Hallmark Care Homes (Wokingham) Limited

Alexandra Grange

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13 and 14 January 2015. Breaches of three legal requirements were found. We issued warning notices for breaches in relation to the provider maintaining accurate and secure records, and ensuring consent to care was sought in accordance with the principles of the Mental Capacity Act (MCA) 2005. We issued a compliance action for a breach relating to safe administration and disposal of medicines.

The provider was required to meet the regulations relating to the warning notices by 6 April 2015. They told us they would address the breach relating to medicines by 31 March 2015.

This report only covers our findings in relation to these areas. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Alexandra Grange' on our website at 'www.cqc.org.uk'.

Alexandra Grange provides residential care for up to 58 older people without nursing needs, but with other care needs, including dementia care. At the time of our inspection 40 people were living in the home.

Since our inspection in January 2015, a new manager had submitted their application as the home's registered manager. They had been in place as the manager of this home for ten days at the time of our inspection. They were being supported through their induction by the provider's managerial and regional staff, including the person who was managing this home at our inspection in January 2015. 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 and associated Regulations about how the service is run.

Summary of findings

At our focused inspection on 28 May 2015, we found that the provider had taken action to ensure the requirements of the Regulations had been met.

People's medicines were stored, administered and disposed of safely. The provider had put systems and checks in place to ensure issues, omissions and errors were identified promptly, and actions demonstrated that learning occurred to address these issues and reduce the risk of repetition.

People's consent to care was documented. When people declined specific areas of care, this was recorded, and their decisions were supported. Where people were unable to sign their consent, records documented how the person had indicated their wishes. If staff were unsure of a person's capacity to consent, an assessment of their mental capacity was documented, and a decision was made and recorded on their behalf by those appropriate and with the person's best interests at heart, such as family, staff or health professionals. Relatives had been supported by the provider to understand the principles of the MCA 2005, including the role and limitations of power of attorney.

Where people had been identified at risk of harm from malnutrition, dehydration or pressure sores, staff completed charts in full to record the support provided to people over each 24 hour period. This ensured people received the care and support they required to protect them from identified risks.

Records were stored in staff offices that were kept locked when unattended. Staff understood and implemented the provider's policy regarding records security. Managers conducted daily checks to ensure confidential information was maintained securely.

The provider had taken sufficient action to meet the requirements of the warning notices and compliance action in relation to maintaining accurate and secure records, ensuring lawful consent to care was obtained and documented, and the safe administration and disposal of medicines.

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?

Requires improvement

We found that actions had been taken to ensure people were safe.

People's medicines were stored, administered and disposed of safely.

This meant that the provider was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question. The period of time since our last inspection is not judged to have been sufficient to demonstrate a consistent and sustained implementation of good practice across all areas of this domain.

We will review our rating for 'safe' at the next comprehensive inspection.

Is the service effective?

Requires improvement

We found that action had been taken to improve the effectiveness of people's care.

People's consent to care, or that of those lawfully able to provide this, was sought appropriately. Staff understood and implemented the principles of the Mental Capacity Act 2005.

People's health and wellbeing was supported through the use of records and charts to monitor their care needs. Staff understood and met the requirement to complete these records fully.

This meant that the provider was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question. The period of time since our last inspection is not judged to have been sufficient to demonstrate a consistent and sustained implementation of good practice across all areas of this domain.

We will review our rating for 'effective' at the next comprehensive inspection.

Is the service well-led?

Requires improvement

We found that action had been taken to drive improvements to the quality and monitoring of people's care.

People's confidential records were held in offices that were kept locked when unattended. Effective systems ensured that the provider's policy to maintain secure records was followed by staff.

This meant that the provider was now meeting legal requirements.

While improvements had been made we have not revised the rating for this key question. We did not look at all aspects of this area, as the purpose of this inspection was to focus on breaches with the regulations identified at the last

Summary of findings

inspection. The new manager had not been in post for a sufficient period of time for us to judge that there was sufficient time to demonstrate a consistent and sustained implementation of good practice across all areas of this domain.

We will review our rating for 'well-led' at the next comprehensive inspection.

Alexandra Grange

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 was 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.

