Lawton Group Limited

Hempton Field Care Home

Inspection report

36 Lower Icknield Way
Chinnor
Oxon
OX39 4EB
Tel: 01844-351766
Website: www.brighterkind.com/hemptonfield

Date of inspection visit: 16 October 2014
Date of publication: 17/04/2015

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

Hempton Field Care Home provides nursing care and support for up to 33 older people including those living with dementia. At the time of our inspection there were 29 people living at the home.

Hempton Field Care Home has a registered manager in place. 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.

This unannounced inspection took place on the 16 October 2014. At our last inspection of Hempton Field Care Home in October 2013 we found the home met all the regulations assessed.

People were positive about their safety and security. Potential risks to people's safety were identified within

Summary of findings

their care plans. For example, from falls. Action was taken to address this, falls risk assessments identified the number of staff and equipment required to move the person safely.

The interaction between staff and people living in the home was polite, respectful and friendly. There was a very relaxed atmosphere throughout the home and staff had time to talk informally to people in lounges and dining areas.

People said there were always sufficient staff available. We checked staffing rotas and found they agreed with the set staffing structure. The provider kept staffing under review and adjusted staffing levels according to the number and dependency levels of people. There was very little recent staff turnover which provided consistency of care for people.

Staff confirmed they received regular training to enable them to meet people's care needs. Domestic support staff confirmed they had received infection control training and training about the safe use and storage of chemical products.

Staff confirmed there was a mixture of formal and informal supervision, together with an annual appraisal. Records showed formal supervision was not at consistent intervals. There were staff meetings, including nurses meetings for qualified nursing staff. This meant although formal supervision was not always planned or carried out at set frequencies, staff felt they had the support they needed as they had the opportunity to discuss any issues with their line manager or the registered manager at any time.

Staff had received safeguarding adults training and this was confirmed from training records. There were 'Safeguarding Champions' in place to advise staff of the appropriate action to take if they had any concerns about potential abuse. There was safeguarding information and contact details displayed prominently in the home for staff and others to refer to.

Care plans included evidence of pre-admission assessments to identify individuals' care needs. This enabled, for example, any specific equipment required to be put in place before the person moved in and ensured their needs could be met from the outset. Staff followed any advice and recommendations given by healthcare professionals involved with the service, for example GPs and specialist nurses. They provided very positive views of their interaction with the service and the quality of care and support they observed. In some cases updates to care records had not been recorded, although care staff were aware of the relevant details and had acted upon them. The need to improve care plans had been recognised and action was being taken to achieve this.

Medicines were administered safely. Routine checks were carried out to monitor records and practice to make sure people received safe and effective support when they needed help with their medicines.

Relatives confirmed they had completed annual questionnaires and had also met informally with the registered manager to discuss their relative's care and provide feedback. People were positive about the leadership of the registered manager and told us they were "Patient and approachable."

Staff had a good understanding of the implications for them and their practice of the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make specific decisions at a given time. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after them safely.

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?
The service was safe.

People told us they felt safe and that there were sufficient numbers of staff available to meet their needs and keep them safe. Risks to people's safety were assessed and action taken to eliminate or manage them.

Recruitment of staff was robust and thorough and meant people were protected from the employment of people who were unsuitable to provide their care.

People received their medicines safely from staff that had been trained to do so.

Good

Is the service effective?
The service was effective.

People had access to health and social care professionals to maintain their well-being.

People received support from staff who had the training and supervision they needed to do so safely and effectively.

People were able to exercise choice about what they ate and drank and where. Where necessary their food and fluid intakes were monitored in order to maintain their health.

Good

Is the service caring?
The service was caring.

People told us they were well cared for. Visitors told us they observed kind and compassionate care being provided by staff.

People were treated with dignity and respect. Appropriate and effective care was provided by staff.

People received care and support from staff that had a good understanding about how they wanted it to be provided and took an interest in them as individuals.

Good

Is the service responsive?
The service is responsive.

People's care needs were assessed and kept under review. People were involved in decisions about how their care was provided.

People's care plans were not always updated promptly; however, staff were aware of their current needs and ensured they were met appropriately.

Healthcare professionals were very positive about the standard of care they saw and the co-operation and information they received.

Good

Is the service well-led?
The service is well-led.

