Care Quality Commission

Lawrence Care (Maids Moreton) Limited

Maids Moreton Hall

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

Overall summary

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 was 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 the Care Quality Commission (CQC) which looks at the overall quality of the service.

This was an unannounced inspection which meant the staff and provider did not know when we would be visiting.

Maids Moreton Hall provides accommodation and care, including nursing and respite care, for up to 60 older people, some of whom may live with dementia. At the time of our inspection there were 39 people living in the service.

Summary of findings

There was a registered manager in post. A registered manager is a person who has registered with CQC to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

People received responsive care from well-supported nursing and care staff. People and/or their relatives, were involved in reviews of their care and were asked for their view of the service through meetings and surveys.

Staff knew what people's care needs were and how they wanted them to be met. Staff had the necessary training to provide them with the skills they needed to provide appropriate and effective care. The process for the recruitment of staff was thorough and robust and protected people from the employment of unsuitable people to support them. People told us there were enough staff available to meet their needs promptly.

Staff knew what to do if they saw or suspected abuse was taking place and understood the requirements of the Mental Capacity Act 2005(MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments and best interest meetings had taken place as required under that legislation. The service was meeting the requirements of the DoLS.

Throughout our inspection we observed very respectful and relaxed interactions between people and the staff supporting them.

We received very positive assessments of the care provided by the service from GPs and other community health professionals.

The environment was clean and well-maintained. The first floor accommodation for people living with dementia had been improved by creating a dementia friendly dining and lounge area. This meant the facilities they needed were now easy for them to reach.

The registered manager and provider regularly assessed and monitored the quality of care. This included audits of medication and care plans to ensure they were accurate and up to date.

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?

Good

The service was safe. People's care plans identified potential risks to their health, safety and well-being and how these were to be managed or eliminated.

People were supported by staff who understood their responsibility to safeguard them from actual or potential abuse

People's medicines were managed and administered safely. Staff were appropriately trained and medicines were safely stored.

Is the service effective?

Good

The service was effective. People were involved with the assessment, planning and delivery of their care. Care plans were reviewed with their involvement and staff were supported and trained to understand people's needs and how they should be met.

People had access to guidance and support from specialist community health services, for example GPs and Dieticians. Staff monitored people's physical and psychological well-being and made sure support was in place to promote them.

People were encouraged to express their views and any concerns they might have through meetings which were arranged for them. They had access to appropriate activities within the service and local community.

Is the service caring?

Good

The service was caring. People were treated with respect, their dignity was protected and staff were seen to be encouraging and supportive of them.

People were encouraged to maintain their independence, interests and contact with family and friends. Relatives said they felt welcomed and the bar-bistro area was used as relaxed, informal area for social contact.

Formal reviews of care, meetings and periodic surveys of people and their relatives sought to ensure people were involved in and could influence the way their care and support was provided. Staff knew the personal preferences of people they provided support to and adapted the way this was done to meet them.

Is the service responsive?

Good

The service was responsive. Staff communicated effectively with people and with those responsible for them. They had good professional relationships with community health and social care professionals, for example, GPs, and

Sought any specialist advice needed promptly.

People were able to express their views about their care and staff sought to meet them. Care documentation included details of how people would like their care to be provided at the end of their life and staff received appropriate training and support for those times.

Summary of findings

There was a complaints policy and procedure in place. Complaints when made formally were responded to within an explicit timescale. People told us they found the service responsive to informal approaches when they had any concerns or issues about their care or the service.

Is the service well-led?

Good

The service was well-led. The registered manager, their deputy and the provider encouraged people to approach them informally. The service was open and made efforts to encourage people to feel able to contribute to the way it was run.

Staff said they felt well-supported by the management team. They were provided with the training needed to understand and follow policies and procedures to maintain an effective and safe system of care for people.

The management of the home carried out checks and audits on a regular basis to monitor the quality of the service. Where issues or concerns were identified, improvements were made where possible to address them.

Maids Moreton Hall

Detailed findings

Background to this inspection

The inspection team was led by an inspector, accompanied by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case they had experience of services for older people, including people who lived with dementia.

We carried out three inspections in 2013, two of which were in response to concerns raised with us. We did not identify any concerns at these inspections.

We reviewed the Provider Information Return (PIR) and previous inspection reports before the inspection and also notifications sent to us by the provider. The PIR contained information about the service from the provider. Notifications are information about specific important events the service is legally required to send to us.

