HC-One Limited

Hodge Hill Grange

Inspection report

150 Coleshill Road
Hodge Hill
Birmingham
West Midlands
B36 8AD

Tel: 01217301999
Website: www.hc-one.co.uk/homes/hodge-hill-grange/

Date of inspection visit:
17 May 2016

Date of publication:
01 August 2016

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 17 May 2016 and was an unannounced comprehensive rating inspection.

Hodge Hill Grange is registered to provide accommodation for up to 54 older people who require nursing and personal care. On the day of our inspection there was extensive renovation work taking place on the ground floor of the home, which meant that fewer people were living at the location at this time. There were 39 people living at the location, many of whom had care and support needs relating to dementia.

At the time of our inspection there was a registered manager in post. The registered manager was new to the provider and had been in post for three months. 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. The registered manager was unavailable on the day of the inspection, therefore we were assisted by the deputy manager.

People were safe and secure because risks had been assessed and managed appropriately. Staff were able to identify possible abuse and take actions to alert the appropriate professionals so that they could be protected.

People safely received their medicines as prescribed to them by staff who were trained appropriately.

Staff had been recruited appropriately and had received relevant training so that they were able to support people with their individual needs.

People were supported to have food that they enjoyed and meal times were flexible to meet people's needs.

Staff understood when the legal requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) should be followed.

People were supported to stay healthy and had access to health care professionals as required. They were treated with kindness and compassion but there was inconsistency of good communication and interaction between staff and the people living at the location.

People's right to privacy was promoted and people were encouraged to be as independent as possible.

People received care from staff that knew them well and benefitted from opportunities to take part in activities that they enjoyed. The provider was in the process of developing a wider variety of activities, having recently recruited a new activities coordinator.

People's care and support needs were not always responded to in a timely manner.

The provider had management systems in place to audit, assess and monitor the quality of the service provided. The provider used feedback from audits to inform future service provision.

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 protected from the risk of harm and abuse because the provider had effective systems in place and staff were aware of the processes they needed to follow.

Risks to people was appropriately assessed and recorded to support their safety and well-being.

People were supported by adequate numbers of staff on duty so that their needs were met.

People received their prescribed medicines as required.

Is the service effective?

Good

The service was effective.

People were supported by staff that had the appropriate skills and knowledge to meet their needs.

People received meals that they enjoyed and met their nutritional needs.

People were supported to stay healthy and had access to health care services when required.

Is the service caring?

Good

The service was caring.

People were supported by staff that were caring and knew them well.

People's dignity, privacy and independence were promoted and maintained as much as reasonably possible.

People were treated with kindness and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care and support needs weren't always responded to in an effective and timely manner.

People had access to activities that were meaningful to them.

People were well supported to maintain relationships with people who were important to them.

Complaints procedures were in place for people and relatives to voice their
concerns. Staff understood when people were unhappy so that they could respond appropriately.

Is the service well-led?

Good

The service was well led.

The provider had systems in place to assess and monitor the quality of the service.

Staff were supported and guided by the management team.

Relatives and staff felt the management team was approachable and responsive to their requests.

Hodge Hill 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.

This inspection took place on 17 May 2016 and was unannounced. The membership of the inspection team comprised of two inspectors and 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.

When planning our inspection we looked at the information we held about the service. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts, which they are required to send us by law. Before the inspection we received two whistle blowing concerns both relating to insufficient staff numbers, (especially during the night) to meet the needs of service users, resulting in slow response times and increased staff stress levels. We also contacted the Local Authority Commissioners and Social Work Team. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spent time with many of the people living at the location. Some of the people living at the home had limited verbal communication and were not always able to tell us how they found living at the location. Therefore, as part of our inspection we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us and we also observed how staff supported people throughout the inspection to help us understand peoples' experience of living at the home.

We spoke with eight people, four relatives, five staff members, two volunteers, a health care professional, the deputy manager and the operations manager. On the day of the inspection the registered manager was unavailable; however we discussed the inspection with her via telephone a few days later. We looked at the care records of four people, the medicine management processes and records maintained by the home about recruitment and staff training. We also looked at records relating to the management of the service

and a selection of the service's policies and procedures to check people received a quality service.