Good

Summary of findings

People were positive about the way the service was managed. They said there was a very open and friendly culture within the home.

The provider took steps to monitor quality and performance. People were asked to give their views about the service and how they felt it could be improved.

Staff were supported by the provider and registered manager to contribute to discussions about the home's operation and to raise any concerns they had openly without being concerned about any negative repercussions.

Hempton Field 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.

This inspection took place on 16 October 2014 and was unannounced.

The inspection team included an inspector 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. In this case both physical disability and older people's services.

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.

We reviewed the information in the PIR together with any other information we had about the home. We contacted people who commission services from Hempton Field Care Home and healthcare professionals with knowledge of the service. This included three GPs, a specialist falls team, an NHS physiotherapist, speech and language therapist and a chiropodist.

During the visit we spoke with 15 people living at the home, two relatives and seven members of staff including nurses, care staff and domestic support staff. We also spoke with the deputy manager and a senior manager for the provider. We observed care and support in lounges and dining areas and with their permission people's rooms. We looked at seven care plans, medicines records, two recent staff recruitment files and records of staff training and supervision undertaken by all care and nursing staff. We also looked at quality monitoring processes and reports undertaken by the provider.

Good

Is the service safe?

Our findings

People were positive when asked about their safety and security. No concerns were expressed about the safety of the premises or their personal safety. One person told us "I consider that I am looked after very well, I feel safe here." Another person told us; "I feel very safe here, if I were to fall, they'd be here in seconds."

Potential risks to people's safety were identified within their care plans. For example, from falls or damage to the person's skin from pressure. There were control measures put in place to eliminate or manage risks where that was possible. For example, falls risk assessments identified the number of staff and equipment required to move the person safely and pressure relieving equipment was identified and put in place to protect vulnerable skin areas.

People and relatives said there were always sufficient staff available to ensure people were safe, although one person did note; "As time goes by staff get busier and busier." We observed at meal times, if people required assistance to protect them from the risk of choking when eating, it was provided. We checked staffing rotas and found they agreed with the set staffing structure. We were told by the senior manager present that they kept staffing under review and adjusted staffing levels according to the number and dependency levels of people.

Staff had received training in infection control. They followed good practice, for example we saw they wore appropriate protective clothing when providing care. There were 'Infection Control Champions' in place to promote best practice amongst the staff team, they reported to an infection control lead nurse who undertook three monthly infection control audits. This helped protect people from the risks associated with acquired infections.

People were protected from abuse. Staff confirmed they had received safeguarding adults training and this was confirmed from training records. There were 'Safeguarding Champions' in place to advise staff of the appropriate action to take if they had any concerns about potential abuse. Staff were able to talk with knowledge about what might constitute abuse and what they should do if they saw or suspected it. There was safeguarding information and contact details displayed prominently in the home for staff and others to refer to. There had been one safeguarding referral made by the provider since the previous inspection. This showed they had taken appropriate action to safeguard people within the home.

People received their medicines safely. We checked four people's medicine records which were accurate. We looked at arrangements for the storage and disposal of medicines and found they were safe. Controlled drugs records were accurate and signed by two people as required. One person had variable ability to self-medicate although was not able to do so at the time of our visit. There was an appropriate risk assessment in place if and when they regained the capacity to self-medicate safely. The expiry dates for medicines were checked and temperatures of medicines storage were recorded to ensure they were within recommended limits. At one stage during the visit a medicines trolley was not securely fixed when not in use and a medicines storage room door was not locked, although the medicines storage cupboards in the room were. Both these issues were promptly addressed as soon as they were brought to the attention of staff. We confirmed medicines audits were completed monthly to monitor and support good practice and ensure people's safety.

Regular maintenance schedules were in place for equipment to ensure it remained safe to use.We looked at service records for fire extinguishers and found they had been serviced in September 2014 to ensure they remained operationally effective in the event of fire.

Staff were provided with training in the safe use of hoists and other equipment used in the care of people. One member of staff said recent moving and handling training had been "Very helpful."

There were effective staff recruitment processes in place to safeguard people from the employment of unsuitable staff to provide their care. We looked at the recruitment files for two recently recruited staff. We found appropriate checks had been undertaken before they commenced work. These included written references, full employment history with gaps accounted for, satisfactory Disclosure and Barring Service (DBS) checks to identify any known criminal record and health screening.

