Lawton Group Limited

Hempton Field Care Home

Inspection report

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Date of inspection visit:
04 February 2016
05 February 2016

Date of publication:
04 March 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 4and 5 February 2016. It was an unannounced inspection.

Hempton Field Care Home is a care home providing accommodation for up to thirty people who require nursing or personal care. The home is situated in the village of Chinnor, Oxfordshire. At the time of our inspection 26 people were living at the home.

The registered manager was not available and the home was being managed by the deputy manager. 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.

Mental capacity assessments were not always completed in line with the Mental Capacity Act (MCA) 2005. The Act provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. In the assessments we saw, triggers prompting the assessments were not identified and the assessments did not relate to specific decisions. This meant some people could be incorrectly assessed as having no capacity to make decisions. However, we saw this had not impacted upon people's care.

Some senior staff and all care staff we spoke demonstrated an understanding of the MCA. We saw staff applied the Acts principles in their work by offering people choices, giving them time to consider, and respecting their decisions.

We have made a recommendation in relation to the Mental capacity Act.

People told us they benefitted from caring relationships with the staff who knew how to support them. Staff were supported through supervision, appraisal and training to enable them to provide the high quality care we observed during our visit.

Staff understood the needs of people, particularly those living with anxiety or depression, and provided care with kindness and compassion. People spoke positively about the home and the care they received. Staff took time to talk with people and provide activities such as arts and crafts, games and religious services.

People were safe. Staff understood how to recognise and report concerns and the service worked with the local authority if there were any concerns. People received their medicines safely as prescribed. Staff assessed risks associated with people's care and took action to reduce risks.

There were sufficient staff to meet people's needs. The service had robust recruitment procedures in place which ensured staff were suitable for their role.

People told us they were confident they would be listened to and action would be taken. The service had systems to assess the quality of the service provided in the home. Learning was identified and action taken to make improvements which improved people's safety and
quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

People were supported to maintain good health. Referrals to healthcare professionals were timely and appropriate and any guidance was followed. Healthcare professionals spoke positively about the service.

All staff spoke positively about the support they received from the deputy manager. Staff told us the deputy manager was approachable and there was a good level of communication within the home. People knew the deputy manager and spoke to them openly and with confidence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People told us they felt safe. Staff knew how to identify and raise concerns.

There were sufficient staff on duty to meet people's needs.

People received their medicines as prescribed. Staff carried out appropriate checks before administering medicines.

Is the service effective?

Requires Improvement

The service was not always effective. Mental capacity assessments were not always completed in line with guidance.

People had sufficient amounts to eat and drink. People received support with eating and drinking where needed.

The service worked with health professionals to ensure people's physical and mental health needs were maintained.

Is the service caring?

Good

The service was caring.

Staff were very kind and respectful and treated people and their relatives with dignity and respect.

People benefitted from very caring relationships with the staff who respected their preferences regarding their daily care and support.

Staff gave people the time to express their wishes and respected the decisions they made.

Is the service responsive?

Good

The service was responsive. People were assessed and received person centred care.

There were a range of activities for people to engage in, tailored to people's preferences.

Issues and concerns were dealt with appropriately in a compassionate and timely fashion.

Is the service well-led?

Good

The service was well led.

The registered manager led by example and empowered and motivated staff to deliver high quality care.

The registered manager conducted regular audits to monitor the quality of service. Learning from these audits was used to make improvements.

There was a whistle blowing policy in place that was available to staff around the home. Staff knew how to raise concerns.

Hempton Field 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.

This inspection took place on the 4 and 5 February 2016. It was an unannounced inspection. This inspection was carried out by two inspectors.

We spoke with seven people, four relatives, five care staff, three nurses, the chef, two healthcare professionals, the deputy manager and the regional support manager. We looked at six people's care records, medicine and administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which captures the experiences of a sample of people by following a person's route through the service and getting their views on it. 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.

Before the inspection we reviewed previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said "I'm safe, I don't ever have to think about it". Another person told how staff checked them regularly. They said "I should think it is every hour, even at night".

