Maria Mallaband 10 Limited

Homefield Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

An unannounced inspection was carried out on the 14 February 2017.

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 32 older people living at the service. People required a mixture of residential and nursing care. The building provided 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 registered manager had left their employment the week prior to our inspection and the operations manager was acting as the interim manager until the post was filled. 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 were not consistently protected from the risk of harm in relation to dehydration, malnutrition or skin damage. Actions and processes had been put in place to minimise the risk but these were not being consistently followed. People were at an increased risk of not having their medicine administered safely as errors had not been reported appropriately. People were not being protected from the risk of deterioriating skin or health conditions that were treated with topical creams as these were not being managed as prescribed. Auditing systems were in place but they had not highlighted that systems and processes in place to protect people from risk were not operating effectively. When actions had been identified through the auditing process they had led to positive changes for people.

Not all senior staff understood their responsibilities for reporting incidents which meant that information had not always been shared with other external agencies. This meant that processes designed to provide oversight and additional safeguards for people were not always being followed. People and their families did not feel the service had always been well led which impacted on communication. They were positive about the new management arrangements.

People using the service told us they felt safe and that their right to make choices about risks they lived with were respected.

People were supported by enough staff that had been recruited safely as checks had been made to ensure they were safe to work with vulnerable adults. Induction, on-going training and supervision provided staff with the skills to carry out their roles.

The service was working within the principles of the mental capacity act. This meant that people were

supported to make decisions and when they had been assessed as not being able to decisions were made in their best interest with the involvement of family and other professionals.

People were supported with their eating and drinking requirements and were offered nutritious meals with snacks and light meals always available. Choices of what to eat and where to take meals were provided and when needed equipment was provided to support people to eat and drink independently.

People and their families described the staff as caring and kind. Staff had a good knowledge of people and the ways they were able to communicate which meant they were able to support people appropriately to make choices and decisions about their day to day lives.

Care and support plans provided clear information to care workers about how people needed to be supported. People felt involved in their care and supported by staff who understood their care needs. Activities were available both in the home and the community and were often linked to people's interests. A complaints process was in place which people and their families were familiar with and felt able to use if needed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not consistently protected from the risk of harm in relation to dehydration, malnutrition or skin damage.

People were at risk of not receiving their medicines as prescribed as topical creams were not consistently administered and medicine administration errors had not been reported.

People were supported by staff who understood how to recognise signs of abuse and the actions they would need to take if they suspected people were at risk.

People were supported by enough staff that had been recruited safely including checks to ensure they are safe to work with vulnerable adults.. This meant that people were at a reduced risk of harm.

Is the service effective?

Good

The service was effective.

Staff received an induction and ongoing training that provided them with the skills to carry out their roles effectively.

People were supported to make decisions in line with the principles of the Mental Capacity Act.

People were supported by staff that understood their eating and drinking requirements, including likes, dislikes and allergies.

People had access to health care when it was required.

Is the service caring?

Good

The service was caring.

People had positive relationships with staff and described them as kind and caring.

People and their families felt involved in decisions about their

care and advocacy services were available for people when needed.

People had their dignity, privacy and independence respected.

Is the service responsive?

Good

The service was responsive.

People had individual care and support plans that were regularly reviewed.

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

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits had not been effective in identifying shortfalls in systems and processes which were failing to protect people from risk.

Senior staff did not always understand their responsibilities for reporting incidents which meant that they were not shared with external agencies such as safeguarding and CQC.

People and their families did not always feel the service had been well led which led to shortfalls in communication. They were positive about the new management arrangements.

Staff felt positive about the service and empowered to share ideas and suggestions with the management team

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 14 February 2017 and was unannounced. It was carried out by two inspectors.

Before the inspection we looked at notifications we had received about the service and we spoke with social care commissioners and the local authority safeguarding team to get information on their experience of the service. We had not requested a provider information return (PIR) but gathered this information during the inspection. 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 six people who used the service and three relatives. We spoke with the operations manager, quality lead, deputy manager, a nurse, activities co-ordinator, three care workers and the chef. We reviewed five people's care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Requires Improvement

Is the service safe?

Our findings

People were not consistently protected from the risk of harm. Assessments had been carried out to determine the risks people lived with but plans in place to minimise those risks had not been consistently followed.

