Hales Group Limited

The Old Maltings

Inspection report

The Old Maltings
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30 July 2018

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This announced inspection took place on 26 July and further visits to people's homes took place on 30 July 2018. The provider was given 48 hours' notice because we wanted to be certain the registered manager and key staff would be available on the day of our inspection. We also wanted to give them sufficient time to seek agreements with people so that we could visit them in their homes to find out about their experience of using the service. This was a first inspection for this service.

The Old Maltings provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service consisted of 24 individual flats and two active assessment rooms for people receiving short term respite care. At the time of our inspection 27 people were receiving a service at The Old Maltings site and four more people received a service in their own homes in the local area.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People received safe care but some improvements were needed relating to the management of people's medicines. Risks were well managed and people were supported to take assessed risks. There were enough skilled staff to meet people's needs and staff had been recruited safely. Staff were aware of their responsibilities to protect people from abuse and to protect them from the risk and spread of infection.

People's needs were appropriately assessed and staff received comprehensive training in order to meet those needs. Staff were well supported and worked effectively with other health and social care professionals to support people's health needs and to manage their eating and drinking.

People consented to their care and the service worked in accordance with the Mental Capacity Act 2005 (MCA). The MCA requires people's capacity to consent to their care to be assessed. If people are found to lack capacity, any decisions made which relate to their care and treatment must be made according to a structured process and must be in their best interests. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the polices and systems in the service support this practice.

People received care from staff who were kind and relationships between staff and those they were caring for were good. People were involved in decisions about their care and were supported to be as independent

as possible.

People received person centred care which was designed to meet their individual needs and preferences. Staff knew people's needs well and information systems captured what was important to people about their care.

Complaints were well managed in line with the provider's complaints procedure.

Staff received training in end of life care and worked in partnership with other healthcare professionals to support people approaching the end of their life.

A system of audits, both internal and external, ensured the provider had oversight of the quality and safety of the service. Staff at all levels were well supported and there was an inclusive and open culture where people were encouraged to raise concerns and provide feedback. The registered manger and regional manager demonstrated a commitment to further improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. Medication administration records were not always filled in and incomplete stocktaking procedures meant errors could not be promptly identified.

Risks to people's safety were assessed and well managed.

There were sufficient numbers of suitably trained and experienced staff to meet people's needs.

Recruitment procedures ensured staff were safely employed and did not pose a known risk to people who used the service.

Staff were trained in keeping people safe from abuse and had a good understanding of safeguarding procedures.

Staff were trained in infection control and understood their responsibilities to protect people from infection.

Is the service effective?

Good

The service was effective.

The provider involved people, and their relatives if appropriate, in assessing their needs.

Staff received a comprehensive induction, ongoing training, supervision and appraisal. Staff felt well supported.

Staff worked with other professionals to support people with their healthcare needs.

Staff supported people well with their eating and drinking

People consented to their care and staff had received training with regard to the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People who used the service praised the caring nature of the staff who supported them. Staff interacted with people warmly and with respect.

People were involved in decisions about their care and support.

Staff supported people to be as independent as they could be.

Is the service responsive?

Good

The service was responsive.

Care was person centred. People's care plans contained specific details about their care needs and preferences and staff knew people's needs well.

A complaints procedure was in place and complaints had been well managed and resolved to people's satisfaction.

Staff received training in end of life care and worked in partnership with other healthcare professionals to support people approaching the end of their life.

Is the service well-led?

Good

The service was well-led.

Quality assurance systems effectively monitored the safety and quality of the service.

There was a positive and inclusive staff culture which developed and supported staff. People who used the service were encouraged to provide feedback.

The registered manager was responsive to issues raised and was keen to learn from incidents and drive further improvements in order to benefit the people who used the service.

The Old Maltings

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 26 and 30 July 2018 and was the first inspection for this service which was registered with CQC on 14 June 2017. It was an announced inspection carried out by one inspector. We gave the registered manager 48 hours' notice of our intention to inspect because the location provides a service in the community as well as at the extra care housing site and we wanted to make sure relevant information and key staff would be available to us at the main office.

Before the inspection we reviewed the information we held about the service. We reviewed the Provider Information Return (PIR). This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We also looked at notifications. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters.

We spoke with four people who used the service, including two people who received care in the community and not onsite. We spoke with the regional manager, the registered manager, one acting senior care staff member and three care staff. We reviewed four care plans, four medication administration records (MAR), two staff files and other records relating to the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

We found that people were kept safe and the service took action to protect people from risk. However, we found that some procedures needed improvement to ensure people always received their medicines as prescribed.

There was a mixed picture with regard to how medicines were managed. Staff had received training in the administration of medicines and demonstrated a good understanding of people's medicines and knew how people liked to take them. Staff competency to administer medicines was checked after they had completed their training. The two care staff we observed administering medicines had had their competency to do so checked twice during 2018.

