Life Style Care (2010) plc

Blandford Grange

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Blandford Grange Care Home is a nursing home registered to provide personal and nursing care for up to 63 people, some of whom are living with dementia. At the time of our inspection there were 39 people living in the home.

The previous registered manager left in April 2014 and the manager who has been managing the home on an interim basis had started the process to become the registered manager at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found staff found staff were up to date with current guidance to support people to make decisions.

Staff were able to describe types of abuse and their role in reporting any concerns they had. This meant people were at a reduced risk of abuse.

Summary of findings

People and their relatives told us they felt safe. We saw that risks were managed effectively and included people's wishes. They also told us that if they were concerned about anything they knew how to raise concerns or complaints. Where people had complained these were responded to quickly and effectively and the information was used to improve quality in the home.

People were cared for by staff who understood their needs and were able to describe how they supported them. This meant people's care needs were met. For example, People received their medicines and other health treatments appropriately and had access to health care when they needed it.

Staff had the skills and knowledge to meet people's needs and we saw they were caring and treated people with dignity and respect. This meant that people and staff had good relationships and people took part in a range of activities that they enjoyed.

The culture within the service was focussed on people as individuals and open communication was encouraged. There was a clear management structure and staff, relatives and people felt comfortable talking to the managers about any issues and were sure that any concerns would be addressed. There were systems in place to monitor the safety and quality of the service provided.

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

The service was safe because staff were trained and risks were managed, however we found areas that required improvement. We found the location to be meeting the requirements of Mental Capacity Act and Deprivation of Liberty Safeguards. This helped to ensure people's rights were respected. However, some decisions about restrictions that kept people safe were not recorded in their care notes in a way that would make it easy to review decisions.

Staff were able to describe different types of abuse and knew what they would do if they were concerned about the welfare of anyone living in the home. This meant people were at a reduced risk of abuse. However, we saw a notification of alleged abuse had not been made to CQC.

Infection control processes were in place and the home was mostly clean, however, some communal areas had not been cleaned adequately.

People and their relatives told us they felt safe. We saw that risks that they faced were considered with them when possible and plans were in place to reduce these risks.

People received their medicines safely.

Is the service effective?

Good

The service was effective. People told us staff had the skills they needed to provide their care effectively. Staff were confident describing the care people needed and their preferences.

People had enough to drink and eat. Meal times were relaxed and the food provided took account of people's nutritional needs and their likes and dislikes.

People had access to health professionals when they needed them. We saw from records that people had regular input from health professionals such as GPs, district nurses and physiotherapists.

Some staff training was out of date. However, there were dates scheduled for training and the senior staff decided where they worked so that people always received care from a group of staff with the necessary skills and knowledge.

Is the service caring?

Good

The service was caring. The people and their relatives told us that staff were kind and caring.

Summary of findings

People and or their relatives were involved in decisions about the support they received and their independence was respected and promoted.

Staff were aware of people's preferences and respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive to people and their needs. People's care was provided in ways that took account of their preferences.

People took part in activities that they enjoyed. Activities were designed to be enjoyed by people individually and as groups. This meant that people were involved in meaningful activity during their day.

People and their relatives knew how to complain or raise concerns at the home about the service.

Information was shared effectively when people moved between services. For example, when people went into hospital.

Is the service well-led?

Requires Improvement

The service was well-led, however we found that not all allegations of abuse had been reported to the Care Quality Commission (CQC). The law says that allegations of abuse must be reported to CQC.

There was a new manager who was working as part of the team to develop the quality of care people received in the home.

There were systems in place to monitor the safety and quality of the service.

There was learning from accidents, incident and investigations into allegations of abuse.

Observations and feedback from people, staff and relatives showed us the service had a positive and open culture.

Blandford Grange

Detailed findings

Background to this inspection

We visited the home on 4 August and 7 August 2014. The inspection was unannounced and was the first inspection of this home since it registered with a new provider organisation in April 2014.The inspection was carried out by an inspector and a specialist advisor with nursing experience. We reviewed all 23 key lines of enquiry at this inspection. These were the lines of enquiry we followed to come to our judgements about whether the service was safe, effective, caring, responsive and well led.

