

Clarendon Care Group Limited

Myford House Nursing & Residential Home

Inspection report

Woodlands Lane
Horsehay
Telford
Shropshire
TF4 3QF

Tel: 01952503286

Date of inspection visit:
14 September 2016
15 September 2016

Date of publication:
05 December 2016

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

The inspection took place on 14 and 15 September 2016 and was unannounced. At the last inspection completed in February 2016 we rated the service as 'inadequate' and placed it into special measures. We also found breaches of regulation regarding consent of people using the service, medicines management, staffing and the overall management of the service, including quality assurance systems. At the most recent inspection we found improvements had been made although there were still breaches in regulation.

Myford House is a nursing home that provides personal care and accommodation for up to 57 older people, most of whom are living with dementia. At the time of the inspection there were 34 people living at the service. The provider is also registered to carry out diagnostic and screening procedures at this location. At the time of the inspection, the provider was not carrying out this regulated activity therefore it was not inspected. A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by a staff team who could describe the signs of abuse. We did however, identify that concerns about people were not always reported to the registered manager and the local safeguarding authority when required. Risk management processes were in place which did protect people against harm in some aspects of their care. However, they did not effectively reduce the risks to people through behaviour by some that may challenge.

People were supported by sufficient staff numbers to meet their needs. Staff members had been recruited to their roles safely and pre-employment checks were completed. People were happy with the support they received with their medicines, however, recording issues meant we could not confirm if some medicines were given as prescribed.

People told us permanent staff had the skills required to support them effectively. However, not all people felt agency staff were able to meet their needs. We did identify areas in which staff did not have the required training and skills. People who lacked capacity to consent to their care did not always have their rights upheld by the use of the Mental Capacity Act 2005. People were supported to maintain their day to day health needs and their nutritional needs were met.

People were supported by a staff team who were kind and caring in their approach. People's privacy and dignity was protected and promoted. People were supported to maintain relationships that were important to them. Relatives were encouraged to visit without restriction and were part of the 'community' within the service.

People mostly received care that met their needs and preferences. People's care plans did not always reflect their needs or the care they received. People were beginning to become involved in reviewing their care

needs and developing their care plans. Staff were engaging people in day to day activities within the home although improvements were needed to the leisure opportunities made available to people. People felt able to make a complaint and complaints made were fully investigated by the provider.

People were not protected by quality assurance systems that always identified the improvements needed in the service or care being delivered to them. People were cared for by a staff team who felt well supported by management and were motivated and committed to their roles. People felt the registered manager had made significant improvements in the service.

We found the provider was breaching the regulations regarding safe care and treatment, the need for consent and good governance. You can see what action we told the provider to take at the back of the full version of the report.

At the last inspection completed in February 2016, we rated the provider as 'inadequate' and the service was placed into special measures. The overall rating for the provider following the most recent inspection is 'requires improvement'. However, as the provider remains to be rated as 'inadequate' for one of the key questions they will remain in special measures.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, we may take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service.

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 consistently safe.

People were supported by a staff team who could describe the signs of abuse. However, concerns about people were not always reported. People were supported by sufficient staff numbers to meet their needs. The administration of people's medicines was not always clearly recorded.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

People were supported by staff who did not always have the skills and knowledge to support them effectively. People who lacked capacity to consent to their care did not always have their rights upheld by the use of the Mental Capacity Act 2005.

People were supported to maintain their day to day health needs and their nutritional needs were met.

Is the service caring?

Good ●

The service was caring.

People were supported by a staff team who were kind and caring in their approach. People's privacy and dignity was protected and promoted. People were supported to maintain relationships that were important to them.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

People mostly received care that met their needs and preferences. People's care plans did not always reflect their needs or the care they received.

People felt able to make a complaint and complaints made were fully investigated by the provider.

Is the service well-led?

Inadequate 

The service was not consistently well-led.

People were not protected by quality assurance systems that always identified the improvements needed in the service or care being delivered to them.

People were cared for by a staff team who felt well supported and were motivated and committed to their roles. People felt the registered manager had made significant improvements in the service.

Myford House Nursing & Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 and 15 September 2016 and was unannounced. The inspection team consisted of an inspector, a pharmacy inspector, a specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a qualified nurse who has experience working with older people.