There was a system in place for the reporting and recording of incidents and accidents. The CQC had been appropriately informed of any reportable incidents as required under the Health and Social Care Act 2008.

Good

Is the service effective?

Our findings

People who lived in Hempton Field and their relatives all thought their health and care needs were effectively met. One person commented "I am well-looked after and can't grumble." They were also positive about the standard of the care and nursing staff. Relatives told us they felt staff were both "confident and competent."

Care plans included evidence of pre-admission assessments to identify individuals' care needs. This enabled, for example, any specific equipment required to be put in place before the person moved in and ensured their needs could be met from the outset. The initial assessment process also included a nutritional assessment which identified any risk factors such as a history of weight loss or swallowing difficulties as well as establishing any dietary requirements. This could include people who were diabetic or who needed their food thickened to assist them to swallow food safely. Specialist healthcare professionals confirmed they received appropriate referrals from the service and had been; "Impressed by the diligence of staff and the level of care and attention they show." They confirmed staff followed any advice and recommendations given and noted the care records they saw included details of the healthcare professionals involved with the service.

The home was part of a pilot scheme which aimed to ensure all 'residents' were receiving the correct care, services, management and treatment to meet their health needs. The healthcare professional involved told us they worked well with the GPs who are involved with Hempton Field and that co-operation and co-ordination with them was good, which benefitted people living in the service. They noted staff were very caring and proactive and keen to improve the care they give. One GP noted the service was very co-operative and met requests, for example for blood tests, very promptly. One person told us a recent visit by an optician had resulted in them having a new pair of glasses which they were currently; "Breaking-in." This confirmed people had ready access to the health service advice, support and treatment they needed.

We observed staff used an audible alert system. This indicated when three people's medicines, which were time critical were due and so they had to go and make sure it was taken. This provided evidence people's individual needs were assessed and appropriate action taken to meet them

Staff confirmed they received regular training to help them meet people's care needs. New staff had been given appropriate induction training which reflected 'Skills for Care' common induction standards. This meant they knew what was expected of them and were given the knowledge, skills and support they needed to carry out their specific role. For example, domestic staff confirmed they had received infection control training and training about the use and storage of chemical cleaning materials which could be hazardous to people's health.

Training records included periodic updates where this was judged as necessary by the provider; for example moving and handling and safeguarding along with others. One nurse talked about the e-learning they had undertaken. They had also received specific training in catheter care and providing people with nutrition through a tube where required. One member of staff noted that the only drawback with e-learning was if the 'technology' let them down. Overall however, they were very satisfied with the approach of the provider to training. "If you ask, they will always try and find some appropriate training for you."

People received support from staff who felt well-supported. Staff confirmed there was a mixture of formal and informal supervision, together with an annual appraisal. Records showed formal supervision was not at regular intervals. When we asked staff, some thought it was three monthly and others four monthly. One supervisor told us how they were going to trial group supervision at six-weekly intervals. They confirmed there were staff meetings which were helpful, including nurses meetings for qualified nursing staff. This meant although formal supervision was not always planned or carried out at set frequencies, staff felt they had the support they needed and also felt able to approach senior staff and the manager at any time if they had a problem or needed advice on a specific matter.

People confirmed choices were available for all meals. People told us the food was quite good and was nutritious and well-presented. One person noted; "The food quality varies, normally at mid-day there is a choice of two and a choice of sweet." There was a four week menu rotation usually in operation with an element of seasonal variation.

We observed two mealtimes. They were quite informal and relaxed. People were able to eat at their own pace. Staff were aware who needed assistance and this was given discreetly. One person confirmed; "Staff will cut my food up for me, but apart from that I'm alright by myself."

Good

Is the service effective?

We found people were offered choice, not only as to what they ate but also where. We found four people had formed a 'lunch club' and had their meals together at a table in the lounge. One member of staff was heard to ask a person if they had finished and was it all right to take their tray, they only took the tray away once the person had said they could. Another person said they thought breakfast and lunch were too close together, however, we also heard staff in the morning remind each other that one person wanted a late breakfast. This suggests meal-times could be flexible but some people might not be aware of that. In each of the rooms we went into to speak with people there was a drink and glass within their reach. They confirmed this was always the case.

