Indigo Care Services Limited

Middleton Park Lodge

Inspection report

Acre Close
Middleton
Leeds
West Yorkshire
LS10 4HT

Tel: 01332712307

Date of inspection visit:
12 April 2018
17 April 2018

Date of publication:
14 June 2018

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place on 12 and 17 April 2018.

At our last comprehensive inspection in March 2017 we gave the service an overall rating of 'Requires Improvement'. This was because we found concern around the deployment of staff, knowledge and understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). We also received mixed views on how the service was run. At this inspection we found improvements had been made.

Middleton Park Lodge is a purpose built home providing care for up to 50 people requiring personal and nursing care. All bedrooms are single occupancy with ensuite toilet facilities. The home is arranged over two floors accessed by stairs and lift. Both floors provide communal lounge and dining areas.

The service had a registered manager. 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.

People received their care and support safely. People's risks were assessed and reduced by staff who understood how to protect people from improper treatment. People's medicines were stored securely and administered in line with the prescriber's instructions. Staff followed appropriate personal care and food safety practices to prevent infection. We found some aspects of the environment could affect people's health such as unlocked fire doors and broken seals round toilets. We raised these with the registered manager who amended these shortfalls during the inspection.

Staff were supported in their role by the registered manager who delivered supervision and appraisal and coordinated staff training. People's needs were assessed and they received support to maintain their nutritional and hydration needs. People were supported to have maximum choice and control of their lives.

Caring staff maintained people's privacy and dignity. People were supported to maintain relationships with relatives and friends. Visitors were made to feel welcome and people were supported to practice their faith.

People had personalised care plans which detailed how they wanted staff to meet their individual needs. However, care records were not always clear, up to date, concise or easy to understand. Staff were allocated to support the implementation of people's personalised care. A range of activities were provided by staff for people to participate in. Information was available for people to access the provider's complaints procedure. The registered manager understood the provider's procedure for handling complaints which we saw was clearly documented.

The registered manager had improved quality assurance processes and actioned the concerns raised at the

last inspection. There was an open culture at the service and the views of people, relatives and staff were gathered. The service worked in partnership with other agencies to secure positive outcomes for people.

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's medicines were stored appropriately and administered safely. People's risks were assessed and mitigated.

There were enough staff to meet people's needs and robust procedures were used to recruit new staff.

The environment and equipment were checked for safety.

Is the service effective?

Good

The service was effective.

People were treated in line with the Mental Capacity Act 2005.

People received the support they required to eat well. Staff supported people to access health care services whenever they were required.

Staff were trained and supervised to aid them in their work.

Is the service caring?

Good

The service was caring.

Staff respected people's privacy and treated them with dignity.

People's spiritual needs were identified and supported.

Visits from relatives and friends were encouraged and welcomed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Individualised care records were not always clear and contained conflicting information.

A range of activities were available for people to participate in.

Complaints were recorded and responded to appropriately.

Is the service well-led?

Good

The service was well-led.

The registered manager audited the quality of the service and made timely improvements.

People, relatives and staff contributed to the shaping of service delivery through feedback and consultation.

The service worked collaboratively with other health and social care agencies.

Middleton Park Lodge

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.

The inspection took place on 12 and 17 April 2018, it was unannounced. The inspection team consisted of one adult social care inspector.

We used information the provider sent us in the 'Provider Information Return' (PIR). This is information we require providers to send us at least annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information that we held about the service such as safeguarding information and notifications. Notifications are the events happening in the service the provider is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

We looked at how people were supported throughout the day with their daily routines and personal care needs. We reviewed a range of records about people's care and how the service was managed. We looked at four care records for people who used the service and four staff files. We spoke with three people who used the service and one relative. We completed observations during the inspection to evidence how people were treated. We spoke with four care workers as well as the registered manager, office staff and one health care professional. We looked at quality monitoring arrangements, rotas and other staff support documents including supervision records, team meeting minutes and individual training records.

Good

Is the service safe?

Our findings

At our last comprehensive inspection in March 2017 we gave the service a rating of 'Requires Improvement' in this key question. This was because staff were not always deployed to keep people safe. At this inspection we saw deployment of staff had improved but we found some concerns with the environment.