Good

Is the service safe?

Our findings

Most of the people and relatives we spoke with told us they felt safe living in the home. A person we spoke with told us, "I feel safe when they [staff] give me a shower or a bath, they [staff] support me". Another person we spoke with said, "I don't think that I'm unsafe".

We saw that the provider had processes in place to support staff if they had concerns about people's safety. We spoke with staff that told us that they had received training in keeping people safe from abuse and could recognise the different types of abuse. One staff member explained how they would make a safeguarding alert if they felt that someone was at risk of harm or abuse. Another staff member explained, "I would report to a senior [staff] if they didn't do anything I'd take it higher [manager or Local Authority]".

We saw that staff acted in an appropriate way to keep people safe and were knowledgeable about the potential risks to people. A member of staff we spoke with told us, "Nurses do risk assessments. We're [staff] asked for our input sometimes or if we see any changes then the care plan's amended". Another staff member we spoke with gave an example of how staff monitor a person using a walking aid, to ensure that their chances of falling are lessened. We saw that the provider carried out regular risk assessments and that care plans were updated. Any changes that were required to maintain a person's safety were discussed and recorded during shift handovers.

Some people we spoke with felt there were sufficient staff working at the home to meet people's needs and to keep people free from risk of harm or abuse. A person we spoke with told us, "I feel safe because there is always someone about". Another person we spoke with said," I feel safe because there are people around me all the time, and at night". However, not all staff and relatives we spoke with felt that there were enough staff to support people. A relative told us that they felt staff were caring towards their family member, but there weren't enough of them. Information gathered from the Provider Information Return (PIR) and discussions with the deputy manager showed that there was a good people to staff ratio at the location, although the provider had recognised that they needed to recruit a nurse to support the care provision for people at night time, and were currently in the process of doing so.

The provider had processes in place to ensure that people were continually supported by staff that knew them well. We saw that the provider had systems in place to ensure that there were enough staff on duty with the appropriate skills and knowledge to ensure that people were cared for safely.

The provider had emergency procedures in place to support people in the event of a fire and staff were able to explain how they followed these in practice. One member of staff explained the fire evacuation procedure, "We [staff] check the fire panel to see where the fire is. We find out if we need to evacuate, then we meet at the front of the building". We saw that each person living at the home had a Personal Emergency Evacuation Plan (PEEP) to ensure that staff knew the best way to support them in the event of a fire.

The provider had a recruitment policy in place and staff told us that they had completed a range of checks before they started work. We saw this included references and checks made through the Disclosure and

Barring Service (DBS). The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care. We reviewed the provider's recruitment processes and these confirmed that staff were suitably recruited to safely support people living at the home. A member of staff we spoke with confirmed that the provider had used the appropriate recruitment process, they told us, "I had to provide references and a DBS was also asked for"

A person we spoke with told us they had no concerns with how their medicines were managed and administered. They told us, "Medication is given regularly, they [staff] don't miss giving it to us [people]". Staff we spoke with told us that they had received training on handling and administering medicines. We saw that the provider had systems in place to ensure that medicines were managed appropriately. This included how medicines were received, stored, recorded and returned when necessary. We saw that daily records were maintained by staff showing when people had received their medicines. Staff told us that they could recognise when people were in pain or discomfort and when medicines were needed on an 'as required' basis (PRN). We saw that the provider had a PRN protocol in place to support people when they required medicines on an 'as required' basis. We saw care plans that identified how staff would recognise when a person was in pain.

Good

Is the service effective?

Our findings

Most of the people we spoke with told us that they liked the food and were given a choice of meals. One person we spoke with told us how they were provided with meals that they had requested, for example West Indian food. Staff we spoke with said, "We offer people food to eat but if they don't want it we offer an alternative". Another staff member told us that people were offered two options at meal times, however if they didn't want either option the kitchen staff would make them something else. They also said, "Some residents have cultural [related] food, so we provide that for them". We saw menus were available with photographs to help people make decisions about what they liked to eat. We saw that there was a good selection of food available and observed that people had access to food and drink whenever they wanted throughout the day. We saw people eating in the dining area and some in their rooms, although meals served in people's rooms were sometimes slow in arriving.