As part of the inspection we reviewed the information we held about the service. We looked at statutory notifications sent by the provider. A statutory notification contains information about important events which the provider is required to send to us by law. We sought information and views from the local authority. We also reviewed information that had been sent to us by the public. We used this information to help us plan our inspection.

During the inspection we spoke with 12 people who lived at the service and six visitors who were friends or relatives. To help us understand the experiences of people living at the service we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, the operations manager, the quality and compliance manager and the deputy manager (clinical lead). We also spoke with 12 members of staff including the kitchen assistant, administrator, nursing staff, senior care staff and care staff. We also spoke with one visiting healthcare professional. We reviewed records relating to 16 people's medicines, nine people's care records and records relating to the management of the service; including recruitment, complaints and quality assurance records. We carried out observations across the service

regarding the quality of care people received.

Is the service safe?

Our findings

At the last inspection we completed in February 2016 we rated the provider as 'inadequate' under the key question of 'Is the service safe?'. We found they were in breach of the regulations regarding safe staffing levels, management of risks to people and the safe management of medicines. At this inspection we found improvements had been made and the provider was now meeting the regulations around staffing levels and the management of medicines, however, further improvement was still required in managing certain risks to people.

People told us care staff understood the potential risks to their safety and how to keep them safe from harm. One person told us, "The [care staff] all make sure I am safe as I have to be helped a lot to do things". A second person told us, "I am safe here I know that and because I can't move they are always checking on me". A third person told us, "I have to be helped a lot by the carers to get about and they are always careful with me and make sure I am kept safe". At the last inspection we found concerns about the assessment and management of risks to people. We identified unsafe practices around the use of bedrails and the management of the breakdown of people's skin. At this inspection we saw staff were safely managing the risks to people in these areas. Staff were using bedrails to support people safely and managing risks associated with the breakdown of people's skin. The provider had taken steps to improve how people were kept safe through the effective assessment and management of risks to people.

We mostly observed staff appropriately managing the risks to people while supporting them. For example, we saw people being supported to move in a way that reduced the risk of injury or harm to them. We did however, see this practice was not always consistent. For example, we saw a person being moved with a stand aid using a sling that was poorly fitting. The person was at risk of injury due to the poorly fitting sling. The registered manager and deputy manager (clinical lead) completed an investigation and confirmed the correct sling was in use however the safety strap had not been correctly tightened. They advised that action would be taken to ensure staff were using the safety strap correctly immediately.

We were told by staff about several people who could display behaviours that challenged. Some of these behaviours had resulted in physical assault towards other people living at the service and staff. We asked some staff members how they recognised any potential 'triggers' for this behaviour. While some staff members could describe ways in which they would try to calm people down and reduce instances of behaviour that challenged, this was not consistent across the staff team. We saw some people were receiving medicines that helped to calm them and manage behaviour without staff having explored other methods of reducing behaviours in the first instance. We looked at the guidelines provided for staff around when people's medicines should be administered and found they did not contain detailed information. Staff knowledge around how to reduce instances of behaviour that challenged without administering people's medicines was not sufficient. One staff member responsible for administering these medicines did not understand that there could be a potential trigger for behaviour that challenged. They did not understand that they may be able to manage the 'trigger' and potentially avoid having to administer medicines that controlled behaviours. Some staff told us they did not always feel confident supporting people when they displayed behaviour that challenged and they had not received training in this area. We looked at people's

care plans and found that people's behaviour was not analysed in an effective way that would allow staff or managers to identify potential 'triggers'. Identifying triggers for behaviours can assist in developing care plans that may help to reduce the risk of harm to people and others. We spoke with the registered manager who confirmed they recognised this was an area for development in the service. They had already sought specialist training for staff in this area which was due to take place shortly following the inspection.

This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

People told us they were happy with the support they received with their medicines. One person told us, "Yes they give me my medication and it's always on time". We found medicines were stored securely and staff monitored the temperature at which medicines were stored to ensure they remained effective. We did see an example of two medicines left unattended on a trolley in an open corridor area. On informing the registered manager, the medicines were removed and locked away immediately. We found that medicines were made available to people when needed. However, gaps in medicines administration records (MAR) and stock records meant we could not always be assured that people were receiving their medicines as prescribed. We looked at the MAR chart for one person prescribed a medicine to prevent blood clots. Their MAR chart documented the correct dose had been administered, however we found that records relating to the amount of medicines available were not accurate, there was no record of receipt of the medicines and no total balance recorded. This resulted in staff not being able to confirm if the information recorded on the MAR was accurate and medicines had been given as prescribed. We could not be certain all people received their medicines as required due to errors or omissions in medicines records.

