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Homefield Grange

Inspection report

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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

We carried out an unannounced comprehensive inspection on the 30November and continued on the 1 December 2017 which was announced. When we inspected the service in July 2017 we found breaches of legal requirements. The service was failing to prevent people from receiving unsafe care and treatment and avoidable harm or risk of harm. Also systems and processes were not effective in monitoring that legal requirements were being met. At this inspection we found improvements had been made and legal requirements were being met.

Homefield Grange is registered to provide accommodation for up to 64 people who require nursing or personal care. At the time of our inspection there were 32 older people living at the service. People required a mixture of residential and nursing care. The building provided single rooms with en-suite wet room facilities. The ground floor had a lounge area, garden room and dining room. The garden room and dining room had level access into a secure garden. Two specialist bathrooms were available, a treatment room and sluice area. Other amenities included a library, hair and beauty salon and cinema.

Homefield Grange is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

The home had a registered manager. 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.

Medicines were ordered, stored, administered and recorded safely. One person had not received medicine for their bowels in line with their care plan. During the inspection this was investigated and actions taken to avoid a recurrence. When people were able to administer their own medicines risk assessments had been completed and reviewed regularly to ensure their safety. People had their risks assessed and reviewed regularly and staff understood the actions needed to minimise avoidable harm. Staff had completed infection control training and understood the actions needed to protect people from risks associated with infection control. Risks were discussed daily with the staff team which included reflective practice when things went wrong. People were supported by enough staff who had been recruited safely and trained to identify any signs of possible abuse and the actions they needed to take if they had concerns.

People had care and support plans that detailed their assessed needs and respected their individuality. Technology and equipment such as call bells and alert mats were available to support people's safety and independence. Staff had an induction, on-going training and support that enable d them to carry out their roles effectively. People had their eating and drinking requirements met and were provided with a menu that offered a range of choices at each meal time. Both care and catering staff were aware of people's likes, dislikes, allergies and specialist diets. The home had developed good working relationships with other

professional agencies enabling positive outcomes for people when receiving care. When people needed access to healthcare they were supported by the service with both planned health check-ups and unexpected health issues.

All areas of the home were wheelchair accessible and any equipment people needed to help keep them safe or maintain their independence was available and in good working order. Signage had been placed around the home to help people orientate themselves independently.

People had their rights and choices respected in line with the principles of the Mental Capacity Act. When people were assessed as unable to make a specific decision these had been made in their best interest with the involvement of family, friends and health and social care professionals.

People and their families described the staff as kind and caring. We observed positive, friendly, patient interactions with people and the staff team and saw that people were treated with dignity and respect. Staff had a good knowledge of people and how they were best able to communicate which enabled people to share their views and be involved in decisions about their day to day care.

People and their families had been involved in initial assessments of peoples care and support needs. Staff had a good understanding of how people needed to be supported and the choices they made about their care. People had an opportunity to discuss their end of life wishes which respected their individuality. Assessments and care plans were reviewed monthly and any changes were communicated effectively to staff which meant people's changing needs were understood and met.

The culture and communication systems promoted inclusion of people, families and the staff team who all spoke positively about the management of the home. Staff had a clear understanding of their roles and responsibilities and worked together as a team to drive improvements. Achievements and areas of improvement were discussed with staff and provided opportunities for reflecting on practice, learning and supporting sustainability. Information was shared with CQC and other statutory agencies in line with legal requirements.

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 supported by staff who had been trained to recognise signs of abuse and understood the actions needed if abuse was suspected.

People had their risks assessed and actions were in place to minimise the risk of avoidable harm whilst respected peoples freedoms and choices.

People were supported by enough staff who had been recruited safely.

Medicines were ordered, stored, administered and recorded safely.

People were protected from avoidable harm as processes; systems and training were in place to manage infection control.

Communication systems were in place that provided opportunities for reflective practice and learning which supports sustained quality improvements.

Is the service effective?

Good

The service is effective.

People had their needs assessed and choices assessed and care is provided in line with current legislation and best practice guidance.

Staff completed an induction and on going training that provides them with the skills to carry out their roles effectively.

People had their eating and drinking requirements met.

Working relationships with other agencies supports positive outcomes for people.

People were supported to access health care for planned and unexpected health events.

