Maria Mallaband 10 Limited

Homefield Grange

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on the 17 March 2016 and was unannounced. It continued on the 18 March 2016 and was announced.

Homefield Grange is registered to provide accommodation for up to 64 people who require nursing or personal care. At the time of our inspection there were 27 older people living at the service. People required a mixture of residential and nursing care. The building is on three levels and people were living on the ground floor. The first floor had not started to accept admissions but was furnished in preparation. All the rooms were single rooms with en-suite wet room facilities. The ground floor had a lounge area, garden room and dining room. The garden room and dining room had level access into a secure garden. Two specialist bathrooms were available, a treatment room and sluice area. The first floor in addition had a library area, a shop selling sweets, toiletries, cards and gifts, and a cinema. There was also a hair and beauty salon.

The home did not have a registered manager at the time of our visit. The manager had submitted their application to the Care Quality Commission and was awaiting the outcome. 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.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the service was not always working within the principles of the MCA. We observed one person being given liquid medicine which staff had disguised as orange juice. The service had a policy for medicines being administered covertly. The policy included guidance on the MCA and DoLs and had not been followed by the nursing team. During our inspection the service organised a best interests meeting with the person's GP and family who had an enduring power of attorney.

We checked a persons' care file that stated they did not have mental capacity. They had a pressure sensor mat in their room due to a risk of falling and if it was stood on it alerted staff. Although this placed restrictions on the person a best interest decision had not taken place. Files contained copies of power of attorney legal arrangements for people but staff did not always understand the scope of decisions the POA could make on a persons' behalf. We discussed our findings with the services quality manager who told us that their findings had been the same and staffs understanding of the MCA and power of attorney were on the quality action plan.

Deprivation of Liberty Safeguards (DoLS) had been applied for people who needed their liberty to be

restricted for them to live safely in the home. Staff were aware of people who had a DoLs authorisation in place. Care records also contained signed consent for sharing information, use of moving and handling equipment, photographs and vaccinations. We observed staff seeking verbal consent before supporting people with care.

People and their families told us that they felt the service was safe. Staff had undertaken safeguarding training and understood what types of abuse people may be at risk from and how to recognise any signs of potential abuse.

Risk assessments had been completed for people. Where a risk had been identified actions had been taken to minimise the risk. We spoke to staff who demonstrated a good understanding of people's individual risks and the actions they needed to take to support the person and keep them safe. People had the freedom to make choices about how they lived with identified risks. Risk assessments had been regularly reviewed.

Accidents and incidents had been recorded. This included notes of any investigations and follow up actions needed. We saw that actions had included referrals to other professionals, contacting the safeguarding team at the local authority, reviewing risk assessments and changing people's care plans.

People had individual personal evacuation plans in place. Staff had received fire training and fire equipment was tested weekly. Records showed us that regular checks were made of hot water temperatures, pressure mattress settings and moving and handling equipment.

We observed staff supporting people in a timely way. Staff told us they felt there were enough staff to meet peoples' assessed needs. The home had reduced the use of agency care staff following a successful recruitment campaign.

We looked at staff files and found that staff had been recruited safely. Files contained evidence of references, criminal record checks and eligibility to work in the UK. Procedures were in place to manage poor practice.

Medicines were stored and administered safely by registered nurses. Senior care workers had also received medicines training so that they could be a second signature on medicines records when needed.

New care staff completed the Care Certificate Induction. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. Senior care staff and nurses had an induction appropriate to their role.

Staff told us they felt they had the training they needed to carry out their jobs. Training records were kept for each person and included dates for refresher training. Staff had opportunities for personal development and training. Nurses had been supported with clinical updates.

Staff felt supported and received supervision. Annual appraisals had been planned.

People had a choice of what they would like to eat and drink and where they would like to have their meal. Staff had a good understanding of risks associated with peoples eating and drinking. We observed people being supported with their meals in a personalised way. Some people had specialist plate guards and drinking beakers to enable them to eat their meal independently. People who needed staff to help them with their meal were supported in an unhurried way. People were weighed regularly and any significant

weight loss was actioned. This included setting up charts to monitor food and drink intake and referrals to GP's and dieticians.

People had good access to health care which included hospital specialists, chiropodists, dieticians and occupational therapists.

People and their relatives told us staff were caring. We observed staff interacting in a positive, relaxed way with people and their families. Staff demonstrated good communication skills and knowledge of the people they were supporting.

People felt they were involved in decisions about how they received their care. We observed staff asking people if and how they would like to be helped and giving people the opportunity and time to decide. People had access to an advocacy service that would be able to speak up on their behalf.

