Runwood Homes Limited

Caldwell Grange

Inspection report

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Tel: 02476383779

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Ratings

Overall rating for this service	Good

Is the service effective?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected this service on 17 August 2017. The service was rated good at our previous inspection on 10 October 2016. This inspection was focussed only on checking only whether the service remained effective and well led. The inspection was unannounced.

The inspection was planned in response to concerns we had received about how people were supported to maintain their health through their diet and to access healthcare services when needed. That is why this report only covers our findings in relation to the effectiveness and management of the service. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Caldwell Grange on our website at www.cqc.org.uk. Following this inspection visit, we were alerted a potential safeguarding concern. This is currently being investigated and we will be reviewing the outcome of this investigation.

The service provides accommodation and personal care for up to 76 older people, who may have dementia, a physical disability or a sensory impairment. Seventy-three people lived at the home at the time of our inspection.

There was a registered manager in post. They had been registered with us since February 2017. 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.

At this inspection we found the registered manager and staff supported people to maintain their health through regular appointments with dentists, nurses and chiropodists and referrals to their GP and specialist services when needed. Some GPs did not visit people as promptly as other GPs when requested, which meant some people had to wait for medical advice or treatment.

If people's GPs did not attend promptly, staff used the national 111 service for clinical advice. The registered manager had taken action to ensure healthcare support was easily available, by dedicating one room for the district nursing team to keep equipment and records on-site. The registered manager had agreed a protocol with healthcare professionals to ensure people's dietary needs were managed effectively.

Where we identified specific healthcare professionals did not offer a prompt or effective service for people living at the home, we shared our concerns with the local clinical commissioning group.

Staff were aware of the importance of maintaining a balanced diet that met people's needs and preferences. Where risks to people's nutrition were identified, there were checks and balances in place to ensure action was taken to minimise the risks.

People were supported by staff who had the skills, experience and understanding to be effective in their role.

The registered manager acted as a role model for staff in their interactions with people. They worked with staff, which enabled them to observe how people were and staff's practice.

Staff were kept up to date with issues and changes at the service through one-to-one supervision meetings and team meetings.

There were systems and processes in place to ensure people received the care and support they needed. The registered manager monitored people's dietary intake and well-being and their access to healthcare services to ensure they received an effective service. They conducted regular audit checks of the premises, equipment, mealtimes and medicines management to ensure the service was well-run.

Where the registered manager identified issues in staffing, they took action to improve the situation. They worked alongside staff delivering care themselves, used agency staff to cover sickness absence and recruited new staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Good

The service was effective. People were cared for and supported by staff who had the relevant training and skills for their roles. Staff understood their responsibilities in relation to the Mental Capacity Act 2005. The registered manager understood their legal obligations under the Deprivation of Liberty Safeguards. People's nutritional and specialist dietary needs were taken into account in menu planning and choices. People were referred to healthcare services when their health needs changed.

Is the service well-led?

Good

The service was well-led. People and relatives knew the registered manager well and were confident in sharing their views of the service. The registered manager worked with and acted as a role model for staff. The registered manager took action to improve the service when they identified that improvements were needed. Their quality monitoring system included checking people received an effective, good quality service that met their needs.

Caldwell 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 checked 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 17 August 2017 and was unannounced. The inspection was planned in response to concerns we had received about how people were supported to maintain their health through their diet and through access to healthcare services when needed. We checked whether the service continued to be effective and well-led. The inspection was conducted by one inspector.

We reviewed the information we held about the service. This included information shared with us by staff, relatives, the local authority and statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We spoke with four people who lived at the home and four relatives. Most of the people living at the home were not able to tell us whether the service was effective or well-managed, because of their complex needs. However, we spent time with them and observed how staff cared for and supported them. We spoke with five care staff, a cook, the registered manager, deputy manager and the operations director about how the service was managed.

