Parkfield Health Care Limited

Adel Grange Residential Home

Inspection report

Adel Grange Close
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Ratings

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

Overall summary

We inspected Adel Grange Residential Home on 22 October 2014 and the visit was unannounced. Our last inspection took place in December 2013 and at that time we found the home was meeting the regulations we looked at.

Adel Grange Residential Home provides care in a building that is listed and retains many original features in North Leeds. Alterations have been made to make the home more accessible. The home provides care and support for up to 30 older people, some of whom are living with dementia or related mental health problems. There were 28 people living at the home on the day of inspection.

Summary of findings

Communal accommodation consists of two lounges and a spacious dining room. Most bedrooms have en-suite facilities and are accessed by a passenger lift. There are some rooms available on the ground floor.

There was a manager in post, however this person was not registered. 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. The home had employed a manager and we were told they will soon be going through the Care Quality Commission registration process.

The experience of people who lived at the home was positive. People told us they felt safe living at the home, staff were kind and caring and they received good care. They told us they were aware of the complaints system. They also said they would be happy to raise any concerns they had with the staff and would be confident these would be listened to and acted upon.

However we found processes to keep people safe were inadequate. For example, staff who had recently been employed at the home did not always have references from their last employer and people who had left employment and returned did not always go through the recruitment process. The lack of robust recruitment procedures risked people being cared for by unsuitable staff.

This is a breach of Regulation 21, (Requirements relating to workers); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not managed safely; where people had 'as required' medication prescribed there was no guidance in place for staff to ensure they received them when they most needed them. This meant people were at risk of not receiving their medicines when they needed them and at the time when they would be most effective.

This is a breach of Regulation 13, (Management of medicine); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the audit system and found some of the audits and t had not been done. For example care plan audits, temperature checks of water and the audit of medication.

This is a breach of Regulation 10, (Assessing and Monitoring the service); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On our visit we saw people looked well cared for. We saw staff speaking in a caring and respectful manner to people who lived in the home. Staff demonstrated that they knew people's individual characters, likes and dislikes.

The service was meeting the requirement of the Deprivation of Liberty Safeguards (DoLs) to ensure people's rights were protected.

The home met people's nutritional needs and people reported they had a good choice of food.

People reported that care was effective and they received appropriate healthcare support. We saw people were referred to relevant healthcare professionals in a timely manner.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

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?

Inadequate

The service was not safe. Medicines were not managed safely. There were handwritten MAR (Medicine Administration Record) charts in place for people who were using the service for respite purposes. However, when we looked at the medication policy we found there was no guidance in place to tell staff how to use handwritten MAR charts safely . We also saw where people had 'as required' medication prescribed there was no guidance in place for staff to ensure they received them when they most needed them..

Recruitment procedures designed to keep people safe had not been correctly followed. The lack of robust recruitment procedures meant people were at risk of being cared for by unsuitable staff.

The staff we spoke with knew how to recognise and respond to allegation of possible abuse correctly and were aware of the organisations whistleblowing policy.

The risks to people were managed appropriately and care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own.

People told us they received appropriate healthcare support. We saw evidence which demonstrated that people who lived at the home were referred to relevant healthcare professionals, such as GPs and district nurses in a timely maner.

Some supervision had lapsed we discussed this with the new manager who showed us evidence staff supervision was booked to take place in the near future. The manager told us this was due to them prioritising the recruitment of staff since they started and some supervisions had not taken place.

People's nutritional needs were being met. People told us the food was good and we saw people were provided with appropriate assistance and support to eat their meals.

Is the service caring?

Good

The service was caring. We observed how staff interacted with people who used the service and we saw they were kind and compassionate. It was clear from our observations that the staff knew people well.

Summary of findings

People using the service said staff were kind and caring, treated them with dignity and respected their choices.

When we looked around the home we saw people's bedrooms had been personalised and contained personal items such as family photographs.

The staff we spoke with told us they thought they provided people who lived at the home with good care. People living at the home seemed genuinely pleased to see staff members when they saw them.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. We saw in one of the communal areas of the home where people were seated by staff there was a call bell tied up on the wall. This meant people were not able to summon assistance if they required it. This was drawn to the attention of a member of staff and addressed immediately.

There was an activities coordinator who set up a card making group. There were two people who wished to participate. We observed the staff member being very patient showing the group members how to do things whilst at the same time taking them through the activity.

