Maria Mallaband Limited

Furze Hill Lodge

Inspection report

Furze Hill
Kingswood
Surrey
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 December 2016 and was unannounced. Furze Hill Lodge care home is a 29 bedded purpose built facility in Kingswood, Surrey. The home provides accommodation and personal care for up to 29 older people, including people with dementia. On the day of our inspection 23 people were using the service. The service was last inspected in November 2013 and was found to be meeting all the regulations we reviewed at that time.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Prior to this inspection we received a monitoring report by a local authority contract monitoring team. This had identified a few areas which required some improvements. At this inspection, we noted that improvements had been made.

Staff knew how to recognise abuse and how to respond to concerns. Risks in relation to people's care were assessed and planned for to minimise the risk of harm. Concerns regarding people's safety had been appropriately managed and staff displayed a good knowledge of safeguarding principles.

There were sufficient numbers of staff on duty to meet the needs of people who used the service. Staff underwent pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks.

Staff supervisions, appraisals and meetings all happened regularly. Staff spoke highly of the support they received from management and were confident they could raise any issues or concerns, knowing they would be listened to and acted upon.

People received their medicine safely. They received their medicines in a way they chose and preferred. The medicines administration records (MAR) were signed and up to date. Staff kept an on-going record of how much medicine was administered and how much was left, to make sure medicines were always available when people needed them.

People were cared for in a clean and safe environment. We saw infection prevention and control policies and procedures were in place.

New staff commenced an induction to ensure they developed the skills and knowledge needed to support people safely. The induction included the opportunity for new staff to shadow more experienced staff until they felt confident.

Staff were encouraged and supported to undertake training. We saw records which showed staff had

received training in various aspects of care delivery. There was a comprehensive training programme that was delivered to staff as part of the mandatory induction.

Staff understood the principles of the Mental Capacity Act 2005 (MCA). MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. This ensured that people's right to be involved in decisions about their own care was consistently upheld and respected.

People had access to a range of health care professionals such as GPs, district nurses, speech and language therapist, dieticians and occupational therapists. Immediate referrals were made with appropriate follow up meetings when staff had any concerns about people's health.

People were supported to have food and drink of their choice. The home operated a 'protected' mealtime system. This ensured staff were available to serve food and assist people if necessary so they could enjoy their food in a more relaxed environment.

People were supported with care and compassion. People told us they were treated with dignity and respect. Staff understood the need to protect people's privacy and dignity.

People received a personalised service which was responsive to their individual needs. Care records were person centred and developed to meet people's individual needs and reviewed if there were any significant changes.

People were supported to lead a full and active lifestyle. Activities and people's daily routines were personalised and dependent on people's particular choices and interests.

Complaints were taken seriously, thoroughly investigated and lessons learnt from them. Any concerns raised were assessed by the management team to see if any changes needed to be made to the service to minimise the risk of similar concerns being raised and to improve the quality of the service.

The provider had a quality assurance system in place and gathered information about the quality of the service from a variety of sources including people who used the service and other agencies. We saw that these were used to encourage best practice.

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 were protected from the risk of abuse and avoidable harm because the provider had systems in place to recognise and respond to allegations or incidents.

People received their medicines as prescribed. The MAR charts were signed and up to date.

There were sufficient staff deployed to provide care and support to people when they needed it.

Employees underwent pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks.

Regular environment and equipment safety checks were carried out, which included gas safety, electrical equipment, fire and water safety.

Is the service effective?

Good

The service was effective.

Staff were supported through an induction, on-going refresher training, supervision and appraisals.

People had access to a range of health care professionals such as GPs, district nurses, speech and language therapist, dieticians and occupational therapists.

People were supported to maintain balanced diets based on their preferences. Staff had a good understanding of people's preferences and supported them to make choices.

Is the service caring?

Good

The service was caring.

People confirmed they were treated with care and compassion by staff.

People who had difficulty communicating were enabled to give their views through a range of methods such as pictorial and photographic prompts to help where appropriate.

The service had a dignity champion whose role was to ensure staff treated every person with dignity. We observed that people were treated with respect and regard to their dignity.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred, with detailed life histories of people and information about their preferences, likes and dislikes.

Care plans were reviewed regularly and with the involvement of people who used the service and their relatives.

People's changing needs were identified promptly and communicated to relatives, as well as appropriate agencies to ensure people's needs could be met.

Is the service well-led?