One person told us, "I have never felt unsafe. Staff look after us well. They help me with my medicines" and another person said, "They help me be safe." Relatives told us, "I visit a lot and there is always staff around. If I did not think there was enough I would say something" and, "I know mum is safe here. I trust the staff and I know her possessions are safe as well."

We looked at how medicines were managed by checking the medicine administration records (MAR) for eight people, speaking to nursing and care staff and observing a medicine administration round. We found records were true and accurate which meant staff were able to demonstrate that people were receiving their medicines as prescribed. Medicines were stored appropriately and securely. Medicines were kept in a locked cupboard inside a locked clinical room. Medicines which needed to be kept cool were stored in a lockable fridge. Staff monitored and recorded the temperature of the clinical room and fridge to ensure they remained within the recommended guidelines.

Staff were knowledgeable about the people they were looking after and when to administer 'as required' medicines. 'As required' medicines are medicines that are to be taken as and when they are required, for example a pain killer would be taken only when someone presents pain. This advice included dose frequency and the maximum number of doses in 24 hours. Where people were administered pain relief patches or creams, there was evidence to support these were applied safely and people's pain relief would be well controlled.

People were supported by staff who understood the potential types of abuse people were at risk of and their responsibility to report and act on any concerns. Staff had received training in dealing with abuse and were provided with a handbook with information on how to raise concerns. One member of staff told us, "If I had any reason to think something bad was happening, I would do something about it straight away." We noted that where safeguarding concerns had been raised, they were responded to and acted on appropriately and saw the registered manager worked in partnership with other stakeholders in order to keep people safe from harm.

People were supported by staff who were aware of the risks to them. For example, a member of staff described how they supported a person, "[Person] can do some things themselves but we have to make sure they are safe when they move, so we are always here to support them." They went on to explain that one person wore glasses, but still required guidance and reassurance when mobilising, adding; "Sometimes [person] gets frustrated and doesn't understand, so it's how you communicate with them." Care plans held detailed risk assessments that were regularly reviewed by a named nurse. This meant reviews were carried out by staff who were aware of people's history and what actions had been taken previously to keep them safe.

We saw where accidents and incidents took place they were recorded and acted on appropriately. For example, where one person had suffered a fall, risk assessments were reviewed and equipment purchased to reduce the risk and a sensor mat was placed in the person's room [with their permission] to alert staff.

One person told us, "They [care staff] do the job but sometimes you have to wait a bit while they finish something else." Another relative observed, "They used to have agency staff but I haven't seen one for a while now. It's good because people are safer if staff know them." We observed staffing levels and saw that at busy times of the day, people sometimes had to wait a short while, but most of the time if people needed support they were quick to receive it. We saw communal areas were always staffed. A member of staff told us, "There are enough staff and people are safe but it's always nice to have more." The registered manager told us one of the challenges they faced was ensuring staff were spread across the service to ensure the communal areas were always staffed appropriately. They told us they had looked at different ways of deploying staff more effectively across the home.

The registered manager told us they had recognised the need to recruit more staff and in response to this there had been and was an active recruitment campaign in place. Vacancies for night staff were being filled by existing staff who were familiar with the service. The registered manager told us, "We have been trying to get agency use to zero." There was a dependency tool in place to assess staffing levels. The registered manager told us, "We will increase our staffing as people's dependency increases."

All staff employed by the service had the appropriate checks in place, including two references, prior to commencing their post. We saw systems and processes were in place to ensure people were supported by staff who had been assessed as being appropriately experienced and skilled in order to meet their care needs.

The home environment and staff practices minimised people's risk of infection. Staff received training in infection prevention and control and we saw hand sanitising gel pumps were available throughout the service including bathrooms, the reception area and along corridors. Staff wore Personal Protective Equipment (PPE) when delivering personal care to people. Kitchen staff wore additional PPE including aprons and hairnets. This practice was in place to prevent staff from inadvertently spreading potentially harmful bacteria.