We found guidelines were made available to staff describing how some medicines should be given and enabling staff to record when medicines such as creams or patches were administered. For example, we saw records to document the site of application of medicated skin patches. This is important to ensure the patch is moved to different parts of the body to reduce side effects and increase the effectiveness of the medicine. We looked at medicines prescribed to be given on an 'as required' basis and found while information was sometimes available to staff, it was not always detailed enough to assist staff in meeting the person's needs. Staff did not always have a good understanding of when they should administer people's 'as required' medicines. The staff and management team had sought advice when it was needed from healthcare professionals around some people's medicines. However, we did identify two additional people who needed to have their medicines reviewed. This had not been identified and the people had not been referred to their doctor. The registered manager did immediately seek advice when we highlighted this issue and action was taken by the doctor with both people's medicines. We also found insufficient advice had been obtained when people needed their medicines to be administered covertly. For example, crushed in food. Guidelines were not in place to outline how to administer these medicines safely and to ensure they remained effective. People did not always receive effective additional support with their medicines, for example when advice from a healthcare professional was required.

People told us they felt care staff protected them from the risk of abuse or mistreatment. One person told us, "I am comfortable here and I know I am safe". Another person told us, "They [staff] look after me well. I am never worried. I have no complaints. They make sure I am safe and secure at all times. I have confidence in the [care staff]". Visitors to the service also told us they felt staff ensured people were safe from the risk of potential abuse. One visitor told us, "I don't worry now about [my relative]. I sleep at night as I know [they are] safe and being taken care of which is paramount to me". Another relative told us, "The staff are kind and attentive and keep [my relative] safe". Staff we spoke with could describe signs of potential abuse and how to report these concerns. We did however, identify that staff did not always ensure the registered manager had been notified about incidents of concern. Not all staff we spoke with knew how to raise concerns

outside of the organisation if this was required. We saw the registered manager had recognised potential concerns about people and understood how to report concerns to the local safeguarding authority. We did, however, identify situations where internal reporting procedures had not been effective in ensuring all potential safeguarding incidents were reported to the local safeguarding authority. This had resulted in some incidents not having been fully investigated. Therefore plans to ensure people were fully protected from the risk of harm had not always been developed. The management team provided assurances that corrective action would be taken immediately.

We looked at how the provider prevented the risk of the spread of infection to people. We saw that the registered manager had not ensured the home was clean and hygienic. As a result we saw people's environment was not sufficiently clean and people were using dirty chairs, tables and stained toilets. We saw some staff members adopting poor hygiene practices while delivering care to people. We confirmed with the training administrator that over half of the staff team required infection control training. We also confirmed there was no infection control lead active in the role at the time of the inspection. We raised our concerns with the management team who began to take corrective action during the inspection.

At the last inspection we found people's safety was at risk due to there being insufficient numbers of staff available to support them. At this inspection, we found the provider had made the required improvements. People told us they felt there were sufficient numbers of staff available to support them promptly and effectively. One person told us, "If I need anything I call and they come quickly. I never have to wait which is good". Visitors told us they felt staffing levels had improved but expressed concerns about the number of agency staff still working in the service. One visitor told us they had concerns about the number of permanent nurses employed by the service and the high use of agency workers. A second visitor told us, "I know [my relative] is safe but the continuity of staff is an issue for me [in the service]. The use of agency staff to my knowledge hasn't decreased and I think the situation is made worse because of staff holidays. I get confused so imagine what it's like if you are really confused". Staff we spoke with told us there were sufficient numbers of staff, however, they also expressed concern about the number of agency staff working in the service. A visiting healthcare professional told us they felt there were sufficient numbers of staff working in the service. They also told us they felt the mix of staff skills and experience had improved and was resulting in improved care for people. We saw there were sufficient numbers of staff working, however, the deployment of staff was not always effective. For example, we saw a number of staff queueing to collect meals for people and not proactively providing support to people who were eating. We spoke to the registered manager and the management team about staffing in the service. They told us they were currently working with a high ratio of care staff to people to assist with making improvements in the service. They recognised concerns raised about the use of agency staff and confirmed recruitment plans and details of new staff due to be starting work on completion of pre-employment checks. The management team were committed to reducing the number of agency staff working in the service. They were also aware they needed to ensure sufficient levels of staff remained available to people as they began to increase the number of people living at the service.