People had their dignity respected and were supported to maintain their independence.

A complaints process was in place and records were kept of any formal written complaint. Included in the records were details of any investigation, action and the outcome. Verbal concerns raised were not always recorded. We discussed this with the manager who told us they would discuss with staff the importance of recording and sharing any verbal concerns raised in the future.

People told us they felt staff listened to them. A suggestion box had been placed in the entrance hall for people and in the staff room for staff to use. Information was on display in the foyer about the complaints procedure and included details of the local government ombudsman.

Assessments had been carried out prior to people moving to the service. People had a plan of care that was individual to their care and support needs. Care plans had been reviewed at least monthly. People, and when appropriate their families, had been invited to care plan reviews.

Staff had a good knowledge of people and their care and support needs. One person had complex health problems which impacted on their risk of falling. Staff understood how to support the person and the importance of gathering information to support the review of the persons' health and care.

Information had been gathered from people about their lives and included their likes and dislikes. Activities had been organised for people in groups and on a one to one basis. Friends and family were able to visit at any time and people were supported to maintain links with the local community.

People, families and staff told us they found the manager approachable and listened to them. They described the service as well organised. All the staff we spoke with had a positive attitude about their work and the service. Staff had a good understanding of their roles and worked as a team. Staff consistently spoke highly of the team work. A 'Carers Award' had been introduced to recognise staff achievements.

The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way.

Audits had been completed and had captured any areas where action was needed. We spoke with the quality manager who explained that the service had a schedule of audits that they checked each month. Areas that audits had highlighted required some further improvement had been put into a quality action plan. The action plan reflected the findings of the inspection. This demonstrated that the service quality

monitoring systems were effective.

A quality assurance survey was sent annually to people, their families, staff and other stakeholders. The process had been carried out by an external company. Results had been shared with people and their families. A copy of the staff survey results had been placed on the staff notice board.

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.

Staff had undertaken safeguarding training and understood what types of abuse people may be at risk from and how to recognise any signs of potential abuse.

Risk assessments had been completed for people. Staff demonstrated a good understanding of people's individual risks and the actions they needed to support them and keep them safe.

People had the freedom to make choices about how they lived with identified risks.

The building and equipment was safely maintained.

Staffing levels met the needs of people. Staff recruitment had been carried out safely. Procedures were in place to manage poor practice.

Medicines were stored and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not always working within the principles of the mental capacity act which meant that some decisions may not have been made in a persons' best interest.

Staff received an induction and training specific to their roles and had opportunities for personal development.

Staff felt supported and received supervision. Annual appraisals had been planned.

Risks associated with peoples eating and drinking were understood and managed effectively.

People had good access to health care.

Is the service caring?

Good

The service was caring.

Staff were caring and had good communication skills and knowledge of the people they were supporting.

People were involved in decisions about how they received their care.

People had access to an advocacy service..

People had their dignity respected and were supported to maintain their independence.

Is the service responsive?

Good

The service was responsive.

A complaints process was in place which people were aware of and felt able to use.

People had a plan of care that was individual to their care and support needs and was reviewed at least monthly.

Staff understood how to support people and the importance of gathering information to support the review of the persons' health and care.

Activities were organised for people in groups and on a one to one basis and people were supported to maintain links with the local community.

Is the service well-led?

Good

The service was well led.

The manager promoted a positive open culture inclusive to people, families and staff.

Staff had a positive attitude about their work and the service and a good understanding of their roles.

The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way.

Audits were completed and shortfalls used to create a quality action plan.

A quality assurance survey was carried out annually to gather feedback from people, their families, staff and other stakeholders and the results shared.	

Homefield 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.

The inspection took place on the 17 March 2016 and was unannounced. The inspection continued on the 18 March 2016 and was announced. The inspection was carried out by one inspector.

Before the inspection we looked at notifications we had received about the service and we spoke with social care and health commissioners to get information on their experience of the service. We looked at information on the 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.

During our inspection we spoke with five people who used the service and six people who were visiting. We spoke with the manager, deputy manager and a quality manager who was visiting the service. We also spoke to one nurse, three care staff, an agency care worker and the activities organiser. We also spoke with a GP and district nurse who had experience of the service.
We reviewed five peoples care files and discussed with them and care workers their accuracy. We checked three staff files, health and safety records, maintenance records, medication records, management audits, staff meeting records and the results of quality assurance surveys.
We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

Is the service safe?

Our findings

People and their families told us that they felt the service was safe. One relative said "Feel my mum is safe here. She has never said she has felt frightened". A person told us "I feel safe, there is always somebody around". Another relative told us, "Care is safe. They also seem to think ahead of any risk".