People who used the service were supported to have a regular a review of their medicines and this was clearly recorded in their care plan. There was very little information in people's care plans about what their medicines were for and little guidance for staff about giving medicines which were only required occasionally. This meant there was a risk that people might not receive their medicines as intended by the prescriber. We discussed this with the registered manager and found that they had begun to address this issue by the time of our second inspection visit on 30 July by adding a sheet of information to each person's MAR chart.

People were encouraged to be as independent as they were able in taking their medicines. One person told us, "They prompt me to take my tablets and hand them to me when I'm ready." Another person had recently been prescribed a new medicine and staff were able to tell us about it in detail. The person told us, "I had some medicines and special creams to put on. They do it for me. It's better now."

Procedures for checking stocks of medication were not robust as staff did not always carry over stocks of boxed medicines from one month to the next. This meant we could not be sure that people always had the correct amount of their medicines. Where stocks were carried over we found totals in stock did not always tally with records. For example, one person's paracetamol record stated that 100 tablets had been received and 18 administered which should have left a total of 82. However there were 79 tablets. It was not clear from the MAR chart when the person had had one tablet administered and when they had had two. The registered manager felt this was a recording issue and explained their plans to introduce a more robust stock control system.

We also noted some gaps on MAR charts where staff sign to record that a medicine has been administered. An audit of the current MAR charts had not taken place since the current MAR chart had been put in place as it was only day three of a twenty-eight-day cycle. The registered manager told us they would raise this issue with individual staff members and with staff as a whole at the next staff meeting.

We found the registered manager responded promptly to all the concerns we raised about medicines management. They drew up an immediate action plan to address the concerns. They discussed this with the regional manager who confirmed to us that some points of learning would be shared with other services,

also managed by the provider, in the local area.

Other risks were well managed and staff demonstrated a good understanding of how to keep people safe. There were systems in place designed to keep people safe from the risk of abuse. Staff had received training in keeping people safe and all staff we spoke with demonstrated a good understanding of how to recognise the signs and symptoms of abuse. They were also clear about what actions they should take if they suspected someone was being abused. One staff member told us what they would do if they discovered some unexplained bruising on a person saying, "Record any injury on a body map, make care notes, report to the manager and report to the local authority safeguarding team if needed." Another staff member confirmed to us that they had made a referral to the local authority when they suspected a person might be being bullied.

There were effective systems in place to assess and manage risk and staff were routinely trained in basic life support. Risks relating to people's mobility, pressure care, health conditions and taking medicines had been assessed. Actions to mitigate these risks had been recorded in care plans and were regularly reviewed to ensure the information was current. People who used the service confirmed to us that staff always worked in a safe manner, hoisting in pairs for example, and told us they felt safe. Care plans contained very specific instructions for staff to reduce any risks. One person said, "They always do what they should – it's written down."

There were enough staff to meet people's needs and help keep them safe. All the people we spoke with told us staff never missed a care visit and came on time. One person living in one of the extra care flats said, "I press my buzzer and they come quickly." People living in the community had no complaints about the reliability and skills of the staff. People confirmed that staff stayed for the required time and did not cut visits short. During our inspection of the extra care flats we observed staff going off quickly in response to people's buzzers and staff confirmed that additional time would be spent with a person if they needed it.

Staff told us they felt there were enough of them and did not feel under too much pressure to carry out their roles. One person said, "We work well as a team. We never use agency." This meant that people would always be supported by regular staff who were more familiar with their needs. Rotas confirmed that staffing levels were appropriate to people's needs. Where a person's needs increased the regional manager and registered manager negotiated for additional staff hours to keep the person safe and meet their needs.

Staff had been safely recruited and had all the required pre-employment checks in place. This included references, eligibility to work in the UK, employment histories and Disclosure and Barring Service checks to make sure staff were safe and suitable to work with this client group.

Staff received training in infection control. We observed staff using personal protective equipment (PPE), such as aprons and gloves, to minimise the risk and spread of infection. Staff told us there were plentiful supplies of PPE available to them. Hand gels were available to staff and visitors in the communal areas of the service and in people's individual flats.

Good

Is the service effective?

Our findings

People who used the service told us they were happy with the way staff supported them. One person said, "They know what they are doing. They are good. I'm very lucky." Another person told us, "I couldn't manage without them. They are wonderful. They wash me and help me to dress… I've got no complaints with this agency. It's wonderful."

All the people who used the service had their care needs assessed by the registered manager and were only provided with a place if the service would be able to meet these needs. We observed that one person was in the process of being assessed and detailed discussions were being held to establish if The Old Maltings was the right place for them. The registered manager told us, "We need to make sure the scheme is suitable for [the person] and that [they] are suitable for the other residents."

