Life Style Care (2011) plc

Moorland Gardens Care Home

Inspection report

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Ratings

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

Overall summary

We carried out this inspection on 8 and 13 January 2015, and it was unannounced.

The service provides accommodation, care and treatment for up 80 people who have a range of care needs including living with dementia, chronic conditions and physical disabilities. The home is spread over three floors, with people living with chronic conditions being cared for on the ground floor, a rehabilitation service on the first floor and a service for people living with dementia on the second floor. There were 51 people living at the home at the time of the inspection.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

There were risk assessments in place that gave guidance to the staff on how risks could be minimised. There were systems in place to safeguard people from the risk of harm.

People's medicines were not always administered in a timely manner.

The provider had effective recruitment processes in place and there were sufficient staff to support people safely. Staff understood their roles and responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

The staff had supervision and support, but the training provided was not always effective to enable them to support people well.

People were supported to have sufficient food and drinks in a caring and respectful manner. They were also supported to access other health and social care services when required.

People's needs had been assessed, and care plans took account of people's individual needs, preferences, and choices.

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

The registered manager provided stable leadership and managerial oversight. The provider's quality monitoring processes had not always been used effectively to drive improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

There were sufficient staff to meet people's individual needs safely.

There were systems in place to safeguard people from the risk of harm.

People's medicines were not always administered in a timely manner.

Requires improvement

Is the service effective?
The service was not always effective.

The staff understood their role in relation to the requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

People were not always supported by the staff that had the right training and skills to meet their individual needs.

People were supported to have sufficient and nutritious food and drink, and to access other health and social care services when required.

Requires improvement

Is the service caring?
The service was caring.

Staff were caring and kind to people they supported.

The staff understood people's individual needs and they respected their choices.

The staff respected and protected people's privacy and dignity.

Good

Is the service responsive?
The service was responsive.

People's needs had been assessed and appropriate care plans were in place.

People's complaints were handled sensitively, and action was taken to address the identified issues to the person's satisfaction.

Good

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

The registered manager provided stable leadership and was a role model for the behaviours and values they expected of the staff.

People who used the service and their relatives were enabled to routinely share their experiences of the service.

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

Requires improvement

Moorland Gardens Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 and 13 January 2015, and was unannounced. The inspection was conducted by two inspectors, a specialist advisor with experience in the care and treatment of people living with dementia and an expert by expert experience whose experience is in supporting someone living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, 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. We also reviewed information we held about the service, including the notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We spoke with 18 people who used the service, seven relatives, four nurses and one trainee nurse, four care staff, the activities coordinator, four visiting health professionals, four cleaning and laundry staff, the registered manager, the deputy manager, the provider's area manager and the quality manager. We also observed how care was being provided in communal areas of the home.

We looked at the care records for nine people who used the service and reviewed the provider's recruitment processes. We also looked at the training information for all the staff employed by the service and information on how the provider assessed and monitored the quality of the service provided. We reviewed an action plan that the manager had prepared following a review by the local authority. We also had discussions with the local authority and a representative from the local clinical commissioning group (CCG).

Requires improvement

Is the service safe?

Our findings

The majority of people we spoke with told us that the staffing numbers seemed to have reduced in recent weeks. A visiting relative said, "There are not enough staff. I don't know what's happened, but the numbers just dwindled after Christmas." Another person said, "Staffing levels are the biggest issue, the staff appear to be busy all the time." People said that at times, they had to wait to be supported when they pressed their call bell, particularly at weekends, and at times the staff responded only to tell them that they will return shortly. However, we observed that the call bells were being answered promptly.

We reviewed the records of the call bell activity from the beginning of January 2015 to the date of our inspection on 8 January 2015. We noted that the majority of the calls had been responded to within a few minutes. However, the limitations of the data were that it did not provide information about the support given each time the call bell was answered and reset. We discussed this with the manager, who told us that they would review how improvements could be made to the monitoring system.

There were enough staff to support people safely. However, we observed that the staff were busy, particularly on the ground floor and this was supported by a staff member who said, "It's very busy here, but there are enough staff." Other staff also told us that there were usually enough of them to support people safely, unless they had unplanned absences. They told us that in such instances, staff on the bank list were contacted to provide the required cover. They also said that there had been instances when it was not possible to cover an absence and they would have had to get support from the other units within the home. The manager told us that there was an ongoing recruitment programme so that they covered any vacancies as quickly as possible when a staff member left. The manager also told us that they and the deputy manager provided additional support if required.