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. Some staff told us they had received training in the Mental Capacity Act (MCA) 2005 and understood about acting in a person's best interest.

We saw that not all of the people who lived at the home had the mental capacity to make informed choices and decisions about all aspects of their lives. We also saw that not all people could verbally communicate, however staff told us that they understood people's preferred communication styles and used these to encourage people to make informed decisions. A person we spoke with told us, "I have a hearing aid and the nurse puts it in for me in the mornings". One member of staff gave examples of the different ways they communicated with people in a way that they would understand and to gain their consent. They told us, "If [person's name] likes something he puts his thumbs up, if not, down". We saw that staff also used communication cards to help them to communicate with people who could not communicate verbally". We saw that care plans identified people's preferred communication styles to aid staff in understanding how people preferred to be cared for.

Staff we spoke with understood about gaining consent from people when providing care and support. They told us how they would ask people about their preferences before supporting their care needs. We observed staff gaining consent from people, an example being; when a person was asked if they were happy to be moved in their wheelchair.

The law requires the Care Quality Commission (CQC) to monitor the operation of Deprivation of Liberty Safeguards (DoLS). This provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. At the time of the inspection we saw that the provider had made relevant applications to the local authority. We saw that staff had been trained in the Mental Capacity Act and could explain to us what was meant by depriving someone of their liberty.

We saw that staff had received appropriate training and had the skills they required in order to meet people's needs. The provider had systems in place to monitor and review staff learning and development to ensure that they were skilled and knowledgeable to provide good care and support. Staff we spoke with told us that they felt they were provided with the appropriate training to support people effectively. A member of staff we spoke with told us that they had completed on-line training a few weeks earlier which included learning about areas of specialised health care. Staff told us that time was set aside during their working week to access online training. We saw that people's specific needs had been identified and staff had received appropriate training to support them, an example being epilepsy training.

A member of staff told us that they hadn't had supervision yet as the manager was still new at the location. Another staff member told us, "Supervisions being sorted out, because the new manager's setting up dates". The deputy manager showed us a new system had been implemented to support staff with supervision, personal development plans and goal setting.

Staff we spoke with were able to tell us about people's nutritional needs and knew what food people liked and disliked. One kitchen staff member told us that they received people's diet sheets from the nurse or dietician to ensure that they were receiving the correct type of meal. We saw that there was involvement from health care professionals where required and staff monitored people's food intake. For example, some people were on special diets and records showed that dieticians and the Speech and Language Therapy Team (SALT) had been involved in developing and supporting the provider in meeting their dietary and nutritional needs. Speech and language therapists assess and support people with communication problems and with people who have difficulties with eating and drinking.

People, relatives, staff and the health care professional we spoke with thought that people's health needs were being met. A health care professional we spoke with told us, "There are no reasons for concern. There's always access for medical staff if needed". They continued by saying how supportive staff were in providing up to date information about people's health needs. People told us that doctors, dentists and opticians come to the home regularly. We saw from care records that people were supported to access a variety of health and social care professionals. For example, psychiatrist's, dentists, opticians and their GP, as required, so that their health care needs were met and monitored regularly.

Good

Is the service caring?

Our findings

People told us that staff were kind and treated them with respect. A person we spoke with told us, "Staff are very nice". Another person said, "The staff here are very good but are often under pressure". A relative we spoke with told us, "When I come there is often food around his [family member's] mouth and his hands and finger nails are always dirty". Another relative said, "I don't think they [staff] give him a proper wash". However a third relative we spoke with told us, "The home is always clean and tidy, and no unpleasant smells". We observed that people and the clothes they were wearing looked clean. We saw that staff ensured that people were supported to eat and kept clean whist doing so. We saw that most staff were attentive and had a kind and caring approach towards people. There was light hearted conversation between people and staff throughout our time at the home.

