Pride Care Homes Limited Liability Partnership

The Malting's Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The Malting's Care Home provides accommodation, support and care, including nursing care, for up to 50 people, some of whom live with dementia. At the time of our inspection there were 48 people living at the care home.

The home is purpose built and is arranged on two floors with an enclosed landscaped garden to the rear. Access to the first floor is by means of stairs or a passenger lift. All bedrooms are for single use only and are provided with en suite facilities. On-site leisure facilities include a gymnasium, cinema, hairdressing, a library, games and sensory rooms. In addition, there are communal bathrooms, toilets, lounges and quiet rooms. The home offers long or short term stays.

The inspection was unannounced and was carried out by one inspector.

A registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

We carried out an unannounced comprehensive inspection of this service on 03 February 2015. A breach of three legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to management of people's medicines; how people were cared for and how their right to consent was valued.

We undertook this focused inspection on 18 May 2015 to check that the provider had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Malting's Care Home on our website at www.cqc.org.uk

At our focused inspection on the 18 May 2015, we found that the provider had followed most of their plan which they had told us would be completed by the 30 April 2015 to show how the legal requirements had been met.

People told us that they were satisfied with how they were supported to take their medicines. The medicines trolley was locked at the times when it was left unattended and staff who were responsible for the management of medicines held the keys to the trolley and storage areas for medicines. People, who were assessed to be able to manage their own medicines, kept their medicines secure.

People were supported in making decisions about their care and were not subjected to unlawful restrictions. Mental capacity assessments had been carried out and the conditions of people's individual authorised Deprivation of Liberty Safeguard (DoLS) applications were adhered to.

People were satisfied with how staff treated them and staff comforted and treated people well. However, this was not consistently carried out. The quality of people's dining and moving and handling experiences was varied and this depended on how staff members interacted with people.

People knew the names of the senior managers and staff had positive comments to make about them. We saw that improvements had been made in relation to the management of the service. Staff were more aware of their roles and responsibilities and audits had identified actions to be taken where improvements were required. Following the last inspection we rated the service and staff were aware of this. However, people and visitors were not aware of the rating as this information was not publicly displayed for people to see.

We found a breach of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

Action had been taken to improve how people's medicines were managed.

People's medicines were kept secure.

This meant that the provider was now meeting the legal requirement.

Good

Is the service effective?
The service was effective.

Action had been taken to improve how people were supported with making decisions and they were not subjected to unlawful restraint. Conditions of people's authorised DoLS were adhered to.

This meant that the provider was now meeting the legal requirement.

Good

Is the service caring?
The service was not always caring.

There were minor inconsistencies in the way staff interacted with people but improvements had been made.

This meant that the provider was now meeting the legal requirement.

Requires improvement

Is the service well-led?
The service was not always well-led.

People were not aware of, and did not have to information about the CQC rating of the home.

Action had been taken to improve the management of people's medicines and how they were supported to make decisions.

There was improved leadership and staff were aware of their roles and responsibilities. This meant that the provider was now meeting the legal requirement.

Requires improvement

The Malting's Care Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of The Malting's Care Home on 18 May 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 03 February 2015 had been made. The inspector inspected the service against four of the five questions we ask about services: is the service safe; is the service effective; is the service caring and is the service well-led. This is because the service was not meeting legal requirements in relation to regulations.

The inspection was undertaken by one inspector. Before the inspection we looked at all of the information that we held about the home. This included the provider's action report, which we received on 18 March 2015.

During the inspection we spoke with two people's relatives and nine people who used the service. We also spoke with three representatives of the registered provider, a senior nurse manager, a registered nurse (RGN), two senior care staff and a health care professional. We looked at six people's care records and records in relation to the training of staff. We observed people's care to assist us in our understanding of the quality of care people received.

Good

Is the service safe?

Our findings

At our comprehensive inspection of The Malting's Care Home on 03 February 2015 we found that people's medicines were not kept secure. This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines (which corresponds to Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.)

At our focussed inspection on 18 May 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulations 13 and12 as described above.

People told us that they were satisfied with how they were supported to take their medicines. One person said, "The staff bring my medicines to me. I know what I take and when I need to take it. They (staff) know I have to take it with food and know exactly when I am to take it." Another person said, "I get my medication when I need it. I now get paracetamol (a pain killer). It helps with the pain in my arm." We saw that when a person complained of pain they were given medication to relieve their discomfort. A health care professional told us that they had no concerns in relation to how people were supported to take their prescribed medicines.