Once an initial assessment had taken place staff drew up a comprehensive care plan. A variety of needs were assessed, and plans took into account current guidance such as that for care of people with diabetes or those at risk of developing a pressure sore.

Staff demonstrated a very good understanding of people's needs and had received the training they needed. New staff had undertaken a structured induction and told us they felt well supported. One staff member said, "I've had lots of training and shadowing…I've learned everything from [a co-worker] It's really natural. You pick it up and you get confident." Another staff member told us, "We are trained well here. If I felt I needed any extra training I feel confident it would be provided."

Staff received training, including refresher training, in a variety of subjects including moving and handling, safeguarding, infection control, food hygiene, fluids and hydration, communication, fire, end of life, dementia care and person centred care. Some training was provided by the provider's in-house trainer and was praised by the staff. One told us, "[Trainer] is really good and is open to questions. She has so much information." Staff competency to administer medicines and to carry out moving and handling was regularly checked. Staff were further supported and monitored with annual appraisal and supervision sessions, although some people were overdue for supervision. The registered manager demonstrated that they had already begun to address this backlog.

Staff supported people with their eating and drinking and we observed staff preparing meals and drinks for people. We noted that one person had been recorded as refusing fluids and staff had arranged a GP referral and hospital admission for the person. Staff had received training relating to food and fluids and further training was planned. Care plans contained information about people's likes and dislikes related to food and staff knew people's preferences very well. We observed one person's plan stated that they always liked to eat toast in the morning and we noted they had been given toast on the morning of our inspection visit and they confirmed this was always the case.

We found that people received good healthcare support from staff who understood their healthcare needs well. It was clear from records that staff worked well with other healthcare professionals to try and keep

people well. One person told us, "The carers come to hospital with me and make notes and it goes in my files. An optician comes here and sorts out my eyes and I've asked them to put an update about my eyes in my care plan." We saw that another person was supported to carry out an exercise programme which a physiotherapist had put in place for them. Staff were clear about this person's needs and exactly what exercises they should do and there had been an improvement in the person's condition.

The service had two reablement flats which were used for people on short stay respite care. We spoke with one person who had come into the service for a period of rest and recuperation. We noted that their health was much improved in a short time and they were very happy with the care and support they had received.

We considered whether the service was operating in line with the Mental Capacity Act 2005 (MCA). The MCA ensures that people's capacity to consent to their care and treatment is assessed. If people do not have the capacity to consent for themselves appropriate professionals, relatives or legal representatives should be involved. This aims to ensure that any decisions are taken in people's best interests according to a structured process.

Staff had received training related to MCA and those we spoke with had an understanding of its principles. We found that people's capacity to consent to their care had been assessed and recorded in their care plan. Some records had been signed by the person they concerned or by the person who had lasting power of attorney (LPA) for them. Staff understood who had LPA and what this meant.

Good

Is the service caring?

Our findings

Feedback about care staff was positive and we observed kind and close relationships between the staff and the people they were supporting and caring for. One person told us, "Staff are respectful and try and encourage me to do a lot."

People who used the service, and sometimes their relatives, if appropriate, had been involved in drawing up care plans and knew all about them in most cases. Care plans included people's likes and dislikes and their preferences with regard to their care. People had regular opportunities to discuss their care and review their care plans if they wished to.

Care plans included a section on people's life story and future goals. This made clear to staff what was important to each person. People's mental health needs were considered alongside their physical health. We saw that where people were prone to anxiety or depression this was noted in care records and staff had guidance about how best to help the person. Staff demonstrated a good understanding of people's needs relating to their mental health and wellbeing.

We saw evidence of staff promoting people's independence and enabling people to remain independent in as many aspects of their life as they could. Some people were responsible for administering their own medicines but just needed some physical help from staff while others did their own cooking with minimal assistance from staff. Staff had a good understanding of how important people's independence was to their self-esteem.

People's particular needs relating to their culture, religion and ethnicity had been considered and formed part of their care plan. One person told us about how they had been involved with their local church over many decades and staff demonstrated an understanding of how important this part of the person's life was to them.

Staff promoted people's dignity and ensured their privacy. Staff asked people if they were happy to talk to us and made sure they understood that they could stop talking to us if they chose. This demonstrated a respectful attitude towards people and the choices they made. When we carried out a visit to a person living in the community staff asked us to wait until all the person's care needs had been attended to and they were ready to chat to us and had not been rushed.

Good

Is the service responsive?

Our findings

People received care and support which was designed to meet their individual needs. People told us they received their care on time and in a way which reflected their preferences and choices. One member of staff explained to us, "We're very person centred here. We really encourage independence. You are in a person's home. You are there to meet their needs and their choices."