We looked at how the provider completed pre-employment checks before staff members started work at the service. We saw a range of checks were completed on staff member's suitability to work in the role they were recruited for. These included interviews, ID and background checks, references and Disclosure and Barring Service (DBS) checks. A DBS check helps employers to screen a new employee's potential criminal history. We did see that where there were queries about the results of pre-employment checks, the registered manager had not consistently recorded the outcome of any risk assessments completed before the staff member had started work. People were however, protected from the risk of harm as the registered manager had discussed potential risks with the senior management team. People were protected by safe recruitment practices that ensured only suitable staff members were recruited.

Is the service effective?

Our findings

At the last inspection completed in February 2016 we rated the provider as 'requires improvement' for the key question of 'Is the service effective?'. We found they were in breach of the regulation around the need to obtain consent to people's care. At this inspection we found that although some improvements had been made, the requirements of the regulation had still not been met.

During this inspection we saw staff asking people for their consent before providing them with support. For example, when providing food and drink or supporting people to move. 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. At the last inspection, staff and managers did not have a sufficient understanding of the MCA. People's rights were not being upheld and decisions were not being made in people's best interests in line with the MCA where they lacked capacity to consent to decisions themselves. At this inspection, we found improvements had been made. Staff we spoke with understood the MCA required decisions to be made in people's 'best interests' when they lacked capacity to make their own decisions or provide consent. We found assessments of people's capacity were being completed for some aspects of their care in order to make decisions in their best interests. However, we found that the application of the MCA was inconsistent and decisions had not always been made in line with the Act where people lacked capacity.

We found some people who were not able to provide consent were being given their medicines covertly, without following the principles of the MCA. Although some people's capacity to make decisions about receiving their medicines had been assessed, others had not. Details of 'best interests' decisions were not always recorded including who was involved in making the decision, the steps taken and the reason for any particular decision. Assessments about some specific decisions made on behalf of people were recorded, for example, the use of bed rails, however this was not consistent across all aspects of people's care. Instructions were sometimes taken about people's care from representatives who did not have the required legal authorisation to make those decisions. These decisions were made without consideration of whether they were in people's best interests in line with the requirements of MCA. We confirmed with the administrator that just under half of the staff members, including management, needed further training on the MCA. We could see that improvements had been made and the management team had begun to implement the requirements of the Act, however, further improvements were still needed to ensure people's rights were fully protected.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

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). At the last inspection we found people were being

deprived of their liberty without the required DoLS application having been submitted. At this inspection, we found where staff felt people were lacking capacity and they had been deprived of their liberty in order to protect their health and well being, applications had been submitted to the Local Authority.

People told us they felt staff had the skills required to support them effectively. One person said, "I wouldn't stay here if I didn't like it or if I didn't feel safe and it is my choice you know. The staff are good and there if needed and know what they are doing". Visitors also shared the view that staff had the appropriate skills, however some did raise concerns about the competency of agency staff. One visitor said, "[My relative] gets good care here. Wouldn't still be here otherwise". Another visitor said, "The good staff are the regular staff. I don't care for the agency staff". Staff told us they felt the skills within the staff team had greatly improved since our last inspection. They told us they had regular one to one meetings with their line manager and felt they could get support when it was needed from the registered manager. Staff told us training had improved but that it still needed further development. One staff member when speaking about training told us, "It's ok. It's quick". Staff told there were some areas in which they needed further training, for example managing behaviours that could challenge. We found this was an area in which staff did not demonstrate they had sufficient skills and knowledge. We saw from the training records provided by the management team, managers had identified there were numerous areas in which care staff required further training. Since our last inspection, training had been completed in areas such as infection control, the safe use of bed rails, and dementia care, however, not all staff members had completed the training. Staff told us there were induction processes in place and we were told how agency staff also had to complete an induction before they began working at the service. The management team acknowledged the need for further staff training and development. They showed us details of training courses they were arranging for staff and spoke about plans to introduce tools to assess the competency of staff and also the 'Care Certificate'. The Care Certificate is a nationally recognised standard for the expected knowledge and skills of staff members working in care. Staff did not have sufficient skills and knowledge in specific areas, however, plans for further training and development were being implemented by management.