Because of the specific concerns raised, we looked particularly at three people's care plan records, risk assessments and daily records to check how people were supported with their diet and healthcare needs and whether staff sought the advice of healthcare professionals when people's health needs changed. We looked at how people's healthcare needs were made known to the registered manager and how the registered manager was assured that people received timely and relevant healthcare support. We looked at the registered manager's quality assurance processes and the methods they used to assure themselves that people received the care and support they needed.

Good

Is the service effective?

Our findings

A relative told us, "There are no problems with health care. Staff thought [Name] had an infection. They called the GP and they prescribed antibiotics. It's cleared up now." Another relative told us staff had acted promptly when they noticed a change in their relation's physical condition and their GP had already referred them to a consultant specialist.

Concerns shared with us prior to this visit, raised questions about how people were effectively supported to maintain their health and well-being. Records showed people were supported to maintain their health by regular visits from healthcare professionals, such as dentists, chiropodists and their GP. The registered manager and staff took all the actions they could take to support people to access healthcare services when their health conditions changed. Most of the people who lived at the home were patients of one GP practice. A GP from the practice visited the home every week and checked those people staff had identified as needing to be seen by their GP. However, some people had not been able to choose their GP due to the size of the local population compared to the number of GP practices. A member of staff told us, "Some GPs take a while to get out. GPs will come out next day or we call 111 who might call the paramedics for us."

Some people had been allocated to a GP practice by the local clinical commissioning group, according to GP availability. Records showed that not all GP practices were as responsive to the needs of frail, elderly patients as they could be. In particular, some GPs did not visit as promptly as requested by staff and did not always send their prescriptions to the pharmacy promptly. For example, records showed a GP had said they would prescribe a medicine for one person on 20 July 2017, but the prescription had not been not sent to the pharmacy or delivered to the home by 2 August 2017.

Another person's records showed staff had asked a GP for advice on 20 April, when they noticed one person was showing signs of an infection. They had followed the GP's advice, tested the person at home on 24 April and again on 25 April 2017, and had increased the amount of fluid the person was encouraged to drink. Staff retested the person on 2 May 2017 and shared the results with the person's GP and requested antibiotics for an infection. On 4 May 2017, staff took the tested sample to the GP's surgery for confirmation that the person had an infection. The person's medical records for 30 May 2017 recorded, "Phoned/fax to GP hasn't dealt with it yet as busy. Chase on 31st to see if antibiotics are being prescribed."

After our inspection visit, we shared our concerns about delays in accessing healthcare services internally at CQC, with the directorate that inspects primary medical services, and externally with the commissioners of care in the local authority and the local clinical commissioning group (CCG).

People were supported to eat a balanced diet that met their needs. Staff monitored people's appetites and their weight and referred them to healthcare professionals, if they were at risk of poor nutrition. People's care plans included a dietary care plan, with risk assessments of any health, physical or emotional conditions that might increase the risks of poor nutrition. They included information about the specific health condition, the signs staff should be alert to and the day-to-day actions for staff to take to minimise the risks. Staff asked people's GPs to refer them to dieticians and speech and language therapists, according

to the signs they observed.

Staff monitored how much people drank and shared information at shift handover meetings. When people were identified as at risk of not drinking enough, staff had calculated the amount they needed to drink, based on their height and weight, and kept a record throughout each day to monitor their fluid intake. We saw people were offered a choice of hot and cold drinks throughout our inspection visit. When people were reluctant to drink, or forgot to drink, we heard staff encouraging them to 'drink for their health'. A member of staff told us, "We cannot force [Name] to eat or drink. It's a form of abuse. We reassure and we assist. They have just been prescribed 'fortisips' (a calorific drink) by the dietician."

At lunch time we saw there were written menus on the tables, but staff also showed each person the two different meals on plates. We saw people who were not able to express themselves verbally, looked at both plates and pointed out their preferred meal. Soft meals were presented by individual ingredients, so people were able to savour the different flavours. Staff sat quietly beside people who needed assistance to eat and were patient and observant to people's individual pace of eating. People were offered an alternative meal if they did not eat much of their first choice and were offered second helpings when their plates were empty.