Good

The service was well led.

The registered manager provided good leadership and staff were confident they could raise any concerns and these would be addressed.

People and their relatives were included in decisions about the running of the service and were encouraged and supported to have their voice heard.

There were systems in place to assess and monitor the quality of the service. This was used to drive improvements.

Furze Hill Lodge

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 on12 December 2016 and was unannounced. The inspection was carried out by one inspector.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted social and healthcare professionals who visited the service, and commissioners who fund the care for some people using the service, and asked them for their views.

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.

During the visit we spoke with seven people who lived at the service and the relatives of some people. We also spoke with eight members of staff, members of the management team which included a deputy manager and registered manager. We also contacted two directors of the service.

We observed care and support in communal areas, including lunch being served. We looked at the care records of six people who used the service. We also saw a range of records which related to the running of the service, including nine staff records and records of internal audits carried out.

Good

Is the service safe?

Our findings

People told us they felt safe in the service. One person said, "I am safe and very well looked after." Another person told us, "I am very happy here. I feel very safe. Staff are very reliable." One relative told us, "[My relative] is well looked after. [May relative] is in safe hands. Staff take good care of her."

We saw people were protected from the risk of abuse and avoidable harm. The risk of abuse was minimised because there were clear policies and procedures in place to provide staff with information on how to protect people in the event of an allegation or suspicion of abuse. Staff had received training in how to safeguard people. They were able to explain the types of abuse that people were at risk of, who they would report this to and where the relevant guidance was. We saw staff had previously raised concerns with the registered manager and she had reported and dealt with the matters appropriately.

There was a whistleblowing policy in place. They confirmed they were aware of the need to escalate concerns internally and report externally if they had any concerns. This indicated they were aware of their roles and responsibilities regarding the protection of people.

Individual risk assessments were completed for people and information was made available to staff on how to manage risks and ensure harm was minimised. Each risk assessment had an identified hazard and management plan to reduce the risk. For instance, one person was at risk of falls and we saw the risk assessment identified environmental hazards, including poor lighting, slippery floors, uneven surfaces, footwear and clothing. The impact of medicines and nutrition were also considered. There were a range of interventions, including modification of the environment, medicines and nutrition reviews. Because most of the falls occurred when the person was in their bedroom, a pressure sensitive mat alarm was fitted in their room to alert staff. Staff were familiar with the risks and knew what steps needed to be taken to manage them. Records showed that staff took appropriate action following accidents or incidents.

People told us staff met their needs and came promptly when called. One person told us, "Staff never let me down if I wanted help." A relative said, "There is enough staff to meet [people's] needs. They now have a permanent maintenance person and an activities coordinator. This has added to the feeling staff can get on with care." The registered manager told us staff rotas were planned in advance according to people's support needs. A dependency tool was used to determine staffing levels, and additional staff were deployed when necessary. There were 23 people in residence at this inspection. We looked at the staff rotas and saw there were always at least four care staff on duty from 8am to 10pm and two from 10pm to 8am. Extra staff were brought in when necessary, for example to escort people to a medical appointment or an activity. Furthermore, the home employed administrators, catering staff, a maintenance person and domestic staff.

We reviewed staff records and saw all employees underwent pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks. This meant the service had in place a robust approach to vetting prospective members of staff. This helped to reduce the risk of unsuitable staff being employed.

We looked at the maintenance records. Regular environment and equipment safety checks were carried out,

which included gas safety, electrical equipment, fire and water safety, environment, and lifting equipment. Any issues regarding equipment safety were reported to the management, who arranged for a suitable contractor to visit the site if the maintenance person could not repair it. We raised concerns regarding the regulation of heating at the home. This was known to the provider and they had assessed the repairs would be best carried out when the weather was warmer. However, at our suggestion, this was escalated as an urgent requirement and we have since received evidence that repairs and improvements have been carried out.

There was a fire risk assessment in place. Staff received fire safety training. All equipment was inspected, serviced and maintained regularly. Each person had a personal emergency evacuation plan (PEEP) in the event of fire or other emergency. PEEPs were individualised and regularly reviewed. This ensured those individuals who may not be able to reach a final place of safety unaided or within a satisfactory period of time in the event of any emergency had an up to date evacuation plan.

People's medicines were administered safely. We looked at the medicine records, which indicated people received their medicines as prescribed. People receiving care confirmed this. Records showed that all staff who administered medicines had been trained to do so. We looked at the medicine storage facilities and found that medicines were stored properly and the temperature of the medicines fridge was monitored.