Staff had undertaken safeguarding training and understood what types of abuse people may be at risk from and how to recognise any signs of potential abuse. One care worker told us, "If I saw poor practice I would speak to the nurse in charge. I do feel I would be able to speak to any of the senior staff".

Risk assessments had been completed for people. Where a risk had been identified actions had been taken to minimise the risk. We spoke to staff who demonstrated a good understanding of people's individual risks and the actions they needed to take to support the person and keep them safe. We spoke with a senior care worker about a person whose risk assessment had identified they were at risk of malnutrition. They told us "They don't eat very much. It's got to be on their terms. If you give too much encouragement they get upset". We saw records where one person had an identified risk of social isolation. Staff had discussed the risk with the person who didn't want to join in with other people but instead said they were happy with staff interaction and one to one activities in their room. This showed us that people had the freedom to make choices about how they lived with identified risks. Some people had charts that recorded when they had been repositioned in bed or the food and drink they had taken. We saw that charts had been completed throughout the day by staff and families. Senior staff checked the charts daily and any concerns were included in staff handovers at the end of each shift. Risk assessments had been regularly reviewed.

Accidents and incidents had been recorded. This included notes of any investigations and follow up actions needed. We saw that actions had included referrals to other professionals, contacting the safeguarding team at the local authority, reviewing risk assessments and changing people's care plans.

People had individual personal evacuation plans in place. Staff had received fire training and fire equipment was tested weekly. Records showed us that regular checks were made of hot water temperatures, pressure mattress settings and moving and handling equipment.

We observed staff supporting people in a timely way. One person told us "The call bell is answered quite quickly". A senior care worker told us "I feel enough staff with five. Four was a struggle. If people's needs go up we talk about it as a team. We would have to look at how we work. As an example we wouldn't support with the laundry if needs were higher". Another senior care worker said "Feel enough staff. Recently one short but we coped well. It depends on the call bells, if they don't all go off at once we're fine. The relationship between the nurses and care staff is quite good. We told the manager we need five on a shift and she agreed. Also agreed always a senior on shift when new starters and that had really helped".

The service had been using agency care workers. One relative shared their concerns about staff retention. We discussed this with the manager. They told us that there had been a successful recruitment campaign. Records showed us that agency usage had fallen from over 500 hours a week to 170 hours the week prior to

our inspection. This was expected to fall further as two registered nurses had been recruited and were undertaking their induction prior to being included on the staff rota. A person said "In the weeks we have been here it's been consistent staff".

We looked at staff files and found that staff had been recruited safely. Files contained evidence of references, criminal record checks and eligibility to work in the UK. Procedures were in place to manage poor practice. We saw records that showed us that poor practice had been reported by a care worker and appropriate actions had been taken by the manager.

Medicines were stored and administered safely by registered nurses. Senior care workers had also received medicines training so that they could be a second signature on medicines records when needed. A new electronic medicine recording method had been introduced to replace a paper administration system. Staff told us they felt this was working well and reduced the risk of error. We checked creams and eye drops and they had been dated and were within there expiry date. Some people had been prescribed controlled drugs which legally required additional recording and administration processes. We checked one of the records and correct processes had been followed. Some people had been prescribed medicines for as and when they were required. This included medicine for pain management. Records were checked and included reasons why the medicine was requested and the result which enabled nurses to review the effectiveness.

Requires Improvement

Is the service effective?

Our findings

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that the service was not always working within the principles of the MCA. We observed one person being given liquid medicine which staff had verbally disguised as orange juice. We discussed this with the nurse who said "We say we've got your juice. We don't mention medicine as they will not take it. We've tried different approaches and they don't work". The service has a policy for medicines being administered covertly. The policy included guidance on making decisions to administer medicine covertly for people who lacked capacity. The nursing team had not followed this guidance which meant the medicine may not have been administered covertly in the persons best interest. During our inspection the service organised a best interests meeting with the person's GP and family who had an enduring power of attorney.

We checked a persons' care file that stated they did not have mental capacity. They had a pressure sensor mat in their room due to a risk of falling and if it was stood on it alerted staff. Although this placed restrictions on the persons' liberty a best interest decision had not taken place. Another person had a pressure sensor mat in their room. We asked them if they knew what it was for and they said "The staff must have put it there to stop people slipping". The person hadn't consented to it being used and there was no consent or best interest decision on their file. Files contained copies of power of attorney legal arrangements for people but staff did not always understand the scope of decisions they could make on a persons' behalf. We discussed our findings with the services Quality Manager who told us that their findings had been the same and staffs understanding of the MCA and power of attorney were on the quality action plan.