People who used the service told us their complaints were effectively dealt with and they felt comfortable to raise any concerns with management.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. The manager of the home was new in post and told us they had been prioritising recruitment. This was because some staff had left. The manager told us they were also issues with long term sickness at the home. We saw this had impacted on the management of the home. For example, we found a number of the monthly audits in place had not been completed for some time.

There were some effective systems for monitoring quality of the service in place. However, some audits had not been completed since June 2014. The quality manager told us they would take action to ensure the audits were completed and recorded.

We saw the home had several ways of recording information regarding people who used the service. For example we saw a 'communication book', a 'GP book' and 'handover sheets' were being used to record information about people's health and wellbeing.

Adel Grange 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.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The inspection team consisted of two adult social care 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. The person used had specific expertise in dementia care.

The inspection took place on the 22 October 2014 and was unannounced. We used a number of different methods to help us understand the experiences of people who used the service. During our visit we spoke with six people living at the home, two relatives, four members of staff, the manager and the quality manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spent some time observing care in the lounge and dining room areas to help us understand the experience of people living in the home. We looked at all areas of the home including people's bedrooms, communal bathrooms and lounge areas. We spent some time looking at documents and records that related to peoples care and the management of the home. We looked at six people's care records.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe at the home. One person said, "I am safe and happy here." Another person said, "There is always someone around if I need them but they don't make a fuss." One relative said, "I know Dad is safe here." Another relative said, "he is safe."

However we looked at the medication administration records (MAR) of five people. We saw three people had handwritten MAR charts in place as they were receiving respite care at the home. We looked at the medication policy in place and saw it did not mention handwritten MAR charts. This meant staff were not provided with guidance on how to complete the MAR charts. We saw one person receiving respite care had brought in their medication from home with them. The home had accepted these in small plastic containers with no guidance as to what the individual tablets were. We spoke with the manager who told us the person received their medication, they had contacted the pharmacy to get the correct details of the medication the person was prescribed. From this the manager had completed a handwritten MAR chart for staff to follow. The manager told us there was no guidance in place within the policies at the home for receiving medication in this way.

We looked at the coding system in place on the bottom of the MAR charts in place at the home. This allowed for staff to record a reason if medicines had not been given to the individual concerned. We saw there was guidance in place for staff at the home however; the guidance in place did not correspond with the coding system on the bottom of the MAR charts. For example, we saw 'Q' had been entered for one person when they had not taken their prescribed medicines on two occasions. However, 'Q' was not within the coding system. Therefore, it was not clear why the person had not taken their medicines. We also saw there was space on the reverse of the MAR chart for staff to record the reason why medicines had not been taken. We saw staff had not recorded a reason. When we looked at four other people's MAR charts and saw this had occurred on 20 separate occasions.

We looked at one person's MAR chart and saw they were prescribed medication which was to be given on an 'as required' basis for agitation. We asked the manager and the senior carer if there was guidance in place for staff to follow regarding the person receiving this medication. We were told there was not. We judged this meant people were at risk of not receiving their medicines safely or when they needed them.

This is a breach of Regulation 13, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Controlled Drug Register was checked: all entries had been signed by two members of staff. There was evidence of stock check balances being recorded; indication of quantities of CDs received from pharmacy. The quantities recorded in the CD register tallied with the amounts of CDs in the CD cupboard

We looked at three staff files and found recruitment processes, which are designed to keep people safe, were not consistently followed. For example, one staff who had recently been employed at the home did not have references from their last employer. In another file, we found someone had been dismissed from the home and then reinstated sometime after without any evidence to show what they had been dismissed for had been addressed before they had been reinstated. The lack of robust recruitment procedures not been followed could mean people were being cared for by unsuitable staff. The home's policy states all staff will complete an application form, two references taken up and Disclosure and Barring Service (DBS) carried out before anyone started work at the home.

This is a breach of Regulation 21, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed care staff were constantly approaching the senior care worker for support with meeting the care needs of people using the service, some of whom had complex needs. The shift system in place meant staff were on duty for 12 hour shift. We saw the senior care worker was very busy with both leading the shift and ensuring people's care needs were met. We spoke with care staff who told us they were expected to carry out cleaning of the home as part of their role due to sickness. The manager confirmed this and told us they had recently recruited staff, some were going through their induction and others are due to start in the near future.

We spoke with one staff member who felt the two induction staff had increased the numbers, they said, "There are enough staff today as we have induction staff." They then went on to say, We have quite a lot of people

Inadequate

Is the service safe?

with a high dependency. There are not enough staff at meal times but I would say people are safe." During our observation at lunchtime we found the experience to be positive for people in the service it was not rushed.