There were robust recruitment procedures in place. Relevant pre-employment checks had been completed to ensure that the staff were suitable for the role to which they had been appointed. The checks included reviewing the applicants' employment history and obtaining references from previous employers, confirmation of registration with the Nursing and Midwifery Council (NMC) for the nurses, and Disclosure and Barring Service (DBS) reports for all the staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

People told us that they felt safe living at the home and their relatives had no concerns about how the staff cared for people. A person who was at the home for short term rehabilitation said, "It is a home from home and if I needed to go to a care home, I would come here." Another person told us, "There is a man who supports me and he listens to me. I trust him." We saw that the provider had an up to date safeguarding and whistleblowing policy and procedures on display around the home. Whistleblowing is when a member of staff reports suspected wrongdoing at work.

Staff demonstrated a good understanding of safeguarding and most were able to tell us about other agencies they would report concerns to. They were also able to demonstrate their awareness of the whistleblowing policy and one member of staff told us, "I would not be afraid to speak up if I felt that people were at risk of harm. It is our duty to look after people well." Other staff and a visiting professional also said that they were confident that the manager would deal appropriately with any concerns raised. Our records showed that the provider had appropriately reported incidents where they suspected that people were at risk to both the local authority safeguarding team and the CQC.

There were personalised assessments for identified risks for each person to address a variety of issues such as pressure area damage, poor nutritional intake, and risks associated with use of equipment. Other assessments included ones to minimise the risk of people falling while walking around the home. Some of the people had restricted mobility and required staff support to walk or reposition themselves in bed. All the risk assessments we saw had been written in enough detail to assist staff to protect people from harm whilst promoting their independence. Staff told us that information about the identified risks for each person and how these should be managed to keep people safe was available in people's individual care records. They also discussed these, as well as people's needs and experiences at shift handovers. This provided staff with up to date information that enabled them to support people safely and to protect people from the risk of harm.

Accidents and incidents were recorded on a specific report book and copies were kept in people's care records. We

Requires improvement

Is the service safe?

saw evidence that each incident was reviewed and the actions taken were recorded. For example, we saw that an incident recorded on 29 August 2014 identified staff error as a contributory factor. A one to one supervision meeting was completed with the staff member on the same day. The manager periodically analysed the incidents in order to put systems in place to reduce the number and frequency of incidents. They told us that it was essential to share the learning from incidents and accidents with the staff during handover meetings, staff meetings and through individual supervision and we saw evidence of this in some of the supervision records we looked at and the minutes of the staff meetings.

There were processes in place to manage risks associated with the day to day operation of the service so that care was provided in safe premises. The lift and equipment, such as hoists had been serviced regularly. A number of other issues, such as fire risk and the risk of the spread of legionella had been assessed. There were emergency plans in place that provided the staff with information of what they were required to do if they needed to evacuate the home.

Medicines were managed safely in accordance with the provider's procedure for the supply, storage, administration and disposal of medicines. We saw that there was additional guidance for the nurses who administered medicines so that people were protected from risks associated with unsafe management of medicines. The medicine administration records (MAR) had been completed appropriately, with no unexplained gaps. We saw the records for a person who was being given their medicines disguised in food. We saw that this had been discussed and agreed with the GP that this was in the person's best interest.

The nurses administered medicines and we saw that they had their competence occasionally assessed to check that their knowledge about medicine handling and administration remained up to date. We observed that the morning medicines round was still in progress at 10.30am on the ground floor. The nurse told us that they had started at 9.00am and they had four more people to administer medicines to. Although we saw that the nurse took great care to ensure that they were not disturbed during this process to prevent any errors, the time taken on this medicine round meant that people did not always get their medicines at the times they are prescribed. For example, two people that were on treatment for diabetes said that they were routinely given their medicine after they had eaten. This was contrary to the prescription which stated these should be given half an hour before food. One person said, "I do my own medication now because they were all over the place with it." This issue had been previously identified during a review by the local authority and the manager told us of their ongoing work to make sustainable improvements.

Requires improvement

Is the service effective?