Before the inspection we checked the information that we held about the home. This included notifications received from the provider. A notification is information about important events which the service is required to send us by law. We reviewed the Provider Information Record (PIR) . The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern. We also reviewed information we had received about this home from members of the public.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

'The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

During our inspection we observed how the staff interacted with people and their families and with each other. We looked at how people were supported during their lunch and we used the Short Observational Framework for Inspection (SOFI) in one of the communal lounges. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also reviewed a range of care records relating to the care of nine people and records about how the home was managed. These included staff files, training records, the complaint records and policies and procedures.

We spoke with four people and five visiting relatives. We also spoke with the manager and 12 other members of staff.

After the inspection visit we spoke with two healthcare professionals with involvement in the care of people living in home.

Requires Improvement

Is the service safe?

Our findings

Staff told us what they would do if they thought someone was at risk of abuse, described different types of abuse and how they might recognise them. Staff were aware of whom to report concerns to within their organisation and when they needed to contact other authorities with responsibility for safeguarding. We also spoke with the manager about safeguarding and saw they had made appropriate referrals to the local authority. However, we found one potential safeguarding incident that had not been notified to CQC. There is a statutory duty to report alleged abuse to the CQC. Training records showed the majority of staff had current training in protecting vulnerable adults. The manager explained that training was part of a rolling program and staff who had missed this training update would attend the next possible training.

Infection control measures were in place and the home was mostly clean although there were some communal areas that had not been cleaned adequately. The manager told us there was currently no lead for infection prevention and control within the home. However, all staff we spoke with were aware of their responsibilities and had recent training in infection control. There were infection control policies and procedures in place for processes such as catheter care and pressure ulcer care.

We saw cleaning equipment was colour coded for each area in line with NHS Cleaning Manual guidance and there were specifications and schedules in place for cleaning. Most of the home was visibly clean however some parts of communal areas including a handrail were not clean and there was a risk that this would result in people not being protected from cross infection of healthcare related illnesses. The laundry was purpose built and contained all the equipment staff needed to follow safe infection control processes. This was mirrored elsewhere in the home, for example the sluice areas were clean and equipment such as commodes and hoists were clean.

Staff had an understanding of how the Mental Capacity Act 2005 affected their day to day work and talked with confidence about how they encouraged people to make decisions. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff also understood how dementia could affect people's ability to make decisions in a variable way. For example, one member of staff explained that some people living in the home could make decisions more easily earlier in the day. Records reflected people's capacity to make decisions and best interest decisions were recorded when people could not consent to their care. In most best interest decisions we looked at these had been done in a way that reflected good practice because they included people who knew the person well and had regard to the person's preferences. However, we noted that the number of people involved in these decisions varied and in some cases they had been made solely by staff in the home.

Staff also knew about the Deprivation of Liberty Safeguards (DoLS) . These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. DoLS can only be used when there is no other way of supporting a person safely. The manager spoke with us about the impact of a recent Supreme Court judgement that had extended the definition of DoLS. They had made the appropriate applications to the supervisory body responsible for granting authorisations. However, the decisions related to these applications were not always available.

People and their relatives told us that they felt safe and well looked after. Due to complex health needs some people were not able to tell us about their experience of care. Therefore we spent time observing people and saw that staff were working in reassuring and validating ways designed to help people feel safe. For example we saw a member of staff speaking quietly to a person with dementia about their hobby at a time during which they could have become anxious.

People were involved in activities they enjoyed and the risks associated with these and their day to day lives were managed with respect for their preferences. We saw that risk management measures such as checks by nursing staff and appropriate equipment were in place. Staff described the risks people faced . For example, staff described both the risks associated with someone's mobility and the methods and techniques they used to keep the person safe. They also described how the person liked to be spoken with at these times and how important this was for their dignity. We saw staff supporting the person and saw that the support was undertaken as described. Care

Requires Improvement

Is the service safe?

records showed that risks were assessed and reviewed regularly. Risks were clearly identified and what staff needed to do to minimise these, whilst respecting the persons dignity and choices, was clear.