People told us staff understood and respected their dietary needs and preferences. One person told us, "The food is nice. It meets my needs." A relative told us, "The food is beautiful. [Name] loves their food and they have really improved (from the food). They were on soft food, but now have a normal diet, and no more sipping cup, but a bone china cup."

The cook told us they operated a four weekly rotating menu, designed to offer a balanced diet. The registered manager shared information about people's dietary needs, preferences and allergies when they first moved into the home. We saw this was recorded in the kitchen communications book, so that either cook was able to make sure people were offered the diet they needed.

People and relatives told us they thought staff had the skills and experience to support them effectively. A relative told us, "[Name] is always cleanly dressed, and washed hair, with their jewellery."

Staff received training in subjects that were appropriate to people's needs, such as dementia care, distraction techniques, food and nutrition and equality and diversity. A relative told us they had just attended a monthly training session for relatives, delivered by the provider's trainer, about vascular dementia. They said this gave them a better understanding of their relation's needs. Staff were encouraged and supported to consider their personal development and to obtain nationally recognised qualifications in health and social care.

Staff had already attended additional training in healthcare support from the local clinical commissioning group, such as, how to 'react to red' skin. Training in continence and catheter care was scheduled for the week following our inspection and falls prevention training was planned within the next six months.

Some staff told us they were only concerned about their ability to continue to be effective in role because of changes in the staff team and the small pool of staff available for holiday and sickness cover. Staff told us, "Staff left and are on annual leave, so we have been short staffed recently" and "It was going really well before the school holidays, but we have to honour new recruits' holiday arrangements, so we have had some agency cover."

Staff told us, "We work well as a team" and "We communicate well." Some staff told us they worked additional hours to make sure people were supported effectively, but they were looking forward to returning

to their regular, agreed hours. The registered manager had supported staff by working alongside them in a care staff role at weekends and on night shifts for the previous two months. They said this had been useful as, "An opportunity to observe staff's practice and to remember the stresses and strains of delivering care."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood their responsibilities under the MCA. People who had the capacity to agree to their own care and support, signed their own care plans.

When people were assessed as lacking capacity to agree to their care, decisions were made in their best interests by people who knew them well. The registered manager had applied to the local supervisory board for the authority to include restrictions to people's liberty, for those people who lacked the capacity to understand risks to their safety. Staff sought people's consent to care and encouraged people to make their own decisions about their care and support. Staff explained what they were doing when they supported people to mobilise using equipment, which supported people to feel in control.

Good

Is the service well-led?

Our findings

The registered manager checked that people received the healthcare they needed. They kept a list of all those people who were visited regularly by the district nurses. The list included the person's medical condition, the reason for the nurses' visits and any specialist equipment prescribed for the person. The registered manager had allocated a dedicated district nurses' room in the home, where they could keep the equipment and records they needed safely and confidentially, which supported effective nurse care.
The registered manager attended monthly meetings with the district nurse team and meetings with the local clinical commissioning group. They told us this helped them to keep up to date with best practice and with local and national changes, because they met with experts in the field of social care.
The registered manager kept a list in the office of those people who had been referred to their GP, so they could monitor how promptly the GP attended, the advice they gave and any further changes in the person's health. The registered manager told us, "Not all GPs act in the same way." When people waited longer than 24 hours for a response from the GP, staff recorded when they telephoned or faxed the surgeries to chase-up a response. Staff told us they could call the 111 helpline if a person's health deteriorated while they waited for a visit from their GP.

The registered manager told us they had already complained to the CCG and raised concern about the timeliness of some GPs' to respond. They said the situation had improved for a while, but was beginning to deteriorate again. We reminded the registered manager they could also raise any concerns about healthcare professionals with CQC directly. After our inspection visit, we shared information with the CQC primary medical services directorate inspector and with the local clinical commissioning group about two particular GP practices who records showed did not respond promptly to people's health needs.