During our inspection of the building we found some shortfalls in the up keep and maintenance of the environment. For example, we saw some broken seals around toilet basins, people's cleaning liquids and razors stored in a communal bathroom cupboard and a fire door cupboard that although was locked, the door could still be pulled open. We mentioned these to the registered manager who dealt with all the concerns during the inspection. Other equipment such as hoists were maintained and people had personal emergency evacuation procedures in place in the event of an emergency people could be evacuated safely.

Good

Is the service effective?

Our findings

A relative said, "I'm sure staff are trained, I have not seen anything to make me think otherwise" and another relative told us, "They [care staff] seem to know what they are doing." Staff told us they felt well trained and competent in their role.

We saw that as well as the providers' mandatory training, staff were offered additional learning opportunities in order to meet people's specific needs, such as epilepsy, when required. As part of the induction process for new staff, employees were expected to complete the care certificate. The care certificate is a national recognised set of qualifications that give care staff all the basic training they require. This meant staff could be confident they would be provided with the training and support that would equip them with the skills required to meet people's needs on a daily basis. We saw and staff told us there were systems in place to ensure staff received the most up to date information about people in order to meet their needs safely and effectively. A member of staff told us, "In handover you find out what's happening." Records showed staff had regular supervision and appraisal with someone senior to them to review their progress and identify any further training required.

People were supported by staff who benefitted from an induction that prepared them for their role. We saw the induction pack and process in place included a handbook providing staff with information to assist them in their role. There was a policy of new starters being able to shadow colleagues for a period of time and learn from more experienced staff. Induction included a mixture of online and practical training and being introduced to the people living in the home. One member of staff told us, "The shadowing of other staff is really useful."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found staff had received training in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People told us staff obtained their consent prior to supporting them and we observed this. Staff were able to demonstrate an understanding of the need to consider people's ability to give consent and what may be considered as a restriction of their liberty, but some staff did require some prompting on the subject. We saw prior to applications to deprive people of their liberty; capacity assessments and best interests meetings had taken place. A number of applications for people using the service had been submitted and one had been authorised by the local authority.

We found the environment met people's needs. The service benefitted from a lift and the building was

accessible for all people with mobility difficulties. We saw communal areas had space for people to sit in comfort and other areas of the service if people wanted a quiet area to sit in. Dining rooms had enough table and chairs for all to sit down at the same time to enjoy their meals. Signage was clear to direct people on where to wanted to go.

We saw people were supported to make choices at mealtimes and menus were on the wall to remind people what was on offer that day. One person told us, "I like the food here" and we observed people enjoying their lunch time experience.

The provider told us in their Provider Information Return [PIR] that people were consulted with regard to the menu choices on offer. We saw the chef had worked to gather more information regarding people's mealtime preferences. We saw this information was then incorporated into menus in order to provide people with a variety of choices of food that were tailored to their preferences. The chef was aware of people's individual dietary needs and preferences and there were systems in place to accommodate these. For example, for those people who were at risk of choking and required their meals to be pureed, their meals were prepared freshly and efforts made to present the food to make it appear more appetising.

People told us they were supported to maintain good health by having access to a variety of healthcare services and we saw evidence of this. For example, their GP, chiropodist, opticians and physiotherapist. We saw where one person was at risk of weight loss, referrals had been made to a dietician and the advice provided was followed. People told us and confirmed they had been referred to health care professionals when they required help and advice. Staff spoken with were aware of people's healthcare needs and how to support them to maintain good health. One member of staff told us, "We keep a close eye on people and look out for any warning signs that they may not be themselves. We can then have a discussion and decide the appropriate action to take."

Good

Is the service caring?

Our findings

One person said, "I like it here, they are always very nice and help me when I need it." People spoke positively about the staff who supported them and we witnessed many instances of staff speaking to people in a kind and caring manner, sharing a laugh and a joke and enquiring after them. For example, we observed a member of staff greet a person enthusiastically saying, "Good morning [person's name], you look lovely this morning." Another member of staff was aware that a person went out with family the day before and asked them about this. We saw one person being encouraged to eat at lunchtime and the member of staff was persuading them kindly. A relative told us, "[Person's name] is doing really well. Much improvement since they moved in."