Our findings

Some people told us that the staff knew how to support them and they supported them well. One person said. "The staff are very good." Another person said, "The care is good and the care staff are excellent." A relative of one person said, "[Relative] has been here for a while. It's good quality care and we have been very pleased." However, other people's comments indicated that the care staff did not always have the right skills and training to provide the required care. For example, one person with an indwelling catheter told us that some of the care staff did not know how to change the bags. Another person said that many care staff were not trained to change their stoma bag. We did not see any evidence that staff's competence to provide this kind of care had been assessed. However, we noted that this care was mainly provided by nurses who would have learnt how to do this as part of their overall training, and the manager confirmed this. Others also commented that it was sometimes difficult to communicate with the staff whose first language was not English, but they had no concerns about how these staff provided care.

The provider had a training programme that included an induction for all the new staff. A person who had recently completed their induction confirmed that they had found the training and support useful. The staff also completed other relevant training and a number of refresher training dates were planned throughout January 2015. The care staff were encouraged to acquire a recognised care qualification and one of the care staff told us that they had completed a National Vocational Qualifications (NVQ) in Level 3 course. Some of the nurses had also completed additional training in diabetes awareness, wound management and palliative care. The manager told us that more training could be sourced if there was an identified need to provide this and further training was planned for 2015.

The staff told us that they had regular support through handovers and regular staff meetings. They also had regular supervision and annual appraisals, and the records we looked at confirmed this. The staff told us that they worked well as a team so that they met people's needs. The team leaders provided the day to day leadership and support that enabled them to carry out their role effectively. One staff member said "People are well looked after here. I would happy for my relative to be here". Another staff member said, "I'm happy here. I find the work interesting and fulfilling."

People told us that they were asked for their consent before any care or support was provided. We observed that the staff told people what they were going to do and waited for people to agree prior to providing the required support. We saw that some of the people had signed their care plans to indicate that they agreed with the planned care and the interventions by the staff. Where appropriate, people's relatives signed the care plans on their behalf. Where people did not have the capacity to consent to their care, we saw that mental capacity assessments had been completed and a decision made to provide care in the person's best interest. This was in line with the requirements of the Mental Capacity Act 2005 (MCA). Some of the people had authorisations in place in accordance with the Deprivation of Liberty Safeguards (DoLS) and the manager was aware that further referrals might be necessary in the future if other people's needs changed. The staff we spoke with understood how best interest decisions were made, their roles and responsibilities in relation to MCA and DoLS and they confirmed that they had been trained.

Although most people told us that they enjoyed the food and there was always something they liked on the menu, other people's comments indicated the food did not always meet their preferences. For example one person said, "The food I am given is enough, but it leaves a lot to be desired. One night I had Spanish chicken, the next night I had American sweet and sour and there was no difference." Other people said that breakfast was a bit disorganised, they did not always get snacks in between meals, hot drinks were provided irregularly and there was not always enough time between lunch and the evening meal.

However in contrast, we saw that people were offered drinks regularly on the day of our inspection and the staff provided the required support to people who were unable to eat their meal without assistance or get their own drinks. Records showed that where people were deemed to be at risk of not eating or drinking enough, the provider monitored how much they ate and drank, and their weight was checked regularly. For example, we saw that there was a risk assessment in place for a person who was identified as being at risk. The staff recorded how much they ate and

Requires improvement

Is the service effective?

drank on a daily basis, and checked their weight regularly so that they were satisfied that the person was able to maintain a healthy weight. We saw that where necessary, appropriate referrals had been made to other health professionals including dieticians, so that people received the care necessary for them to maintain good nutritional intake.

People on longer term care within the home told us that they were supported to access additional health and social care services when required and we noted this in the records we looked at. These showed that people had access to a range of professionals including dentists, chiropodists, and opticians. People using the rehabilitation service were at the home for between six to twelve weeks, for specific care and treatment. The majority were discharged back to their own homes having recovered enough to be able to live without staff support. They told us that they did not usually access other services during this period, apart from those essential for their rehabilitation. The range of professionals involved in their rehabilitation included occupational therapists, physiotherapists and specialist doctors. Multi-disciplinary reviews of people using the rehabilitation service were held regularly and one was in progress during our inspection. All the external professionals we spoke with visited the home daily to provide rehabilitation care and treatment. They confirmed that the provider worked closely with various health and social care professionals so that people had access to any additional services that they needed. They had no concerns about how people were cared for and they found the provider took prompt action to refer people to other services when required and that their interventions were necessary to maintain people's wellbeing.

Good

Is the service caring?