One person had been assessed by a speech and language therapist as being at risk of choking. We saw on their bedroom wall a diet and fluid plan produced by the therapist. It stated that any fluids needed to be thickened to a single cream consistency. We observed at approximately 11.15 am that this person had a jug and beaker of lemon squash on their bedside table which had not been thickened. We asked the person if they could reach the drink and they demonstrated they could. We discussed this with a care worker who was aware that drinks required a thickener adding. They agreed the drink hadn't and told us the previous shift had left the drinks. We went back at 1.20pm and the drink remained unthickened on the bedside table. This meant that the person people was being placed at risk of harm. We spoke with the manager who organised for the drink to be thickened correctly. They told us in the last month staff had revisited training on how to support people with their food and fluid but staff competencies would be reviewed again as a priority.

People who had been assessed as at risk of dehydration or malnutrition had food and fluid charts in place so that a person's intake could be monitored. We found these had not been completed consistently, reviewed regularly, or that processes in place to manage changed risks were being followed. We looked at records over the previous 13 days for one person. We found they had only achieved their fluid target on one day. The review of people's fluid intake as satisfactory was not supported by the records relating to their fluid intake. The minimum fluid intake was set at 1090mls. One day the person's fluid chart had recorded 300mls but the daily record stated 'OK fluids'. On the day the fluid chart recorded the person had reached their target the daily record stated 'fluid poor'. A checking system had been introduced whereby a senior staff member reviewed food and fluid charts each day. We saw that this had not consistently happened. A person's care plan stated that if for three days consecutively they drank less than 800mls their GP needed to be informed. Records showed us this had occurred but the GP had not been contacted. We checked the records of four people who were assessed as requiring their weights to be monitored weekly. We found this was not always happening. One person's weight had not been taken for six weeks and when it was there had been a weight loss of 4.6kg. This had prompted a referral to the GP and they had been seen by a dietician and prescribed a drink supplement twice a day. We checked records over 10 days and found only three had been recorded as given. This meant that people were at risk of harm as actions and processes put in place to minimise risks of dehydration and malnutrition were not being followed.

Assessments had been carried out to determine people's risk of skin damage. The risk assessment tool had been completed incorrectly in January and February 2017 for one person. Ten days later the assessment was reviewed and the error rectified. The care plan had not been changed to reflect the higher risk. Actions to reduce risk of skin damage had included an air flow mattress. These need to be set to match the person's weight to maximise their effectiveness. The plan did not include the required mattress setting and this information was also not available in the person's room. We checked other people's air mattresses and

found information on settings was not consistently available. Some people at high risk of skin damage required staff to support them in changing their position either two or four hourly. One person needed support re-positioning every four hours. The person's charts indicated they were on their left side at 0630am and we found they were still on their left side 5 hours and 40 minutes later. We looked at charts for the previous week but they did not always indicate the position the person was supported to achieve but instead started 'bed' or 'asleep'. This made it difficult for care staff to evaluate how long the person had been in what position. We spoke with the deputy manager who told us that senior staff were responsible for checking re-positioning charts but agreed that this had not occurred consistently for the charts we showed them. This meant that people were at risk of harm as assessments, actions and processes put in place to minimise risks of skin damage were not being followed.

People were at risk of not having their topical creams administered safely. Medicine administration charts (MAR) for topical creams were in people's bedrooms. One person had two separate prescribed creams in their bathroom. There was no record of the creams on the persons MAR chart. A member of staff caring for this person was not sure how to use one of the creams. Another person had three prescribed creams. In their bathroom there was an empty box for one cream. The second cream had not been entered onto the MAR chart. The third cream had clear instructions on the container of where it needed to be applied each day. The MAR sheet over 14 days indicated the cream had only been applied on one day. This meant that people were not being protected from the risk of deteriorating skin or health conditions due to prescribed creams not being managed and administered appropriately.

Some people had been prescribed controlled drugs which are medicines that require additional storage and administration safeguards than other medicines. We checked entries in the controlled drug record book and found entries unclear. We looked at a medicine audit carried out by an external pharmacist on the 12 January 2017 which highlighted that care was needed with entries. This had not been actioned at the time of our inspection. We found one incorrect recording of a delivery which had been signed by a nurse and care worker. The entry stated five pain patches had been delivered. Three days later the same two members of staff changed the records to read four had been delivered and signed the record. The error was not reported as an incident to the manager or notified as a safeguarding incident to external agencies. We spoke with a nurse about reporting medicine errors and they told us "To be honest I'm not 100% sure what you do". This meant that people were at an increased risk of not having their medicine administered safely due to safeguarding processes not being followed.

The week prior to our inspection changes had taken place in the management of the service and plans had begun to be put in place to address the issues identified.

Risks identified for people in relation to skin damage and malnutrition had not been consistently managed or actions taken in order to minimise the risks. People were at risk as medicine administration was not always carried out in a safe way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living in the home. One person told us "I'm confident I could call and they (staff) would come and help me. That makes me feel safe". Staff were aware of what constitutes abuse and the actions they would take if they suspected if someone was being abused. Staff were able to explain how to escalate any concerns about poor practice.

