Lifestyle Care Management Ltd

Moorland Gardens Care Home

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

We carried out an unannounced inspection on 16 November 2015. The service had recently been re-registered as the provider had changed.

The service provides care and support for up to 80 people, some of whom may be receiving short term rehabilitation care and treatment, living with dementia or chronic health conditions. On the day of our inspection, 46 people were being supported by the service.

There is a registered manager 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.

Summary of findings

The provider had effective systems in place and staff had been trained on how to safeguard people. There were individual risk assessments that gave guidance to staff on how risks to people could be minimised. People's medicines had been managed safely and administered in a timely manner.

The provider had effective recruitment processes in place and there was sufficient staff to support people safely. The manager and staff understood their roles and responsibilities in ensuring that people consented to their care. Also, that care was provided in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS) for people who lacked mental capacity to make informed decisions about their care. Staff had received effective training, support and supervision that enabled them to provide appropriate care to people who used the service.

People's needs had been assessed and they had care plans that took account of their individual needs, preferences and choices. They were supported to have sufficient food and drinks, and had access to other health and social care services when required in order to maintain their health and wellbeing.

Staff were kind and caring towards people they supported. They treated people with respect and supported them to maintain their independence as much as possible. Some activities had been provided to occupy people within the home, but more needed to be done to support people to pursue their varied hobbies and interests outside of the home.

The provider had a formal process for handling complaints and concerns. They encouraged feedback from people or their representatives, and acted on the comments received to improve the quality of the service provided.

The registered manager provided stable leadership and effective support to the staff. The new deputy manager had new ideas to further improve the quality of the service provided. However, more needed to be done to change people's perception that there was not always sufficient staff to provide the support they wanted. Quality monitoring processes had not always been used effectively to drive improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People felt safe and there were effective systems in place to safeguard them.

There was enough skilled and experienced staff to support people safely.

People's medicines were managed safely.

Good

Is the service effective?
The service was effective.

Staff received adequate training and support in order to develop and maintain their skills and knowledge.

Staff understood people's individual needs and provided the support they needed.

People had enough and nutritious food and drink to maintain their health and wellbeing.

Good

Is the service caring?
The service was caring.

Staff were kind and caring towards people they supported.

People were supported in a way that maintained and protected their privacy and dignity. Where possible, they were also supported in a way that maintained their independence.

People's choices had been taken into account when planning their care and they had been given information about the service.

Good

Is the service responsive?
The service was responsive.

People's care plans took into account their individual needs, preferences and choices.

The provider worked in partnership with people and their representatives so that their needs were appropriately met.

The provider had an effective complaints system and people felt able to raise concerns.

Good

Is the service well-led?
The service was not always well-led.

The registered manager provided stable leadership and effective support to staff.

Requires improvement

Summary of findings

People were enabled to routinely share their experiences of the service. However, the provider had not effectively dealt with some of their concerns about staffing levels, food choices and the provision of activities or opportunities to pursue their hobbies and interests outside of the home.

The provider's quality monitoring processes had not always been used effectively to drive improvements.

Moorland Gardens Care 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.

The inspection took place on 16 November 2015 and it was unannounced. It was carried out by two inspectors 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.

Before the inspection, we reviewed information we held about the service. The service had recently re-registered under a new provider and we had not yet received any notifications from them. A notification is information about important events which the provider is required to send to us.

During the inspection, we spoke with 11 people who used the service, four visiting relatives, eight staff, the deputy manager, the registered manager and a visiting professional.

We reviewed the care records for 12 people who used the service. We checked how medicines and complaints were being managed. We reviewed the provider's staff recruitment, supervision and training processes. We looked at information on how the quality of the service was monitored and managed and we observed care in communal areas of the home.

Good

Is the service safe?

Our findings

People told us that they were safe living at the home and this view was supported by the relatives we spoke with. One person said, "I feel safe here. There is always someone to call on." Another person said, "I leave my door open and I have never heard staff speak to anyone in a way that would worry me." A person's relative told us, "I can leave him here, go home and sleep at night. I know he is safe."

The provider had processes in place to safeguard people, including safeguarding and whistleblowing policies. Whistleblowing is a way in which staff can report concerns within their workplace. Information about how to safeguard people had been displayed around the home, including in the lift. This gave people who used the service, staff and visitors guidance on what to do if they suspected that a person was at risk of harm. This also contained relevant contact details of organisations where concerns could be reported to. We noted that staff had been trained on how to safeguard people and they had good understanding of how to keep people safe. They all said that people were safe at the home and were also able to describe the procedures they would follow if they suspected that people were at risk of harm. This included reporting any concerns to the manager or the local authority safeguarding team. Staff were confident that the manager would deal appropriately with any concerns they would report. A member of staff said, "I have not had to report anything, but the manager is always telling us we can go to her with any concerns."