Our findings

People told us that the staff were friendly, caring and kind. However, the majority of people using the rehabilitation service said that the staff were mainly busy and they did not have time to sit and talk with them. One person told us, "The staff are very kind, but they have no time to chat." The staff were happy with the standard of care they provided to people. One member of staff told us, "We care about people we support."

We observed that the staff were caring towards people who used the service, but they were sometimes too busy on the ground and first floor to engage people in conversations, other than when they are providing care and support. However, there was a happy and friendly atmosphere throughout our time at the home and the activities coordinator took time to talk to people who had attended the coffee morning in the first floor dining room. We also observed that people living with dementia were positively engaged in conversations with each other and the staff, and they were getting a lot of individual attention.

There were restrictions to visiting times in the rehabilitation service to enable people to take part in their treatment, including exercises with the physiotherapists and the occupational therapists. Although people and their relatives accepted this, one person told us that this had not been explained to them when they moved to the home. We saw that visitors were welcomed anytime in other areas of the home. The manager also told us that in certain circumstances when a person was very unwell, they offered family members the option to stay overnight if they wished to. This enabled people to maintain positive relationships between people who used the service and their relatives and friends.

We saw positive interactions between the staff and people they supported, and people told us that they were treated with respect. One person said, "The staff are always respectful." We noted that while supporting people, the staff gave them the time they required to communicate their wishes. People told us that the staff understood their needs well and provided the support they required. The staff we spoke with were knowledgeable about the needs of the people they supported and what was important to them. One staff member said, "People always come first. This is a friendly unit, people and ourselves are always very well treated." They also said that they assisted people to make decisions about their care and support and acted on people's views and choices to ensure that they received the care they wanted. This was particularly evident in the care records of people living with dementia, where we saw that the staff also involved people's relatives so that they were able to gain as much information as possible to enable them to support people well.

People told us that the staff supported them in a way that maintained their privacy and protected their dignity. We saw that if people were in their bedrooms, the staff knocked on the door and waited to be invited in before entering the room. The staff were able to demonstrate how they maintained people's privacy and dignity when providing care to them. A staff member told us that they would always close the door when supporting people with their personal care and would be discreet when asking people if they needed supporting while they were in the communal areas. We observed that some of the people being constantly supported by one staff had their bedroom doors opened for the majority of the time, but the staff closed these when they were assisting them with their personal care. The staff were also able to tell us how they maintained confidentiality by not discussing people's care outside of work or with agencies who were not directly involved in the persons care. We also saw that all confidential and personal information was held securely within the home.

Good

Is the service responsive?

Our findings

People were mainly positive about the care and support they received. The majority said that the staff responded quickly when they needed assistance and they were supported in the way that they liked. One person said, “The staff are always helpful.” Another person said, “They provide the care I need." The records indicated that the provider responded quickly to people’s changing needs and where necessary, they sought advice from other health and social care professionals. For example, people had been referred to other services when they became unwell. Also, appropriate actions had been taken to support a person who had been losing weight. This included involving a relative to support them to eat as their involvement was more effective in getting them to eat more food.

People’s needs had been assessed and appropriate care plans were in place so that people were supported effectively. People told us that their preferences, wishes and choices had been taken into account in the planning of their care and support and the care plans we looked at confirmed this. These were reviewed regularly or when people’s needs changed. We saw that people were also able to bring items that were important to them, including photographs of friends and family members and small pieces of personal furniture when they moved in to the home. These familiar items made the environment feel homely and comfortable for them. The staff told us that they worked regularly with an identified group of people so that they provided consistent care. This also enabled them to know those people really well, including understanding their needs, preferences and choices. The relatives we spoke with were happy with the level of information they received from the service which kept them informed of any significant events or changes to people’s care needs. We saw evidence of this in the care records and one relative told us, “The staff keep us informed. We have mature conversations about [relative]’s care.”

People also told us that they were supported to maintain their independence as much as possible and were involved in making decisions about their care and support. For example, one person who was there for rehabilitation support told us that they would choose to return to their home as soon as they felt able to cope without support. They said, “I am here for six weeks, but I might leave as soon as I feel that I can manage at home.” Other people told us that they were supported daily to choose their food, what to wear and how they wanted to spend their time.

People were supported to take part in activities within the home. Coffee mornings were held weekly on each floor of the home and we saw that people from other floors were facilitated to mix and socialise together at any of these. One was in progress on the first floor during our inspection and we saw that it was well attended. The activities coordinator supported people to attend these from other floors, but some people using the rehabilitation service told us that they chose not to attend any of the activities offered. We also saw a display of pictures showing the activities that people took part in over the Christmas period.