Current information about people's care was recorded in daily notes and handed over to colleagues. The daily task sheet was signed by staff and included additional tasks, such as cleaning wheelchairs and doing laundry, which staff could carry out if they had time. Care plans were in the process of being reviewed and entered onto a new format which included more comprehensive information about people's care needs and preferences.

Care plans contained specific guidance for staff, especially newly employed staff, to help meet people's needs and respect their specific preferences. For example, one person's moving and handling care plan contained detailed instructions such as 'lift my left leg and then pull the sling under'. The plan also documented the order in which the person wished to dress and undress. The person confirmed to us that staff always did this task as recorded in their care plan. Another person's plan reflected that they did not like to ask the staff for any help and outlined strategies for staff to use to discreetly offer care and support without upsetting the person.

One person was regularly supported to have Skype calls with their family and care plans carefully documented what help the person needed and what they were able to do for themselves.

People were supported to access their local community, although where this was in addition to their assessed care needs, this was funded through an additional fee. People told us the ability to do this was very important to them.

Although CQC does not inspect communal areas of the service, people told us they welcomed the social activities provided in the communal areas and enjoyed the opportunities to make new friends. Staff were available to support people in these areas as well as in their individual flats for the scheduled care visits. External organisations also came into the service such as The Stroke Association which used one of the lounges for meetings.

A complaints policy was in place and we reviewed the two complaints the service had received. Both had been well managed and included a thorough investigation of the complaint and a written response to the complainant. Both issues had been resolved to the complainant's satisfaction. Informal concerns were well managed and the tenants' meetings gave people a forum to raise any concerns if they needed to. People were also clear about how they could raise a concern privately with one person telling us, "If I have a problem I can talk to one of the team leaders or [the registered manager] and they'll help me."

Most care staff had received end of life care training and this was planned for others. People's end of life

wishes were recorded in their care plan, if appropriate, and it was clearly recorded where people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order and staff knew if people had this in place.

Good

Is the service well-led?

Our findings

The registered manager was open, transparent and keen to address issues as soon as they were raised. A regional manager provided support and visited the service regularly. The registered manager was aware of their responsibilities to report significant information to CQC and to work within the regulations. We also noted that they understood their responsibilities to report any safeguarding concerns to the local authority.

We received very positive feedback about the management team from people who used the service and staff. The working culture was positive and inclusive. One member of staff told us, "I love working here. [The registered manger and the regional manager] are both very supportive….we all pull together. I've never worked anywhere quite like it." Another staff member commented, "[The registered manager] was really good to me recently….We are a good team and we help each other." An out of hours system was in place which ensured staff could always contact a member of the management team should they need advice or support.

People who used the service knew who the registered manager was and told us they trusted her and enjoyed a chat with her when they could. We saw several people calling into her office throughout the day and she spent time helping them or just chatting. The registered manager, in turn, felt supported by the regional manager and also by their peers running services in the local area. They also attended local groups to network and ensure they were aware of any local initiatives which might benefit the people who use the service.

Regular tenant meetings and staff meetings took place and these helped the management team focus on the issues which were important to people. We also saw that independent surveys had been sent out to staff and the people who used the service. Responses from both sets of people were very positive. Staff in particular were very positive about their training, supervision and access to policies and procedures. Both the people who used the service and staff were given the opportunity to raise any concerns or contribute ideas as part of the survey process.

The provider's 'Vision and values' were clearly displayed in communal areas of the service and known by staff. We noted strategies which were designed to recognise staff good practice where it goes 'the extra mile' and to support staff wellbeing. A scheme was in place to recognise and celebrate outstanding practice and reward staff with a financial bonus. It was hoped that this recognition of staff would also contribute to maintaining the staff team. We noted that staff retention was good and turnover was low.

There was a robust system of audits in place as well as an external audit which had been carried out in July 2018. Audits identified patterns and trends and helped the registered manager determine what they needed to focus on. The registered manager also sent weekly reports to the regional manager to ensure that more senior staff had oversight of the service. A quarterly action plan was drawn up in response to the audits and the registered manager was able to explain to us the current targets they were working in line with. Following discussions with the local authority who place people at the service, they had re-evaluated the

assessment process for prospective new tenants. The assessment was now focussed on a maximum number of care hours per person so that the service could be sure to meet people's needs in the future.

The registered manager had created a link with a dementia support group, which held meetings at the service. Staff had been trained as 'dementia friends' which is a nationally recognised movement to raise awareness of those living with dementia and the challenges they face. The service worked in partnership with other health and social care professionals including GPs, physiotherapists, occupational therapists, the dementia intensive support team and district nursing team. Information was appropriately shared with other professionals and records documented their involvement clearly. Records were clear and well organized and there was a commitment to further improving people's care plans to ensure all important information was captured.