People's care and support had been planned and delivered in a way that ensured their safety and welfare. The care records showed that assessments of potential risks to people's health and wellbeing had been completed and detailed risk assessments were in place to manage the identified risks. For example, there were assessments for risks associated with people being supported to move, pressure area damage to the skin, falling, not eating or drinking enough and medicines. Also there was a risk assessment, where it was considered in the person's best interest to have bed rails in place to reduce the risk of them falling out of bed. We saw that the risk assessments had been reviewed regularly or when people's needs had changed. We observed good techniques when staff used equipment to support people to move safely.

The provider had robust recruitment procedures in place because thorough pre-employment checks had been completed for all staff. These included requesting appropriate references for each new employee and completing Disclosure and Barring Service (DBS) checks. DBS helps employers to make safer recruitment decisions and prevents unsuitable people from being employed.

There were mixed views about whether there was enough staff to support people safely. Some people said that there was not always enough staff and so were some of the relatives we spoke with. A relative of a person being supported in a unit for people living with dementia said, "Sometimes there are not enough staff. There is not enough monitoring in the lounge. No-one here, we look and we can't find anyone. It seems a bit dangerous to me." Another relative said, "They aren't even at half full and they could do with more staff." A third relative told us that it was better in the summer when the service had a number of students working. They added, "There are more staff around then, but as soon as term starts, they are back to square one." However, we found the provider's staff retention was good as there was evidence that some of the staff had worked for them for many years.

The staff rotas also showed that sufficient numbers of staff were always planned to meet people's needs safely and in most cases, the manager covered shortfalls resulting from staff sickness. Although staff told us that there was very rarely a problem getting staff to cover sickness, they said that in such instances, staff redeployment was necessary to cover busier areas of the home. One member of staff said, "Most of us are happy to pick up some extra shifts." The manager also told us that in rare cases where additional staff could not be found, they, the deputy manager and the clinical lead would work alongside staff to provide care to people. When needed, they also had arrangements to get staff from another home owned by the provider. The three members of staff who were less positive about the staffing levels were not able to tell us how the current staffing levels had impacted on people's care. Their comments like, "We would be able to get people up earlier" and "We would be finished quicker" did not support people's comments that they had not been left in bed for longer than they would have wanted. We noted that on the rehabilitation unit, 13 people were being appropriately supported by two nurses and four care staff. A member of staff on this unit said, "Staffing levels are good at the moment, but we would be

Good

Is the service safe?

busier if we have more people as there would not be any more staff." However, the manager told us that they always reviewed and sometimes, increased staffing when more people were admitted to the home.

The provider ensured that the environment where care was provided was safe. For example, the maintenance records showed that issues within the home were resolved promptly, and we observed workmen painting, decorating and carrying out repairs throughout the inspection. Fire safety checks had been undertaken regularly, including the testing of the fire equipment. Fire safety information was displayed next to the emergency alarm activation points, so that staff had the information they required to evacuate people quickly in an emergency. The manager kept a record of all incidents and accidents that had occurred at the home so that they analysed these and identified ways of reducing the likelihood of them happening again. Also, all the equipment used within the home including hoists and slings, was regularly inspected to ensure that it remained safe for use by people.

There were systems in place for ordering, recording, auditing and returning unrequired medicines to the pharmacy. Medicines had also been stored appropriately in locked trollies, within locked medicine rooms. People we spoke with had no concerns with how their medicines were being managed and given to them. We saw that medicines were being administered by nurses and their competence was occasionally checked to ensure that they did so safely. We observed that when administering medicines, nurses had dedicated time to ensure that they were not disturbed. This reduced the risk of them making errors. The 24 medicine administration records (MAR) we looked at showed that people's medicines were being managed safely and administered as prescribed by their GP.

Good

Is the service effective?

Our findings

People told us that staff had the right skills to meet their support and treatment needs. A relative of one person said, "I can tell you now, the staff here are fantastic. Everything is a gamble when a loved one comes into a home, if I thought there was a problem I would come down on them because he is my life." The professional we spoke with worked on a rotational basis with people on the rehabilitation unit. They said, "The care is generally good, the staff are doing their best and hardworking. Sometimes issues arise because people had not been given enough information about the service before admission." They also said that they had various professionals meetings to address these issues and they knew people who had chosen to stay at the home after a period of rehabilitation because they found the care good.

