Care Quality Commission

Allandale Care Group Limited

The Croft

Inspection report

94 Irby Road
Heswall
Wirral
Merseyside
CH61 6XG

Tel: 01513427004
Website: www.abbeyfieldheswall.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 9 February 2017. The Croft provides privately funded personal care and accommodation for up to ten people. At the time of our visit eight people lived at the home. The home is a single storey house set in its own grounds in Heswall, Wirral. People's bedrooms are single occupancy and there is a communal lounge and dining room for people to use. Specialised bathing facilities and a walk in shower are available for people to use and a small car park is situated at the front of the home.

At the time of inspection there was a registered manager in post. They had been in post approximately six months on the day of our visit. 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 registered manager reported directly to the general manager. The general manager supervised the registered manager in the day to day management of the home. The general manager had also been in post for approximately six months prior to our visit.

We looked at the care files belonging to three people who lived at the home. We found however that risk management advice with regards to people's identified risks was not always sufficient or specific to the individual. This meant there was a risk that staff would not know how to mitigate these risks in the delivery of care.

On the day of our visit, we found the laundry door had been left open posing a fire containment risk and a cupboard containing products potentially harmful to health left unlocked. This meant these areas were not secure. We saw that a manual sluice was in operation in the laundry and fabric hand towels for people to use in the communal toilets. Neither promoted good infection control practices but we saw that there were plans in place to improve these arrangements.

We saw that staff were recruited safely with appropriate checks made on their suitability to work with vulnerable people. There were sufficient staff on duty to meet people's needs and we saw that they were regularly supervised by the registered manager. We found limited evidence that staff had received an annual appraisal prior to the registered manager coming into post. The registered manager told us that they had not yet had chance to conduct appraisals but that they had plans in place to do so.

We saw that people's care plans were person centred with sufficient information about their likes and dislikes and how they wished to be cared for. Personal life histories were gained from people to help staff understand the person they were supporting and to assist them to provide person centred care.

People we spoke with during our visit told us the staff were kind, caring and looked after them well. Staff

spoken with, were knowledgeable about the people they cared for and had received sufficient training to meet their needs. It was obvious from our observations that people felt relaxed and comfortable in the company of staff and it was clear that staff and the people who lived at the home knew each other well.

People had sufficient quantities of nutritious food and drink. They were given a choice of menu options or, offered an alternative, if the options weren't suitable. People's weight was monitored to ensure they maintained a healthy weight and people's care was responsive to their needs.

There were a variety of activities on offer from quizzes, to baking to fitness exercises that promoted people's physical health. People's opinions and suggestions on the range of activities and the running of the home were regularly sought and where people had made suggestions we saw evidence that these had been acted upon where possible.

We saw the beginnings of good practice in relation to the implementation of the Mental Capacity Act 2005 and the obtaining of people's consent. We found however that the assessment of people's capacity to make specific decisions required review. We spoke to the registered manager and general manager about this and they assured us they would do this without delay.

People's medications were administered safely and people had access to 'as and when' required medication such as painkillers to ease any discomfort. Accident and incidents were investigated with appropriate action taken when people required medical attention. Staff we spoke with were knowledgeable about types of abuse and the action to take should they suspected abuse had occurred.   People we spoke with said they felt safe with staff.

The provider's complaints policies did not give people clear information on how they could make a complaint. We spoke to the general manager about this. The people and the relative we spoke had no complaints or concerns.

There were a range of audits in place that gave the provider a good picture of the performance of the service. We saw that where issues had been identified they had been acted upon. We found that although some improvements were required with regards to the service, the overall management of the home was good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was generally safe but some areas required improvement.

The majority of people's needs were low risk but where risks had been identified, risk management guidance was limited.

Some areas of the home were not secure and accessible to unauthorised persons.

Staff were recruited safely and sufficient staff were on duty to meet people's needs.

Medication was managed safely. Safeguarding and accidents and incidents were investigated and responded to appropriately.

Is the service effective?

Good

The service was effective.

People told us staff looked after them well and supported their needs.

People were given enough to eat and drink and people's nutritional health was monitored effectively. People told us the food was good.

Staff had been trained and supervised. Staff appraisals were required and there were plans in place to do so.

People's consent to their care had been sought but the assessment of people's capacity did not comply in full with the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

People and a relative we spoke with said the staff were kind and caring. Our observations confirmed this. Staff were warm and pleasant and people were seen to be relaxed and comfortable in their company.