The staff we spoke with had a good understanding of the implications for them and the service of the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make specific decisions at a given time. When people are assessed as not having the capacity to make a decision themselves a decision is taken by relevant professionals and people who know the person concerned. This decision must be in the 'best interest' of the person and must be recorded.

The Care Quality Commission (CQC) monitors the operation of the DoLS as they apply to care services. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after them safely. Two people were subject to an agreed DoLS, the conditions of which were being met. There were no applications outstanding at the time of the inspection. The management of the service were aware of the implications for the potential increase in applications as a result of a recent Supreme Court judgement which widened and clarified the definition of what constitutes a deprivation of liberty. There was an easy read explanation of the DoLS process in the reception area of the home.

In the PIR the provider stated none of the people who currently received care had made an advance decision to refuse treatment (DNAR) at the end of their life. Twenty six people were stated as having given another person valid and active lasting powers of attorney with authority to take decisions about the service provided to them. Care plan documentation included details of these and any DoLS in place.

Good

Is the service caring?

Our findings

People were very positive about the standard of care they received or observed. "I think the staff are dedicated to their task. They don't just rush in and out; they chat and make sure I'm comfortable." "I regard them as friends, not just as staff;" and "There's always someone there if I need them" were comments from three people who received care. Two relatives said their informed research had caused them to choose Hempton Field for their relative and they had; "Not regretted that choice".

People who received care and support, together with people responsible for them were involved with care planning. Care plans included varying levels of evidence of this, however people and their relatives told us they felt as formally involved as they wanted or needed to be . They indicated they were far more likely to achieve what they wanted from their care through informal conversations rather than formal reviews, although they confirmed these did take place.

We received feedback from GPs, falls specialists and the Care Home Matron Service and Speech and Language Service. They provided very positive views of their interaction with the service and the quality of care and support they observed. "Open and honest and eager to find alternative ways to improve on the excellent care they already seem to provide"…"They always follow advice and recommendations…the written care plans seen have the patient's needs clearly presented with any appropriate correspondence from other therapists or medical staff to refer to." Where there were any areas of concern, they said these had been addressed promptly.

Interactions we observed between staff and people living in the home were polite, respectful and friendly. There was a very relaxed atmosphere throughout the home and while staff were busy, they were able to 'chat' informally to people in lounges and dining areas.

People's dignity was upheld. The home had 'Dignity Champions' to raise awareness amongst staff and model good practice. We observed staff were involved with people in an appropriate and positive way. For example, while we were with one person a member of the domestic services team went past and had a respectful but very friendly and informal few words with them, using their preferred name. We found this pattern was repeated throughout our visit and helped create a relaxed and informal atmosphere within the home. One member of staff summed up their approach by saying; "Our role is to make their experience as pleasant as possible for as long as possible."

People told us they had found staff listened to what they said and the views they expressed. There was a residents forum. This was arranged by the activity staff who asked groups of people what they thought about various areas of the home's operation. Some of the people we spoke with were not sure if the forum was always effective; "I don't think it changes anything" however, most people felt they were able to influence how their individual care was provided on a one to one basis. There were contact details for; "Care Aware" advocacy service in the reception area for those people who might want support to express their views.

The home had dignity champions who worked with staff and others to promote care with dignity throughout the home. In their PIR the provider cited specific 'Dignity days' to raise awareness. People's spiritual needs were addressed through contacts with caring and religious organisations within the community.

Good

Is the service responsive?

Our findings

People told us they felt their care was focussed on their individual needs and were confident staff knew them as individuals. They confirmed they were able to vary their daily routine, for example what time they got up and had breakfast. On our arrival we heard staff discussing who was up and wanted breakfast and who wanted to have a lie–in and a late breakfast.

People were aware of there being a complaints policy. However, none of those we spoke with had made a formal complaint and felt it unlikely they would ever need to. They said they could raise any concerns they had informally with staff or the registered manager and were confident it would be sorted out. They confirmed there was a regular residents' forum, held in the lounge with the activities co-ordinator where issues could be raised and questions asked. In the PIR, the provider recorded one written complaint being received in the previous 12 months, which was resolved within 28 days in line with the complaints policy. Over the same period the provider recorded 12 written compliments.