The provider had a training programme that included an induction for all new staff and regular training for all staff. Staff said that the training they had received had been effective in giving them the right skills and knowledge to enable them to support people appropriately. A new member of staff said that they had a three day induction, as well as, working alongside an experienced member of staff. They also told us that they were confident to ask for help if they were unsure about what to do. They said, "I definitely wouldn't do anything without asking if I didn't know what to do." Staff told us they had a number of training opportunities and could request any training they needed to meet people's needs. Some care staff had also been able to gain nationally recognised qualifications in health and social care, including National Vocational Qualifications (NVQ) and Qualifications and Credit Framework (QCF) diplomas. A member of staff told us, "I have had the opportunity to do NVQ level 2 and 3, and I am now completing an online 'stroke awareness' course as I have a particular interest in supporting people who have had a stroke." A nurse told us that they were confident they had been given the training opportunities necessary to meet the requirements of their registration with the Nursing and Midwifery Council (NMC). The manager told us that the provider was looking at how they would support the nurses to meet the NMC's new revalidation process that is due to start in April 2016.

The recent change in the provider of the service meant that we were unable to review supervision records beyond the time the service was re-registered on 4 November 2015. However, staff told us that they had received either individual or group supervision every six to eight weeks. They said that during these meetings, they were given opportunities to talk about issues relevant to their roles. A member of staff said, "I believe having time for a good supervision session shows I am a valued member of the team." The manager told us that the new provider had not indicated any plans to change how often staff received supervision and they anticipated that the current process would remain unchanged.

People told us that they consented to their care and support and we saw evidence of this in the records we looked at. Some of the care records had a form signed by the person to indicate that they consented to their care and treatment. However, for those who did not have capacity to consent to their care or make decisions about some aspects of their care, their care and treatment were provided in accordance with the requirements of the Mental Capacity Act 2005 (MCA). In such cases, we saw that mental capacity assessments had been completed. The 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.

We noted that staff understood the relevant requirements of the MCA, particularly in relation to their roles and responsibilities in ensuring that people consented to their care, and made decisions about their care and support. We observed that staff asked for people's consent, they respected people's choices and views and supported them in a way that respected their rights. For example at lunchtime, a member of staff said to a person, "Can I help you with that? Would you like to wear an apron to protect your clothes?" We also saw that when required to safeguard people, referrals had been made to the relevant local authorities so that any restrictive care met the legal requirements of the Deprivation of Liberty Safeguards (DoLS). Some authorisations had been received.

Most people told us that they enjoyed the food provided by the service and that there was adequate choice. They said that cooked food was always served hot and there was

Good

Is the service effective?

plenty of it. However, one person told us that there always had enough to eat, but there was not much choice, adding, "One thing is that there isn't much fruit about, that would be nice." The manager told us that the menus were reviewed with people during meetings and changes had been made if people did not like particular food. Although some people who lived on the first and second floors of the home told us that the dining rooms were rarely used, we observed people eating in one of the dining rooms during our inspection. A relative commented about this by saying, "No one uses the dining room, not ever. That's a first, it must be because you are here." The manager told us that people chose where they wanted to have their food and although they encouraged people to sit in the dining rooms, they could not make them do so if they did not want to. Some people felt that meal times needed to be reviewed because there was not enough time between lunch and the evening meal. The evening meal being served at 4:30pm meant that people who went to bed early did not have anything else to eat until breakfast at 8am. However, the manager told us that people would always be given a snack if they felt hungry at any time of the day or night.

People with specific dietary requirements had also been supported to eat well. We saw that a variety of options were available for people who required soft food, high calorie food and food low in sugar for people living with diabetes. Staff regularly monitored people's weight to ensure that this remained within acceptable ranges. Appropriate action had been taken to monitor this closely if people had been assessed as being at risk of not eating enough and Malnutrition Universal Screening Tool (MUST) forms were completed regularly to assess this risk.

People were supported to access other health and social care services, such as GPs, dentists, dietitians, opticians and chiropodists so that they received the care necessary for them to maintain their health and wellbeing. There was evidence of involvement of various professionals in people's care and treatment, particularly for those receiving rehabilitation care, as they were reviewed regularly by a multidisciplinary team. There was evidence that staff responded quickly to people's changing needs and where necessary, they sought advice from other health and social care professionals. For example, a person had been referred to the tissue viability nurses when it had been noted that their pressure wound had worsened.

Good

Is the service caring?