Deprivation of Liberty Safeguards (DoLS) had been applied for people who needed their liberty to be restricted for them to live safely in the home. Staff were aware of people who had a DoLs authorisation in place. Care records also contained signed consent for sharing information, use of moving and handling equipment, photographs and vaccinations. We observed staff seeking verbal consent before supporting people with care. We spoke with a nurse who told us they had received MCA training. They said "Feel I have a good knowledge of the subject".

We spoke with a care worker about their induction. They told us "Prior to the first day of working there was one week of e-learning here in the building and that was an introduction to the care certificate". The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. They then continued and told us "My first day was very welcoming. The senior introduced me to people and other carers. They explained the help people needed. I observed practice. The next day I helped a person with personal care and that was observed. I've now started a 12 week care certificate course. On your first day you get to feel how people must feel. Wow it's a big place. It's good to be in their shoes". We spoke to an agency worker about their induction. They said "One of the better inductions. Shadowed with a permanent member of staff. The member of staff would introduce me to each resident which helped the resident feel confident. Shown the staff room and layout of the home. Felt welcomed and part of the team. Staff and senior staff give you time". We spoke to a senior care worker who said "I had an induction into the senior care role. Nurse observed practice and signed me off. It included checking charts, showing families and residents around, running the floor, delegating staff and problem solving. Felt it was a good induction".

Staff told us they feel they had the training they needed to carry out their jobs. Training records were kept for each person and included dates for refresher training. Training had included moving and handling, infection control, safeguarding, dementia awareness and food hygiene. We spoke with a nurse who said "I have opportunities to speak with the manager about personal development. I have catheter training booked in March".

Staff felt supported. One care worker said "I have supervision. I feel supported most of the time". A senior care worker told us "I have regular supervision. The plan is that senior carers will be completing supervisions. That would be good as I would get to talk to the carers. Currently if carers speak to the manager and there are problems they would share but not if it breaks a confidentiality. Feel supported in my role. Appraisals are annually".

People told us the food was good. One person said "The food is to a high standard". We observed two lunches and the food looked and smelled good. People had a choice of what they would like to eat and drink and where they would like to have their meal. Staff had a good understanding of risks associated with peoples eating and drinking. One person had a very small appetite. We saw records of a conversation the chef had with the person to establish their favourite foods and portion size. We observed one person who was disorientated and reluctant to go into the dining room for their lunch. A care worker walked with them and encouraged them to sit down in a quiet part of the building. Staff had a good knowledge of the person. They told us they had found the person will sometimes eat better when alone. They understood the risks associated with the person not eating due to their diabetes.

We observed people being supported with their meals in a personalised way. Some people had specialist plate guards and drinking beakers to enable them to eat their meal independently. People who needed staff to help them with their meal were supported in an unhurried way. People were weighed regularly and any significant weight loss was actioned. This included setting up charts to monitor food and drink intake and referrals to GP's and dieticians.

People had good access to healthcare. One person told us "I have good access to my GP". We looked at care files that contained evidence of healthcare support from hospital specialists, chiropodists, dieticians and occupational therapists.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring. One person said "The staff are brilliant". Another person said "The staff have always been kind". We spoke with a relative who said "The staff are marvellous. We are really happy with the staff, they are lovely". We spoke with a relative who told us about their relatives experience when -they first moved to the service. They had been reluctant to have staff help with any personal care. They said "But the staff won her over and I know now that she has a bath and hair wash".

We observed staff interacting in a positive, relaxed way with people and their families. Staff stopped and talked to people and sometimes shared a joke. One person was very restless and agitated. Staff spent time with the person offering reassurances and walking hand in hand with them. This calmed the person down and they settled in a quiet part of the lounge. We saw two people become upset with each other. Two staff immediately went and supported each person individually and calmed the situation. Staff demonstrated good communication skills and knowledge of the people they were supporting.

People felt they were involved in decisions about how they received their care. One person said "I don't like men helping me. I said no men and that has been respected". We observed staff asking people if and how they would like to be helped and giving people the opportunity and time to decide. We heard one care worker say to a person at lunch "Are you OK and would you like me to cut it up", they answered "No I'm fine thank you". Another care worker asked a person "Would you like an apron to protect your blazer", and they replied "I would, thank you". One relative told us "Mum usually not in bed but likes to sit by the French doors looking into the garden. She didn't feel well this morning and so has decided to stay in bed".

People had access to an advocacy service that would be able to speak up on their behalf. Information about the advocacy service was given to each person when they moved to the service.