People's independence was promoted and people were able to make everyday choices in how they lived their lives.

People were given appropriate information about the home. Regular residents meetings took place and people were able to express their views.

Is the service responsive?

Good

The service was responsive.

People's care plans were person centred and contained clear information about people's wishes and preferences with regards to their care.

People had access to other healthcare professional in support of their needs and health.

People had access to a variety of activities to promote their social and emotional well-being and people and staff interacted socially throughout the day.

The provider's complaints policy required improvement but the people and the relative we spoke with during our visit had no complaints.

Is the service well-led?

Good

The service was well led.

There were a range of quality assurance systems in place to enable the provider to come to an informed view of the quality and safety of the service.

People's satisfaction with the service was sought and people were able to feedback their views about the quality of the service.

Some improvements to the service were required but overall the management of the service was good.

The culture of the home was open and transparent. Staff worked well together and the atmosphere was positive and homely.

Care Quality Commission

The Croft

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 9 February 2017 and was unannounced. The inspection was carried out by an Adult Social Care (ASC) Inspector. Prior to our visit we looked at any information we had received about the home and any information sent to us by the provider since the home's last inspection. We also contacted the Local Authority for information in relation to the safety of the service.

During this inspection we spoke with two people who lived at the home, a relative of a person who lived at the home, one care staff member, the registered manager and the general manager.

We looked at the communal areas that people shared in the home and visited some people's bedrooms. We looked at a range of records including three care records, medication records, three staff personnel files, staff training records and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We spoke with two people who lived at the home. They told us they felt safe and well looked after. The relative we spoke with confirmed that they had no concerns about the person's safety and that they were pleased with the care they received.

We spoke with the registered manager about the people who lived at the home. They told us that most people required low level support with their personal care from one member of staff at any one time. From our observations, we saw that the majority of people were independently mobile and able to complete the majority of daily living tasks with minimal assistance from staff.

We reviewed three people's care records. We found that whilst risks in relation to people's needs were assessed, their risk assessments and management plans sometimes lacked sufficient detail of how these risks should be managed in the delivery of their care. For example, some of the risk management plans in place were generic. This meant they contained general risk management advice in respect of everyone's care as opposed to specific advice about the care of the individual. This aspect of risk management required improvement.

On the day of our visit, we found the door to the home's onsite laundry open. Equipment in use in the laundry for example, a tumble dryer can be a source of potential fire and because of this, the door to the laundry should be closed at all times to prevent a fire from spreading. We also found that a cupboard in the laundry that contained COSHH items had been left unlocked. COSHH items are substances which may be hazardous to people's health if used in the wrong way. A secure place to store these items is required to prevent unauthorised and inappropriate use. Hazardous substances found in care homes include cleaning materials, disinfectants and maintenance products containing chemicals. This is particularly important when caring for people who live with dementia who may not recognise that these substances are hazardous.

We noted that the home's laundry contained a manual sluice for the rinsing of soiled clothing and the home's communal toilets also contained hand towels that were not suitable for single use. This did not promote good hand hygiene or mitigate the spread of infection. We spoke with the general manager about this and they showed us evidence that improvements to infection control procedures were in progress.

We saw that the provider had organised for an annual test of the home's water supply to be undertaken in respect of Legionella bacteria. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. The annual test undertaken in 2016 showed that no legionella bacteria had been detected. The provider did not however have a risk assessment in place to show how they were mitigating the risk of Legionella developing. Under the Health and Safety Act 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed. Shortly after our visit, the general manager showed us evidence that they had acted immediately upon this. They had conducted an interim risk assessment for Legionella and organised for an external company competent in Legionella management to visit the home to complete a professional risk assessment and management plan.

We looked at a variety of safety certificates for the home's utilities and services, including gas, electrics and specialised bathing equipment. Records showed the systems and equipment in use were of a satisfactory standard and that regular checks of the condition of the home and the equipment in use were undertaken to ensure they were safe and suitable for use. We saw however that the provider had recently had a fire risk assessment completed by an external supplier competent to do so. The fire risk assessment outlined that a number of fire safety improvements were required to ensure that people who lived at the home were sufficiently protected in the event of a fire. We spoke to the general manager about this, who told us that the necessary improvements would be completed without delay.