People were supported by staff who could explain how they would recognise and report abuse. They told us they would report concerns immediately to the deputy manager. Staff were also aware they could report externally if needed. Comments included; "We have all had the training. I'd report any issues to the manager and the local authorities safeguarding team", "I'd go to the senior in charge and the manager. I would also document everything and then call CQC (Care Quality Commission)", "If I saw something I didn't like I'd report it to the deputy manager. I would also call CQC" and "I'd report to the nurse in charge and record that. I can also call the police the local authorities or CQC". Records confirmed the service had systems in place to report any concerns to the appropriate authorities.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person had difficulty mobilising and was at risk of falls. The person used a frame to mobilise independently and had stated they 'wanted to remain as mobile as possible'. Staff were advised the person could only mobilise with their frame for short distances before becoming tired. The risk assessment detailed how staff were to monitor this person mobilising and staff and records confirmed this guidance was followed.

Another person required the use of a hoist to transfer. The risk assessment gave staff guidance on how to support this person safely, which included two staff. We saw that two staff were consistently deployed to support this person.

There were sufficient staff on duty to meet people's needs. The deputy manager told us staffing levels were set by the "Dependency needs of our residents" This was regularly assessed and recorded in people's care plans. Staff were not rushed in their duties and had time to sit and chat with people. People were assisted promptly when they called for help using the call bell. Staff rota's confirmed planned staffing levels were consistently maintained.

Staff told us there were sufficient staff to support people. Comments included; "There is a nurse vacancy but this is covered by a bank nurse and I know they are currently recruiting. We have enough care workers here", "I would say yes, we have enough staff. The only time we are short is if someone goes sick at the last minute but we all cover for each other so it is not a problem", "We've enough staff, if someone goes sick we cover it but it is rare so it's not a problem" and "This can be hard physical work so I'd always like an extra pair of hands but we have enough staff so people get good care".

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role.

People had their medicines as prescribed. The staff checked each person's identity and explained the process before giving people their medicine. Medicines were stored securely and in line with manufacturer's guidance. Staff were trained to administer medicine and their competency was regularly checked by the deputy manager. We observed a medicine round and saw correct procedures were followed ensuring people got their medicine as prescribed. Medicines were audited monthly and medicine administration records (MAR) were accurate and up to date.

People's safety was maintained through the maintenance and monitoring of systems and equipment. We established that equipment checks, water testing, fire equipment testing, hoist/lift servicing, electrical and gas certification was monitored by the maintenance staff and carried out by certified external contractors. We saw equipment was in service date and clearly labelled.

Requires Improvement

Is the service effective?

Our findings

We discussed the Mental Capacity Act (MCA) 2005 with the deputy manager and regional support manager, both of whom were knowledgeable regarding the act. 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.

However, there was some confusion in relation to mental capacity assessments amongst both management and nurses as to when and how a person's capacity should be assessed. For example, in one person's care plan we saw their capacity had been assessed and concluded the person could, 'make simple choices but would be unable to make complex decisions about their care'. The assessment did not state what triggered the assessment and we could not identify what decision the person was struggling to make. Another person had been assessed as 'not being able to understand or make complex decisions'. Again, we could not identify what decision the assessment was referring too or why the assessment was deemed necessary. This problem was compounded by the fact the assessment forms did not prompt the assessor to ask relevant questions relating to decisions and triggers. This is not in line with the Acts guidance. However we saw this had not impacted uopon people's care. We raised this with the deputy manager who took immediate action by planning the review of all capacity assessments using new paperwork. They also told us they would arrange further training for staff.

People were supported by staff who had been trained in the MCA and applied it's principles in their work. Staff offered people choices and gave them time to decide before respecting their decisions. However, not all staff we spoke with could demonstrate an understanding of the Act and its principles. Staff comments included; "I'm not sure. I think it's about helping people to make decisions and keeping them safe", "I assume people have capacity to make decisions for themselves and I always consider their best interests" and "It supports people to make decisions on their own". One nurse said "I'm not that sure on the mental capacity act. I have had the training". When prompted they said "I don't think our assessments are decision specific".

Staff demonstrated a good understanding about how to ensure people were able to consent to care tasks and make choices and decisions about their care. Throughout our visit we saw staff offering people choices, giving them time to make a preference and respecting their choice. For example, at the lunchtime meal we saw people's preferences regarding food and drink were respected. We spoke with staff about consent. Comments included; "I ask people's permission and try to explain to them in an easy way. I will offer a choice and show them as it helps" and "I always ask. Even if I know what the answer will be I ask, just to be sure".

