Horizon Residential Homes Limited

# Middleton Hall Care Home

## Inspection report

205-207 Grimshaw Lane
Middleton
Manchester
Lancashire
M24 2BW

Date of inspection visit:
04 December 2018

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24 December 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

# Summary of findings

## Overall summary

The inspection took place on 4 December 2018 and was unannounced. The previous inspection was undertaken in December 2017 when we found a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to good governance. This was because of some inaccurate documentation with regard to food and fluid charts.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question to at least good. At this inspection we found the provider had addressed this because documentation was an accurate record of care provided and regular audits ensured continued accuracy with regard to this documentation. The regulation was met.

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

Middleton Hall provides residential care for up to 24 people. At the time of the inspection there were 21 people using the service. The home is a detached building providing accommodation over two floors and is situated in the Middleton area of Rochdale. It is surrounded by a large garden. There is a small car park to the front of the property.

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. There was a registered manager in place at the service.

There were up to date safeguarding policies and staff had safeguarding training. Health and safety measures were in place with regard to environment, fire safety and equipment. People were kept safe within the home via locked doors with key pads, so that people could not just gain access to the building unseen. Accidents and incidents were recorded clearly and were analysed monthly to look at any patterns or trends.

Staffing levels were sufficient to meet people's needs and the recruitment system was robust. General and specific risk assessments were in place and up to date.

Medicine systems were safe and there had been no medicines errors in the last 12 months. Infection control measures were in place to help prevent the spread of infection within the home. The premises were clean and clutter free and there was signage around the home to assist people with orientation.

Care files included relevant health and personal information. A thorough induction was in place for all new employees and the training matrix evidenced regular mandatory and refresher training. Staff files confirmed regular staff supervision and appraisals took place.

Nutritional and hydration information was recorded and charts, which had not been accurate at the previous inspection, were completed accurately, evidencing no continuing breach of the regulation. Food was plentiful and nutritious and sufficient drinks were offered throughout the day.

The service was working within the legal requirements of The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Throughout the inspection day we observed staff to be kind, patient and friendly. People's dignity and privacy was respected by staff. Information was supplied to people in the form of a service user guide. Confidentiality was taken seriously at the home and staff had received training in data protection.

Care files were person-centred and included people's choices, likes and dislikes. Care plan evaluations were undertaken monthly and people who used the service, and their relatives where relevant, were involved in these reviews.

There was a programme of activities and outings on offer to people who used the service. However, people we spoke with said they would like more activities.

There was a complaints policy in place and complaints were addressed appropriately. We saw a number of compliments received by the service.

Consideration was given to people wishing to stay at the home when nearing the end of their lives. Staff were undertaking training in palliative care.

Staff told us the registered manager was approachable and had an open-door policy and the registered manager said he was well supported by daily contact with the provider.

There were a number of audits and checks in place to help ensure standards were maintained. These were all clearly documented and records were up to date.

We saw evidence of good partnership working with other agencies and professionals and the service had good links with the wider community.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People were kept safe within the home via locked doors with key pads, restricting access to unauthorised visitors. There were up to date safeguarding policies and staff had safeguarding training.

Staffing levels were sufficient to meet people's needs and the recruitment system was robust. General and specific risk assessments were in place and up to date.

Health and safety measures were in place. Accidents and incidents were recorded clearly and were analysed monthly to look at any patterns or trends. Medicine systems were safe.

### Is the service effective?

Good

The service was effective.

Care files included relevant health and personal information. A thorough induction was in place and the training matrix evidenced regular mandatory and refresher training. Staff files confirmed regular staff supervision and appraisals.

Nutritional and hydration information was recorded and charts were completed accurately. Food was plentiful and nutritious and sufficient drinks were offered throughout the day.

The premises were clean and clutter free and there was signage around the home to assist people with orientation.

The service was working within the legal requirements of The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

### Is the service caring?

Good

The service was caring.

Throughout the inspection day we observed staff to be kind, patient and friendly. People's dignity and privacy was respected

by staff.

Information was supplied to people in the form of a service user guide.

Confidentiality was taken seriously at the home and staff had training in data protection.

## Is the service responsive?

Good

The service was responsive.

Care files were person-centred and evaluations were undertaken monthly. People who used the service, and their relatives where relevant, were involved in these reviews.

