to them.

Is the service effective?

Our findings

Staff were knowledgeable and skilled to effectively carry out their roles and responsibilities. People commented on staff skills, "They seem to know what they are doing" and "They [management] do ensure they have the right staff". One person's relative said, "The staff are the best in this place".

Newly appointed staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. This induction plan was designed to ensure staff were confident and sufficiently skilled to carry out their roles before working independently. One member of staff commented, "The induction was great. I got lots of training. I was also shadowing another person for a period of two weeks".

Staff had completed the provider's initial and refresher mandatory training in areas such as, manual handling, safeguarding and infection control. Staff were supported to attend other training courses to ensure they were skilled in caring for people. One member of staff said, "The dementia training really helped me to understand how to work with people suffering from dementia". Staff told us they had the training to meet people's needs. We observed staff were aware of people's needs and could identify any need for extra training.

Staff were supported to improve the quality of care they delivered to people through supervision and annual appraisal. Staff comments included; "My one to one meetings with manager help me to reflect on things" and "I have my supervision with [person] every three months. I find this useful and you can say if you have any problems or training needs". Regular supervisions gave staff the opportunity to discuss areas of practice and improvement. Any issues were discussed and actions were set and followed up at subsequent supervisions. Staff were also given the opportunity to discuss areas of development and identify training needs. Development and training plans formed part of the annual appraisal process.

People were supported to stay healthy and their care records described the support they needed. People had access to healthcare services and on-going healthcare support. Staff accompanied people to specialist appointments such as dentists and opticians. One person told us, "The doctor is here every Monday afternoon. Since being here I have made a surprising recovery so far".

People told us they enjoyed their food. Comments included; "The quality of the food is very good" and "The main menu is very good". People were supported to have a meal of their choice by organised and attentive staff.

People's specific dietary needs were met. Kitchen and care staff had the information they needed to support people. People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. They also told us they met with people regularly to discuss if they needed any changes in the food they were getting. The kitchen staff knew all the residents and had flexible menus. Some people had special dietary needs, and preferences. For example, people having diabetic diet, pureed food or thickened fluids where choking was a risk. The home contacted

GP's, dieticians, speech and language therapists as well as care home support if they had concerns over people's nutritional needs. Records showed people's weight was maintained. Snacks were available for people throughout the day, such as fruit, cakes and biscuits. Staff were aware of how much fluid people needed on a daily basis and this amount was clearly recorded on each chart.

People enjoyed the lunch time meal experience. The atmosphere was pleasant. There was conversation and chattering throughout the dining room. People chose where they wanted to sit and did not wait long for food to be served. People were given choices and staff showed them two plates for each course of meal. Staff sat with people and engaged with them whilst supporting them to have their meals at a relaxed pace. People supported with meals in their rooms had the same pleasant dining experience as those in dining rooms.

People's consent was sought before any care or support was given. Staff knocked on people's doors and sought verbal consent whenever they offered care interventions. Records showed people, or family members on their behalf, gave consent for care they received and in line with best interest decision making guidance. For example, all files reviewed showed consent for taking and using photographs.

The registered manager and staff followed the Mental Capacity Act 2005 (MCA) code of practice and made sure that the rights of people who may lack mental capacity to take particular decisions were protected. The MCA provides a legal framework to assess people's capacity to make certain decisions at a certain time. People were always asked to give their consent to their care, treatment and support. Where people were thought to lack the capacity to consent or make some decisions, staff had followed good practice guidance by carrying out capacity assessments. Where people did not have capacity to make certain decisions, there was evidence of decisions being made on their behalf by those that were legally authorised to do so and were in a person's best interests.

The registered manager and staff followed the requirements in the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. Applications under the DoLS had been authorised and the provider complied with the conditions applied to the authorisation. People who had DoLS in place were being supported in the least restrictive way. Staff had been trained and understood the requirements of the MCA and the specific requirements of the DoLS.

Is the service caring?