At the time of our visit no one was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. These safeguards protect the rights of people by ensuring that if there are any restrictions to their freedom and liberty these have been authorised by the supervisory body. The deputy manager told us they

continually assess people in relation to people's rights and DoLS.

People were supported by staff who had the skills and training to carry out their roles and responsibilities. Staff told us they had received an induction and completed training when they started working at the service. Induction training included fire, moving and handling and infection control. Comments included; "We have in house training, it is effective and we also have external training, especially for nurses" and "I had a very good induction. Then I shadowed an experienced member of staff until I was ready to work alone".

Staff told us, and records confirmed they had effective support. Staff received regular supervision. Supervision is a one to one meeting with their line manager. Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, one member of staff said "I do get supervision which has really been helpful. Everything is documented. I asked for a change in my hours to suit my home circumstances and it was done just like that". One staff member told how they had requested extra training. They said "I asked to do my level three in care and I have been really supported to do that".

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included the GP, care home support service (CHSS) and speech and language therapist (SALT). Visits by healthcare professionals, assessments and referrals were all recorded in people's care plans. One healthcare professional we spoke with said "On the whole the service is good. They deal with any issues effectively and I get good referrals. They also follow any advice".

People told us they liked the food. One person said "It is very good". A relative said the chef was "Better than (naming a celebrity chef)". People also told us they were looking forward to celebrating the Chinese new year with a special meal.

We observed the midday meal experience. This was an enjoyable, social event where the majority of people attended. Food was served hot from the kitchen and looked 'home cooked', wholesome and appetising. People were offered a choice of drinks throughout their meal. People were encouraged to eat and extra portions were available. The meal was a friendly and communal experience. Where people required support to eat their meals staff were caring, patient and discrete. Staff told us they also assisted people with their menu choices. One staff member said "We ask what they want to eat in the morning and then we check again at mealtimes in case they have changed their mind". Where people required special diets, for example, pureed or fortified meals, these were provided.

We recommend the service refers to the Mental Capacity Act codes of practice for guidance in relation to the principles of the MCA.

Good

Is the service caring?

Our findings

People told us they enjoyed living at the home and benefitted from caring relationships with the staff. People were extremely positive with their praise for staff. Comments included; "I love it here", "They're (staff) marvellous, all very thoughtful, very caring", "I get help all the while, night or day" and "I'm happy here. I think it provides a good service." One person was very positive about the staff. They said they are "Perfect. I get on very well with the staff". Relatives were also positive in their comments about staff. These included; "The people (staff) are so kind. They look after Mum so well. They're wonderful, really kind", "The nurses are never too busy and members of (named) care staff go above and beyond" and "It seems like they can't do enough. Nothing's too much trouble".

Staff told us they enjoyed working at the service. Comments included; "I love it here. I've had so much support from everybody", "This place is very homely and everyone gets on together" and "I love it. Just being with the residents and hearing about their lives. I just love making them smile".

People were cared for by staff who were knowledgeable about the care they required and the things that were important to them in their lives. Staff spoke with people about their careers, family and where they had lived. During our visit we saw numerous positive interactions between people and staff. For example, one person was involved in a review of their care. The nurse was talking through their care plan and we saw the person laughing and smiling with the nurse. This was clearly an enjoyable experience for them. Another person was being taken back to their room following an activity. The member of staff supporting them chatted as they went along and the person responded with smiles and comments. One relative we spoke with said "This is an amazing place, I can't praise them enough. Care here is very good. We've had bad experiences at another home but this place is superb". Another said "They do a good job".

We observed staff communicating with people in a very patient and caring way, offering choices and involving people in the decisions about their care. For example, at the lunchtime meal a member of staff noticed a person was struggling to cut up their meal. The staff member asked if the person needed assistance and offered to cut their meal up for them. The person considered this and then said yes. The staff member cut up their meal and asked if that was all right. The member of staff spoke with kindness and compassion and we saw the person was grateful for the assistance.

People's independence was promoted. For example, one person's care plan noted they were able to wash the top half of their body but needed prompting with the lower half. Staff were guided to prompt the person but to 'only assist where necessary'. Another person's plan stated 'likes to clean their own teeth'. Staff were guided to encourage the person to do this. Staff we spoke with were aware and followed this guidance supporting people's independence.