We saw that staff were busy but they were able to take time to talk with people and were not hurried. The manager told us there had been recruitment difficulties. We looked at the rota and saw the use of agency was reducing alongside a recruitment programme. The manager explained that staffing levels were set to reflect people's needs and that these levels were being maintained using agency staff and senior staff when necessary. The domestic staff were trained to provide care and they and senior staff worked alongside care staff if staff were unavailable at short notice. One member of staff said: "It is much better. People always have the care they need." We saw one person who was at a high risk of falls had been identified as needing a staff member with them at all times when they were not in bed and there was an extra member of staff available to do this. There was a registered nurse on each floor of the home during the day time and one registered nurse covered both floors at night. We also heard from the manager and senior staff that decisions about where people worked was informed by their skills and knowledge.

A nurse had the main responsibility for medicine management. They explained the processes for ordering , receiving, storing and disposing of out of date or no longer used medicines. Medicines were stored safely. For example, medicines that required refrigeration were stored in medicines fridge and controlled drugs (CDs) were stored in a locked cupboard and recorded in the CD register as required. The nurses giving medicines were assessed as competent to do so and we observed a nurse giving medicines safely and recording their administration accurately.

The needs of people who required their medicines to be hidden from them so they would take them were met safely. We saw three care plans had a documented process for best interest decision making in relation to the covert administration of medicines. There was also a process to document should the service user refuse or accidently destroy covert medicines. People were receiving their medicines safely, however, the home had a medicines policy dated the 13 Sept 2011 and as such it did not fully incorporate the latest best practice guidance from NICE (National Institute for Health and Care Excellence) on medicines in care homes.

People were safe because the premises and equipment were well managed and checked regularly. We spoke with the member of staff responsible for this and they showed that all equipment and premises checks were up to date. They kept well-ordered documentation that meant it was easy to check when services had happened. They also did this for checks and practices related to fire safety.

Good

Is the service effective?

Our findings

People and their relatives told us that the staff had the skills needed to provide care. Staff spoke with confidence about the needs of the people living in the home. The care staff described people's needs and how they were best supported in detail and in respectful terms. The care staff knew people well and newer members of the team told us that more experienced members shared their knowledge with them. One said: "I'm proud of the team. I think they are doing a great job."

Staff received regular supervision. These covered practice issues and focussed on their development. Staff told us that the training they received helped them understand their work better and encouraged their own development. For example, one staff member told us about specialist training they were undertaking in palliative care and other staff spoke about the positive impact of dementia training on their work. We looked at the training records for the home and saw that most staff had current training in all the topics the manager deemed necessary. This training included moving and handling, first aid, dementia awareness and challenging behaviour. All staff had received induction training, however some staff were overdue refresher training. The manager had identified this within the PIR and we saw that training updates were happening regularly. We spoke with the manager about the possible impacts of staff not having their refresher training. They explained that where staff worked within the home was based on their knowledge and skills and this meant that people's care was not impacted upon if staff missed a refresher training session. We observed people receiving care from competent staff throughout our inspection.

People were supported to have sufficient to eat and drink. We saw that people were assisted with drinks throughout the day and all the staff we spoke with were aware of the importance of people staying hydrated. Care records included regular assessments related to weight loss and risks of malnutrition. We asked staff about people's nutritional needs and they knew which people had specific dietary needs and how people's diets changed. Staff worked with kitchen staff to make sure people had food they needed and liked and care records reflected what staff told us. For example, we saw that someone was no longer on a food chart after their appetite had improved and they had gained weight. This showed that their care needs were being reviewed and all the staff involved in their care were aware of the changes. We spoke with the chef who explained they always served the food and talked with people to find out about their likes and dislikes. They had recently passed an intermediate food hygiene course which meant they had good knowledge about ensuring safe food preparation. We observed people eating lunch in the upstairs dining room. Staff sat with people and supported them to eat. They did this respectfully and paying attention to the person they were supporting. One person commented that the food was, "not my sort of food", and they were immediately offered an alternative.