We saw that staff knew people well and communicated effectively. Staff told us how they used pictures, communication cards and photographs to help people communicate when they needed support. Staff also explained that people's care plans identified the preferred communication methods for people who communicated differently. We saw that individual support plans documented people's preferred style of communication.

Information was available about independent advocacy services and we saw that some people had been supported by an advocate. Advocates are people who are independent and support people to make and communicate their views and wishes. The provider had supported people to access advocacy to ensure they could fully express their views.

People told us that they were treated with dignity and respect. One person told us, "The doors and curtains are closed in the morning when they [staff] administer care, and they treat me with respect and talk to me". A member of staff we spoke with explained to us how they promoted people's privacy and dignity within the home. They said, "Don't expose them [people], cover them when providing personal care". Another member of staff told us, "We knock doors before entering people's rooms but not everyone can answer". We found that people could spend time in their room so that they had privacy when they wanted it.

Everyone we spoke with told us there were no restrictions on visiting times and we saw relatives coming and going throughout the day.

Staff told us how they supported people to be as independent as possible. A staff member told us, "I encourage people to do little things. For example; using the flannel to wash their own face. Empower them to things for themselves". Staff also told us how they encouraged people to eat for themselves. We saw most people needed support from staff to move around the home and were not always able to carry out everyday tasks independently.

Requires Improvement

Is the service responsive?

Our findings

There were a sufficient ratio of staff to provide safe care of the people living at Hodge Hill Grange. However we could see, and from talking to staff and relatives, that they were finding it difficult to provide a responsive service. Some people told us that there were not enough staff available. People and relatives we spoke with told us had mixed views on how responsive staff were to people's individual needs. One relative we spoke with told us, "They (staff) are moving my husband upstairs and I was worried that the change might disorientate him, but they made sure that the room was identical in layout, so it worked well". Alternatively a person told us that staff were slow in responding to them when they pressed their call buzzer. A relative we spoke with told us, "My husband is sometimes taken to the toilet and because he forgets to press the buzzer he is sometimes left for a long period of time before he is taken off". We observed an occasion when a person pressed their buzzer for assistance and it took the staff member six minutes to respond. A third person we spoke with told us that staff were slow in responding to them following a period of incontinence. Staff told us that they couldn't respond to people's needs as quick as they would like to, especially at meal times. We saw that some meals were slow in reaching people who chose to eat in their own rooms. A staff member we spoke with explained how meals were sometimes late getting to people on their section of the home, "There's 24 people and four staff, but I think we could do with more [staff] for breakfast and morning drinks, it would take pressure off us here. To do breakfast and then get them [people using the service] out of bed, then do the 11 o'clock tea round is really hectic at the moment". Another staff member said, "At breakfast, it's hard for four staff with 11 or 12 people to feed in their rooms. You can't rush people, it takes time". A relative we spoke with told us, "Staff don't interact with residents, they're too busy. The staff here are very good but are often under pressure". A volunteer we spoke with said, "There are never enough staff. There are a lot of good carers here but they leave because of the pressure". Prior to our visit there had been two whistle blowing concerns raised, both relating to insufficient staff numbers to respond to people's care and support needs in a timely manner. Concerns raised by people, staff and relatives had highlighted that although staff numbers were sufficient to ensure that people were safe, their deployment meant that for some people, slow response times were still seen as an issue. Another person also told us, "They [provider] ran out of [continence] pads yesterday, this happens now and then". A relative we spoke with told us that the location occasionally ran out of incontinence pads and that they sometimes brought their own in. We discussed this with the deputy manager who told us that the delivery service was late and that the order had been placed in time. On occasions when the provider ran out of pads they did buy them from local shops to cover demand at the time.

We saw that staff knew people well and were focussed on providing person centred care. Staff explained to us how they supported people to access religious and cultural activities. We saw that people were encouraged to make as many decisions about their support as was practicable on a day to day basis. A relative we spoke with told us, "I was involved in my husband's care plan but now that his needs are greater I think that he needs to be reassessed". Another relative said, "The family are involved in the care plan and are invited to review meetings". The Manager told us that resident and family meetings happen on an ad hoc basis and that people and their families could come and talk to them at any time. We saw records of family meetings taking place as well as detailed, personalised care plans that identified how people liked to receive their care. We saw notices around the home highlighting dates for residents meetings. A staff

member told us, "I sit and listen to people and try to do what they want. I respect their culture and values, for example; what they don't eat for cultural reasons".