There was a programme of activities and outings on offer to people who used the service. However, people we spoke with said they would like more activities.

There was a complaints policy and complaints were addressed appropriately. We saw a number of compliments received by the service.

Consideration was given to people wishing to stay at the home when nearing the end of their lives. Staff were undertaking training in palliative care.

## Is the service well-led?

Good

The service was well-led.

Staff told us the registered manager was approachable and had an open-door policy and the registered manager said he was well supported by daily contact with the provider.

There were a number of audits and checks in place to help ensure standards were maintained. These were all clearly documented and records were up to date.

We saw evidence of good partnership working with other agencies and professionals and the service had good links with the wider community.

# Middleton Hall Care Home

**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.

The inspection took place on 4 December 2018 and was unannounced. The inspection was undertaken by one Adult Social Care inspector from the Care Quality Commission (CQC).

We looked at notifications received by CQC. Notifications consist of information that the service is legally required to tell us about regarding such as accidents, injuries, deaths and safeguarding notifications. We had received a provider information return form (PIR). This form asks the provider to give us some key information about what the service does well and what improvements they plan to make. Following our inspection we contacted the local authority commissioning team and the safeguarding team. We also contacted the local Healthwatch service. Healthwatch England is the national consumer champion in health and care. This helped us to gain a balanced view of what people experienced accessing the service.

During the inspection we spoke with the registered manager, a senior carer, a member of care staff, the housekeeper and the chef. We spoke with five people who used the service. We also spoke with a visiting health professional to gain their views.

We looked at records including three care plans, three staff personnel files, training records, health and safety records, audits and meeting minutes. We observed care throughout the day and undertook a Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us understand the experience of people who cannot talk with us.

Good

# Is the service safe?

## Our findings

People were kept safe within the home via locked doors with key pads. There was a signing in book for visitors to help ensure staff were aware of who was in the home at any time.

There were up to date safeguarding policies in place and staff had safeguarding training on induction and annual refreshers. Key policies were discussed at daily meetings to ensure they were embedded into practice. Staff we spoke with were aware of how to recognise and report any concerns. There were anti-bullying and whistle blowing policies in place to help ensure staff were able to safely report any poor practice they may witness.

Staffing levels on the day of the inspection were sufficient to meet people's needs and we saw that care files included a dependency tool on which staffing levels were based. On the day we visited staffing levels consisted of the registered manager, one senior carer, two carers on for the full day and one on half a day, a housekeeper, a chef and a maintenance person. An activities coordinator was on shift three mornings per week and occasionally at other times dependent on activities arranged. The night shift comprised of one senior carer and one carer with the registered manager or a senior carer on call. There was occasionally a carer on a late evening shift depending on the level of need of the people currently using the service. We checked staff rotas which confirmed these levels were consistent.

We looked at three staff files and saw that the recruitment system was robust. Each file included an application form, full employment history, job description, interview notes, proof of identity and at least two references. Each person had a Disclosure and Barring Service (DBS) check. A DBS check helps a service to ensure people's suitability to work with vulnerable people. Where people had recorded convictions there was a risk assessment in place to rationalise the reason for employing them.

General risk assessments, relating to the premises and equipment, were in place and up to date. Specific risk assessments relating to people who used the service were present in care files. These related to areas such as mobility, falls, skin integrity, nutrition and hydration and medicines.

We looked at health and safety records kept by the service. There were up to date certificates for gas safety, legionella testing, passenger lift examination and lifting equipment testing. Thorough records were kept of water temperatures, wheelchair checks and window restrictor checks.

We looked at the fire risk assessment which was up to date and we saw that recommendations made had been actioned or were in progress. Fire detection systems, doors and escape routes were regularly checked for effectiveness. Fire drill simulations were undertaken regularly and any issues recorded and actioned. There was a fire folder which included a business contingency plan and personal emergency evacuation plans (PEEPs) for each person who used the service to ensure fire operatives would be aware of their particular needs in the event of an emergency evacuation. These were updated monthly or when changes occurred.

Accidents and incidents were recorded clearly within people's care files. These were analysed monthly to look at any patterns or trends.

We looked at the medicine systems at the service, which were robust and there had been no medicines errors in the last 12 months. Annual competency tests were undertaken with staff to help ensure their knowledge remained current.