People had regular access to community health professionals and their input was incorporated into care plans. One person said: "The nurse comes in a lot and if you need a doctor they will get you one." A relative told us that the chiropodist came in regularly for their relative. We saw that some people did not have dental visits recorded. The manager said that dental care was not in place for everyone but they would make sure they were seen in an emergency. We saw in one person's records that they had developed an urinary tract infection. This had been identified promptly and the GP was contacted quickly. The staff monitored the person's drinks to make sure they were drinking enough to help treat the infection. Another person had changes made to their care plan following a review by the diabetic nurse. This included input from a dietician and changes to the person's diet. This meant people got the support they needed to maintain or manage their health.

Care plans included information about people's health needs. For example, we saw in care records that people's personal hygiene needs, continence, and pain control were all regularly reviewed and changes made when appropriate. Risk assessments were also undertaken to support health. For example a Waterlow risk assessment was carried out for all service users. This assessment took account of various risk factors to help staff plan how to support people and their pressure area care. We looked at three people's pressure care mattresses and saw they were in place and on the right setting.

The care was planned in ways that reflected current best practice and that input was sought from health professionals such as dieticians and physiotherapists. For example we heard from nurses and saw from records that that pressure ulcer care was delivered in line with the most

Good

Is the service effective?

recent NICE guidance and that professional support from a tissue viability nurse was sought appropriately. We also saw that diabetes care was delivered in line with NICE guidance. The nurses told us that they had appropriate training and we saw in two care records that people's needs relating to their diabetes were reviewed monthly.

People's general health was routinely monitored by the registered nurses and care staff. Care staff told us that they referred any changes in a person's well being to the nurses straight away. Some people were on frequent monitoring programmes for temperature, pulse and respiration and blood pressure. All others had routine monthly monitoring observations and the care files we looked showed that this was maintained. Referrals had been made to people such as dieticians, speech and language therapists, and physiotherapists and their recommendations had been included in the care plans.. One health professional told us that they were always informed of changes in the well being of clients they visited in the home.

The people living in the home were older people and some had mobility difficulties and/or were living with dementia. The home had adequate storage for people's mobility equipment and bedrooms and communal areas were spacious and light. Technology was used to support people's independence, for example, sensors were used as a least restrictive way to ensure people's safety whilst encouraging choice and independence. There were boxes on the wall outside people's bedrooms which contained pictures and things that were meaningful to them. For example, pictures of the town they grew up in or objects related to their family or work. These were designed to help orient people with dementia and also provided staff with reminders of the individual life and aspirations of the person living in the room. Other necessary provision such as the laundry , bathrooms and treatment areas were accessible and designed to support good care.

Good

Is the service caring?

Our findings

Staff were respectful and kind towards people. People's experiences and skills were valued by staff who spoke with people about their lives and the people who mattered to them. We saw for example, a person waiting to be seen by the nurse before a trip out. A member of care staff stayed with them and talked gently about their hobby in a way that showed they valued the person's interests and skills. Relatives commented on the caring nature of the staff team. Comments included: "They have endless patience."; "I have a sense that (name of relative) is liked. That is important." And "The carers I know are excellent. They genuinely seem to be nice to (name of relative) and like them. They speak of them fondly."

People were encouraged to express their views and relatives were consulted about decisions when appropriate. We spoke with relatives about their involvement in people's care. They told us that they felt listened to and we saw from records they were involved in most best interest decisions made about people's care. Where people didn't use words to communicate, information was gathered about their preferences and used to inform their care plans. Individual needs were considered alongside the needs of the group. For example, we saw one person did not like background music but other people did so the music was playing at a volume that they couldn't hear due to hearing loss. One person told us that the staff asked them what they wanted and another told us that they were asked to take part in activities they had told the staff they enjoyed. Care staff described how people were encouraged to take part in activities. One member of staff told us that a person had just told them they wanted to go to the seaside and they would share this with the team at handover and make sure that it happened.