We undertook an unannounced focused inspection of Alexandra Grange on 28 May 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 13 and 14 January 2015 had been made. We inspected the service against three of the five questions we ask about services: is the service safe; is the service effective; and is the service well-led? This is because the service was not meeting legal requirements in relation to these questions.

The team comprised of two inspectors, one of whom was a pharmacist specialist. Before our inspection we reviewed the information the Care Quality Commission (CQC) held about the home. This included the provider's action plan, which set out the actions they would take to meet legal requirements. We spoke with the local commissioning authority about the home prior to our inspection.

During the inspection we spoke with three people and one person's relative, as well as ten care workers and the care manager. We also spoke with the current and outgoing home managers, and the regional operations manager. We observed people's care to help us understand the experience of people who were unable to talk with us.

We reviewed care plans and daily records relating to seven people's care, as well as charts recording regular daily support provided to 14 people during May 2015. These recorded support provided to maintain people's nutrition, hydration and re-positioning to promote their health and welfare.

We also reviewed staff training records, and the managers' action plans and audit records. We used this information to consider whether the provider had taken sufficient actions to address the breaches of the Regulations found in January 2015.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Alexandra Grange on 13 and 14 January 2015 we found staff did not always dispose of medicines safely. There was a risk people's medicines may not be administered safely.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focused inspection on 28 May 2015 we found that the provider had followed the action plan they had produced to meet the shortfalls in relation to the requirements of the Regulation described above.

People's prescribed medicines were managed and administered safely. The provider had ensured all staff, including agency, understood the home's procedures to reduce the potential for medicine administration errors or omissions. Staff had been reminded to ensure sufficient supplies were carried to ensure spoons were not re-used when administering medicines to people. The provider's checks and audits demonstrated medicines had been administered safely, and wasted and unused medicines were stored and disposed of safely.

Some medicines were prescribed for people as and when required, for example to address instances of pain. These are known as PRN medicines. Staff guidance was not always provided to direct when and how to administer these medicines. The care manager explained that some people were able to verbally communicate their need for these medicines. The PRN medicines without staff guidance related to these people. Staff followed these people's wishes, and medicine administration safety guidelines specific to the medicine, to ensure that these PRN medicines were administered appropriately and safely.

Senior staff carried out daily, weekly and spot checks to ensure the provider's processes for medicines management had been implemented. Issues had been identified through these checks, such as untidy medicines trolleys, and unlocked cupboards containing medicines awaiting disposal in March 2015. The provider had implemented actions to address these issues, and checks demonstrated that these issues had been addressed in an audit carried out in April 2015. We did not find these concerns at our inspection in May 2015. This indicated that staff had appropriately implemented the improvements required to administer and dispose of people's medicines safely.

Requires improvement

Is the service effective?

Our findings

At our comprehensive inspection of Alexandra Grange on 13 and 14 January 2015 we found people's lawful consent to their care had not always been documented, or provided by those legally able to do so. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Daily charts did not always document that people had received their prescribed care, such as support to maintain adequate nutrition and hydration, or re-positioning to support their skin integrity and protect them from the risk of pressure ulcers. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focused inspection on 28 May 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulations 18 and 20 described above.

People told us staff listened to their comments and wishes. A relative stated staff treated their mother with "Respect and dignity", and understood and met her wishes and preferences. We observed staff requested people's consent before supporting them, and listened to their responses to ensure they supported people as they wished.

A senior care worker described how they sat with people individually to inform and review their care plans. They explained how this helped them to understand people's care needs from their perspective, and pick up any issues promptly. Care plans evidenced review and update of people's consent to care records since our inspection in January 2015. These were person-centred to reflect the individual's preferences for care, and who they wished to be involved in decision-making and information sharing. Documentation showed that people and others significant to them had been involved in care plan reviews, and their views and comments used to inform their plans of care. For example, living will wishes had been used to inform a person's end of life care plans. Care plans documented people's consent or otherwise to the use of their photograph, or those people information about their health could be shared with, such as health professionals and family members. Where people had declined specific support, their care plans or daily notes logged their wishes to ensure staff were aware of this, and met people's preferences.

The staff office on each floor maintained a list of how people indicated their consent. Some people were unable to comment verbally or sign their care plans, but this record documented if they were able to nod, shake their head, or otherwise indicate their wishes. An information sheet provided staff with guidance on how people living with dementia preferred to take their medicines. This ensured staff were able to understand how people communicated their consent or declined care or support when offered.