People had their freedoms and wishes respected when involved in decisions about actions needed to manage risks they lived with. We read that one person had requested not to be checked at night unless they call for assistance. Another person found their pressure cushion uncomfortable and had agreed with staff

they would spend parts of the day without it on their chair.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

People were supported by enough staff that had been recruited safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Baring Service and the Nurse and Midwifery Council to ensure that staff were safe to work with vulnerable adults. Processes were in place to manage unsafe practice and we saw evidence these had been followed when appropriate.

Good

Is the service effective?

Our findings

People were supported by staff that had received induction and ongoing training that enabled them to carry out their roles and responsibilities. Induction included completion of 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. Files contained signed copies of an in-house induction that included health and safety, policies and working practices. Records were kept of training staff had taken and where appropriate the date it required renewal. Recent staff training had included nutrition, hydration and dysphagia.

Staff told us they felt supported. One care worker told us "I feel supported by the management. I get an appraisal and feedback". Another said "I feel adequately trained and can ask for additional training if needed".

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.

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 found that 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 how to support people to make decisions. They explained it included finding out about prior wishes and trial and error to see what people liked. They went on to explain that they offered choices in people's preferred communication methods which included showing people things or pictures. Where people had been assessed as not being able to make a decision about aspects of their care such as using bed rails or receiving personal care best interest decisions had been made involving relevant people and in line with the principles of the MCA. We saw one file where a family member had signed consent for the use of bed rails. Although the file indicated that the family member had LPA for welfare decisions a copy of the legal arrangements were not on the file. We discussed this with the deputy manager who told us they would confirm the legal arrangements.

People were supported by staff who understood their eating and drinking likes, dislikes and allergies. The chef told us "We've updated dietary sheets detailing peoples requirement; food likes, dislikes, allergies. I attend residents meetings and encourage people to suggest menus". We spoke with one person who said "The quality of the food is good. The chef said we can come and have a look at the kitchen if we wanted". We observed lunch and the food was served hot and looked and smelled appetising. People were offered a

choice and where needed had specialist cutlery and plate guards to support their independence. Where people needed help to eat staff supported them discreetly and at the persons pace.

People were able to access healthcare when needed. I person told us "I can see the doctor when I need to. They usually call here". Records indicated contact with opticians, dentists, dieticians and specialist health teams.

Good

Is the service caring?

Our findings

People and their families described staff as caring. One person said "Staff are kind to me and there isn't much that I want that they can't get. They look after me well". Another told us "The staff are quite good. On the whole they are very friendly. All go by their Christian names". A relative told us "Staff are very caring towards (name). They treat her like a sister or mother figure". Another said "Lovely, friendly, caring; everybody cares. We can have a laugh and joke and that's great for (name)".

We observed staff interacting with people in a relaxed and friendly way. Staff were thoughtful of people's wishes when providing support. We spoke with a housekeeper who explained that they didn't clean one person's room at the time sport was on the TV as they knew they liked this and wouldn't want to be disturbed. We observed staff checking people were warm and offering to get them something extra to wear. Another example we observed were two people who became irritated with one another and a staff member immediately took action to de-escalate the situation. They approached them calmly and offered reassurance and gently persuaded one to sit with a carer in another area of the home. Both people visibly calmed down and responded positively to the support.

Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example talking with people at eye level and using hand gestures and facial expressions. A relative explained how staff understood the communication needs of their relative. "They understand (name) behaviours. (Name) knows she can't talk and so doesn't want to talk to people. Staff deal with (name) very well. Staff have learnt not to put a hand on her. They don't try and touch (name) to perhaps get (name) to do something different but they distract instead. I couldn't get a better place"

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. A relative explained how they regularly joined their relation for a meal and had a particularly special Christmas lunch together. Staff had prepared a table in a quiet area and made a real fuss. They told us "It's the best Christmas we have had in years".

People felt involved in decisions about their care. One person told us "I will ask them to shave me first sometimes or clean my teeth. I feel in control of the care. I could call them now and they would come and close curtains, get something for me". Another person said "They provided all the information I needed to make a decision about coming here". People who needed an independent representative to speak on their behalf had access to an advocacy service.

People's clothes and personal space were clean and reflected a person's individuality. People told us they had their privacy and dignity respected. The operations manager explained that the library room could be used for families who want some privacy with their relatives and didn't want to sit in their bedroom. Dementia friendly signage was available in parts of the building for toilets and bathrooms which enabled people more opportunity to be independent when in public areas of the home.