Staff told us there is no dedicated laundry or domestic so they are having to fill in for those post. One member of staff said, "You don't always get your full hours break during the day because we get so busy." This was discussed with the manager who told us some people were on long term sick and they were recruiting for those posts.

Staff told us they reported safeguarding issues to the manager who would respond appropriately to any concerns raised. Staff knew about whistleblowing and who to contact if they felt concerns were not dealt with properly. Staff knew about local safeguarding policies, making alerts and identifying signs of abuse. People spoken with told us they felt safe in the home

For each assessed risk, we saw information that clearly explained who was at risk, under what circumstances, specific triggers and signs/ identifying factors. This information was then supported by a 'reduction plan' which provided the guidance for staff to follow in order to support people and safely manage the risks.

Requires Improvement

Is the service effective?

Our findings

We spoke with one staff member who told us they had not received regular staff supervision. This was discussed with the manager who showed us dates of supervision booked for staff in the near future. We looked at the home's training matrix. This showed staff had received required training in areas which helped staff to keep people safe. These included safeguarding, moving and handling and fire training.

In all of the six care records we looked at we saw there was evidence to show peoples nutritional needs were assessed and there nutritional needs were being met.

However, we saw one person had Diabetes which was controlled by medication and diet. We spoke with the senior care worker on duty who told us they only needed to carry out the monitoring on a 'random' basis. However this was not recorded in the person's care plan, this was immediately rectified during the inspection.

We observed the lunch time meal. We noted there was a choice of main meal, one being vegetarian. The menu was written on a black board but was difficult for all people in the home to see. We saw that staff asked people individually what they would like. We noted that sometimes staff did not explain the choice fully for example it was a vegetable lasagne on the menu but this was not always made clear.

We observed staff sitting on stools which were just the correct height to be able to assist people with their meal. We noted staff assisted in a caring and calm way, giving people chance to eat a mouthful without hurry. However we did note one member of staff supporting two people, which meant people did not get individual support to eat their meal.

One relative said, "The food always looks good. They sometimes ask me if I want to stay but I decline." Another said, "They get good home cooking; really nice homemade soup (name) likes that." One person who used the service said, "I don't think there is much choice but they will always get you something else if you don't like it."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The home had made a Deprivation of Liberty application to the local authority for one person. This was because the person had made several attempts to leave the home. The DoL's assessment was granted in order for the home to keep the person safe. This showed the home had followed guidance as directed under the Mental Capacity Act 2005.

People told us they felt the staff were well trained to carry out their role. A relative told us, "The home is mainly calm; I believe the staff know what they are doing." A person who used the service said, "The staff are very good."

We spoke with a new member of staff who was on their second day and were very much enjoying their role. They said, "I am on induction and so far feel well supported. It is a two week induction. I have been given paperwork with a list of training areas."

People spoken with felt their health needs were being met, one person said, "The doctor comes round sometimes if I need him."

A relative told us, "The home is very good, unfortunately Dad fell a couple of months back. They rang me up and straight away and sent a member of staff with him to the hospital."

Good

Is the service caring?

Our findings

One person who lived in the home said “There are some lovely people here, they know my routine.” This person went on to tell us, “I can be independent and the staff help me. I take myself to bed when I want and one of the ladies will come in to check on me.”

We observed how staff interacted with people who used the service and we saw they were kind, patient and compassionate. It was clear from our observations that some of the staff knew people well.

We observed staff interactions with one person who needed to be moved from a wheelchair into a more comfortable chair. We saw staff were very patient with the person and explained the reasons for wanting to move them. The person became angry and stated they did not want to move. Staff left the room and fetched the person a warm drink and then sat with them for a few minutes. They approached the person again asking if they would like to move into a more comfortable chair. The person was happy to move this time around. We spoke with staff afterwards and they told us the person always refused but after a drink they usually agreed to be moved. This showed staff at the home knew the person’s preferences.

Our use of the Short Observational Framework for Inspection (SOFI) tool found interactions between staff and people who lived in the home were positive. We found people’s choices were respected; staff were calm and patient and explained things well. We saw people were asked whether they wanted to wear an apron and their choices were respected. People were regularly spoken with as staff went about their duties.

One relative told us, “The staff are very caring, they always treat Dad with dignity and respect.”

This relative went on to say, “I would say the staff are very open and honest, we are happy with the care he is getting overall.” Another relative said, “We are very happy with the care.”