The two people we spoke with during the inspection told us there were enough staff on duty. There were two staff on duty at all times. The registered manager shared their time between the home and a sister home and we saw that staff had access to a 24 hour on-call system in their absence. We observed staff caring for people throughout the day and saw that the number of staff on duty was sufficient to meet people's needs. Staff were unrushed in the delivery of care and we saw that people were assisted promptly and in a patient, friendly manner.

We looked at the provider's safeguarding records and saw that any potential safeguarding incidents were properly investigated and responded to, to mitigate risks to people's safety and welfare. We asked one member of staff about different types of abuse and what they would do if they suspected abuse had occurred. We found they had sufficient knowledge to be able to ensure people were protected from potential harm.

We looked at the way accidents and incidents were managed. Records showed that any factors leading up the accident and incident was reviewed. The action taken following the accident and incident was clearly documented and we saw that people's health and well-being was monitored for 48 hours following an accident and incident to ensure their safety and welfare was maintained.

We looked at the personnel records for three members of staff and saw that staff have been recruited safely. Previous employer references had been sought and a criminal conviction check completed. This meant the safety and suitability of staff had been checked prior to employment.

We looked at the arrangements for the safe keeping and administration of medicines. The majority of medication was dispensed in the blister packs that contained the required dose of each person's medication. Some medication was also boxed for example, 'as and when' required medication such as painkillers and prescribed creams. We saw that there were 'as and when' required medication plans in place which provided staff with clear information on how and when these medications should be given.

We checked a sample of three people's medication administration charts (MARS) and found they matched what medicines had been administered. MARs were completed and signed for properly and stock levels of medication were correct. This indicated people had received the medications they needed. People we spoke with confirmed this.

The majority of medication was stored securely but some people's bedrooms contained prescribed creams. We spoke to the manager about ensuring these prescribed medications were stored securely. They told us they would do so without delay.

Good

Is the service effective?

Our findings

People we spoke with said they felt well looked after by staff. One person said "Staff can't do enough for you". Another person said the staff were "Very good" and the relative we spoke with said the care was good and that staff kept them up to date with the person's progress.

We spoke with the registered manager, the general manager and a care assistant about the people they cared for and found them to be knowledgeable about their needs and wishes. We saw staff supporting people throughout the day and it was clear from our observations that staff knew people well.

We reviewed the personnel files of three members of staff. We saw that the provider had a training programme in place which offered staff training in topics relevant to the needs of the people who lived at the home. For example training was provided in the safe administration of medications, moving and handling, safeguarding, dementia awareness, pressure area care, managing challenging behaviour, falls prevention, first aid and food safety. Records showed that the majority of staff had completed the training provided. Those who still had some of the training to complete had been booked on training courses to enable them to do so.

We reviewed staff appraisal and supervision records. We found evidence that since the registered manager had come into post approximately six months ago, staff had received regular supervision. There was however limited evidence to show that staff had received an appraisal prior to, or after the new registered manager had come into post. We asked the general manager about this. They told us that they had been unable to find previous evidence to demonstrate staff had received a regular appraisal of their skills and competencies. The registered manager told us that they had not yet had chance to appraise the staff team since coming into post but that a plan was in place to ensure that staff appraisals were completed in a timely manner.

People we spoke with confirmed that they were able to choose how they lived their life at the home and we saw examples of this throughout the day. We saw that staff were courteous and respectful when providing support and ensured people's consent was sought prior to support being provided. People were given choices and explanations and staff were seen to respect people's decisions. Consent forms were in place in all three care files we looked at. For example, consent forms were in place for the taking and use of photographs and the administration of medication by staff.

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. hen 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We looked at people's care files and saw the beginnings of good practice in relation to how the service ensured people's consent was sought. We saw that the service ensured that the support provided to people was the least restrictive method as possible, so as not to impact on the person's independence and care plans contained guidance for staff on how to support people's independent decision making. It was clear therefore that the service had considered the Mental Capacity Act 2005 and associated code of practice when planning people's care.

We found however that where people's capacity to consent to decisions was in question, the way in which people's capacity was assessed required improvement for it to comply fully with the Mental Capacity Act 2005 (MCA). Capacity assessments had been completed but they tended to be generic as opposed to decision specific. This was not in accordance with the Mental Capacity Act 2005. We spoke to the registered manager and general manager about this. They told us that they would review how they assessed people's capacity to ensure it met MCA requirements.