The building, design and decoration met the needs of people and promotes independence.

People are supported with their rights and choices in line with the principles of the Mental Capacity Act.

Is the service caring?

Good

The service is caring.

People were supported by staff who are kind, caring, patient and emotionally supportive.

People were able to express their views and be involved in decisions about their care.

People had their dignity, privacy and independence respected.

Is the service responsive?

Good

The service is responsive.

People had their care needs assessed which create person centred care plans that recognise people's individuality, relationships and interests.

People had been given information on how to make a complaint and felt listened to when they raised a concern.

End of life plans reflected people's wishes and cultures.

Is the service well-led?

Good

The service is well led.

The culture of the service was positive and transparent providing opportunities for people, families and staff to feel included and empowered.

Staff had a clear understanding of their roles and responsibilities and had their achievements recognised.

People, families and staff were involved in the development of the service and felt listened to and positive about the future.

Audits and feedback were used effectively to drive improvements and ensure improvements were sustained.

The service worked in partnership with other agencies to

improve outcomes for people.

Homefield 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 checked 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.

The inspection was carried out on the 30 November 2017 and was unannounced; it continued on the 1 December 2017 and was announced. It was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of care service. The expert had experience with older people and people living with a dementia.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners and safeguarding teams to gather their experiences of the service.

The provider was not asked to complete a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with 10 people who used the service and 11relatives. We spoke with the regional director, quality manager, registered manager, deputy manager, two nurses, three care workers, two activities staff, the chef, hostess, receptionist, administrator and housekeeper. We reviewed seven peoples care files and discussed with them and care workers their accuracy. We checked four staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

Is the service safe?

Our findings

When we last inspected the service in July 2017 we found a breach in regulation in relation to safe care and treatment. People had not been protected from the risk of avoidable harm and medicines had not been administered safely. At this inspection we found that improvements had been made and the service was no longer in breach of regulation.

People had their medicines ordered, stored, administered and recorded safely. Some people had been prescribed a laxative for as and when needed. A monitoring system was in place to record bowel movements and support nursing decisions to administer a laxative. We found that the system had not been effective for one person. The MAR stated the medicine needed to be administered if the bowels had not been opened for three days. Records showed us the person had not had their bowels opened for 13 days. We discussed this with the registered manager who took immediate action to correct this. This included organising a meeting with nursing staff to discuss what had gone wrong and lessons learnt. Risk assessments had been completed for people who were assessed as able to manage their medicines independently. One person explained "I have meds in my room but they (nurses) do check every day that I have done it properly". Some people needed topical creams administered. A care worker explained "There is a body map for each cream detailing where to apply and then we sign a MAR (medicine administration record) sheet". Nurses were able to explain the actions needed if a medicine error occurred.

People and their families described the care as safe. One person told us "The staff are very good and look after me". A relative said "The staff respond really quickly if the panic button goes. There's no fluster; it doesn't affect clients". Staff had completed training and understood what types of abuse people could be at risk from, what signs to look for and the actions they needed to take if they suspected abuse. People were protected from discrimination as staff had completed training in equality and diversity. We observed interactions between staff and people that respected people's individuality.

People's risks had been assessed and plans developed to ensure that they received care which minimised the risks of them coming to harm. Some people had risks associated with choking or malnutrition. A dietary sheet had been introduced that contained information on each person and detailed any risks and the actions staff needed to take. The sheet was reviewed weekly or if changes happened and was shared with the catering team and beverage hostesses. A hostess told us "The diet information is changed weekly or if anything happens. It's always right up to date". One person who had a swallowing problem said "I have a thickener in my tea; it stops me from gulping and choking". We read in a care file that one person had been losing weight and a referral had been made to a dietician. Another had been prescribed a food supplement twice a day and records showed us this was happening.

Some people were at risk of skin damage and had air pressure mattresses on their beds to help protect their skin from pressure damage. We checked settings and they had been set correctly matching the person's weight. An electronic system had been introduced to alert nursing staff that the mattress setting required checking each day. Other measures included changing people's positions regularly. One person told us "They wake me regularly at night to turn me".

Some people were at risk of falls. We read one care file where a referral had been sent to a specialist fall team who had carried out an assessment and identified an underlying health condition that when treated reduced the risk. Other actions had included using alarm sensors which alerted staff that a person had stood up and needed support.