Before the inspection we contacted 11 health and social care professionals who gave us feedback about the service. This included GPs, community dietician service, care commissioners and the local authority quality in care team.

During the inspection we spoke with 12 people, five relatives, 11 members of the nursing and care staff team, a member of the housekeeping staff, one kitchen staff, the registered manager of the service and a director of Lawrence Care (Maids Moreton) Limited.

We looked at six people's care records and the medication records for five people. We looked at three staff recruitment files and staff training and supervision summaries for all care and nursing staff.

We observed people in different parts of the service, for example lounges and dining areas. In the part of the home for people who lived with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

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.'

Is the service safe?

Our findings

People told us they felt the service was safe. One commented; "If it wasn't I would jolly well be out of here".

People said they felt staffing numbers were sufficient to meet their needs. Call bells were answered within two minutes during our inspection. People told us this was usually the case, although at night time it might be longer. Staff said the staffing levels were adequate.

Staff did not appear rushed and had time to stop and talk to people. Meal times were busy; however we saw staff were aware which people required additional support to maintain their safety. For example, some people received one to one support whilst other staff distributed meals to those who were able to manage for themselves.

The number of staff required to safely meet people's needs had been assessed by the provider taking into account numbers and the needs of people. The home, which became opened in October 2012, was not at full capacity as the number of people who lived there was intentionally being progressively increased over time. This enabled the staff team to be gradually built up and systems and procedures assessed to make sure they worked well. There was currently no use of agency staff, which meant people received support from staff they knew well and who knew them.

Staff understood the requirements of the Mental Capacity Act 2005(MCA) and the associated Deprivation of Liberty Safeguards (DoLS). These are important pieces of legislation which establish people's right to take decisions over their own lives wherever possible and to be included in such decisions at all times. They also establish people's right not to have their liberty restrained where there is a less restrictive way of protecting their best interests and safety. People's human rights were recognised, respected and promoted and this was supported through staff training.

The service was meeting the requirements of the DoLs. Care homes have to apply for authorisation when restrictions are placed upon people to keep them safe if they do not have the capacity to consent to those restrictions. Ten DoLS applications had been made with six of these agreed and in place at the time of our inspection.

One person living with dementia was monitored discretely when they visited their partner on a different floor. They were able to come and go as they pleased, however, whilst they were away from the dementia floor, the reception doors were closed and put to keypad operation for their safety and security. This procedure had been appropriately documented as being in their best interest in line with the MCA and DoLS.

Arrangements were in place to protect people from abuse. Staff had received safeguarding adults training. They told us what the signs of different forms of abuse might be and how to report it. They had access to policies and guidance on safeguarding, safeguarding training was included in staff induction and updated thereafter.

People's care plans included detailed assessments about potential risks to their health and safety. There was information about how identified risks could be eliminated or managed. Staff were able to tell us about how individuals 'care was provided to minimise identified risks to them and keep them safe. Assessments of risks had been kept under review and updated where necessary. This helped keep people safe if risks changed. Staff confirmed they used the care plans as the basis for the care provided. They recorded the care provided each day in the care plan, which helped identify if people's needs or risks to their health and safety had changed.

A system was in place to record and review incidents, for example falls. Risk assessments were then reviewed and appropriate action taken to reduce future risks to the person. In one case, for example, additional staff had been provided for a person when they moved from one place to another in order to reduce the risk of the person falling.

People's medicines were managed safely by staff. Storage was safe and records were kept of temperatures to make sure they were within the range recommended by the manufacturer. For some medicines this meant they had to be stored in a refrigerator. This was because the effectiveness of some medicines were reduced if they were stored above certain temperatures. Controlled drugs were stored and recorded in line with legal requirements which specify the sort of records which have to be kept and how they should be stored.

The administration of medicines was safe. We saw in care plan documentation that people who received support

Is the service safe?

with their medicines had a medicines risk assessment in place. We looked at five people's medicines records in detail. They were accurate and balances of their medicines agreed with records.

We looked at the recruitment records for three recently recruited staff. Appropriate checks were in place to ensure applicants were suitable to provide care and support to people. For example, checks on previous employment history, any relevant criminal convictions and the applicant's health. Staff confirmed they had been required to provide references and other details for the provider to check as part of their recruitment. The registered manager confirmed applicants were subject to an interview process and if successful an induction training process.

The premises were clean and people told us the home, including their bedrooms, was kept clean and tidy. We did not see any obvious hazards to people's safety. Staff told us they had received training in good infection control practice. We confirmed this from staff training records. This helped them to protect people from the risks associated with infection.