Our findings

People told us that staff were caring and compassionate when supporting them with their care. One person said, "I like it here, she's [care staff] is so kind to me." Another person said, "It really is a home, the carers come and cuddle the residents if they are having a bad day." A person's relative told us, "I heard a carer say, I treat them like my mum and dad, and how they would want to be treated." Another person told us about how they appreciated staff support when they could not sleep. They said, "When I rang the bell, she came in, plumped my pillows and made me a cup of tea. We had a little chat, she rearranged my pillows and I went to sleep. The next night she popped in to see if I was ok."

We observed positive and respectful interactions between staff and people who used the service. Staff spoke with people whenever they came into the communal areas. Also, we observed that the two visiting hairdressers had lively conversations with the people whose hair they were grooming.

Some people told us that they been actively involved in making decisions about how they were supported. Their choices had been taken into account in planning their care and had been respected by staff. People said that they felt listened to, their views were acted on and were supported to maintain their independence as much as possible. Staff recognised what people enjoyed doing and as much as possible, they supported them to live happy and fulfilled lives. A member of staff said, "She likes folding. So when I can get her napkins, she folds them. Very useful." Another member of staff told us how they supported people for whom dementia has changed how their view of the world around them. They said, "You have to live in their world, it's no good trying to get them to live in ours." We noted that people were enabled to maintain relationships with their family members and friends because they were able to visit them whenever they wanted. A relative we spoke with confirmed this when they said, "I'm here every day." On the day of the inspection, we observed that the manager made themselves available to speak with a relative about an incident that had happened a few days before, and the relative really appreciated that.

People told us that staff supported them in a way that maintained their privacy and protected their dignity. One person said, "They are very careful about closing doors if they are helping me with personal stuff." Another person said, "They always close the door to help me wash and dress. They always knock first too." Several people told us that they could choose whether to have their doors open or closed when they were relaxing in their bedrooms. When we asked staff about how they promoted people's privacy and dignity, they spoke about offering people choices of clothes, meals and when they went to bed or got up. Also, they said that they shut the doors when providing personal care and knocked on doors before entering people's bedrooms. We noted that staff also understood how to maintain confidentiality by not discussing about people's care outside of work or with agencies that were not directly involved in their care.

People had been given information in a format they could understand to enable them to make informed choices and decisions. We noted that when people started using the service, they had been given a range of information about the service. Records indicated that some people were able to understand this information, but other people's relatives or social workers acted as their advocates to ensure that they received the care they needed. Also if required, people could be supported to contact independent advocacy services so that they had the advice they needed.

Good

Is the service responsive?

Our findings

People's needs had been assessed prior to them moving to the service. The information gained from these assessments was used to develop appropriate care plans so that people received the care and support they required. The care plans showed that people's preferences, wishes and choices had been taken into account and there was evidence that wherever possible, people had been involved in planning their care. We saw that each person had an allocated keyworker and a named nurse who reviewed their care plans regularly or when their needs had changed.

People told us that staff normally responded quickly when they need support and used their call bells. One person said, "I don't have to wait too long, but I'm fairly independent really. Another person said, "They respond as quickly as possible. At night it's just the same. I keep my door open, so I know what happens." However, we observed staff responding to a call bell and being more concerned about turning it off first before finding out why it had been activated. It took other people telling them that a person needed the toilet before the person could be supported. If other people were not in the room, staff's actions could have resulted in unnecessary delays in supporting the person. The service monitored how quickly the call bells were responded and the manager told us that staff were expected to check why a person activated the call bell before switching it off.

Some of the people on the ground floor of the home said that they were bored because not many activities had been provided. One person said, "I get two choices. I stay in bed or I get up, sit in that chair and stare at the wall. There's nobody ever in the lounge. They ask me if I want to go, but what's the point." Another person said, "I go up to the rehabilitation floor to join in their coffee mornings and their activities. We did painting and I even played bingo just for the company. That's the only place there are any activities, so I have to wait to be asked. The trouble is that they often talk about when they are going home, so when they ask me I just say, not for a long while yet." However, we noted that although the service had a new activities coordinator to ensure that appropriate activities were provided within the home, it was difficult to provide group activities on the ground floor because the majority of people on this floor were very unwell. It was for this reason that people on this floor were encouraged to socialise with those living on the rehabilitation floor. The activities coordinator was not available on the day of our inspection, but we saw evidence of some themed activities that had recently taken place and those planned for the rest of the year. For example, we saw that everyone had been encouraged to wear something pink on 23 October 2015 to raise awareness of breast cancer. A Halloween party had been held the following week on 30 October 2015. The new provider had also planned an open day on Saturday, 21 November 2015 and this had been widely advertised in the local area.