Our findings

People told us they enjoyed living at Middletown Grange nursing home. They said, "This place is far superior to others", "It's a lovely nursing home and I'm very happy here" and "I'm very pleased about being here". People complimented the care they received from staff. Comments included; "The nursing care is good", "I have no complaints about the standard of care. I am very happy" and "The staff are lovely, very kind and very caring".

We observed many caring interactions between staff and the people they were supporting during our inspection. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere in the home was calm and pleasant. There was chatting and laughter throughout the day. One member of staff won the Oxfordshire Age UK Care Staff Category award for caring. This is an award nominated by people and their relatives given to individuals who have demonstrated excellent caring within their field of work.

Staff told us they were caring and enjoyed working at the service. Some of the staff members had been with the provider for a number of years. Comments included; "I am happy here. I like the continuity", "I have worked here for a very long time because I like how we care for the residents" and "I look after people the way I would look after my grandparents".

Staff were aware of people's unique ways of communicating. Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication. For example, one person suffered from anxiety and repeated words over and over during communication. Staff took their time to listen carefully to this person and allow them to calm down.

People were treated with dignity and respect by staff and they were supported in a caring way. We saw staff ensured people received their care in private and staff respected their dignity. Staff told us how they treated people with dignity and respect. Comments included; "I always knock before I enter somebody's bedroom. I close the curtains, close the door and I use a towel to cover them and protect their dignity" and "We cover people during personal care. One person told us, "I'm quite happy here, I feel well treated and still have my dignity".

People were supported to be as independent as possible. Records showed people's independence was promoted. For example, one person's condition had deteriorated and they had lost their balance. Staff supported this person to remain independent by using a walking aid. Staff told us, "If they are able to eat and drink themselves, we help them to do this. We encourage them to do as many things as possible" and "We allow residents enough time to do what they can for themselves".

Staff told us they understood and respected confidentiality. Comments included; "We do not discuss personal information with people who don't need to know" and "We do not discuss residents in public and we keep their records secure". Records were kept in locked nurse's stations only accessible to staff.

People and their relatives where appropriate were involved in decisions about end of life care and this was recorded in their care plans. For example, one person had an end of life care (a plan of their wishes at the end of life), an anticipatory plan for hospitalisation and a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person and their family were involved in this decision. Staff knew this person's wishes and made sure the person had dignity, respect and comfort at the end of their life. Staff described the importance of keeping people as comfortable as possible as they approached the end of their life. They talked about how they would maintain people's dignity and comfort and involve specialist nurses in the persons care. One member of staff said, "We ensure comfort and families as well as professionals are involved". The registered manager told us they had received, 'Great feedback from families during end of life care'.

Is the service responsive?

Our findings

When we last inspected Middletown Grange nursing home in February 2016, we found people did not receive activities, stimulation or engagement which met their needs or preferences. Staff did not always engage with people and ensure care was person centred. These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection on 21 March 2017 we found some improvements had been made. People had access to activities and staff engaged meaningfully with people. However, improvements could still be made.

The registered manager was actively recruiting for an activities coordinator. There was a choice of activities offered to people. However, staff commented that the range of activities could be wider if an activities co-ordinator was in place. Staff told us, "Our activities are rather spontaneous than planned. We find it difficult to structure anything in terms of activities", "There are not many activities here. I remember when we went out in a minibus to the garden centre, they remembered it too and they were talking about this each time they recognised my face. We need an activity co-ordinator to organise more for people" and "I think they have enough activities. Painting, crafting and flower arrangement. One of the carers even brings his own karaoke machine so the residents can sing with us". One person's relative said, "There are no activities. They need activities. The only thing they do is flower arranging. The men won't do that". Residents and relatives meeting records showed activities were still discussed as an issue in most of the agendas in the previous months.

The activities available to people included games, sing-alongs, flower arranging, listening to music and arts and crafts. We saw people sat in the communal areas and listening to music and reading newspapers. Others stayed in their bedrooms, watching television, reading or being visited by their relatives. Staff offered one to one activities to people who remained in their rooms. Records showed people received activities. The registered manager told us they were in the process of incorporating people's life histories, social circumstances and preferences to form person centred activities. However, this was taking longer than anticipated without a dedicated activities coordinator. They said, "We are looking to broaden activities to include more outgoing". On the day of our inspection we observed good staff engagement as well as a flower arranging session which people enjoyed. People were actively involved and staff were at hand to support people who needed help.