Records were in place to confirm equipment, for example hoists and assisted baths, were properly maintained. Where people required specific equipment to keep them safe, for example pressure relieving mattresses and bed-rails, assessments were in place to show why these were required. People were involved in decisions about their use.

There was a system to record accidents and incidents. Where it was possible to do so, action had been taken to prevent these from happening again. For example, where people had falls, the causes were established and precautionary measure taken to reduce the likelihood of further falls. This could be by increasing the number of staff present during transfers or the provision of protective equipment like bed rails. The manager told us they would also involve specialist community health professionals for advice and support.

When we spoke with staff we found they were aware of the service's whistle-blowing policy. This process enabled staff to raise concerns at either a senior level inside or outside the organisation without negative consequences for themselves.

Is the service effective?

Our findings

People said they were respected and felt involved in their care and care plans. Relatives also confirmed they were appropriately involved in decisions about their relative's care. For example, we saw care plans had been signed by the person concerned or their representative. Care plans were reviewed with the involvement of the people concerned and those people responsible for them. We confirmed this with people and their relatives. " I am kept informed of any significant events and communication is generally very good indeed" one relative told us.

Care plans included records of people's end of life care wishes where these had been given. The PIR indicated there were 25 'Do Not Attempt Resuscitation' (DNAR) agreements in place. Where people did not have capacity to make specific decisions, appropriate records were kept and processes followed to protect their best interests. Additional care support was provided into the service when necessary at the end of people's lives.

The care plans we looked at identified people who required their food and drink intake monitored because they were at risk from not eating or drinking enough. People's weight was monitored and appropriate action taken if they were not maintaining a healthy weight for them. This included providing food supplements or special diets for example. Speech and language therapy services were involved, for example, where people had difficulty in swallowing. A community dietician said; "Paperwork is always up to date" and "staff appear knowledgeable about the clients when discussed…"

People said they enjoyed the food and had; "plenty of choice". We spent lunchtime at a table talking with people and observing how staff served people their food and interacted with them. We heard staff telling people what the choice of food was and chatting informally with them as they offered help. There were three courses; drinks were readily available, including wine. People could have as much or as little as they wanted and where any assistance was required, it was provided discretely in a dignified and unhurried manner.

Two people confirmed they had received medical support and treatment from community health professionals when this was needed. Care plans included details of people's appointments made with community health services, for example, GPs, dentists and opticians. We received positive feedback from community healthcare professionals. These include GPs, a community psychiatric nurse and community dietician. They said they received appropriate and timely referrals and were supported by staff as necessary during their visits. One noted; "Nurses and carers know what they are doing".

The local authority Quality in Care Team provided details of the support and training they had provided Maids Moreton Hall up to April 2014. This included stroke awareness workshops which 10 staff attended, person centred planning workshop with five staff, record keeping workshop with 10 staff attending and six staff attended a dignity in care workshop.

We saw records which provided details of the staff training programme. Recently recruited staff told us they had a structured induction and worked initially with more experienced staff to gain experience and confidence. Longer-serving staff told us there was ongoing training provided in different formats, including e-learning, distance learning, national vocational training and training provided by external specialists, for example dementia crafts through the Alzheimer's Society.

Staff told us they met regularly with their line manager for supervision. This was where they received support and guidance and could discuss any issues or concerns, including training and personal development. We saw records of staff supervisions booked for the rest of the year and those which had taken place. Staff confirmed supervision frequencies as between four to six times per year on average.

Staff said there were infrequent staff meetings. However they confirmed they had ready access at any time to their line manager, the registered manager or their deputy to raise any issues or concerns. They told us that team issues were also discussed at handovers between shifts and more informally. Staff said they felt supported; "Best team I have ever worked with" was one comment. Following the inspection we were sent minutes of two staff meetings held on the 9 September 2014.

We were told, before the inspection, of concerns about the suitability of the first floor for people who were living with dementia. This was because, at that time, staff had to accompany them across a glazed area to get to the ground floor lounge and dining facilities. This could be confusing

Is the service effective?

and unsettling for them, and decreased their independence. The provider had subsequently changed the layout of the first floor, which now had an additional lounge and dining area for people who were living with dementia. This enabled people on the first floor to use their own lounge and dining areas more easily.

Is the service caring?