A weekly activity schedule showed that as well as coffee mornings, people had access to other activities, including a breakfast club, afternoon tea, art and craft activities, and a cinema club. The activities coordinator also provided one to one input for people who were unable to join group activities. However, we observed that the staff were not always facilitating social networks as the two lounges on the ground floor did not seem to be used much by people living at the home. Although we were aware that some of the people were too unwell to leave their bedrooms, there were some people who would have benefitted from, and enjoyed using these areas to socialise if they had been encouraged to do so. The manager told us that most people chose not to use these areas because they had televisions in their bedrooms. They also said that they had recently recruited two volunteers to further support people to pursue their hobbies or interests.

People told us that they would speak to the manager if they had concerns or any cause to complain. We saw that information was available to inform people what to do if they wished to raise a complaint or if they had concerns about any aspect of their care. As well as the information displayed around the home, it had also been added to the booklet available in each persons, bedroom so that people had access to the information if they needed it to raise a complaint. One relative said, “I don’t have any concerns or complaints, but if I did, I am confident that the manager would deal with this quickly and appropriately.” A person who used the service said, “I have not had any reason to complain.” We saw that any complaints received by the provider had been recorded, investigated and responded

Good

Is the service responsive?

to appropriately. There was also evidence that they monitored the themes of issues arising from these and they discussed them with the staff in order to make the required improvements.

Requires improvement

Is the service well-led?

Our findings

The staff told us that the registered manager provided leadership and was a role model for the behaviours and values expected of them. They also said that they felt supported and teamwork was really good. Most people knew who the manager was and they commented that they saw her regularly when she walked around the home. People told us that she was always pleasant and spoke to everyone she met, enquiring on their wellbeing and checking if there was anything her and the staff could do better. One person said, "[Manager] is a really nice lady. She cares about people." Another person using the rehabilitation service said, "She has popped in to see me twice since I have been here."

The manager promoted an 'open culture', where people or their relatives could speak to her at any time without a need to make an appointment. We also saw the manager phoning a relative who had not been able to speak with her when they visited. The staff told us that they were encouraged to make suggestions on any actions that they could collectively take to ensure that they provided good quality care that met people's needs and expectations. We saw that regular staff meetings were held for the staff to discuss issues relevant to their roles. The staff said that the discussions during these meetings were essential to ensure that they had up to date information that enabled them to provide care that met people's needs safely.

A number of quality audits were completed regularly by the manager and the actions required to make improvements had been taken promptly. For example, a 'Quality Monitor Form' was completed by the manager or deputy manager on a monthly basis and sent to the provider's head office. Other audits included monthly medication, health and safety, equipment checks, and quarterly infection control audits. However, the medication audit had not identified that people were not always being given this in a timely manner, and the concerns about the call bell system had not been identified and addressed.

Other senior managers from the provider's head office also completed bi-monthly audits. We looked at the audits completed in 2014, including the most recent one dated 28 November 2014 and we saw that the areas checked included the quality systems, the home's presentation, care documentation, review of pressure ulcers, and others. An action plan had been completed to identify areas where improvements were required and there was evidence of a review by the manager and a date by which all actions should be completed had been included.

The provider sent an annual survey to people who used the service and their relatives and we saw the results of the one sent in April 2014. Although we saw that the results had been analysed and people mainly provided positive feedback, there was no plan in place to show how the provider will make improvements so that people are fully satisfied with the care they received. A questionnaire had also been sent to the professional stakeholders and the comments from these were mainly positive too. There was a 'comments' box at the entrance to the home and the manager said that people had occasionally used this to leave comments about the service. We also saw a number of compliments from people or relatives of people who were happy about the care they had received.

The provider also encouraged people and their relatives to make suggestions and provide feedback about the service they received during regular meetings. We saw that 'Relatives and Service User Meetings' were held occasionally, but these were not always well attended. The most recent meeting in January 2015 had been attended by 20 people and they agreed to have the meetings bi-annually as they felt that they could address any urgent issues directly with the manager. We saw that a number of issues had been discussed, including the possibility of inviting art students from local colleges to paint murals on the walls to add colour and visual stimulation. As well as improving the environment for people who used the service, the manager told us that this would further enhance local community links.