People were involved in their care. They were involved in care reviews and information about their care was given to them. We saw people attended reviews of their care and noted they had signed their care reviews. During our visit one person had a care review and we saw the GP, a visiting healthcare professional and their family were invited in to attend along with a staff member and themselves. One member of staff said "I

always make sure reviews focus on them (people)".

People's dignity and privacy were respected. We saw staff knocked on doors that were closed before entering people's rooms. Where they were providing personal care people's doors were closed and curtains drawn. This promoted their dignity. We saw how staff spoke to people with respect using the person's preferred name. When staff spoke about people to us or amongst themselves they were respectful. Language used in care plans was respectful and appropriate. Throughout the day we saw people were appropriately dressed, had their hair brushed and looked well cared for.

We spoke with staff about promoting people's dignity and respecting their privacy. Comments included; "I shut doors and close curtains to keep their privacy and I cover them up when I give personal care to promote their dignity. It's about making them feel comfortable" and "I cover them with towels when washing. I always knock on doors and make sure it is ok to enter the room". One nurse told us how they respect people's privacy and dignity when hoisting. They said "If we transfer someone from a wheelchair to an armchair in the lounge we use mobile screens to keep it private as it is a public place. Residents appreciate that".

A 'values and attitudes' poster was prominently displayed in the staff room. This had been published by 'Skills for care'. It highlighted the seven principles to 'support dignity'. These included people's individualism, meaningful communication and challenging care that reduced people's dignity. Staff were aware of this information and we saw staff promoting people's dignity throughout our visit.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission to the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. Care plans were detailed, personalised, and were reviewed regularly.

A dependency tool was used to assess people's ongoing care needs, highlighted specific needs and rated their dependency as low, medium or high. The assessment covered all aspects of care and support and was reviewed every month.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person required assistance with their personal care. They had stated their desired outcome was 'to maintain a high level and standard of person hygiene and dignity'. As the person also wished to remain as independent as possible staff were guided to allow the person to do as much as they could for themselves and to only assist when asked or where necessary. Daily notes evidenced this guidance was being followed.

Another person had a history of pressure ulcers and had struggled with this condition prior to living at the home. The person had been assessed by healthcare professionals who had provided guidance for staff. This included the application of 'wound gel', the use of pressure relieving equipment and regular monitoring of the person's skin condition. Body maps and photographs were used to manage the condition and monitor the person's progress and we saw pressure relieving equipment in the person's room. Care records evidenced two of the wounds had healed and the last wound was healing.

People received personalised care. One person was at risk of losing weight. A malnutrition universal screening tool (MUST) was used to monitor and manage their condition and records confirmed the person was regularly visited by the GP. The care plan noted the person had 'a good appetite and could eat and drink independently'. The person was weighed regularly and their food and fluid intake consistently recorded. We saw this person was now gaining weight. Another person was diabetic. The care plan contained detailed guidance on managing the person's condition including dietary advice and the need to monitor the person's weight. Records confirmed the guidance was being followed, the person was regularly weighed and kitchen staff were aware of this person's dietary needs.

Care plans and risk assessments were reviewed to reflect people's changing needs. Staff also completed other records that supported the delivery of care. For example, where people needed topical creams applied, a body map was in use to inform staff where the cream should be applied. Staff signed to show when they had applied the cream and there was a clear record of the support people received. People and their relatives were informed about any changing needs.

People were offered a range of activities including games, quizzes, sing a longs, arts and crafts, keep fit, talks

with guest speakers and gardening. Hairdressers attended the home every week and people were encouraged to go out with families and friends. Church services were regularly provided for people to attend. Regular trips out of the home were organised using the services mini bus. Trips to local places of interest, the cinema, canal boat trips, pub lunches and shopping were regularly provided. One person said "I'm hoping to go out on the minibus. I love to go out for a pub lunch".

The home also had large, well maintained garden areas for people to enjoy. Access to the garden was unrestricted and accessible for people who used wheelchairs. The garden contained a 'garden of remembrance'. One large flower bed had been designated and flowers were planted to remember people who had passed on. The deputy manager told us the home held a service once a year where "People and their relatives could remember old friends and relations". Garden benches were situated around the garden and were dedicated to past 'residents' with named plaques on the benches.