One person had behaviours that placed them at risk. Their family told us "The staff are quite insightful. They have a good idea of how to roll with (relatives) behaviour. Some behaviours may put them at risk but she is safe".

We spoke with staff who had a good knowledge of the risks people lived with and understood their role in reducing the risk of harm. A resident at risk form was reviewed weekly and discussed with staff daily at shift handovers.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

People were supported by enough staff who had been recruited safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults. One relative told us "There has been some improvement with staffing over the last six months; there are more staff and they are staying longer". A care worker explained "We work well as a team and I feel confident with staffing". The registered manager told us that they were recruiting over the level of staff assessed as needed in preparation for an increased number of people living at the home.

People were protected from risks associated with infection control. Staff had completed infection control training and we observed them wearing gloves and aprons when needed. The home was clean and odour free. Infection control audits were completed quarterly and had been effective in monitoring infection control standards and driving improvements. Staff had completed food hygiene training and the service had a five star food rating.

Processes were in place to support learning and improvement when things had gone wrong. An example was a medicine audit that highlighted that medicine had not been disposed of correctly. A group supervision had taken place to discuss the correct procedures for medicine disposal.

Good

Is the service effective?

Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. Care was delivered in line with current legislation, recognised professional standards and good practice guidance. Technology and equipment was available that increased people's independence and safety. Examples included sensory alarm mats for people at risk of falls and a call bell system that enabled people to call for assistance whenever needed.

Staff had received an induction and on going training specific to their roles which enabled them to carry out their roles effectively. We spoke with a care worker who told us about training carried out by a community mental health nurse specifically related to challenging behaviours presented by a person living at the home. They explained "We had advice on how to approach things differently. The training left us with the necessities for the (person)". People and their families described the staff as well trained. One relative told us "The nurses are very professional and kind". Another told us "They (staff) are absolutely brilliant. (Relative) needs a hoist and wheelchair. At night (relative) gets restless but they cope very well with (relative)". Nurses had opportunities for updating clinical knowledge. This had included wound management and continence management.

Staff told us they felt supported in their roles and this included supervision with a senior member of staff and an annual appraisal. Staff had taken opportunities for professional development which included level 2 and level 3 diplomas in health and social care.

People had their eating and drinking requirements understood by the care and catering teams. The registered manager explained "Resident dietary forms have been introduced and includes information on special diets, fluid consistency of beverages, what level of assistance the person requires and the information is reviewed weekly or sooner if any changes". We spoke with a hostess serving mid-morning drinks and snacks who told us the dietary information had been a great success made their job easier. One person's swallowing had been reassessed and we saw that changes had been shared at the shift handover and incorporated onto the resident dietary form. People and their families all described the food as good. One person told us "The food is good and they will do you something else if you don't fancy what is on the menu". A relative said "The food in wonderful and (name) eats better if somebody is with them. They have put on weight and although they walk non-stop the weights maintained". Menus offered choices of hot and cold snacks at each meal time. Snacks were available throughout the day and night. The chef told us "One person is at hospital today and requested a packed lunch". We read an entry by night care staff where one person had been hungry and had cheese and biscuits in the middle of the night".

Working relationships with other professional agencies supported positive outcomes for people when receiving care. Examples included working with dieticians to ensure people's swallowing risks are assessed, understood and managed effectively. Working with GP's to ensure people have their medicines reviewed to ensure they meet their changing health needs. One person had been visited by the community mental health team and the care staff were completing a seven day monitoring chart recording the person's

behaviour. This was to enable the community mental health professionals to review the person's behaviour, any triggers and plan appropriate interventions.

People were supported to maintain their health and had timely access to healthcare when needed. One person was on a short stay at the home and explained how they had needed a temporary GP as the home was too far from their own GP surgery. They told us "I needed a (medical assessment at hospital) and the deputy wrote a letter to the covering GP practice. Wasn't that great; they haven't let it slip".

The environment provided opportunities for people to access communal areas, private areas to meet with family and friends and accessible outside space. All areas were wheelchair accessible including en-suite shower rooms. One relative told us "Equipment in the shower is fabulous". Signage in word and pictures had been used to help orientate people independently around the home. Examples included images on people's bedrooms doors of hobbies and interests such as a favourite pet or football team.