Our findings

People or their relatives, said care was very good. "The care is good, the girls work very hard", "They have a lovely lot of girls working here".

Relatives told us they felt welcome and were able to contact or visit the service at any time. "I can come at any time I please" one said. In addition to lounge areas on both floors, which included large screen televisions, there was a bar/coffee shop adjacent to the reception area. We observed this was used by relatives and people they were visiting for socialising informally. The service also had a 'fine dining' room where people could celebrate special occasions with relatives and friends. One family told us they had used this recently to celebrate a person's significant birthday; "It was a wonderful afternoon in lovely surroundings".

Throughout the day we saw staff interacting with people in a caring and professional way. They used people's preferred names and people responded warmly. Staff asked people how they were as they passed and engaged them in conversation. They offered drinks to people as it was a warm day. The activity staff gently and patiently helped one person towards the reception and bar area, talking to them as they did so about what they were going to do later on.

We found people's privacy was respected. All rooms were for single occupancy which meant people were able to spend time in private if they wanted to. Those bedrooms we saw had been personalised with things like photographs or ornaments to help people feel at home. We saw bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. The PIR indicated all staff had received training in dignity, respect and person centred care within the last 12 months. This was reflected in the way we saw care was provided during our visit.

When we spoke with staff we found they had a good understanding of people they provided care and support for. They told us about people's backgrounds and what events and people were important to them. They explained the key worker role and how they got to know people's life histories and preferences. This included, for example, the time people liked to get up in the morning and go to bed at night and what their interests and hobbies if any were.

We were told by the registered manager that independent advocacy services, which helped people express their views, were available if people required them. They said currently people either advocated for themselves or families did so on their behalf, with their consent. When we talked with people and their relatives they all said they could approach staff readily when they wanted to and felt they were listened to when they did.

We spoke with activities staff who told us they carried out one to one sessions with people up to 11am and then group activities from 11am to 12.30pm usually every weekday. They made use of external specialist resources and guidance, for example the Alzheimer's Society dementia café and dementia crafts within the local community.

We looked at activities records and spoke with activities staff about group activities. They said there was a book club, outside entertainers, some trips out and a film club in the service's own cinema. Provision was made for people who wished to maintain religious practice or worship. People told us there was croquet on the lawn when weather permitted, they said they were able to go to lunch in the nearby town and could make free use of a chauffeur driven car for individual trips out, subject to availability. We saw one person going out in the car during our visit.

The care plans we reviewed contained information about people's wishes about their care around the end of their life. This included appropriate documentation about resuscitation at that time. This decision was recorded and included the signature of a GP, the person concerned if possible or a person acting on their behalf. In the PIR 25 people were said to have a current and complete Do Not Attempt Resuscitation (DNAR) agreement in place. Training records showed that 80% of staff had received palliative care/end of life care training in the previous 24 months. Three members of staff specifically mentioned how helpful this training had been for them.

Is the service responsive?

Our findings

Throughout our time in the service we saw staff responded promptly and appropriately to people's need for support. We observed care throughout different areas of the service at different times of the day. People were consistently offered choice and asked what they would like to do when. Staff always spoke to people and asked them if they needed help. They told people what they were going to do and offered reassurance as they did it. Care staff and nurses were patient and interactions were positive. At meal times staff responded promptly to meet any choices made or changes to choices previously made.

We were told that everyone had a care plan that was personal to them. When we spoke with people and their relatives they all confirmed this to be the case. People's individual needs were assessed and they were involved, with their representatives and relevant health and social care professionals in drawing their care plan up. Those care plans we saw included details of how people's care was to be provided and risks to their health, safety and welfare managed or eliminated. We saw for example that a tissue viability nurse had been involved in one person's care when staff identified an increased risk of skin damage due to deterioration in the person's health. People's needs were monitored effectively. Care plans included monthly reviews of the level of people's needs and whether they had changed. Where they had, for example, an increased incidence of falls or an unusual change in the person's weight, action was taken to address this and care plans were updated to reflect them.

People were assisted to maintain family contacts and were supported to maintain a religious adherence if they chose to do so. Relatives were positive about the care and support people received; "Care and nursing very professional and caring". One relative told us they mentioned to the provider it was difficult for them to move their relative in a wheelchair, because of a high threshold at one exit. This was addressed within days, by the provision of a permanent ramp and paving at the outside to enable the wheelchair to be turned more easily. The provider had also responded to concerns about the built environment for people who were living with dementia by providing additional dining and lounge facilities for their use on the first floor.