People were supported to be actively involved in making decisions about how they spent their day. One person told us, "I choose when I want to go to bed. Staff will help me when I am ready." We saw for people who struggled to communicate verbally, alternative systems of communication were in place such as picture guides. This meant staff were able to communicate effectively with the person and also respond to their requests for assistance and/or support. We observed people were dressed appropriately for the time of year, many were wearing jewellery or scarfs and had had their hair done. This meant that people were supported to maintain their individuality when it came to their appearance.

People were supported to maintain their independence where possible. One member of staff described for one person, how important it was to get the balance right when providing support, at the same time ensuring people were able to retain the skills they had. They told us they had considered how they were supporting the person and questioned their practice. This meant that staff were mindful of their role in people's daily lives in supporting them to be as independent as possible.

All people spoken with told us staff treated them with dignity and respect and we observed this. One person said, "They are all very nice. We have a nice chat and a laugh. They always listen to what I have to say." We saw one person was supported to the bathroom. The member of staff reassured the person they would be standing outside the bathroom door and told us, "[Person] wants me to stay here so no one walks in on them and so I can help when they are ready." Staff were able to provide us with examples of how they maintained people's dignity when supporting them, one member of staff told us, "If I am supporting someone with personal care I make sure the curtains and doors are closed."

We saw people were supported to access advocacy services should they wish to have someone act on their behalf. An advocate can be used when people have difficulty making decisions and require this support to voice their views and wishes.

Requires Improvement

Is the service responsive?

Our findings

We saw people were involved in the development of their care plans. Care plans included information about people's history, their likes and dislikes and how they liked to spend their time. A relative commented, "Staff make the effort to get to know them."

We noted care records were being transferred to an electronic system and all staff would be provided with training to enable them to make contributions to care records. At the time of inspection, the care records we reviewed were hand written on paper documentation. We saw people's care plans had been reviewed and changes were added as additions to the care records. This meant some care records were large and took time to read and understand. Hand written care records were also not clear to read depending on people's hand writing and some information was repeated or old. For example, one person's plan of care described two hourly continence checks, but evaluations of the plan indicated three to four hourly checks. We also saw two care records that were difficult to read due to the handwritten nature leading to potential confusion or misunderstanding. This meant up to date information was not always easily accessible for staff. We discussed this with the registered manager who acknowledged the issue and told us the new system they were entering information into currently was all computerised, allowing plans to be shorter but still maintain the valuable information, clear and easily reviewed and edited. Expected timescales for the completion of the new electronic system had not expired. People and their relatives told us they could speak to the registered manager at any point to discuss any issues or concerns with their care and any changes were followed through.

The provider told us in their Provider Information Return [PIR] people, families and friends were involved in putting together life histories which provided staff with a variety of information regarding people's likes, dislikes, hobbies and how they wished to live their lives now and in the future. Staff spoke positively about these files and the information provided within them.

Meetings took place which provided people and their relatives the opportunity to discuss any issues or ideas they may have. For example, we saw families had asked for access to their loved one's care records and this had been provided in line with data protection requirements. We noted care records had been amended and updated to include people's particular preferences.

People were supported to take part in a variety of activities which they told us they enjoyed and we observed this. One person told us, "The (activities) staff are very good; they are always around and try different things." A relative commented on the positive impact the activities co-ordinator had had on their loved one and told us, "They have got [person] to join in and get involved."

The activities co-ordinator had asked people what they liked to eat, their favourite recipes/meals and what they liked to do. The activities co-ordinator told us how getting people involved had worked well. We saw there was a noticeboard that displayed a variety of daily activities. For example, there was bingo, gardening, exotic animals visiting and exercises made fun. The service also supported people out to areas of their interest. For example, some people visited the Emmerdale experience while others watched contemporary

dance at the service.

We saw when new people came into the service, they and/or their relatives were asked to fill in details of activities they enjoyed, this included not just what people currently enjoyed doing, but what they enjoyed in their past and also what they would like to do in the future. The activities co-ordinator said, "We try to find out what people want to do." This meant that information collected on what was important to people was used to create activities that helped fill people's lives and provide meaning to their days. We saw for those people who were cared for in bed, activities came to them. For example, some people had one to one time with the activities co-ordinators chatting or looking at photographs.