A relative was able to tell us they were involved in developing of the care plan of their relative when they first went into the home they said, “We sat down as a family with a member of staff to discuss Dad’s needs when he first came.”

We observed staff helping people move about the home making sure the appropriate equipment (wheel chair, walking frame) was being used correctly. All staff appeared patient and calm.

We saw people looked well cared for. People were wearing clean clothing and their hair had been brushed or combed. This showed us staff had taken time to support people with their personal appearance. When we looked in people’s bedrooms we saw they had been personalised with pictures, ornaments and furnishings. Rooms were clean and tidy showing staff respected people’s belongings.

Requires Improvement

Is the service responsive?

Our findings

We looked at six people's care records and found evidence that their needs were assessed prior to admission to the home. This information was then used to complete more detailed assessments which provided staff with information to deliver appropriate, responsive care. However, we were unable to find documented evidence to show people had been involved in any reviews of their care. In discussion with people they told us that their care plans were reviewed and amended to incorporate changes in their needs and they had been involved in this. However we found care plans did not always show they were meeting peoples needs ie those living with dementia.

We saw that in one of the communal areas of the home where people were seated by staff there was a call bell tied up on the wall. This meant people were not able to summon assistance if they required it. This was drawn to the attention of member of staff who dealt with it immediately.

There was one member of staff allocated to one particular person. We were told this person could get quite upset and anxious as they wished to leave the home. The member of staff sat with person engaging them in games and chatting with them. The interactions were appropriate and when the person did become upset the staff member handled it well by talking calmly to them. The person care record informed staff of ways to ensure the person is safe at all times.

People we spoke with said they felt comfortable to raise concerns with staff who assisted them. For example one person told us "I am really happy here." "The staff are really good." Staff we spoke with told us they would immediately raise any concerns with their manager and they were confident they would take action to address concerns raised.

One person who lived in the home told us, "The staff are very good they help me keep going." The person went on to say, "It's homely and if you want something you usually get it." The person also said, "My worst problem is I have always been independent but now I need others. I like to go out and I miss it."

When asked about being able to do the things they liked, the person said, "I sometimes go out to church, a friend will take me or the priest comes here." "Also I like to go to concerts, we sometimes have singers."

One relative explained, "Dad has never been one for much socialising; since Mum died he has lost interest. I think they try to get him to do things but it's difficult. There is usually someone here on a Thursday doing exercises and sometimes a lady comes with old objects and things to get them (the residents) talking."

We observed staff talking to people and trying to get them to engage in everyday activities. There was an activities coordinator who set up a card making group. There were two people who wished to participate. We observed the staff member being very patient showing the group members how to do things whilst at the same time talking them through the activity.

We looked at the concerns and complaints records. Complaints were recorded it was clear how the provider/ manager had responded to them and what action was taken. This included meeting with families and giving staff feedback on issues raised to prevent re-occurrence in the future.

Requires Improvement

Is the service well-led?

Our findings

We spoke with the quality manager about the audit system in place at the home. The quality manager told us they had not completed the audit in the absence of a manager. We looked at the audit system and found the non-completion of some of the audits. For example care plan audits, temperature checks of water and the medication audit. The environmental audits was also not up to date.

We asked for the analysis of accidents and incidents. We were told there was no analysis being completed. This meant no one was looking at the overview of accidents and incidents to identify any themes or trend and then identifying any actions that needed to be taken.

We spoke with the manager of the home who was relatively new to the home and had not yet registered with the Care Quality Commission. They said they had been occupied with the recruitment of staff and were having to cover shifts at the home because of high sickness levels. This meant that audits and the associated records had not always been completed

This breached Regulation 10,(Assessing and Monitoring the quality of the service); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff spoke about the changes the manager had implemented since they took up their post. They said, “It does seem better since the new manager came, things seem to be flowing better.”

Staff talked to us about the new rota system. Two members of staff felt the change in the system had not been for the better. Staff also went on to say “It was better when it was two shifts as you didn’t get as tried.” We discussed this with the manager who said the rota is something that they will raise with the provider.

Resident and staff meetings were in place which were an opportunity for staff and people to give feedback on the quality of the service. Staff and residents both spoke positively about these meetings. Changes had been made with menus and activities.

We asked the manager about improvements that had been made or were planned to the home. They told us some areas of the home had been refurbished and this will continue throughout the year.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person did not operate effective recruitment procedures.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not operate effective recruitment procedures.**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.