In the information provided by the service prior to the inspection, they told us there were residents and relatives meetings held approximately every two months. We saw minutes of separate residents' and relatives' meetings held on the 30 June 2014. There were 17 people at the residents' meeting and four relatives at their meeting. Both meetings included open discussions about a range of issues and provided opportunity for people to give their views about the service. One person, for example, said it would be good to have more garden umbrellas and was told these were already on order.

We spoke with staff and looked at training records. Staff were provided with appropriate training, for example, in dementia care, to ensure they could effectively and safely meet people's needs. Where people had specific nursing needs, trained staff and appropriate equipment were in place to meet them effectively. "The staff have the necessary understanding and skill to carry through what we ask them to do" one visiting professional told us. Health and social care professionals told us staff had always been very responsive to their requests for information and had supported their work around specialist feeds and nutrition. A community dietician noted extra snacks had been incorporated and prescriptions for supplements had been reduced without compromising 'patient safety or nutritional safety'

Other community healthcare professionals confirmed the standard of care they saw was good. They also said, that liaison and co-operation between them and the service was now very good, following some; "Initial teething problems". The service told us they sent a 'transfer of care' form with people who had to go to hospital or another external health service to make sure key information was available to them. There was a formal complaints procedure in place and readily available to people and their relatives. In the information provided by the service prior to the inspection, they told us there had not been any written complaints made to them. In the same period they reported receipt of 20 written compliments. People told us they knew how to make a complaint if they needed to. They said they were most likely to raise any concerns they had informally with the carers, nurses or the service's manager. During our visit we saw the registered manager was readily available and visible throughout the home. We saw them talking informally with people who lived in the home and their relatives.

Is the service responsive?

During the period October 2012 to November 2013, CQC had been contacted by two people raising concerns about the standard of care experienced by their relatives. Some of these concerns were also dealt with under Buckinghamshire County Council's safeguarding policies and procedures. Whilst these concerns had not all been able to be resolved to the full satisfaction of the people concerned, the provider had co-operated in the relevant investigations and processes and had notified the CQC where required to do so.

Is the service well-led?

Our findings

Staff and visitors said the management of the service was very open and approachable. When we spoke with relatives they were supportive of the culture and values of the service. "I can raise anything I like and have felt able to approach the management team at any level; they are both open and responsive".

There was an effective management structure in place. There were clear lines of responsibility and accountability between the registered manager, the deputy, nurses and care staff. There were effective quality assurance systems in place to monitor care. In the PIR the service detailed a robust quality assurance programme. This included weekly and monthly audits, 'customer' satisfaction surveys with analysis of the feed-back received. There were action plans in place to monitor progress in implementing changes where applicable. There were records to support this.

Senior managers for the provider were also involved in monitoring quality, performance and satisfaction within the service. We saw copies of reports and associated action plans following monthly provider audits. Senior managers for the provider took an active interest in the running of the service and when we talked with them they had a good understanding of the people who used the service and the staff. During the inspection we saw that people, including staff and relatives appeared very comfortable and relaxed talking with members of the management team at all levels.

There were systems in place to share information and seek people's views about the way the service operated. People confirmed they had been asked for their views on the service in a satisfaction survey. We saw minutes of both 'residents' and relatives' meetings held in June 2014 which looked at the results of these. There were mostly favourable comments, especially about the staff and facilities. The agendas for both meetings included consideration of areas of the service under the headings of safe, effective, caring, responsive and well-led. Where any issues were raised, these were addressed, for example whilst only two people thought call bells could be answered more quickly, it had been decided to introduce automatic monitoring of call bell response times. This would help identify any delays and enable them to be investigated.

Community health professionals were positive about the level of communication and active co-operation they received from the manager and staff. A health professional visiting the service told us they felt the current management team had made significant progress and were proactive and responsive in their dealings with them.

We saw from CQC records that the service had notified CQC appropriately of incidents and significant events as required to by law.

A member of staff said they felt the values of the service were; "Striving for excellence".

Minutes of a staff team meeting in September 2014 reflected discussion about teamwork, observations about the relationship between nursing and care staff and differences in culture between day and night staff. The importance of acting as a team had been agreed and the Deputy Manager had helped with 'team building' whilst working during the night. The manager had nominated the care team for an annual award because of their teamwork and high standards of care. We saw staffing rotas which showed there was always a senior member of staff on each shift. Staff said they were able to contact a senior manager at any time for advice or guidance.