A clear medicines policy was in place and included all relevant areas. There was information in people's care files with regard to their medicines. This included a medicines log, dosage frequency and details of how the person liked to have their medicines administered. Senior care staff were responsible for the ordering and checking in of medicines, ensuring safe storage and disposal of surplus stock. Audits were carried out on the day the new order of medicines were received and these were then stored within a locked trolley in a locked medicines room. Controlled drugs (CDs) are prescription medicines subject to controls under the Misuse of Drugs legislation. We saw that these were locked away safely and signed for by two staff as required. Some medicines, such as insulin and eye drops, were kept in a medicines fridge. The fridge temperatures were taken daily, as was the room temperature and the records were up to date and showed that the temperatures were within the manufacturers' recommended range.

One person had been prescribed a thickener to be added to drinks to alleviate the risk of choking. There was information and guidance about this in the person's care plan but not in the medicines room. The senior carer added this information immediately. We observed a medicines round and saw that medicines were administered safely, the staff member explained what medicines were being given to each person and gave encouragement where required.

There was a policy and procedure in place with regard to infection control and we saw an infection control action plan dated January 2018 with issues identified having been actioned. There had been no recent outbreaks at the home, but an infection control file with information and guidance was available to staff. Posters about how to prevent the spread of infection were displayed in the reception area of the home. Since the last inspection a new sluice room had been added to the premises, which was clean and tidy on inspection. We saw that staff used appropriate personal protective equipment (PPE), such as plastic aprons and gloves, when carrying out personal care tasks. Hand gel was available throughout the home. There was a daily cleaning schedule which was followed by housekeeping staff and all staff had undertaken training in infection prevention and control.

Good

# Is the service effective?

## Our findings

Nutritional and hydration information was recorded within people's care files and food and fluid charts were in place where required. These charts had not been completed accurately at the previous inspection, which constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to good governance. We checked to see if these were now being completed accurately and found that they were, therefore there was no continuing breach. A visiting professional told us, "Weights are taken regularly and the staff know how to refer to the dietician service if needed".

We asked people if they liked the food provided. One person said, "The soup was nice today". Another told us, "There is plenty to eat and drink. We need more cups of tea, but there are jugs of juice out all the time". A third person told us, "I had a nice lunch". A professional visitor we spoke with told us, "The food always looks good".

We looked at the kitchen, which was clean, tidy and well organised. The home's most recent food hygiene rating was 5 star, which is very good. We spoke with the chef who explained that all the food was home-made and good quality ingredients were used. There was a chef on duty throughout the day and night staff were responsible for supplying supper to those who wanted it. Breakfast consisted of cereals and toast or a cooked breakfast if preferred.

We observed the lunch time meal using a Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experience of people who cannot talk with us.

There was a menu board in the dining room and people were asked for their choice of meal by the chef each morning. Food picture charts were available and new pictorial menus for the tables were to be introduced in the near future to help people living with dementia to make choices.

The tables were set nicely with cloths and flowers and condiments were available for those who required them. No napkins were available for people to wipe their faces and hands and we spoke with the registered manager about this. He agreed to ensure napkins were available in future.

The food was home-made and people were offered bacon and lentil soup, followed by fish fingers and chips or waffle egg and beans. We saw that there were a few people who did not want either of these choices and they chose to have cheese on toast instead. All the food looked appetising and appealing. People were offered a choice of tea, coffee or cold drinks. Pudding consisted of orange sponge and custard or fruit.

Throughout the meal we saw friendly, polite and patient interactions between people who used the service and staff. It was clear that staff knew people well and understood their likes and dislikes. Encouragement and assistance was given where required and special equipment, such as a plate guard, used to promote independence.

We looked at care files for three people who used the service. These included a pre-admission assessment

and an admission assessment. There was clear information on all aspects of daily living, routines and health needs as well as personal information.

There was a general information sheet which had basic details about the person, health information and allergy status. Care plans were completed for areas such as personal hygiene, mobility, nutrition and hydration, continence and personal preferences. There was a relatives' communication log and records of professional referrals and input.

A professional visitor to the home, who visited on a regular basis, told us, "I have no issues whatsoever. I get on with the staff really well and have a good rapport with the seniors. Staff always have the answers and information needed and refer appropriately to our service".

The service used a transfer to hospital form for any admissions. This included general information, next of kin details, GP contact number, relevant health and medical history, observations where relevant, medicines information, body map where appropriate, information about mobility and recent falls history.