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. 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.

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 found that the service was working within the principles of the act. Mental capacity assessments had been completed for people and DoLs applications had been submitted to the local authority. We saw that best interest decisions had been taken for people and had included input from staff, families and health and social care professionals. Staff had completed MCA training and had a good understanding of the legislation and how to put it into practice when supporting people. Some people living at the service were not all able to express their consent verbally. Staff told us of communication tools used to help people express how they felt and the different non-verbal ways people expressed themselves. A care worker explained "(Name) is not able to verbally consent. If I'm drawing a bath I run the water and then show her. If (name) fancies it they will walk in and if not walk away". Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf.

Good

Is the service caring?

Our findings

People and their relatives described the staff as kind and caring. One person told us "The staff are kind, understanding and we have some fun. They listen to what I have to say; I'm a great talker". Another told us "I'm just back from hospital. I prefer it here with people (staff) who I know and they know me". A relative said "Staff are insightful and good. There is positivity about how they treat (relative) which raises (relatives) mood". Another relative told us "The staff always give me such a lovely welcome. When it was our wedding anniversary they made a real fuss; it was lovely". Another explained "Staff volunteered on their day off to bring (relative) home to see us. They went above and beyond".

We observed friendly, warm interactions between people, their families and the staff. We observed one care worker offering a drink to a person. They asked a person if they were well and gently hugged them. Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. We heard conversations taking place about families, animals and TV programmes. One family visited who had recently had bereavement and staff spent time offering them emotional support.

Throughout the inspection we observed staff explaining their actions to people, giving people time and listening to what they had to say. Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example talking with people at eye level and using hand gestures and facial expressions.

People were encouraged to share their views and be involved in decisions about their care and support. We read a daily care file entry that provided an example. It explained how a person had decided to spend a little longer in their room that day. People had their cultural differences understood and respected. One person told us "I was surprised there was no form of Christian worship at any time and I feel it's essential. The manager said we can put that right and within an hour they were in touch with the local vicar and he starts visiting in January".

People who needed an independent representative to speak on their behalf had access to an advocacy service.

People had call bells in their rooms if they needed to call for staff to help them. We observed staff popping in and out of rooms throughout the day of our inspection checking whether people needed anything and having a quick chat.

People told us that staff respected their privacy and dignity. One person said "They (staff) always knock on the door and are very polite". Another told us "There is always courtesy". Another said "They (staff) are great; they respect my dignity but with a bit of a laugh". A relative told us "Everybody treats (name) as an individual person. Everyone knows (relatives) name". Confidential information was stored in a locked cupboard or stored on password protected electronic devices.

Good

Is the service responsive?

Our findings

A formal process for involving people and families in planning and reviewing care and support was not in place but due to be implemented. The registered manager told us "The plan is that each family will be able to log into care plans electronically". People and their families had been involved in planning care and support when initial assessments had been completed. One person told us "When I came here I filled in all sorts of forms such as my end of life wishes". We found examples of involvement in decisions at times of significant change. One example was a family involved in decisions about a relative requiring the support of one care worker most of the time.

One relative described how care staff had been responsive to change. They explained "Staff recently recognised a deterioration as (name) has started not to always be able to use their knife and fork or know how to dress".

Care and support files included details about the person's history, interests, people important to them and significant events in their lives. When we spoke with staff they demonstrated a good knowledge people past employment, war time experiences, family celebrations and events. Activities and conversations reflected people's individuality. A care worker told us "(Name) loves sport and so do I so we spend one to one time talking sport especially the snooker". They went on to say "I was talking to another person and they told me they love darts so we now have a darts board".

Activities were planned seven days a week and displayed on a monthly activity planner. We observed arm chair exercise, quizzes, music and word games. Other activities had included indoor basket planting and making bird boxes for the garden. One person told us how they had enjoyed making Christmas decorations earlier in the week. Another told us "We have sing songs and we play games. I couldn't help put up the decorations but loved watching other people putting them up". Some people spent their time in their rooms. The activities co-ordinator told us they try and see everybody every day. They said "(Name) doesn't make conversation but loves us and will smile and laugh when you talk with her". A relative told us "The activities have improved; there's more singing and music and it seems more organised". We observed people enjoying a private meal together with their families and friends.