A care worker told us how they help maintain people's dignity. They said "When I am helping somebody with a wash I ask them if they would like to wash areas they can reach. I hold their clothes up to let them choose. Also I shut the door and curtains and let people use the toilet in private". A relative told us "Mum is happy, content and her self-respect maintained".

People were supported to maintain their independence. A male care worker told us "I'm working with a person today who prefers men. He wants to be independent and is hoping to take a walk up and down the corridor later today. Staff are very supportive and encouraging".

Good

Is the service responsive?

Our findings

A complaints process was in place and records were kept of any formal written complaint. Included in the records were details of any investigation, action and the outcome. We spoke with a relative who had raised a verbal complaint to staff about the provision of equipment and bedding. This had not been captured in the complaints records. We discussed this with the manager who told us they had not been made aware of the concerns and would discuss with staff the importance of recording and sharing any verbal concerns raised in the future.

People told us they felt staff listened to them. One person said "My husband asks lots of questions and staff are very accommodating". A suggestion box had been placed in the entrance hall for people and in the staff room for staff to use. Information was on display in the foyer about the complaints procedure and included details of the local government ombudsman. Changes had been made to the menu and activity programme in response to people sharing their views at resident meetings.

Assessments had been carried out prior to people moving to the service. One relative told us "A care plan was in place within 24 hours. I was also asked for information on power of attorney and any decisions on resuscitation".

People had a plan of care that was individual to their care and support needs. Care plans had been reviewed at least monthly. We spoke with a senior care worker who told us "One person came from another home and we were told they always stayed in bed. When they got here we asked if they wanted to get up and they said yes". People, and when appropriate their families, had been invited to care plan reviews. The manager told us that some people had moved from another service and they had been offered settling in reviews. One family accepted the invitation and an informal meeting had taken place to discuss how their relative was sleeping and how they were generally coping with the new environment.

Staff had a good knowledge of people and their care and support needs. One person had complex health problems which impacted on their risk of falling. Staff understood how to support the person and the importance of gathering information to support the review of the persons' health and care.

Information had been gathered from people about their lives and included their likes and dislikes. We spoke with the activities organiser. They told us "One person likes the library and so we organised a monthly visit. We tried audio books but they prefer books. Quite content. Enjoys looking out watching the birds and likes a little chat". Some people chose to spend time in their rooms. The activities organiser told us "I carry out one to one activities for people in their rooms. It might be jigsaws or knitting".

We observed one person enjoying walking around the garden tidying up fallen twigs. The person had always enjoyed the outdoors and arrangements had been made for them to enjoy the garden independently.

Friends and family were able to visit at any time. We observed people going out with family for the afternoon. One person told us "I go out to visit friends and family". The activities organiser told us about a

trip that had taken place to the local pub. A monthly activities planner was on display and included entertainers, quizzes, bingo and film shows.

Good

Is the service well-led?

Our findings

A senior care worker said "The manager is approachable. You can ask her things and she does listen". Another care worker said "The new manager is more organised, much better". We spoke with a care worker who said "Feel supported big style. They're not only caring to residents but also each other. Staff morale is really good". A relative told us "The service seems well organised. Feel joined up conversation between staff the GP and district nurses". Another relative said "I've nothing but praise for the place from bottom to top". A third said "The manager always has time to talk and is approachable".

All the staff we spoke with had a positive attitude about their work and the service. Staff had a good understanding of their roles and worked as a team. Staff consistently spoke highly of the team work. One care worker said "We work together as a team really well. Its calm, we're not rushing around. The nurses help and get involved with residents".

The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way.

A 'Carers Award' had been introduced to recognise staff achievements. A senior care worker told us that the first award had gone to a care worker who had done some Christmas shopping for a person who wanted a present for their son and hadn't been able to go themselves. The second had been awarded to a kitchen assistant who always made time to talk to people when serving drinks.

Audits had been completed and had captured any areas where action was needed. Audits included medicines management and administration, resident at risk reports, safeguarding, infection control and health and safety. In February 2016 an additional audit had been carried out to gather people's views on the lifestyle and choices at the service. The manager had introduced this as people had expressed in a previous quality assurance survey they felt their views on the service were not being sought. The audit included the dining experience, events and entertainment, views on a book of life and life histories and raising concerns.

We spoke with the quality manager who explained that the service had a schedule of audits that they checked each month. Areas that audits had highlighted required some further improvement had been put into a quality action plan. The action plan reflected the findings of the inspection. This demonstrated that the service quality monitoring systems were robust.

A quality assurance survey was sent annually to people, their families, staff and other stakeholders. The process had been carried out by an external company. Results had been shared with people and their families. A copy of the staff survey results had been placed on the staff notice board.