People told us they enjoyed the food and drink they received. We received mixed views about the choices available to them. One person told us, "It's lovely food here as well – very good and you get a choice". Another person told us, "I say the food is excellent and I wouldn't stay if it wasn't I would be out of here and I like my food and it's got to be good". Visitors also told us they thought the food available to people was good. One visitor said, "You cannot knock the food here it is excellent and I eat here every day". Another visitor told us, "[My relative] eats well and seems to enjoy the food which is good. I come in daily to feed [them]." Some people however did say the choices available to them did not meet their preferences. One person we spoke with said, "This food is alright. I can eat it but I would really love some nice white chicken breast with a nice white sauce". Some relatives also shared this view and said they did not always feel meals met people's preferences. They gave an example of the curry available to people on the day of the inspection and we did observe people not wishing to eat this option in one dining area. We saw visitors were encouraged to be involved in the lunchtime experience. Friends and relatives could sit and enjoy lunch with people or support people to eat if this was preferred. We saw support was not always provided by staff to enable people to be as independent as possible at mealtimes. For example, two visitors told us how they had brought in adaptive cutlery for their relatives as this was not provided by the service. We observed one person knock their drink over as they struggled to eat with standard cutlery. We saw staff proactively encouraging people to drink during the inspection. Staff were aware when it was a warm, sunny day and we saw lots of fluids available to people. We shared some of our observations around mealtimes with the registered manager. They told us about some improvements that had already been made to the dining experience for people and acknowledged there was further work to be done. People's nutritional needs were met although people could be supported more effectively at mealtimes.

We saw where people required a special diet to support their health needs this was provided. For example, we found staff knew where people needed a diet to assist with the control of their diabetes or where a soft diet was needed. Staff knew how to support people's health needs and could recognise signs that would indicate when people needed further support. For example, when someone's blood sugar may not be in the desired range to support their health. People told us they were supported to see healthcare professionals when needed to promote their day to day health. One person told us, "I go out to the optician. It is arranged for me if needed. The chiropodist comes in as well which is very good and the doctor comes if needed". Another person told us, "If I need to see anyone it is organised I think the optician does come here if needed. I am well apart from my back and if I need anything I just ask for it". Visitors also told us people could access healthcare assistance when needed. One visitor told us, "[My relative] sees the doctor if necessary and they are arranging for someone to come and do her fingernails. They are going to soak them first to make it easier." A visiting healthcare professional told us there had been positive improvements made by the registered manager. They told us staff understood people's needs well, that they sought prompt advice from healthcare professionals and implemented any advice and guidance given. We confirmed in people's care records they had regular access to healthcare professionals including the chiropodist, doctor and specialist services such as speech and language professionals (SALT). People were supported to maintain their day to day health needs.

Is the service caring?

Our findings

At the last inspection completed in February 2016 we rated the provider as 'requires improvement' for the key question of 'Is the service caring?'. We found people's dignity was not always upheld. At this inspection we found significant improvements had been made.

People told us they felt care staff were kind and caring towards them. One person told us, "They [care staff] care for me very well. The staff all of them are good and care for me". Another person told us, "I have very good care here and everyone looks after me. They are all kind when they do things for me. It's always done in a nice way". A third person told us, "The staff are good and caring, always ready for a chat and a laugh which I enjoy. Visitors also told us they felt staff were kind and caring. One visitor told us, "The staff are good and caring with all the residents here". Another visitor told us, "[My relative] has been here for just over a year and I am happy with [their] care. I come in at other times and have only seen kindness and caring. The staff are always kind and attentive". Staff we spoke with told us it was important to them to provide good care for people and they were committed to making people feel valued and important. One staff member told us, "I just want things to be right for the residents". This approach by staff was reflected in our observations within the service. We saw some positive interactions between staff and people living at the service. Staff used a kind and caring approach when trying to encourage people to complete different tasks. For example, we saw one care staff using a book and pictures of fruit to gently engage a person and encourage them to drink. We saw the engagement by the registered manager with people was also caring. We saw one example where a person's eyes lit up when the registered manager entered the room. The registered manager and the person were smiling, clapping and singing together. People were supported by a staff team who were kind and caring in their approach.

