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Homefield Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Homefield Grange on the 21 July 2017 and continued on the 27 July 2017 and this was announced. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 14 February 2017 had been made. The team inspected the service against two of the five questions we ask about services: is the service safe, is the service well led? This is because the service was not meeting some legal requirements.

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 36 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. The first floor in addition had a library area, a shop selling sweets, toiletries, cards and gifts, and a cinema. There was also a hair and beauty salon.

The service did not have a registered manager. A manager had been in post for two months and was in the process of registering with the Care Quality Commission. 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.

People were at risk of harm as actions needed to minimise identified risks had not always been followed. Risk assessments did not always reflect the current practice being followed by care staff which meant people were not consistently protected from the risk of harm. Information collected to monitor risk was not always used to support reviews and evaluations of on-going risks.

People were at risk of harm as medicines were not always ordered, recorded or administered safely. Information had not been made available to care staff to ensure the correct administration of topical creams. Storage and administration safeguards for prescribed controlled drugs had not always been applied.

Management quality systems and processes were not effective in identifying areas of improvement which meant risks to people were not always being monitored. When actions had been identified they had not always been completed which placed people at risk of harm.

Staff understood how to recognise signs of abuse and understood their role in reporting concerns. People were supported by enough staff and they had been recruited safely which included criminal record checks and obtaining references.

A new manager had been in post for two months and staff spoke positively about the impact they were

having on the service. Staff had been involved in setting values for the service and felt involved and appreciated.

Staff told us communication in the home had improved. Meetings had begun to be held with all staff teams and minutes had been shared with staff which identified actions agreed, who was responsible and a time deadline.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 not always safe.

People were at risk of harm as medicines had not always been recorded or administered safely.

People were at risk of harm as actions to minimise risks to people were not always implemented, monitored and reviewed.

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

People were supported by staff that had been trained to recognise potential abuse and understood their role in reporting concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality monitoring processes had not been effective in monitoring and improving service delivery or monitoring the effectiveness of the services action plan to meet previously identified breaches in regulation.

Staff spoke positively about the new manager and felt involved and enthusiastic about plans for the homes development.

Staff understood their roles and responsibilities and described communication as improving.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Homefield Grange on the 21 July 2017 and continued on the 27 July 2017 and this was announced. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 14 February 2017 had been made. The team inspected the service against two of the five questions we ask about services: is the service safe, is the service well led? This is because the service was not meeting some legal requirements.

The inspection was carried out by one inspector. 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.

During our inspection we spoke with three people who used the service and three relatives. We spoke with the manager, the regional quality manager, three nurses, six care staff, an agency care worker, the activities co-ordinator and chef. We reviewed five people's care files and discussed with them and care workers their accuracy. 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. We checked three staff files, care records and medication records, management audits, staff and resident meeting records. We walked around the building observing the safety and suitability of the environment and observing staff practice. After the inspection we spoke with a health commissioner about their experience of the service.

Requires Improvement

Is the service safe?

Our findings

When we last inspected the service in February 2017 we found a breach in regulation in relation to safe care and treatment. The provider sent us an action plan which detailed how they would reduce risks to people related to skin damage, malnutrition and administration of medicines. They told us that actions would be completed by 30 April 2017. We found at this inspection that improvements had not been carried out which meant people remained at risk of harm.

People at risk of choking were not having the risk effectively managed. One person had been assessed by a Speech and Language Therapist (SALT) and a safe swallowing plan was on display in their room. It stated the person required a soft diet when well and a pureed diet if unwell. For drinks it read 'No beakers or straws'. On both days of our inspection we observed the person being left with drinks in beakers with a straw and biscuits. Their care and support plan had been reviewed on the 10 June 2017 and stated 'straw and beaker at (persons) request'. We discussed this with the manager who agreed the person probably would not have had the mental capacity to understand the risks associated with swallowing and this should have been considered as part of the review. The plan was reviewed again on the 10 July 2017 and stated 'Normal consistency of diet and fluids and if deteriorates follow SALT plan'. The records contained no risk assessment, provided no instructions for staff to enable them to determine if the person was well enough to safely eat a normal diet and no reference to discussions with the SALT team about changes to the safe swallowing plan. We asked a senior care assistant how the person was supported with food and drink. They told us the person "Needs assistance to ensure somebody is with them as a risk of choking". They went on to say "A pureed diet, porridge, soaked cornflakes. It boils down to staff knowing (name); not the best way really. I know her well but the agency would struggle to know that". This meant that the person was at an increased risk of harm as information being provided to care staff was not kept up to date or detailed enough to ensure risks were minimised. We checked records in the kitchen and spoke with the chef who had been instructed by the care staff to provide a pureed diet. We observed care staff providing a pureed diet at lunch times. During our inspection the senior nurse spoke with the SALT team who confirmed they were happy for the person to use a beaker and straw if this helped with fluid intake.