A thorough induction was in place for all new employees and we looked at records of induction within staff files. The induction programme, in line with Care Certificate standards, included training and information on fire safety, general duties, role and responsibilities, principles of care, promoting equal opportunities, confidentiality, health and safety, communication, safeguarding and whistle bowing. There was also an introduction to the organisation. Each new employee was required to sign a confidentiality statement and read key policies and procedure.

We looked at the training matrix which evidenced that regular mandatory training and refresher courses were given to all staff as well as supplementary training courses relevant to the service. The matrix flagged up the due dates of all refresher training to help ensure staff knowledge and skills remained up to standard. Staff we spoke with told us there was lots of training on offer. One said, "The training is brilliant. There is plenty and you get paid if you come in on your day off".

The staff files we looked at evidenced regular supervision meetings where discussions included key areas achieved or not achieved, further development required, comments on performance, training outstanding or attended and general comments.

Staff also had annual appraisals where they could discuss their main duties and responsibilities and reflect on the good and bad things about the last year. The appraisal provided an opportunity to look at actions and training required to benefit staff performance and aims and objectives for the coming year.

We looked around the premises and saw that all areas, including communal spaces, bedrooms, bathrooms, corridors and laundry areas were clean and clutter free. Bedrooms were personalised with people's own possessions and there was signage around the home to assist people with orientation. The dining room had a clock with the date and time and an orientation board. There were some appropriate reminiscence pictures around the home and Christmas decorations were in evidence. The registered manager showed us the new build where four new bedrooms were being built. The building work was not infringing on the rest of the home and there were no apparent hazards due to this work.

The reception area had a number of posters, an activity board and a 'you said, we did' board where suggestions made had been responded to. There was also a residents' and relatives' meeting calendar on the notice board.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. There was appropriate MCA information within care plans and we saw a DoLS file where all the relevant paperwork was kept and expiry dates noted. Staff we spoke with were able to give good examples of how they worked in people's best interests, using the least restrictive practice.

Good

# Is the service caring?

## Our findings

Throughout the inspection day we observed staff to be kind, patient and friendly with people who used the service. One person who used the service told us, "People are alright here". Another said, "Staff are nice, they are polite. Never had any problem with them". Staff we spoke with commented, "I like my job. The best thing about it is the people, they are genuine"; "It's different every day – a cracking place to work".

People were well presented and there was a 'Dignity Matters' board on one of the corridors, with information about ways to ensure dignity. Staff undertook training in dignity and we saw that they respected people's dignity and privacy throughout the day, assisting people discreetly with personal care tasks and intervening unobtrusively when needed.

Staff received training in equality and diversity and were aware of cultural differences. Those we spoke with were able to give a number of examples of how people's equality and diversity was respected. One staff member told us, "People's differences are respected and choices given to them. People are all individual". People's faith and religious beliefs were recorded and they were supported to continue to follow their beliefs if they wished to do so.

There was no one at the home for whom English was the second language. However, we saw that staff paid attention to communication, speaking clearly and giving explanations where necessary and ensuring hearing aid batteries were in place for those who had a hearing impairment.

We saw that the home had a Skype facility for those who wished to communicate with their families in this way. Advocacy could be arranged for people who required an independent person to represent them.

There was evidence in people's care files of their involvement in care planning and review. Monthly relatives' and residents' meetings were held and we saw that these were well attended. Discussions included suggestions for activities and outings.

Information was supplied to people in the form of a service user guide. This included information about the philosophy of care, aims and objectives, services offered, health and safety and accommodation. There was an outline of the staff team, details of how to make a complaint and contact details for the CQC and the local authority.

Confidentiality was taken seriously at the home and was outlined within the service user guide. Staff undertook training in data protection and were aware of the need for confidentiality within the service. All staff signed a confidentiality agreement at the start of their employment.

Good

# Is the service responsive?

## Our findings

Care files that we looked at were person-centred and included people's likes and dislikes. There were details of people's background history including family, past employment, leisure and sport, music preferences, favourite newspapers and magazines, food and drink preferences and entertainment.

There was also good information about people's preferred routines, for example night time habits. This included whether they liked the door open or closed, if they wished for a 'do not disturb' sign on the door, TV or radio on, bedside lamp on or off, preferred nightwear and bedding and whether a snack may be required. People's retiring and rising times were documented and whether they liked an early cuppa in the mornings. People we spoke with told us they could go to bed and get up when they wanted to.