People's privacy and dignity were promoted. Sometimes the effects of dementia caused people to behave in ways that could be difficult or upsetting for other people in the home. We observed staff anticipating this and using distraction techniques and their knowledge of individuals' preferences to avoid conflict. For example, one person became agitated and began to focus their attention on one other person. Care staff were quick to sit with the person and begin a conversation about a topic they knew would distract them. Staff then involved the other person in the conversation. This supported the relationship between the two people and promoted their dignity within this relationship. We also saw that people's personal care needs were attended to in a discreet manner. Staff talked with people quietly and explained before they used mobility equipment or encouraged people to leave communal areas in order that personal care could be provided in a private space. People's care needs were never discussed in a way that others could hear.

Records relating to people's end of live wished were mostly generic and did not include the personal details about who people would like to be with them and how they would like their environment at the end of their lives. We spoke with care staff about this and they acknowledged that this was an area they were working on within the home. They described how they had supported people at the end of their lives and made sure they always had someone with them because they knew they wanted this. All the care staff we spoke to said they used their knowledge of the people they cared for to ensure they had appropriate support at the end of their lives. We spoke with the manager about end of life care. The home was working with in a national accreditation scheme that promotes good practice in end of life care. Staff were using this to support conversations with relatives that would inform the care people received at this time. We also spoke with the nursing staff who described how they used the local NHS pain team expertise as required.

Good

Is the service responsive?

Our findings

We spoke with people and their relatives about the care they received. We heard that the staff were responsive to changes in people's needs. One relative told us: ""(name of relative) waxes and wanes. They do respond." They were kept informed if there were changes in their relative's health and general wellbeing. Care plans included detail about people's likes and dislikes and described the support they needed. We observed that staff followed the guidance in the care plans whilst assisting two people with mobility. We also saw one person being supported whilst they were anxious as described in their care plan. However, we also spoke with one person, and their relative, who told us that not all staff told them when they would be getting support with personal care and this could make them feel anxious. They described feeling "ever so worried" about the timings of care although they acknowledged they didn't "have to wait long". The person and their relative explained that just giving them the information as to when things would happen alleviated the anxiety. We discussed this with the manager and they assured us that they would share this information with the team.

The care plans included the service user's social history, likes, dislikes, social, cultural and religious preferences. Care plans were reviewed on a monthly basis, involving professional support where required. For example we saw that a physiotherapist and dietician had been contacted and their input had led to changes in two people's care plans.

Other care plans included details where people required assistance with their personal hygiene care such as brushing their teeth, cleaning their dentures, brushing their hair, shaving, wearing spectacles and dressing. People who had additional needs and spent the majority of their day in bed were kept safe. Staff that carried out checks throughout the day at regular intervals and recorded them, in accordance with person's care plan.

People had access to activities they enjoyed. One person described going to see "the activities lady" and enjoying spending time socialising with other people. Another person spoke to us on their return from a day out sailing. This was an activity that had always been important to them and they told us that they valued doing this. We spoke with a member of staff who organised activities and they described how they focused on both individual and group activities. They also described how they provided feedback to the care staff if people enjoyed a particular activity. The activities coordinator showed us that each person had a care plan for activities. Activities were personalised and varied, such as receiving and having opportunity to discuss the content of a daily newspaper, trips out, and activities that promoted movement and flexibility. A member of care staff commented that activities and care were "far more person centred now... people aren't just sitting around getting bored."

Staff shared information through records and at handovers. The daily records tended to be very health focused and there was a risk that this could lead to information about how the person had spent their day, and what they enjoyed, being lost. However, care staff we spoke with were able to describe how they shared this amongst themselves verbally. We spoke with the manager about records and they identified that having more social care information recorded was part of some training that was already planned for the home.