People at risk of dehydration or malnutrition were not having the risk effectively managed. Food and fluid charts were being completed by care staff and checked by senior staff throughout the day. The minimum amount of fluid the person needed each day was recorded on the form. A senior nurse told us that any concerns about poor fluid or food intake was shared verbally at shift handovers but had not been recorded. This meant records did not provide details of how risks of malnutrition or dehydration were being communicated between shifts to ensure peoples risks were being effectively reviewed, monitored and any necessary actions taken. On the second day of our inspection we spoke to a night nurse who told us "Our reporting style has changed since the inspection began and it's now much clearer (handover sheet) about reporting risk".

People at risk of pressure damage to their skin were not having the risk effectively managed. People had their risk of skin damage assessed on admission to the service and where risks were identified actions were detailed in the person's care and support plan. Actions to minimise risk included people having specialist

pressure relieving mattresses on their beds. In order to offer protection to people the air pressure must be set according to the person's weight. We checked seven people's air mattresses and four had been set incorrectly. We discussed this with the manager who agreed the process for checking settings was failing. On the second day of our inspection the system had changed and had been added onto an electronic system which the nursing staff would monitor. One person's risk of pressure damage had been reviewed on the 13 July 2017 and the outcome had been that an air mattress was required. We checked the person's bed on the 21 July 2017 and this had not been actioned. We discussed this with the manager who immediately organised an air mattress. This person had been left at risk because this action had been delayed.

People at risk who had wounds were not having the risk effectively managed. One person had a wound related to a health condition. We checked the person's file with the manager and found no wound assessment had been completed. They agreed the file should have contained a skin integrity plan which included a wound chart. This meant information was not available to enable consistent and effective monitoring of the wound and treatment. We read that nursing staff had sought advice from the dermatology team and recorded the condition was improving.

People were at risk as their medicines were not always being administered safely. One person had been prescribed a medicine for as and when required (PRN) due to agitation. Their file contained two letters from the community mental health team one dated 16 May 2017 and the other dated 2 June 2017 containing different advice. The information in the second letter had not been used to review the information recorded on the Medicine Administration Record (MAR). The MAR stated the medicine could be given up to two times a day. We looked at the records for July and on one occasion the medicine had been given three times of which one had been a dose double what had been prescribed. A recommendation from the community mental health team read 'Management care plan – give paracetamol four times a day on a regular basis as there is sufficient evidence that this may help reduce agitation'. There was no PRN protocol in place that included this information or provided details to support decisions on when it was appropriate to administer the medicine. We counted the stock of this medicine and found a box that had not been recorded as being received into the home. When we calculated the number of tablets against the amount given we found seven tablets were missing. This meant that people were at risk of not receiving their medicines as prescribed by their doctor.

People were at risk of not having their topical creams administered safely. One person had seven creams recorded on the MAR. We checked creams in their room and found only two creams were in the en-suite. We were told by a nurse that three were out of stock and awaiting delivery. The MAR showed the three creams had not been signed as given between the 12 and 26 July 2017. One cream in the en-suite did not have a person's name on it. Another person had two creams that did not correspond with their MAR. Two creams were in the person's ensuite and on the MAR but had not been signed as given between the 12 and 26 July 2017. The nurse was not able to explain why this had occurred. A nurse told us that care staff applied the creams and then told the nurse who would sign the MAR. There were no instructions available for care staff describing how often the cream needed to be applied or where it needed to be applied. Some cream labels read 'As directed'. This meant that people were not being protected from the risk of deteriorating skin or health conditions due to prescribed creams not being managed and administered appropriately.