The MAR charts were signed and up to date. Staff kept an on-going record of how much medicine was administered and how much was left, to make sure medicines were always available when people needed them. Audits records showed management regularly checked medicines were stored, administered and disposed of safely.

People were cared for in a clean and safe environment. We saw infection prevention and control policies and procedures were in place. Staff had received training in infection prevention and control. Liquid soap and paper towels were available at all wash handbasins. Staff demonstrated their awareness of the actions they should take to prevent the risk of cross infection. They used personal protective equipment, such as gloves and aprons.

Good

Is the service effective?

Our findings

People who used the service and relatives consistently praised the skills of staff working in the service. One person told us, "Staff are excellent at what they do." Another person said, "Staff are good. They listen to us." Relatives were equally complimentary. They told us staff were approachable and looked after people very competently.

We saw people were supported by staff who were trained and given opportunities for development. We spent time observing and talking with staff. Staff had an in-depth knowledge of people's individual needs and preferences. They knew where to find information in people's care plans and were able to tell us about how they were meeting specific needs of people, without referring to the individual's care plans. Most of the staff had worked at the home for many years and had got to know people's needs well.

When staff started working in the service they commenced an induction to ensure they developed the skills and knowledge needed to support people safely. Staff enrolled on the Care Certificate which is a nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe care. The induction was described by staff as 'excellent'. The registered manager told us new members of staff spent time working with more experienced staff, until they got to know people and were confident and competent to work unsupervised.

The service had processes to support staff in place. Staff were consistently positive about the support they received from management. One said, "The manager is very good. We have an administrator now and the manager comes out more to help us." All confirmed they received regular supervision and annual appraisals to ensure that competence was maintained.

Staff were encouraged and supported to undertake training. We saw records which showed staff had received training in various aspects of care delivery. There was a training programme that was delivered to staff as part of the mandatory induction. This included safeguarding, fire safety awareness, health and safety, infection control, moving and handling, Mental Capacity Act 2005 (MCA), medicines, which were refreshed as required. Staff also received training which was specific to people's individual needs such as dementia and falls awareness. Staff who were responsible for administering people's medicines had regular training and completed annual competency assessments. Throughout our inspection we saw this training had a positive impact on the way staff supported people.

Staff understood the principles of the Mental Capacity Act 2005 (MCA). 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.

Care files contained signed consent to the care provided, whilst staff we spoke with demonstrated a good understanding of mental capacity and consent. This meant that people's right to be involved in decisions

about their own care was consistently upheld and respected.

People were supported to make decisions and chose what they did on a day to day basis. We saw people could make choices about where they ate, how they spent their time and what activities they did. One person told us, "Staff ask me what I want and I tell them. They have always respected my choice." Throughout this inspection we observed staff gave people information to enable them to make an informed choice.

People's care plans contained clear information about their level of capacity to make own decisions and where they may need support. Detailed assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. For example, one person was not free to leave the building on their own for their safety. The registered manager had assessed the person's capacity to see if they understood the information relevant to the decision in order to identify if a Deprivation of Liberty Safeguards (DoLS) application was required.

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 DoLS. We saw that the conditions of authorisations to deprive people of their liberty were being met. For instance, best interests decision meetings had been held with multi-disciplinary teams, including people's families and GPs where decisions was reached and recorded.

The registered manager had assessed people who lacked the capacity to make certain decisions to identify if a DoLS application was required. We saw there was an up to date DoLS authorisation in place for six people who were under constant supervision and not free to leave the building for their own safety. There were records of involvement with health care professionals when staff had concerns about people's capacity.

Care plans provided evidence that people using the service had accessed a range of other health care professionals such GPs, district nurses, speech and language therapist, dieticians and occupational therapists. We also saw people were supported to attend hospital appointments. Key issues such as people's weights, blood pressure, dietary and fluid intake were routinely monitored as and when required. This helped to maintain an overview of the health and wellbeing of people living in the home.

The service had been awarded a five star food hygiene rating at its most recent inspection by Environmental Health. This rating means the home was found to have 'very good' hygiene standards. Relatives of people told us people were supported to have food and drink of their choice, which people confirmed. One person told us, "The food is very nice." Another person said, "We are given choice about what we want to eat." A relative told us, "The food is good. [My relative] is always happy with it." We saw detailed entries in care documentation of the food people had chosen and the means by which staff supported people to have a nutritious diet. Advice from Speech and Language Therapists (SALT) had been incorporated into people's care planning to ensure staff adhered to this guidance about what people could eat. The home operated a "protected" mealtime system. This ensured staff were available to serve food and assist people if necessary so they could enjoy their food in a more relaxed environment.