We observed people having lunch. We saw that people had the choice of eating their meal in the dining room or in their own bedroom. The dining room table was nicely set with a tablecloth, napkins and china dinnerware. The environment was light, airy and set out in such a way as to promote social interaction. We saw that people had a three course meal at lunch with a choice of two options for each course. We found that people received a balanced diet based on their nutritional needs and preferences. The food provided was of sufficient quantity and the people we spoke with said the food was very good and that they had enough to eat and drink.

Records showed that people's weight was monitored to ensure their nutritional needs were met. The registered manager monitored people's weights monthly by using an audit tool which tracked people's weight gain and loss. This was good practice as it ensured any changes in people's nutritional well-being were picked up quickly. We saw that where people's dietary needs changed, a referral to the community dietician had been made to ensure people received the support they needed.

The care plans we looked at contained brief details about people's health conditions but lacked information on how people's health conditions impacted on their day to day life and the signs to spot in the event of ill health. We spoke to the registered manager about this. We saw however that people's care records showed they had access to a variety of healthcare professionals, in support of their health and well-being. For example, district nurses, falls prevention team, dermatology, opticians, dentists, community dieticians and their own GP. This demonstrated that people's health needs were supported and acted upon effectively. Where people had attended appointments in relation to their physical health or where they had received support from visiting healthcare professionals, these visits were noted and any advice given in relation to people's care clearly documented for staff to follow. This ensured staff remained up to date on people's needs and care.

None of the people who lived at the home lived with advanced dementia. Some people experienced memory loss due to early signs of dementia and at times required help from staff to orientate themselves to their environment, time and place. The home was single storey and all of the home's facilities and accommodation were on the ground floor. The layout to the home was simple with one corridor leading from one end of the home to other. This made it easier for people who lived with memory loss to find their way around the home.

We saw people had memory boxes outside of their bedrooms. These contained items familiar to the individual such as a favourite picture, a photograph or a birthday card they had received. This helped those people who lived with signs of dementia such as memory loss to locate their own bedroom. We found that people moved about the home easily and we had no concerns about the layout of the home impacting on people's ability to be independent.

Good

Is the service caring?

Our findings

One person said the staff were "Marvellous" and both people we spoke with told us the staff were kind and treated them with respect. The relative we spoke with said that the staff kept them up to date on the person's progress and that they were always made to feel welcome at the home.

During our visit, we observed staff supporting people and noted that they did so in a kind, discreet manner and in a way that supported the person's ability to be independent. There were lots of positive, warm interactions with staff chatting to people socially throughout the day. It was clear staff knew people well and talked to them about the everyday things that most people talk about. his promoted people's emotional well-being.

We saw positive touch was used by staff to reassure people who became unsettled during the day. We observed that staff took the time to listen to their concerns and gave simple explanations to diffuse the person's anxiety. From our observations it was clear that staff genuinely cared about the people they looked after.

Staff checked frequently on people's welfare, whether they needed any help or whether they would like a drink or snack. Staff maintained people's dignity at all times and people looked well dressed and well cared for. We saw that people responded positively to staff and it was obvious they felt comfortable and relaxed in their company. The atmosphere at the home was warm and homely and people were able to spend their time as they chose.

We found people's care plans were written in a person centred way and contained sufficient information for staff to understand how the person preferred to be cared for on a day to day basis. Information in relation to people's end of life wishes however required improvement to ensure that people's preferences were recorded and adhered to should their health decline.

From looking at people's care files, we saw that people were supported to have their say about the care and supported to participate in any decision-making that affected them. We also saw that regular resident meetings took place to ensure people's feedback, opinions and suggestions about the service were gained and acted upon where possible. This showed that the provider cared about people's views of the service and the support they received. For example, the minutes of the resident meeting in November 2016 showed that people had been involved in deciding upon the new colour scheme for the communal lounge, new activities and menu choices.

We spoke with the registered manager, general manager and a care assistant about the people they supported. We found that they had a good knowledge of people's needs. They spoke about people warmly and were able to describe people's preferences and likes and dislikes with regards to their care. This showed that the things that were important to people were at the forefront of the support they received from staff.

The home had a service user guide for people to refer to. We looked at the information provided and saw that it was easy to read. It included information about the home, its staff and the services. This showed us that people were given appropriate information in relation to their care and the place that they lived.

Good

Is the service responsive?

Our findings

People we spoke with told us that they received the support they needed. One person who had not lived at the home for very long told us that they had felt "Immediately welcome" on their arrival, that staff were "Very good" and came quickly when they needed help.