People's opinions were sought and acted upon. The service operated a 'resident of the day' scheme. When a person is 'resident of the day' all heads of department at the home visit the person. People could raise issues or concerns with staff relating to their department and concerns or issues were discussed and acted upon. For example, one person raised a menu issue with the chef which was immediately resolved. This ensured people met with senior staff on a formal basis at least once a month.

People and relatives could attend and raise issues at regular meetings. Information was also shared at these meetings. For example, up and coming activity events, giving people the opportunity to discuss what was going on and make suggestions. We saw where people made suggestions these were acted upon. One person suggested a bread roll and butter should be provided with their soup at meal time and we saw this was provided.

People were confident to raise issues or complain. One said "I'd tell one of the nurses". Another person told us "I'd tell my (relative) and they'd do something about it." One relative said "No worries, they seem very good".

People were provided with details of how to complain. We looked at the complaints folder and noted there were no complaints recorded. We spoke to the deputy manager about this who said "Because we communicate with our residents they are confident to speak to us about any issues and we deal with them long before it reaches a formal stage". During our visit we saw one person raise an issue with the deputy manager and this was immediately resolved.

Good

Is the service well-led?

Our findings

People told us they knew the deputy manager. They also commented how the service was led. Comments included; "It couldn't better it wherever I went" and "I'd say eleven out of ten".

Staff told us the deputy manager was supportive and approachable. Comments included; "The deputy manager is friendly, supportive and very approachable", "Very supportive and helpful", "Wonderful and so helpful" and "She is lovely, I can go to her with anything".

The deputy manager led by example. The deputy manager supported people individually throughout the day and greeted relatives and visitors in a warm and welcoming fashion. Their example gave staff clear leadership and we saw this enthusiastic, person centred approach repeated by staff throughout our visit.

The service had an open and honest culture. Throughout our visit the deputy manager and staff were helpful, transparent and keen to improve the service they provided. One member of staff said "We are honest here. The manager is a good leader because she doesn't sit in the office, she helps out. I'd be confident to raise any issues with her. If I made a mistake I know I would be supported and we'd look to put things right. There wouldn't be a cover up".

Accidents and incidents were recorded and investigated. The deputy manager analysed information from the investigations to improve the service. Information and investigations were also analysed by the regional support manager who looked for patterns and trends across the service. For example, a monthly falls report was compiled and any actions arising from the report were forwarded to the deputy manager to action. A system had been created whereby any person who suffered three falls in three months were automatically referred to the GP and care home support service for a review. Reports from all the provider's services were analysed collectively to enable any learning to be shared.

The service had been accredited under the 'Gold Standards Framework' (GSF) in end of life care. To attain accreditation the service must have met GSF standards and were inspected by the organisation. The standards recognised some of the innovations the service had made. For example, when a person died a book of condolence was provided for staff to write messages and express their feelings. The book was then passed on the person's family.

The deputy manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care including safeguarding, infection control and staff training. The results were analysed resulting in identified actions to improve the service. For example, one audit identified the need for a lock on the sluice room door. We saw this had been actioned and a lock installed. Although we identified concerns regarding the Mental Capacity Act, the deputy manager took immediate action to address our concerns which included a full review of all capacity assessments and planning further training for all staff.

Regular staff meetings were held and were scheduled throughout the year. Information was shared and

learning highlighted to improve the service. For example, it was raised where people approached end of life certain medicine may be needed at short notice and on occasions there had been short delays in obtaining this prescribed medicine. A system of end of life assessment was created, in consultation with the GP and medicine was obtained prior to being needed ensuring that if the person declined and needed the medicine it was immediately available. Staff were also given time in meetings to reflect on issues and express their feelings. The deputy manager said "This is an important but effective way for all staff to deal with events that happen".

People's opinions were sought by the provider. An annual survey was issued to people and their relatives by the provider. The results were analysed and forwarded to the service. Actions from the survey were highlighted and the regional support manager and deputy manager worked through any actions to completion. The survey result was positive and presented in a format that mirrored the five domains the Care Quality Commission inspected against. The deputy manager said "This allows us to manage actions in line with the inspection standards, it works really well".

There was a whistle blowing policy in place that was available to staff around the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. One member of staff we spoke with said "I am aware of this system and yes, I would use it if I needed too"