The registered manager told us they checked that people were offered enough to eat to meet their needs and preferences, by observing mealtimes and checking people maintained a stable weight. At lunchtime, we saw a senior member of staff observed a 'mealtime experience' in one of the dining rooms. They checked that the atmosphere, the service and staff's attitude and behaviour encouraged people to enjoy their meal. They checked people were offered a visual choice and were individually encouraged and assisted, if they needed assistance. They told us they shared their observations with staff, to consider how they could implement any improvements in the mealtime experience overall, and any changes in strategies to encourage individual people to eat.

The registered manager's quality assurance process included checking that people who were identified as 'at risk of poor nutrition', were offered enough to eat and drink. Staff recorded how much they ate and drank and shared their records with the care team managers and registered manager each day. People at risk of not drinking enough had individual targets for their fluid intake. For people who were at risk of poor nutrition and needed assistance from staff, staff recorded the number of spoons of food the person ate. The registered manager told us, "We do individual and home wide monitoring. If we are concerned and the GP says there is no medical reason, we might move to weekly, not monthly weights. If we are concerned prior to referral to the GP, we weigh weekly and refer."

The registered manager told us they had also raised concerns about the timeliness of some GP's referrals to other healthcare services, such as dieticians. They had liaised with the local hospital dieticians, who had agreed they would accept referrals directly from the home, if GPs were slow to refer. The dietician team had shared their referral form with the registered manager so they could be confident the person they referred met the criteria for dietetic support.

The culture of the service was open and person centred. Most people who lived at the home were not able to express their opinion of the staff and management verbally. However, we saw people responded positively to offers of support and assistance, which showed they trusted staff. Several people made their preferences for staff's company obvious by actively seeking staff out and telling them about their day and asking their opinion. Staff responded with kindness and understanding of people's needs. The registered manager was equally knowledgeable about people's needs, abilities and preferences, which showed they spent time getting to know people, and acted as a role model for staff.

The registered manager and staff told us their greatest challenge was in maintaining a regular workforce. One member of staff said, "There is nothing to improve other than staffing and GPs." The registered manager told us, "We need more staff for flexibility and for staff to rest."
They had recruited new staff to replace staff who had left, but the delay between recruitment and start dates was exacerbated by staff's annual leave bookings for their summer holidays. Some agency staff had been engaged, but several staff reported feeing 'exhausted' from working more hours than usual to cover gaps in the rota. Staff told us, "The last month we have been rushed" and "The rota includes enough staff, but sickness cover is by bank or agency and staff volunteer. A small group of staff regularly do overtime, but we have recruited this week."

The registered manager had identified the importance of having familiar staff and had included themselves on the rota for weekends and night shifts, to make sure people were supported consistently. They told us, "At lunch and peak times, all staff on site support." They told us they were able to observe staff's practice informally and to identify any changes in people's needs at first hand by working with staff.

The registered manager completed monthly audit checks of the equipment people needed to mobilise safely, such as the hoist, slings, mattresses and pressure relieving cushions. They conducted regular quality assurance checks of the premises, medicines management and staff's practice and checked people received the care and support they needed. The registered manager told us they conducted twice daily 'floor walks', to 'see how people look' and monthly care audits, when they sat quietly in a room and monitored people's well-being through their engagement and interactions. They told us, "Any issues are talked about with staff and the supervision rate is increased for more direct observations. Small issues are discussed at staff meetings and considered for training."

Staff told us they had attended regular team meetings. They said they had discussed changes to how staff were allocated at a recent staff meeting. Staff were currently allocated as keyworkers to individual people, but worked across all the areas of the home, which made it difficult to keep up to date with the individuals' needs. The registered manager told us, "The keyworker scheme is under review. Keyworkers will be in the same matched area of the four parts of the home. Staff will work regularly on one unit to improve familiarity and befriending and to encourage people to confide."