There was on-going work for the home to be dementia friendly. Of the current 23 people, approximately eight people had early stage dementia. A recent local authority report stated the home was not dementia friendly, which we found to be the case during this inspection. For example, there were no dementia friendly signage and carpets were patterned which could add to confusion for people with dementia.

Good

Is the service caring?

Our findings

People told us staff showed them compassion and empathy. They said staff gave them time and listened to them. One person told us, "I enjoy my life here. Staff are very nice and friendly." Another person said, "You can see this place is comfortable. Staff are so caring." A relative said, "Staff are very caring. [My relative] is fond of them."

Care plans included guidance for staff on how to approach people with care and compassion to ensure staff understood when people may need more support and attention. For example, in order to calm one person, there was guidance for staff to take the person to a quiet place (bedroom), to listen to music, which was reported to have a soothing and calming effect on the person.

We spent time with people in the communal areas and observed people were comfortable and happy around staff. People freely expressed views and staff listened with interest and patience to their responses. We overheard staff talking with people about activities and Christmas plans. In all examples, staff gave the impression they had plenty of time; they were not rushed or quick to move on to the next person. They spoke with people who were seated so that they were on eye level with them, and we could see people were comfortable and receptive to what they had to say. In one example, we observed one staff calmly reassuring one person who was visibly distressed because they couldn't find their property. The staff reassuringly told the person, "I think your [property] is in your room. I will go and look for it", before they left to bring the property.

Some people were able to express their views clearly but there were others whose voices may not have been so easily heard. The service made effort to ensure their views were heard and acted on. People were enabled to give their views through a range of methods. For example, the service consulted with people's relative, having gained people's consent. In other instances, staff used pictorial and photographic prompts to help where appropriate. If people couldn't read, staff read for them, as was the case when they were supporting people to choose meals on the menu.

Visitors told us they were welcomed at all times into the home. Throughout the inspection we observed visitors being warmly welcomed by staff. Staff paid attention to them and facilitated any discussions where necessary. In some occasions staff supported people to feedback any progress or what they had been doing. People told us relatives were able to visit at any time without restrictions.

Staff spoke knowledgeably about what they would do to ensure people had the care they needed for a variety of diverse needs, including spiritual and cultural differences. The home had regular religious services and encouraged visits from priests and ministers of differing religious backgrounds. Weekly Communion services were held for those who wished to partake. An activities coordinator who was in charge of organising this told us, "I try to facilitate a normal life as much as possible."

The service had a dignity champion whose role was to ensure staff treated every person with dignity. We observed that people were treated with great respect and regard to their dignity. In a recent survey, people

were asked if 'staff treated them with kindness, dignity and respect', 100% of respondents thought so. Staff told us they explained what they were going to do before care was delivered. A staff member said, "I say what I am going to do before I proceed." We observed staff knocked and waited for a response before they entered people's rooms. Staff were not hurried when they assisted people with personal care. We observed they waited patiently for people who needed to be prompted and encouraged to mobilise independently.

Good

Is the service responsive?

Our findings

We looked at seven files of people living at the home. These contained a range of personalised and comprehensive care plans and risk assessments. These had recently been improved following a local authority monitoring visit. The files were clearly indexed according to different care plans relating to the specific care needs of people. For example, there were specific person-centred plans for such areas as, maintaining safety, nutrition and hydration, pressure relief and skin integrity, communication, mobility, managing pain, social interaction and activity and end of life wishes. Each set out in detail the way daily care and support must be provided to an individual. One person told us, "Staff are very reliable. They know exactly how to support me." Another person said, "Staff are very nice. They know me very well." A relative told us, "Staff are aware of my relative's needs. They take good care of her."

Information relating to personal histories of people; their likes and dislikes was also included in the care plans. This was important in order for staff to respect people's needs and beliefs. As we established, people's religious, cultural or dietary needs may not have allowed them to eat certain foods. By having an insight into their likes and dislikes, we saw the service had adjusted aspects of people's care to meet their individual needs. So, halal meat was made available to a person who observed Islam as a religion.