Some people had been prescribed controlled drugs which are medicines that require additional storage and administration safeguards than other medicines. We checked entries in the controlled drug record book and found one page were entries on the 14 June 2017 were unclear. The first entry recorded a stock of four, the second recorded a stock of three and noted 'Stock check one ampule broken during stock check' and recorded three, both entries had been signed by one member of staff and crossed out. The third entry

recorded 'stock checked and correct' and recorded four. The process for recording controlled drug incidents was on display in the medicines room. We spoke with the manager who told us the error had not been reported as in incident and they would investigate what had happened.

Risks identified for people in relation to skin damage and swallowing had not been consistently managed or actions taken in order to minimise the risks. People were at risk as medicine administration was not always carried out in a safe way.
This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their families told us they felt safe. One person needed assistance with standing and said "Staff help, I feel safe as they know what they are doing". A relative said "I feel the care is safe". Staff had received safeguarding training and were able to recognise signs of potential abuse and understood the actions needed if abuse was suspected.

People were supported by enough staff to meet their care needs. People told us that staff responded quickly when they pressed their call bell. A care worker told us "We have enough staff and if somebody is poorly we get an agency. There's been some new staff on nights which is great". We spoke with staff who told us they were able to work a variety of shifts to meet the needs of the home and included some night rotation. One person had increased risks associated with their agitation and additional staff had been organised through the day to provide 1-1 support. Staff had been recruited safely which included carrying out checks to ensure they were fit to work with vulnerable people. References had been obtained and verified and any employment gaps investigated.

Requires Improvement

Is the service well-led?

Our findings

When we last inspected the service in February 2017 we found a breach in regulation as systems and processes were not effectively monitoring and reducing risks to people related to their health and welfare. The provider sent us an action plan which detailed how they would meet the regulation. They told us that actions would be completed by 14 May 2017. We found at this inspection that improvements had not taken place.

The action plan included a named person auditing records daily to check correct administration of topical creams. We found this was not taking place which meant risks to people with skin conditions were not being effectively monitored. A weekly controlled drug medication audit was included in the action plan. This had not taken place which meant that safeguards in place to ensure the safe storage and administration of medicines had not been followed. We were told bi- monthly medication audits would take place but this had not been implemented. A medication audit had been completed on the 9 February 2017. No further medicine audits had been carried out until the 25 July 2017 after this inspection commenced. This meant that medicine errors that were placing people at risk of harm had not been identified as audits were not being carried out.

We read a care plan audit carried out on the 29 April 2017 that found one person had last had their assessment of needs completed on the 3 September 2015. An action had been set to reassess the person's needs. We checked the person's records on the 27 July 2017 and this had not taken place.

We discussed our findings with the Quality Manager who agreed auditing processes had not been effective in monitoring and improving service delivery. We read an audit they had completed in July 2017. It had identified areas that required improvement but actions that had been agreed with the home had regularly missed deadlines and been carried over to the next month. One example highlighted in April 2017 had been for residents at risk information to be sent to head office weekly. The audit record showed that this had only happened once in May 2017 and recorded no improvement for June 2017.

Systems and processes were not effectively monitoring and reducing risks to people related to their health and welfare.
This was a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had been in post for two months and was in the process of registering with the Care Quality Commission to become the registered manager. Staff spoke positively about the impact they were having on the service. One care worker told us "(Manager) is fantastic. They've only been here since May but are really good. There's more of a presence; much more on the floor. A hands on boss. If I had a concern I know something would happen". Another told us "(Manager) had done wonders; you can really tell the difference. We have high hopes. She talks to us and listens". This reflected the responsiveness demonstrated by the manager throughout our inspection.

Staff had been involved in setting a vision statement and spoke enthusiastically about the home's values. One care worker told us "We've all been involved in setting values. We all sat down and (Manager) asked us how we felt. One of the things we said is that it's a luxury care home but (person) likes walking around in their dressing gown. It's their home so why shouldn't they. (Manager) makes us feel more involved".

The manager had held meetings will all departments and staff teams and we saw that minutes of the meetings contained action plans that included the name of the person responsible and a time deadline. They told us "All the staff have access to the action plan and we discuss again at the next meeting". Positive outcomes from the meetings had been an increase in housekeeping from five to seven days a week and following feedback from relatives a room set aside to use to store unnamed clothes from the laundry.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The service was failing to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

The enforcement action we took:

We served a Warning Notice advising the provider they need to become compliant with Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 11 September 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The service was failing to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A)

The enforcement action we took:

We served a Warning Notice advising the provider they need to become compliant with Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 by 11 September 2017.