People's needs were assessed before they came to live at Middletown Grange to ensure those needs could be met. These assessments were used to create a person centred plan of care which included people's preferences and choices.

Care plans were personalised and contained detailed daily routines specific to each person. Care plans reflected how each person wished to receive their care and support. For example, people's preferences about what time they preferred to go to bed. People and relatives confirmed they were involved in planning their care. One person's care plan review stated 'Very happy with care'.

Care plans were reviewed monthly to reflect people's changing needs. Where a person's needs had

changed, the care plan had been updated to reflect these changes. For example, one person refused to use equipment for protecting their palms. They were reviewed by physiotherapists and staff were encouraged to 'wash the person's hand twice a day'. Staff updated the person's care plan to reflect the changes and daily records showed staff followed the advice of monitoring the person's hand.

Staff told us and records confirmed the provider had a keyworker system in place. A keyworker is a staff member responsible for overseeing the care a person receives and liaises with families and professionals involved in a person's life. This allowed staff to build relationships with people and their relatives and aimed at providing personalised care through consistency.

People's views and feedback was sought through regular family meetings as well as quality assurance surveys. Records of family meetings showed that some of the discussions were around what changes people wanted, people's opinions were sought and action was taken to respond to issues raised. For example, in one meeting, people's relatives had requested white boards to be put in people's rooms to aid communication. This had been actioned and people and their relatives found them very useful.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and clearly displayed on notice boards. People's relatives commented that the registered manager was always available to address most issues. We looked at the complaints records and saw all complaints had been dealt with in line with the provider's policy. Records showed complaints raised had been responded to sympathetically, followed up to ensure actions completed and any lessons learnt recorded. People spoke about an open culture and felt that the home was responsive to any concerns raised. Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

Is the service well-led?

Our findings

During our last inspection in February 2016, we found the provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of the people. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection on 21 March 2017 we found improvements had been made. The provider assessed, monitored and mitigated the risks relating to the health, safety and welfare of the people.

The provider had a clear procedure for recording accidents and incidents. Accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the risk of further incidents occurring. For example, one person had been referred to the occupational therapist (OT) following a couple of incidents. This person was subsequently referred to their GP to have their medicines reviewed since OT had suggested that the incidents were a result of side effects of some medicines. The person did not have further incidents. The registered manager audited and analysed accidents and incidents to look for patterns and trends to make improvements for people who used the service. Staff knew how to report accidents and incidents.

The home was led by the registered manager who was supported by a deputy manager. The registered manager had been in post for a year. They demonstrated strong leadership skills and had a clear vision to improve the quality of the service. There was a clear leadership structure which aided in the smooth running of the service.

Staff had mixed views of the management team, the support they received and the way the service was managed. They told us, "She [manager] is approachable. She tells us her door is always open but she could be a little bit more visible on the floor", "They [management team] are lovely. They are open and encouraging us to share our opinion with her", "I find the deputy very supportive and very easy to talk to" and "Manager difficult to approach at different times of the day, not very supportive consistently". The registered manager had an open door policy, was seen around the home on inspection day and had a good rapport with people and staff.

People and their relatives knew the registered manager, however, they had mixed views on the way the home was managed. One person told us, "The home is well managed and well run. The day to day manageress is an excellent person". People's relatives commented, "I don't feel the manager is pulling her weight. They are only existing", "The manager is good, I know her and see her around" and "They [management team] definitely need to get organised".

The provider had quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits including catering, medicine safety, quality of life and care plans. Quality assurance systems were operated effectively and used to drive improvement in the service. For example, a medicines audit had identified missing records for as and when needed medicines and action had been taken to ensure that record keeping in this area had improved.

Staff commented positively on communication within the team. Team meetings were regularly held where staff could raise concerns and discuss issues. The meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. During one meeting staff discussed shortfalls identified in a records audit and agreed on a plan to address it.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.