We saw that care plans were dynamic, and were constantly reviewed and updated in response to changing needs and preferences of people. The reviews looked at what was working well, what was not working, and what might need changed. We read reviews of people's care, some of which we saw led to changes in the way people were supported. In one example, a person's diet was changed and in another, a mobility plan was adjusted. We found staff to be knowledgeable of people's needs because they always had up to date information on the individual, which enabled them to provide person-centred care.

The home regularly held meetings to gain people's feedback and also often asked for the views of relatives and other visitors which were recorded. These meetings offered one way for the service to hear people's experiences and their views about the service. A periodic 'resident' satisfaction survey was also another source of information. It included questions around people's satisfaction with meals, choice, access to medical professionals, responsiveness of the service to people's needs, dignity, and privacy. We saw any agreed changes arising from meetings or people's feedback were written down, including updates on progress.

People and relatives said there were no restrictions to visiting. A person told us, "My relative visits me and feels welcome." A relative said, "You can come anytime of the day to visit. I always feel welcome. They make the home so accessible to us." A newsletter was used to publish upcoming activity schedules. A relative told us, "The care coordinator is excellent. She emails a list of events, [people's] meetings for us to attend. The home hosted birthday parties for people, which relatives were invited to. In addition to inviting relatives to participate in events happening at the care home, activity schedules were displayed in a prominent place so that relatives and people could see what was happening in the home.

The home had a varied programme of activity and entertainment on offer. A weekly activities planner was

given to people to keep in their room. This was also displayed in the home for information. Activities included board games, bingo, cheese and wine evenings, music and quizzes. Pampering sessions were also at hand. The hairdresser visited the home regularly. Nail manicure was provided by the activities coordinator, who had an NVQ Level 1 in Beauty Therapy. In addition to organised activities, the home also scheduled unique observances throughout the year, including Remembrance Day, Diwali Festival, Christmas and Birthdays. For example, people were involved in Christmas decorations and Christmas pantomime. Participation was voluntary and there were other lounges available for people who did not want to take part in organised activities. We could see the benefits to people's well-being. People looked comfortable and happy.

People told us they had nothing to complain about, but they would be comfortable to raise any issues with the staff. There were accessible and detailed complaints procedures displayed in the service so that people would know how to escalate their concerns if they needed to. Relatives told us when they had made a complaint they were happy with the registered manager's response. One relative told us, "I have raised a concern before. The service has listened to what I had to say and took on board my views." Any concerns raised were assessed by the management team to see if any changes needed to be made to the service to minimise the risk of similar concerns being raised and to improve the quality of the service.

Good

Is the service well-led?

Our findings

People who used the service, their relatives and staff told us they considered the leadership to be good. One staff member told us, "The manager is very supportive. She is approachable and has always taken our views on board". One person receiving care said, "The manager and staff are very supportive. A relative told us, "The manager is honest. She is also open to suggestions"

There was a clear management structure in the home. Senior staff were allocated lead roles in such as infection and control, first aid and moving and handling. Staff understood their lines of responsibility and accountability for decision making about the services. Staff were able to refer us to appropriate personnel to address our specific enquiries. The management team demonstrated a strong commitment to providing people with a safe, high quality and caring service and to continually improve.

The registered manager and senior management recognised the importance of capturing people's comments. There was a comments and suggestions box in the reception area of the service, along with forms for people to either leave feedback on the service or make suggestions for improvements.

Results of a recent survey were positive. Notably, all questions regarding the leadership and direction of the service prompted favourable responses, with 100% approval.

A regular newsletter was circulated to people who used the service and their relatives and this gave information including an introduction to staff and what their area of delegation was, an update of staff training completed, details of social events, how to access health services and a record of any achievements in the service.

Regular audits were carried out. This included auditing aspects of the service such as medicines administration, daily logs and care plans. showed the auditing process was effective at identifying errors and addressing them to ensure people's needs were met.

Monthly audits were completed on any falls. These were analysed to identify whether there had been any environmental hazard or identifiable trend. An assessment was also carried out to ensure staff had taken the appropriate and on-going action needed to reduce the risk of further falls. Records of one analysis undertaken showed that a discussion had been held with the person's GP who had stated they were happy to support the decision taken to reduce the risk of further falls.

The registered manager sent us regular notifications, as required by the regulations. People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly. A newsletter kept people and relatives up to date with developments. This included stories about people's experience of care at the home.