The manager told us that the new activities coordinator had a lot of ideas about how they could help people to positively occupy their time within the home. We saw that they had written some of their ideas on a board in the activities room and these included creating a 'spiritual room' where people could go if they need a quiet space to pray, meditate or relax. A board titled 'our best memories', displayed pictures of people taken when they took part in various activities including gardening and birthday celebrations. A mobile library was available for use by people and this had a selection of books borrowed from a local public library. The manager told us that the activities coordinator was also able to get specific books for people if they wanted this. Coffee mornings were held twice weekly and the manager said that these were normally well attended. Boxes with a selection of cards, board and ball games were available on each floor so that care staff could provide activities for people in the absence of the activities coordinator. These were also useful for providing individual activities for people mainly cared for in bed. However, apart from individual activities when staff read to some people, very little took place to occupy people's day during our inspection. We discussed with the manager that they needed to review how activities would be provided in the absence of the activities coordinator and how they could support some people to pursue their hobbies and interests outside of the home. This was because most people had told us that they had only been able to go on outings when accompanied by their family members.

The provider had a complaints policy and a system to manage complaints. The information about how to raise complaints was displayed around the home and it had also been included in the 'service user guides' available in each bedroom. People we spoke with told us that they were aware of it and knew who to speak with about any concerns. One person said, "If I need to complain, I would

Good

Is the service responsive?

talk to the manager. She pops in my room during the week." A person's relative who had previous concerns about how their relative's special diet was being managed said, "Now, if we have any concerns we go straight to [Manager]. There had been no complaints recorded since the service had been re-registered.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in post, who was supported by a new deputy manager and a clinical lead. People and their relatives knew who the manager was and they were very complimentary about the support she had given them. Some people said that she visited them in their rooms regularly. One person said, "[Manager] talks to me regularly, I don't have to look for her." Another person said, "[Manager] pops in to see me now and again." We noted that the manager was very passionate about providing good care to people who used the service and people said that she put a lot effort in ensuring that they were happy with the quality of the service. One person said, "The manager is very good and very strict. I would go straight to her with any problems." Another person said, "The manager doesn't let them [staff] get away with things. If she sees something going on she doesn't like, she tells them."

Staff told us that the registered manager provided good leadership, guidance and the support they needed to provide consistently good care to people who used the service. A member of staff said, "The manager is very visible around the home." Another member of staff said, "The manager is easy to talk to." We saw that regular staff meetings had been held for them to discuss issues relevant to their roles. Staff said that these discussions ensured that they had up to date information so that they provided good care and that appropriately met people's needs. Staff felt valued and they also said that they had been enabled to contribute towards the development of the service and any suggestions they made were respected and considered.

The majority of people described the service as 'good'. Although in itself not an indication of poor care, we were concerned that people's perception was that there was not always sufficient staff to support them safely and in a timely manner. There were also comments about limited choices of food, inadequate provision of activities and opportunities for people to pursue their hobbies and interests. We acknowledged that these issues mainly happened under a different provider, but we could not ignore their impact on people's perception of the quality of the service provided. The new deputy manager told us of some ideas they had on how this could be improved so that people's level of satisfaction with the service remained high. We were also aware that the service was going through a transitional period, when the new provider's policies and paperwork was being implemented. The manager assured us that no major changes were planned to policies and systems they used, and there should be no significant changes to people's care.

People said that they were able to give feedback about the quality of the service at any time by speaking with the manager. There were also planned monthly 'residents' meetings that some people chose to attend. The manager also met weekly with people who received rehabilitation care and was also available to meet with people's relatives every Wednesday evening from 5 to 7pm. We were informed that the new provider will also complete annual surveys to determine if people were happy with the quality of the service they received.

The registered manager and the deputy manager completed a number of quality audits on a regular basis to assess the quality of the service provided. These included checking people's care records, health and safety of the environment, medicines management processes and staff records. Some of the audits, such as the checking of medicine administration records (MAR) and medicine stocks had been completed by nurses and the clinical lead. However, we found that audits of MAR did not always identify missed signatures. On the ground floor unit, there were missed signatures for two people on 13 November 2015. Although these MAR had not yet been audited by the deputy manager, there was a system that required that nurses checked them daily as well as, checking the stock levels of all boxed medicines. On another unit, we saw that no action had been taken when a stock check had found that there were two tablets less than expected. This amounted to four doses being unaccounted for, as the person took half a tablet each time. The auditing processes had clearly not been effective on these occasions.