We saw people's diverse needs were accommodated in a variety of ways. Care was taken to support people in celebrating their chosen faith and offers of assistance were provided. For example, one person enjoyed having religious passages read to them. This information on people's faith was gathered as part of their monthly assessment.

People told us they felt listened to. Meetings took place providing people with the opportunity to raise any concerns and share their points of view. We saw there was a system in place to log, investigate and respond to any complaints received. We noted where complaints had been received they had been investigated and responded to appropriately and actions taken, staff spoken with, where appropriate. There was information on display providing people with details how to raise a complaint. There was a complaints and compliments folder which held many compliments. For example relatives thanking the staff team for their support and hard work with their family member towards the end of their life.

People were supported with their end of life care. People and their families were asked about how they wanted to be supported as part of the care records formulation. We saw advanced decision paperwork completed for some people directing staff exactly what people's wishes were at the end of their life.

Good

Is the service well-led?

Our findings

One person told us, "[Registered manager's name] is good. I often see them round the home." A relative told us, "I know who the manager is and see them when I visit" and another relative said, "We really like it here. I would recommend it." We gathered many positive comments regarding the registered manager's ability to manage, lead and support staff in a way that ensured people's needs were met. Staff told us they would recommend the home to other people and considered it to be well led. A member of staff told us, "Oh yes I would recommend it here. I think everyone is looked after and I know we can go to the manager if we have any problems." We observed the registered manager had a visible presence in the home.

People were supported by staff who were aware of their roles and responsibilities. The registered manager had a comprehensive knowledge of the people living in the home. This in turn enabled them to discuss with staff the needs of the people living at the home and the support staff required to meet those needs. For example, we saw the registered manager discussing people's needs with people and staff in confidence. Further, we saw guidance and training was provided in how to support the person safely, ensuring staffs safety was considered at all times.

Staff spoke positively about the teamwork in the service and there was a culture amongst staff to support each other. One member of staff told us, "We get along and work well together" and provided an example of how they were welcomed by colleagues. Another said, "We have had some ups and downs in the past but we are settled know and everyone (staff) knows what they are doing." These examples meant the registered manager had worked with staff to create a working atmosphere that was supportive so staff felt they could approach their colleagues or manager for support and know it would be there for them.

The provider told us in their Provider Information Return [PIR] staff were encouraged to raise any concerns they may have and we saw evidence of this. Staff told us they felt supported and listened to. They spoke of the changes the registered manager had introduced into the home and the positive impact this had had. One member of staff told us, "We have the chance to raise our concerns in meetings or supervision. Although if it was urgent we could just go speak to them (registered manger)."

The service was led by a registered manager who had a clear vision for the service. We saw the local authority and Clinical Commissioning Group (CCG) had worked with the provider. There were a number of plans in place for the future of the service, such as electronic care records and building maintenance. This showed us the registered manager was working with the providers to assess the existing environment and how it could be improved upon in order to meet the future plans for the home. The registered manager worked as part of a 'discharge sub group' that regularly met to discuss ideas of how to improve people's experience when discharged from hospital.

We saw there were a variety of audits in place to assess the quality of the service provided. For example, audits looked at the environment, infection control and medicines. Audits were completed on behalf of the local authority and where accidents and incidents took place, they were analysed for any trends. Where audits had identified areas for improvement, action plans were in place. For example, the registered

manager had identified the staff manual did not contain all relevant policies and procedures through their own audits. However, at the time of inspection care records were sometimes hand written making them difficult to understand and gave conflicting information. We mentioned this to the registered manager who acknowledged the issue and shared our concern. They told us a new electronic care records system was currently being updated for use. Other regular checks including the dining experience tool and head of regional operations monthly visit looked at specific areas of the service. The registered manager completed a daily walk around the service and a daily flash meeting with staff to hand over important information.

The provider had a history of notifying the Commission of any events they were required to by law. We saw the provider had on display their rating poster from their previous inspection, which they were required to do so by law.