Good

Is the service responsive?

Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. Files contained information and fact sheets about people's health conditions which meant that care workers had an understanding of how they possibly impacted on people.

People felt that staff understood how to support them. One person said "I need the care I get here. I'm 10 times better now than I was when I got here". A relative explained "I had a conversation with the managers to ensure that (relative) wasn't overwhelmed when she got here. People went to see her in her room for a time". Staff were aware of people's individual preferences. A care worker explained how one person liked their door to be left open overnight as they didn't like total darkness.

People and when appropriate their families were involved in reviewing care. One relative told us "I feel really involved. I have just been in for a care plan review. We talked through (name) care plan". We read a review record for a person who didn't have the capacity to be involved in their care review. Records showed us that the review had taken place with two close relatives. Another record evidenced a telephone call to family for feedback regarding a person's care and recorded they were happy with the care provision.

Some people had information collected on a 'Me and My Life' document. It detailed a person's family composition and previous occupations. Information had also been collected about people's interests and activities they enjoyed. One person told us "I spend most of my time in my room. I like my room. I go into the big room if there is music or singing. (Activities worker) comes in every day to ask if I want to do anything. I've been out in the vehicle to Holmsley, to an old railway station that does cakes and things". A relative told us "They've encouraged (relative) to join in activities. They're joining in activities they haven't done before". Records showed us that activities people were taking part in matched their interests and places people had fond memories of visiting in the local area. The activities co-ordinator recognised that some people who were more frail would not be able to participate in some of the organised activities. Examples included chair exercises or music quizzes and explained that they were hoping to attend some training to help expand their role.

People and their families had been given information about how to make a complaint and told us they felt able to raise concerns. One person told us "If I want to make a complaint I would speak to staff and they would do something about it". Resident and relative meetings had been held. One relative told us "We had a resident and family meeting. We learnt a lot from that. We talked about issues such as the speed of return of the laundry. (Relative) was concerned that their night clothes were not being ironed. They are being ironed now". We saw minutes of a meeting held in January 2017. Relatives had asked for a book to be introduced that they could record any maintenance issues. Topics discussed at the last meeting had included the complaints policy, had explained duty of candor responsibilities and encouraged use of the suggestion box.

Requires Improvement

Is the service well-led?

Our findings

Auditing systems were in place and had been monitored by the registered and operations manager but they had not always recognised areas that needed improvement to ensure the best outcomes for people. This included areas of risk in relation to peoples weight, skin care and medicine administration as identified at this inspection. A safeguarding investigation earlier in the year had concluded that a person had not been supported safely with an identified risks of choking, dehydration and malnutrition. Since the inspection training and monitoring measures had been put in place in response to our findings. However, the management oversight to ensure competencies and practice were safe had not been effective.

Systems and processes were not effectively monitoring and reducing risks to people related to their health and welfare. This is a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all senior staff had an understanding of their responsibilities for reporting incidents which meant that not all statutory notifications had been reported to external bodies. When the registered manager had been aware of an incident they had a good understanding of thier responsibilities for sharing information with CQC and our records told us this was done in a timely manner. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

People, their families and staff did not feel that the service was always well led. At the time of our inspection the registered manager had left their employment the previous week and the Operations Manager was acting as interim manager until the post was filled. One relative told us "I've been coming here since word dot – we must be looking at the sixth manager". One person told us "It would benefit from better leadership. (Operations Manager) an asset to the home now she has returned". We read minutes of a staff meeting in October where staff had raised concerns about poor handover and communication. A relative told us "There is little communication. I've given my e-mail address. (Registered Manager) left but we were not informed; it's a worry". We spoke with the operations manager who told us that it had been agreed at the last resident and family meeting that future meetings would be held quarterly and this had been scheduled in the evenings as families had agreed this would make attendance easier for them.

Staff described the culture of the home as open and inclusive. They told us they felt able to make suggestions and would be listened to. We observed a relaxed but professional relationship between senior staff and the care workers.

We saw that where areas for improvement had been identified actions had been taken to improve outcomes for people. These had included monitoring accident/incident reports. An example was an immediate response to an incident by arranging a referral to the local authority safeguarding team and the mental health in reach team. Following a resident and family meeting a questionnaire had been sent to people asking them to share their meal, food and fluid experience. The results were going to be shared with the catering and care staff and used to review practice.

A variety of health and safety checks had been recorded on file and the maintenance person explained fully how these checks were carried out.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks identified for people in relation to skin damage and malnutrition had not been consistently managed or actions taken in order to minimise the risks. People were at risk as medicine administration was not always carried out in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effectively monitoring and reducing risks to people related to their health and welfare.