Relative's told us they felt listened to and had a sense that any complaints would be handled effectively. One relative told us: "I am confident they take me seriously." We looked at the complaints records kept in the home and saw that three complaints had been received since January 2014. These had all related to housekeeping concerns and had been responded to individually in a timely manner. We spoke with the manager who described that they were addressing this as a theme by increasing housekeeping staff. Staff told us concerns were raised at staff meetings as well as individually if necessary to ensure that care improved as a result of concerns and complaints. This showed that the management analysed concerns and complaints and addressed the cause as well as dealing with issues as they arose.

There were systems in place to ensure information was passed between professionals and services. All care files included a section that recorded information that would be needed should a person need to be admitted to hospital. These were filled in but had space for the nurse on duty to add current information about their health and medicines at the time. These forms were designed to ensure that people would receive care in a way that met their needs if they needed to go to hospital. We saw in three people's care plans that information received when people had returned from hospital had been recorded and formed part

Good

Is the service responsive?

of the person's care plan on their return. We also spoke with staff about how they worked with health professionals who provided a service to people living in the home. They told us they shared information with other professionals and followed instructions given, which health professionals we spoke with confirmed.

Requires Improvement

Is the service well-led?

Our findings

We noted that an incident involving two people who lived in the home had not been reported to the Care Quality Commission. This was recorded in the incident records of the home but there was no record that the local authority or the care quality commission had been informed. The manager assured us that the incident had been reported to safeguarding. There is a statutory duty to notify the Care Quality Commission of all abuse or allegations of abuse. The manager acknowledged this omission and committed to sending the notification after the inspection.

The manager of the home had joined the team in April 2014 and planned to register with the CQC. Everyone we spoke with described them as having a positive influence on the home. A relative told us: "It is early days, but (manager) is out and about spending time with them." Another relative commented that "(manager) will go and sit and talk with them. That is nice." We saw that this was the case and noted the manager spent a sustained period with a person who had recently moved in providing reassurance about a concern they had.

Staff were confident in the new manager and told us that they were clear about what was expected from them and their colleagues. One member of staff explained: "(the manager) is part of the team." Another member of staff told us: "(manager) is lovely. I could go to them about anything." We observed that the manager was visible and approachable to staff, people living in the home and visitors throughout our inspection.

There was a staff meeting during our inspection. The manager ran the meeting twice to ensure that staff working different shifts were able to participate in discussions. We sat in on part of a staff meeting and saw that staff were confident to express their opinions and to discuss differing points of view. The discussion centred around changes to staff allocation that was the result of observations and discussions between the staff team about how people's care worked best and how to manage the skills and resources available to them. We saw the decision making process was clear with all staff contributing to the process and their voices heard. Outside of the meeting, two members of staff confirmed they had felt listened to. This showed that the manager based their decisions on the welfare of the people living there and they did this by promoting open communication.

We asked about how the provider or manager was improving practice. Staff said training was helping them provide high quality care. For example they spoke about the positive impact of dementia awareness training on helping them to understand people's behaviour. Staff described how they had time to discuss care and learn from each other. The manager told us more training was scheduled. Policies were reviewed in line best practice. For example the home used nationally recognised clinical procedures as a baseline for their procedures and had practice development nurses available to advise them from within the provider group. They were also involved in pilot work around quality in dementia care. We spoke with the lead health professional involved with this work and they told us that the manager was positive about the work and making improvements in care quality.

The provider had systems in place to monitor and improve quality. For example we saw that the home was working on an action plan following a recent monitoring visit undertaken by an area manager from the provider organisation. We saw that the actions identified were being addressed appropriately. Accidents and incidents were recorded and actions taken to reduce risks these identified.

Local health professionals were also available to advice on care and treatment and the manager and staff were working closely with the local health professionals.

Staff understood their responsibilities and accountability. We discussed professional accountability with care staff and nurses and they described how they would raise concerns or information with the manager.