We saw people were supported to make choices about their day to day care and activities. We heard staff offering people choices around various options such as where they wanted to spend time and what they wanted to eat and drink. We heard staff speaking with one person asking if they wanted to sit with a group of residents to talk or if they wished to stay watching the television alone. They chose to watch television and staff respected their choice. We saw another person like to read the paper with a glass of red wine and staff supported this person to do this. We saw where people needed support to make choices about their care this was provided. For example, we saw examples of where advocates had been appointed for people where it was required.

People told us staff respected and promoted their privacy and dignity. One person told us, "They are always very respectful and careful with your privacy which again I like". Another person told us, "My privacy is always respected I am never awkward or embarrassed when they are doing things for me I am at my ease. No complaints". A third person said, "The [care staff] are good and care for me and they take care of my privacy which is nice". Visitors also supported this view with one visitor saying, "My [relative's] privacy is always respected and [they] is always clean and smells good". Staff told us how they tried to promote dignity while caring for people and gave us examples such as how they covered people while they completed personal care. We saw care staff promoted people's dignity while supporting them.

People were supported to maintain relationships which were important to them. We saw visitors, including relatives and friends were able to visit the service without restriction and were supported to be involved in people's care where this was appropriate. We saw relatives were part of the 'community' within the service and were encouraged to take part in activities such as mealtimes. We saw one person's spouse visited the service regularly with the family dog. We saw how other people also living at the service responded positively and enjoyed seeing the dog in the communal areas of the service. The management team spoke to us about further plans to involve family and friends in the service, including new tools to share family photographs with people through a new care management system that had been introduced.

Is the service responsive?

Our findings

At the last inspection completed in February 2016 we rated the provider as 'requires improvement' for the key question of 'Is the service responsive?'. We found staff did not always understand people's care needs and these were not reflected in care plans. We also found some people did not feel their complaints were always addressed adequately. At this inspection we found they had made some improvements. Staff understood people's care needs and complaints were addressed. However, some further improvement was still required, for example in ensuring care plans were up to date and reflective of the care people received.

People told us they felt the care they received met their needs and preferences. Visitors told us they too felt care staff provided support that met people's needs. One visitor told us, "Staff know [my relative] well". We found staff did know people well and they did mostly understand how to support people effectively. We did however identify that staff knowledge around how to safely support people with behaviour that challenged was not always effective. Staff were not always confident in how to respond to behaviours that challenged. Care plans had not yet been developed to provide guidance to staff about how to meet people's needs when they demonstrated behaviours that could challenge others.

A visiting healthcare professional told us they felt significant improvements had been made in the service and the care provided met people's needs. They did however suggest some improvements could be made around documentation and record keeping. This reflected what we saw as we found care plans were not always accurate and reflective of people's needs. Staff did, however, possess appropriate knowledge about people's needs and provided appropriate care. We found staff understood how to meet the needs of people with diabetes but their care plans did not always accurately outline the support they required. We found one care plan outlined an incorrectly sized sling should be used to support someone, however, staff did know this information was not accurate. Staff knew which sling was the correct size to be used. These inaccuracies in people's care plans had not impacted on the care provided to these people. There was, however, an increased risk of people receiving care that did not meet their needs due to the service engaging regular agency staff. Agency staff did not have accurate records to refer to and people told us they did not always feel agency staff understood their needs. Managers advised that they tried to engage specific agency staff repeatedly to minimise these risks. However, they recognised improvements were required.

A new electronic care management system had been introduced into the service. The management team told us this was assisting in improving the quality of care provided and ensuring people's needs were met. We saw staff were alerted when people needed routine tasks completing to ensure their needs were met, for example, when people needed to be turned to ensure their skin was protected from potential pressure areas. The management team recognised there were improvements needed regarding the quality of care planning. They advised all care plans were under review to ensure they outlined clearly how staff should effectively meet people's needs. However, people's care plans were not always reflective of their needs or the care provided at the time of the inspection.