The relative we spoke with told us that staff always ensured that the person was smartly dressed and cared for in the way they (the person) preferred. For example, they said staff always ensured the person had a collar to their clothes, had bubble bath in their bath and scent on during the day. They told us these things were important to the person and that staff ensured that they had them. They told us the "Girls (staff) are spot on".

We saw that each person's care file contained a person centred assessment and care plan. People's preferences, likes and dislikes and daily routines were all documented for staff to follow. Each person's personal life history had been gained from them to assist staff to provide person centred care. Personal life histories capture the life story and memories of each person. They enable the person to talk about their past and give staff, visitors and other professionals an improved understanding of the person they are caring for and topics to chat about to build positive relationships. Personal life histories have been shown to be especially useful when caring for a people with dementia or memory loss.

We found that the majority of people who lived at the home, interacted socially throughout the day with other people who lived at the home and staff. People's care plans included details of their social interests and the activities they enjoyed and we saw that there was a range of board games, books and access to music in the communal lounge. An activities list was displayed on the noticeboard outside of the lounge. This showed people had access to a range of activities such as bingo, pampering sessions, cup cake decorating, music quizzes, skittles, card making, 'fit for life' exercises and movies. One person said that the home had recently organised a trip to the local cinema and that they had enjoyed a trip to Gordale garden centre at Christmas.

The registered manager reviewed the activities to people on a regular basis to ensure they were happy with what was on offer. For example, in the registered manager's activities audit in October 2016, one person had said they liked to knit and following this, knitting supplies had been purchased for people to use.

People we spoke with told us they had no concerns or complaints about the care they received. They said that if they did they would speak with the care staff or registered manager. The minutes of the resident meetings held in November 2016 and January 2017 showed that the registered manager routinely checked that people had no concerns of complaints about their care and ensured people knew who to talk to should they do so.

We reviewed the provider's complaints procedure and found two different versions of the procedure in operation. Neither policy gave clear information on how to make a complaint or which organisations people could contact should they wish to take their complaint further. We spoke with the registered

manager and general manager about this. The general manager told us that they would review the procedure without delay.

We reviewed the provider's complaints records. Complaints about the service in the last 12 months were minimal but the two complaints we looked at, showed that the registered manager had responded appropriately and with empathy to the complaints received.

Good

Is the service well-led?

Our findings

People and the relative we spoke with told us that they felt the service was well managed. Both the registered manager and the general manager were fairly new, having only been employed six months prior to our visit.

The home had previously been run by an alternative provider and transferred to the new ownership of Allandale Care Group in October 2015. We could see that improvements to the way the service was managed had been made since both the registered manager and general manager had come into post.

There were a range of audits that checked the quality and safety of the service. For example, there were care plan audits, medication audits, environmental audits, equipment audits and accident and incident audits. We could see that where actions had been identified, these had been undertaken.

We saw that general manager undertook a quality assurance visit to the home each month and checked that the providers audit programme was being completed appropriately by the registered manager. They reviewed the actions identified and undertaken by the registered manager to continually improve the service and spoke to people who lived at the home and staff as part of the visit to gain their feedback on the service. This was good practice.

The majority of these audits were effective in monitoring the quality and safety of the service. We found however that care plan audits needed to be reviewed to ensure the risk management guidance in care plans was adequate. A review of the security of the laundry and COSHH cupboard also needed to be considered in the environmental audits in place.

The general manager told us that there were a number of improvements still to be made to the home for example, improvements to the laundry and the removal of the manual sluice, a programme of re-decoration and improvements to the fire safety arrangements. Following our inspection and in response to our feedback, the general manager showed us evidence that they had acted immediately to improve the system in place to monitor the risk of Legionella. This showed a responsive management approach.

We saw evidence that staff meetings and management meetings were held regularly with issues associated with the running of the home discussed and planned for, where appropriate. For example, resident welfare was discussed, staff training, fire drills and staffing issues.

There were lots of opportunities for people to voice their opinions and suggestions about the service. An activities audit took place regularly where people were asked for feedback on the activities and entertainment provided. People's views were sought during resident meetings and a satisfaction questionnaire was given to people to complete on all aspects of service delivery. This enabled the provider to come to an informed view of the quality of the service provided.

During our visit, we found the culture of the home to be open and transparent. The registered manager and

general manager demonstrated they were committed to continuous improvement. and staff members worked well together as a team. Staff we spoke with told us the registered manager and general manager were approachable and supportive.