Two people were not sure minor 'grumbles' were always addressed. One gave the example of their bathroom being too hot, although they also said there was "Nowhere for a window to be put." Formal feedback from people was received through regular surveys. The results of the survey for January to March 2014 was included in the visitors information pack in reception, together with the complaints policy and procedure and contact details for appropriate external organisations people could contact if they chose to. The registered manager also kept a record of any relevant discussions with family contacts arising from telephone calls or visits. This enabled minor concerns to be dealt with promptly and any trends or patterns in concerns identified and acted upon.

People were very supportive of the activities staff; People said "The programme is quite varied" and they spoke warmly of the trips out arranged to popular local attractions. There was an activities board with details of the day's activities; on the day of our visit activities included hairdressing and memory games. Staff confirmed people were supported to maintain their religious observance if they chose to do so. Where requested it was possible for celebrations of people's lives to be held by their families in the home following their death so that people could participate. There was also an annual memorial service held in the home to remember those people who had died, when families were also invited. People were encouraged and assisted, where required, to access the garden. This included a large paved area accessible to wheelchairs, with seating available. There were a selection of sun hats and walking sticks available for people to use.

Care plans included assessments of people's needs prior to them moving into the home. They included details of the support people required including with their mobility, medicines and any specific health conditions, for example Parkinson's disease. There were details of their medical history together with details of their preferences as to daily routines and care, including their end of life wishes.

Care plans included background history of the person concerned where it had been possible to get the details from the person or their families. Staff knew the individual preferences of people they provided care and support for and addressed them appropriately and with patience to make sure they understood. One person told us of an occasion when they had fallen in their room. They said staff responded 'Very quickly' and the follow up treatment was also very quick.

We received mostly positive comments from healthcare professionals about the standard of care planning. "The written care plans I have seen have the patient's needs clearly presented, with any appropriate correspondence from other therapists or medical staff included" and another person noted; "Staff ensure visiting GPs have a copy of my recent recommendations…and it seems always to be clear in the resident's notes what action has been taken". One person did note that whilst weights are taken monthly, there could be a delay in transferring that information onto the care plan.

Care plans were reviewed monthly and we were told that was when any significant changes were recorded. Staff confirmed they had access to care records and demonstrated a good knowledge of individual people and their current needs. They were able to give details about how people's care needs had changed over time. This confirmed people's changing needs were being met.

Good

Is the service well-led?

Our findings

Relatives confirmed they had completed annual questionnaires and had also met informally with the registered manager to discuss their relative's care and provide feedback. People were positive about the leadership of the registered manager and told us they were "Patient and approachable."

Staff said they were well-supported and had the opportunity to discuss any issues with their line manager or the registered manager formally or informally. One member of staff said the home was "An open and caring environment", they said staff were "Well-led" and felt staff enjoyed working for the organisation. Staff told us they were aware of the provider's whistle-blowing policy and would not hesitate to share any concerns they had with them as they were confident they would be addressed.

The staff team included champions who shared responsibility, with the management team, for promoting consistent good practice in specific areas of care provision. The service was in the final stages of their accreditation under the Gold Star Framework scheme which promotes good practice, including management within care homes. This showed the provider was prepared to be assessed by a recognised external quality monitoring team in order to improve the standard of care provided in Hempton Field.

We saw minutes of heads of department and staff meetings held to discuss issues and share information. There were also a series of regular audits carried out on specific areas of the home's operation. We saw results of a care plan audit carried out on the 28 May 2014 which had identified issues with care plan completion. An action plan was in place to address this. There were systems in place, for example, to monitor and record the administration of medicines and maintenance of equipment, including call bells and fire alarms. This helped ensure any safety or maintenance issues could be promptly identified and addressed.

The PIR had been completed appropriately and returned promptly. This showed the provider was aware of and met their responsibility to report and respond to information requests in line with their requirements of their registration with CQC. In the PIR, when providing examples of how the service was to be improved, the provider informed CQC there was to be a change of medicines provider for the home. This was in order to facilitate better training for staff, enhanced medicines monitoring and quality control and improve the delivery of medicines in particular those required at short notice. In making this change the provider demonstrated a willingness to consider new ways of providing care and services in order to enhance people's care experience.