Throughout our inspection we saw that people had things to do, for example, puzzles and board games. A person we spoke with said, "A new activities coordinator just started, we haven't had one for months". The activities co-ordinator had only been working at Hodge Hill Grange for a few weeks and they told us, "Yesterday we had a movie night". They continued, "There's no structured programme yet as we're still assessing peoples choices". A relative we spoke with said, "My husband does nothing now, but enjoys sports. I was able to have SKY (TV) installed in his room to watch the sports channel". Staff explained how they discussed hobbies and activities with people, one staff member told us, "[Person's name] liked dancing when she was young, but she's not doing that now".

A staff member explained how people were able to make their own choices of what they wanted to do, they told us, "We get to know people's likes and dislikes, we give them options to make choices". We saw that people had choices of what they wanted to do on a daily basis, for example; meals they ate, clothes they wore and activities they wanted to participate in.

We saw that all people living at the home had their own rooms and choose whether to stay in them or join in, in the communal areas. Rooms were clean and personalised to the requirements of the people that occupied them.

Staff supported people to maintain relationships that were important to them. Relatives were happy that they were able to maintain regular contact with their family members and there were no restrictions on visiting times.

People and relatives we spoke with said they knew how to complain if they needed to and would have no concerns in raising any issues with the management team. A person we spoke with told us that their family member usually liaised with the manager on their behalf, "I would make sure I speak to my family if I had any concerns, I always make them aware of what's going on". A relative we spoke with explained how they had raised issues with the manager in the past. We found that the provider had a structured approach to dealing with complaints in the event of one being raised and acted promptly to resolve issues.

Good

Is the service well-led?

Our findings

We saw that quality assurance and audit systems were in place for monitoring the service provision. This included surveys from people and relatives where they were encouraged to share their experiences and views of the service provided at the location. We saw that audits were used to identify areas for improvement and to develop the service being provided to people. These included audits of plans, risk assessments, training for staff, daily records and medication recording sheets. However, there appeared to be areas for improvement regarding stock control which was evident from the times when the provider ran out of continence pads. The system for ordering pads is ineffective.

We saw that the provider reported any incidents and concerns, relating to peoples safety and well-being, to CQC and the local authority appropriately. We saw that lessons learned from accidents or incidents at the location were used to support staff and service development.

Staff told us that they understood the whistle blowing policy and how to escalate concerns if they needed to, via the management team, the local authority, or CQC.

We saw that the provider had plans and resources in place to develop and improve the service they provided. At the time of our inspection the location was being refurbished as the provider had plans in place to develop part of the location into a specialist dementia unit.

We saw that the provider supported staff and that the staff were clear about their roles and responsibilities. Staff told us that they were happy with how the home was managed. Staff told us the manager was approachable and responsive to requests. Staff we spoke with told us that they felt that they were listened to by the manager. They said, "The manager listens to us [staff]". Another staff member said, "To me, she's [manager] very polite, but I can't say more because she's new and I haven't had much to do with her". Staff told us that they felt confident about raising any issues or concerns with the manager. We saw that the manager listened and acted upon issues and concerns raised by relatives. For example; a relative was unhappy that staff were not following their family member's health care protocol correctly, as set out in their care plan. We saw that the manager put systems in place to ensure that staff fully understood the person's care and support needs and that they were adhered to correctly. Following our inspection visit we received confirmation from the relative that their family member was now being cared for safely.

At the time of our inspection there was a registered manager in post and this meant that the conditions of registration for the service were being met. A registered manager has legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run. The provider had a history of meeting legal requirements and had notified us about events that they were required to by law.

From informative provided to us in the PIR we could see that the provider was aware of where their strengths lay and where there were areas to develop service provision. They had plans in place highlighting how this would be done, including; Consistent and safe person centred care for people who use the service,

greater transparency and involvement with relatives, carers and health and social care organisations.