A mini bus was available and recent trips out had included going and looking at the Christmas displays and going to garden centres Links with the community included a local church choir, the local Brownies and a pet therapy visiting service.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government ombudsman. Since our last inspection there had been two recorded complaints and we could see these had been investigated in line with policy and reached satisfactory outcomes.

People and their families told us they felt listened to and confident if possible actions would be taken to put

things right. A relative told us "We had a complaint to make and (relative) made the complaint to (registered manager). You could see she was taking it on board". We spoke with the Head of Housekeeping who told us people had complained about the laundry service and garments going missing. They told us "We tried various laundry pens but the problems continued. I attended a resident meeting and put a suggestion forward for using a net wash bag system which residents agreed worth trying. Pleased to say it's going really well". This was confirmed when a person told us "When I first moved here we had problems with the laundry but now it's marvellous".

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted. We spoke with a relative who explained "We have a warm relationship with the staff. Staff took us to one side and explained the medicine in place (for end of life care) if it was needed to keep (relative) comfortable".

Good

Is the service well-led?

Our findings

When we last inspected the service in July 2017 we found a breach in regulation as systems and processes were not effective in monitoring that legal requirements were being met. At this inspection we found that improvements had been made and the service was no longer in breach of regulation.

The registered manager explained why improvements would be sustained. "The culture before was nobody knew what the outcome of the last inspection was or aware of the action plan; there was no feedback. This time all staff were spoken with about the warning notices (enforcement action), and also we shared this with residents and relatives. We now have a Heads of Department monthly meeting. It includes audit information and actions from the CQC inspection. Each department is given an action plan which is monitored closely." A staff member told us "Head of Department meetings are brilliant. She (registered manager) listens and we try new things. If they work we keep it and if not try something else". Sustainability meetings were being held monthly to ensure improvements were maintained and included nurses and senior care staff. We spoke with a relative who told us "Staff seem more motivated, empowered. There's a greater will to get things to a good standard".

People, their families and the staff team consistently spoke positively about the management of the home. One person told us "(Registered manager) had made a difference. Systems, structures, training of staff and communication with us has all improved". A care worker told us "The new manager is quite approachable, always happy and eager to help". A relative said "(Registered manager) is very efficient. Always there to listen. She comes and chats with (relative) and seems well liked".

The registered manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

A range of processes were in place to promote good communication which included daily staff handovers, a range of staff meetings, relative and resident meetings, and information shared on noticeboards such as the last CQC report and the homes vision statement. Staff understood their roles and responsibilities and were clear about their level of decision making. Achievements were discussed at team meetings to support positive learning and service development. A staff member of the month scheme had been introduced and people, relatives and staff had a vote and the winner had their photo on the noticeboard. It had been awarded for 'Incredibly hard work and supportive to new staff'. We spoke with a care worker who had been successful the previous month. They told us "It was for extra detail to care I have given. Things like helping people with makeup and hair plaits".

People and their families felt involved in the service. One relative told us "(Registered manager) has talked about staffing at relatives meetings and talked about the homes strengths and weaknesses and explained the changes they have put in to effect". The registered manager told us that resident and relative meetings took place bi-monthly and the residents and their families chose the time. Every person and family received

a copy of meeting minutes. One relative told us "We get the minutes of the relative and resident meetings. They seem thorough and constructive". Another relative told us "They (service) are conscientious about keeping us up to date". One person told us "(Registered manager) is very receptive and will sit with people and listen". Another said "(Registered manager) is very efficient. Always there to listen. She is very well liked".

Audits were carried out by the regional manager, quality manager and the registered manager and were used to drive improvement and provide oversight of what was going well and the areas for improvement. Action plans were clear, detailed who was responsible and monitored which had led to improvements in meeting legislation. .When things had gone wrong reflective practice meetings had taken place to examine why and put actions in place to avoid a recurrence. The quality manager explained how a medicine audit had shown stock discrepancies. They told us "We investigated why and found a technical issue between the pharmacist's computer and ours. We met with the pharmacist and this has now been resolved".

The service worked in partnership with other agencies to improve outcomes for people using the service. An example was the home working with the ambulance service, health authority and hospitals to introduce a scheme that ensured a seamless transition for people between services.