Care plan evaluations were undertaken monthly and we saw evidence that people who used the service, and their relatives where relevant, were involved in these reviews. There was also a 'resident of the day' review, where one person who used the service was spoken to by all heads of department to review all aspects of their care and support and help ensure their continued satisfaction.

People were assessed for relevant equipment, such as wheelchairs and walking aids, on their admission to the home. We saw that equipment was in place for those who needed it.

The Accessible Information Standard, looked at by CQC, applies to people using the service (and where appropriate carers) who have information or communication needs relating to a disability, impairment or sensory loss. We spoke with the registered manager about accessible information and he explained that any information supplied could be produced in easy read format, large print, braille or other languages where required.

There was a programme of activities on offer to people who used the service, including keep fit and ball games, board games, crafts, outings to the local garden centre, hairdressing, bingo, making Christmas cards, shopping, pamper days and quizzes. On the day of the inspection some people were having their hair done by the visiting hairdresser and we saw a game of bingo taking place in the afternoon.

We spoke with people who used the service about activities. One person told us, "There is not enough to do. There used to be games in the afternoon, I would like more games it keeps your mind going". Another person said, "I would like more to do". We saw that suggestions had been made during service user and staff engagement about more activities. The registered manager told us they were looking into having more activities and that more emphasis was to be placed on meaningful one to one interactions in the future.

There was a complaints policy which was on display in the home and outlined within the service user guide. There had only been one recent complaint and we saw that this had been dealt with appropriately, following the home's procedure.

We saw a number of compliments received by the service. Comments included; "We would like to say a huge

thank you for everything you have done for [relative]"; "Thank you for the care you gave to [relative]".

Advance care plans, outlining people's wishes for when they were nearing the end of their lives, were included in care files. However, these were not all completed. The registered manager agreed to review these to ensure people's wishes were documented. Five staff were currently undertaking palliative care training with the local hospice and plans were in place for other staff to access the training in the near future. The service worked closely with the district nursing service and this included supporting people at the end of their lives.

Good

# Is the service well-led?

## Our findings

The service had a statement of purpose which detailed their core values, goals and objectives. The service's aims and objectives were also outlined within the service user guide so that people could see what the service was about.

Staff we spoke with told us the registered manager was approachable and had an open-door policy and the registered manager said he was well supported by daily contact with the provider. One staff member said, "We are a good little group here. There is an awful lot of teamwork, staff help each other out". Another told us, "We are supported well. We can see the manager about anything and if there is anything he can do to help, he will".

There was a daily handover with details of people's well-being and information about any issues encountered during a shift. Staff told us they had regular supervisions and appraisals and found these useful in discussing any issues.

There were a number of audits and checks to help ensure standards were maintained. The registered manager did a daily walk round/staff meeting where he looked at care issues, environment, general staff practice, well-being of people who used the service, care plans, resident of the day, nurse calls and equipment. Issues and actions needed were recorded and discussed with staff. The registered manager also undertook unannounced night checks and we saw evidence of a recent visit where checks were carried out on well-being, paperwork, medicines, cleaning, security and environment.

Health and safety checks, such as weekly lighting, fire detection systems tests, water temperature tests, wheelchair checks and window restrictor checks were undertaken regularly and documented clearly. Monthly infection control audits and hand hygiene audits were undertaken and actions recorded. General cleaning audits were also undertaken by the registered manager and the provider.

In addition to these there were room checks, staff call system checks, equipment checks, evaluations of accidents and incidents to look at patterns and trends and individual medication reviews all undertaken on a monthly basis. The service carried out six-monthly care plan evaluations. All the checks were all clearly documented and records were up to date.

Surveys were regular given to people who used the service and relatives, professional visitors and staff to evaluate their level of satisfaction. We saw the results of the most recent survey, which were positive about all aspects of care and support. Comments included, "My [relative] couldn't be better looked after anywhere"; "Very happy with the care my [relative] receives"

We saw evidence within the care files of good partnership working with other agencies and professionals, such as the district nursing service, chiropody service and dieticians.

The service had good links with the wider community. Local church groups visited regularly and communion

was given on Sundays to those who wished to partake. Students from a local college had placements with the service and were currently fund raising to buy Christmas presents for the people who used the service.