We saw the registered manager had begun to complete reviews of people's care needs in partnership with the person themselves and any appropriate representatives, for example their relatives. We saw the quality

and compliance manager had also begun to complete comprehensive reviews of care plans in order to identify inaccuracies and areas for improvement. We saw actions had been identified as a result of these reviews and steps were being taken to resolve any issues found. The management team advised that all care plans were being reviewed as they were entered into the new electronic care planning system to ensure they were accurate and reflective of people's needs. People's care needs were starting to be reviewed and people were being involved in a review of their care plans.

People told us they felt improvements were needed to the leisure opportunities available to them. Visitors also shared this view. One visitor told us, "Weekends can be dull but they have taken someone on, they are working on improving that". Staff told us they too felt the leisure opportunities available to people needed improvement. The registered manager told us they had appointed a new activities coordinator who was due to start work at the service shortly following our inspection. The management team spoke of various plans they had to make improvements to the quality of life of people living at the service; including the introduction of some specialist activities for people living with dementia.

We saw staff worked hard to engage people while they provided care to them. Staff demonstrated a good knowledge of people while engaging them in conversation and day to activities. We saw one member of staff obtain a delighted response from one person when they showed them a photograph of an item they had been reminiscing about. We saw staff engaging with one person who liked to paint and they encouraged this person to tell people about their passion. We also saw staff effectively using an reminiscence calendar and using the photos to talk to someone about their past career and time spent abroad. We saw a religious minister visit the service to meet with people who wished to see them. We saw staff were supporting people with day to day activities that met their individual preferences where possible.

People told us they knew how to make a complaint and felt comfortable in raising concerns if necessary. One person told us, "Yes I know who to talk to if I had a complaint which I don't or if I was unhappy about something". Visitors also told us they felt able to raise complaints if necessary. One visitor told us, "I know who to speak to if I see or hear something that isn't right but I have no concerns or complaints". Another visitor told us, "I feel able to raise concerns, I would tell them straight away". We saw the management team kept a comprehensive log of complaints made into the service, including comments that had been made on an informal basis. We saw thorough investigations had been completed into complaints raised and letters were sent to the person or relative raising the complaint. The management team identified actions that were required to make improvements to the service as a result of complaints made. These actions were reviewed to ensure the required steps had been taken. We saw complaints were recorded and investigated thoroughly by the management team in order to make improvements to the service provided to people.

We saw the management team had developed a range of methods outside of their complaints procedure in order to capture people's feedback about the service. We saw feedback surveys were issued to people and meetings were held during which people were encouraged to share their views. One person told us, "I am on a committee here representing the needs of the residents which I think is a good thing". A visitor told us, "I raise things if necessary at the regular meetings we have to discuss care and issues. Things are always dealt with to my satisfaction". People and visitors to the service felt confident their views were sought and improvements to the service were made as a result of any concerns shared.

Is the service well-led?

Our findings

At the last inspection completed in February 2016 we rated the provider as 'inadequate' for the key question of 'Is the service well-led?'. We found they were in breach of the regulation around the effective management of the service. At this inspection we found while improvements had been made, the requirements of the regulation were still not met.

At the previous inspection we found quality assurance systems were ineffective and were not identifying risks to people and areas of improvement required within the service. During this inspection we saw that a new quality management system had been developed and was currently being piloted within the service. This system had already identified shortfalls within the service and had enabled improvement plans to be created and completed to improve the quality of service provided to people. For example, we saw inaccuracies identified in people's care plans, mattresses that needed replacing had been identified and other areas of improvement highlighted, including the introduction of reminiscence items at mealtimes and memory boxes. People and a visiting healthcare professional told us improvements had been made within the service. They told us the registered manager was developing a strong staff team and people's needs were being more effectively met in recent months since our last inspection.

We did, however, identify some serious concerns that had not been identified by the quality assurance system as it was still in the process of being developed and implemented. For example, we found widespread concerns about the cleanliness of the service and some infection control practices. We saw the home was particularly dirty and equipment used by people such as chairs and tables had not been cleaned. These concerns had not been identified by the management team and plans were not in place to make improvements in this area. We looked at an action plan for infection control that had been submitted by the provider to the local Clinical Commissioning Group (CCG). In this action plan it was stated several areas of improvement required were complete. We saw these actions were still in need of completion during our inspection. For example, washbasins were not always in a good state of repair, bins were not always clean and in a good state of repair and the environment was not visibly clean. The provider had not recognised the extent of the issues with the cleanliness of the service and infection control practices prior to the inspection and sufficient action had not been taken.