Staff had attended training in the Mental Capacity Act (MCA) 2005 in January 2015, and understood and demonstrated the principles of this Act in their actions and conversations. Staff told us the training had bolstered their confidence to implement the requirements of the MCA 2005.

Where people had been identified to have fluctuating capacity, care plans guided staff to support the individual to make a decision at a time and place suitable to support them to do so. When people had been assessed to lack mental capacity to make specific decisions, there was a record of the assessment and subsequent actions to support decisions made on their behalf. This included involvement of family, staff and health professionals as appropriate to make a decision in the person's best interests.

One person had a letter from the GP authorising their medicines to be provided covertly. Staff and family had taken this decision in the person's best interests. However, we did not see evidence that the person's capacity to make this decision for themselves had been assessed. The care manager explained that this person was not given their medicines covertly. They were able to consent or decline their medicines as they wished, and actions were in place to ensure that when medicines were declined this did not adversely affect their health. Therefore the principles of the MCA 2005 were applied appropriately.

Since our inspection in January 2015, the provider had written to people's relatives to explain the legal rights of power of attorney to provide consent to care on people's

Requires improvement

Is the service effective?

behalf. They had invited relatives to attend a meeting and presentation with solicitors to support their understanding of the rights and restrictions associated with power of attorney.

A list held by the managers noted relatives and others with power of attorney for health and welfare for people. This meant they were lawfully able to make decisions on this person's behalf. Staff sought consent to people's care in accordance with the MCA 2005.

At our inspection in January 2015, charts recording people's food and fluid intakes, and recording their regular re-positioning, had not been completed fully. This meant people at risk of malnutrition, dehydration or developing pressure sores may not receive the care and support they required to mitigate these risks to their health.

Staff told us training on chart completion, provided in January 2015, had been clear and provided the guidance they required. One care worker said changes made to charts meant "We can see exactly what people have had", and prompted them to record information in full. We observed staff updated charts throughout the day, which meant staff had a clear understanding of people's current care needs. Offices listed people requiring chart completion to ensure staff unused to working on a floor were aware of these people's needs. Staff told us they had sufficient time to keep records up to date.

We reviewed a range of charts completed in May 2015 on all floors in the home. There were appropriate charts in place for all people identified as requiring charts to monitor their needs. Food charts documented the amounts people had eaten each day, including snacks, and recorded when people declined food. Fluid charts included the target amount the person should aim to intake, when the person was asleep or declined liquids, the type of liquid taken, and amounts drunk on an hourly basis. A pictorial guide provided staff with a record of the amounts held in each of the drinking vessels used in the home. This ensured staff could complete records accurately.

The person's intake was totalled over a 12 and 24 hour period to ensure staff changing shifts had a clear understanding of how much encouragement the person required to achieve their target intake. When people's intake was not sufficient to maintain healthy nutrition or hydration, staff understood actions to address concerns, such as referral to the person's GP or dietician.

Re-positioning charts demonstrated people had been supported to change their position regularly. This action, in conjunction with mitigating factors such as use of pressure mattresses, meant the pressure on their body was managed to reduce the risk of developing pressure sores.

Senior staff reviewed chart completion morning and evening to ensure people received their planned care. Any errors or omissions were clarified with the member of staff before they finished their shift. Chart completion ensured people were monitored to protect them from known factors affecting their health and wellbeing.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection of Alexandra Grange on 13 and 14 January 2015 we found that records had not always been stored securely. Systems put into place to monitor actions to promote records confidentiality had not been effective in driving improvements.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our focused inspection on 28 May 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 20 described above.

Throughout our inspection we found office doors were kept locked. A care worker explained that managers were "Strict about doors being locked". They told us they had noticed improvements over the previous few months regarding record keeping and security of information held. They said "The team understand why this is important". We found confidential information was kept inside locked offices, and stored in cabinets when not in use. This ensured personal records could only be viewed by those authorised to do so.

Meeting minutes dated January 2015 confirmed group supervision meetings reminded staff of the provider's policy on confidentiality of records. Daily walk rounds by the manager in charge reviewed security actions on each floor, and documented that doors were found to be locked. This meant appropriate actions had been implemented to protect people's confidential information.