People were not always protected from potential risks as auditing processes were failing to identify and effectively review incidents of concern. For example systems were not in place to ensure incidents were recorded, investigated and reported appropriately. We found several recording documents and auditing tools that detailed incidents were not fully and consistently completed. Information recorded in people's daily care records, behaviour monitoring charts and incident records did not match and this had not been identified by management. Systems were not in place to ensure all incidents of concern were accurately reported and the registered manager notified. We identified incidents that had not been reported to the local safeguarding authority due to these inaccuracies in recording and the insufficient review of care records by management. As a result of these errors in recording and reporting, the information collated on monthly management reports to analyse incidents was not accurate. For example, the monthly management report for August outlined there had been one incident involving behaviour that challenged.

We identified at least thirteen incidents involving just one person living at the service. This resulted in the management team not identifying key areas within the service that required urgent improvement in order to protect the safety of people and to keep them safe from harm.

We saw the management team were aware of their statutory responsibilities. Where certain adverse incidents were identified, a statutory notification had been submitted to CQC as required by law. A provider is required to submit a statutory notification to notify CQC of serious incidents such as injuries, deaths or allegations of potential abuse. We did however, identify that as systems were not always in place to ensure incidents were recognised and reported, the registered manager had not always submitted notifications when required.

Systems were not yet in place to ensure care plans and risk assessments accurately reflected people's needs. While plans were in place to review care plans and risk assessments as they were transferred into the providers new electronic care system, this had not yet taken place at the time of the inspection. For example, we looked at the risk assessment for one person who we saw moved in an unsafe way. Staff had not tightened a safety belt on a sling that was in use. This person's care plan and risk assessment outlined an incorrect sling should be used to support them and also did not highlight the importance of tightening the safety strap when the sling was in use. Systems were not yet in place to ensure care records were up to date and reflective of people's needs or the care provided.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

We saw the management team were working to make improvements to the quality assurance and auditing processes within the service. We saw the new electronic care planning system that was being introduced into the service. We saw care staff proactively using this system and the operations manager told us how there had been an increase of approximately 80% in the recording of the care being delivered to people. This increase in recording had assisted the registered manager in ensuring that people were receiving care that met their needs. We saw the registered manager was able to continually monitor people's care needs during the inspection through the system to ensure people's needs were being met. We found the management team were committed to making the required improvements within the service. We saw the management team were creating improvement plans during the inspection and began to make some improvements before the inspection had been completed.

People told us they knew who the registered manager of the service was and that they felt the service was well managed. Visitors to the service told us they felt the registered manager had made some positive improvements to the service since our last inspection. One visitor told us, "I am pleased with how they have really upped the standards. The difference is really noticeable". Another visitor told us, "[The service] has improved noticeably over the last 6 to 9 months. [The registered manager] is first class. We have real faith in her. She is absolutely on the ball and always tries to put things right for you quickly. She is great". A third visitor told us, "Overall I am very pleased with the care here now especially with this new manager". People told us they felt involved in the service and that their views were heard. Both people living at the service and their relatives told us they were able to share their views at regular intervals, such as at meetings. People and their relatives felt supported by the registered manager and told us the service was now well-led.

Staff we spoke with also told us they felt the registered manager was supportive of them. One staff member said, "[The registered manager] is brilliant. I can't speak highly enough of her." They told us, "[The registered manager] is very hands on and will support the care." We were told by staff they felt they could speak with the registered manager whenever they needed to. They told us the registered manager was creating a strong

team of motivated, committed care staff. A staff member told us, "The staff we get on really well as a team. It's quite pleasant to work [at Myford House] at the minute." Another staff member told us, "I absolutely love it! My [relative] jokes and say if I won the lottery I'd still come [to work] at Myford". People were supported by a staff team who were motivated in their roles.

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 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	People's rights were not protected through the effective use of the Mental Capacity Act 2005 (MCA).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not consistently supported to move in a way that protected them from the risk of harm. The potential risk of injury or harm to people due to behaviours that could challenge was not always effectively managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	People were not protected by effective quality assurance processes that identified all of the required areas of improvement within the service.