There was a procedure in place to assess people in managing their own medicines and this was based on a risk assessment. A person told us, "I give my tablets myself. I take it (medicines) regularly and I don't ever miss it. I also give [brand name of prescribed nutritional supplement] as well." They told us that the senior nurse manager had carried out a risk assessment and said, "They went through this form with me and I signed it." They understood their responsibility in keeping their own medication secure. They said, "There's a cupboard in my wardrobe and I always lock it. And I always check it again to make sure it is locked." They told us that they had the keys to the cupboard and to the door of their room, which was locked.

We saw that medicines were kept secure during the medication round and that the medicines trolley was locked during the times when it was left unattended. We also saw that the keys for the storage of people's medicines were held only by staff who were responsible for the management of medicines.

Good

Is the service effective?

Our findings

At our comprehensive inspection of The Malting's Care Home on 03 February 2015 we found that assessments were not in place to determine people's mental capacity to make decisions about their care. Decisions about their care were made on their behalf without such an assessment in place. This was a breach of Regulation 18HSCA 2008 (Regulated Activities) Regulations 2010 Consent (which corresponds to Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Need for consent.)

At our focussed inspection on 18 May 2015 we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulations 18 and12 as described above.

People told us that they were asked by the staff for their decisions about how they wanted to be looked after. A person said, "I do as I please. I tell them (staff) when I want to go to bed, when I want to get up and what I want to wear." Another person said, "They (staff) ask me if I want to get up. I'm awake anyway and I'm usually waiting for them." We were also told by another person, "The staff asked me if I wanted to get up. It was only 7:00 and I told them it was too early." They told us that staff had helped them get up at the time they preferred.

Minutes of a staff meeting demonstrated that staff were reminded that people's choice about when they wanted to get up and go to bed were to be respected. A member of staff told us that they had gained an increased awareness in respecting people's choice. They said, "We have to give people choice." The member of staff told us that it was not what the staff thought the person must do but what the person wanted to do.

People's mental capacity to make decisions about their care had been carried out and DoLS applications had been made to the local supervisory bodies. People were only restricted, which included leaving the home supervised, as conditions of their DoLS. We also saw that people had access to their walking frames which enabled them to freely move about.

Requires improvement

Is the service caring?

Our findings

At our comprehensive inspection of The Malting's Care Home on 03 February 2015 we found that people were not provided with care in a kind and caring way. This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare (which corresponds to Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person centred care.)

At our focussed inspection on 18 May 2015 we found that the provider had followed most of their action plan they had written to meet shortfalls in relation to the requirements of Regulations 9 as described above

A health care professional told us that they had seen staff treat people well and were kind and patient with them. Relatives told us that they had no concerns about how their family member was looked after and people also told us that the staff treated them well. A person said, "Staff treat me very well. My door is always open and the staff just tap on my door and they ask me how I am." Another person said, "It's first class living here. Staff treat me very well." They told us that staff knocked on their door before they entered. However, we saw a member of staff walk into a person's room, without knocking on the door and without the permission of the person to enter the privacy of their room.

We saw that staff comforted people when they were coughing and when they were distressed with being moved from their chair to a wheelchair by means of a hoist. We saw that staff spoke with people during the moving and handling procedure but this was not consistently carried out. We saw that some staff failed to engage with a person and did not explain to them what they were doing throughout the moving and handling process. We also saw staff members move people, who were seated in their chairs, to be near the dining table, without telling them what was happening. Therefore, there were times when staff missed opportunities to value and care for some of the people as an individual.

During lunch time we saw some staff members sitting down and talking with people whilst they were helping them to eat their food. We saw that people were asked what they would like to eat and talked about members of their family. However, this was not carried out in a consistent way by all staff members. We saw one person being prompted and encouraged to eat their food by staff members who were standing over the person, in an unsociable and non-caring way. We also saw that the person was being given spoons of soup (by staff) in a hurried and task-driven way.

Requires improvement

Is the service well-led?

Our findings

The Malting's Care Home was awarded ratings for our five key questions and for the overall rating when we published the report of the last inspection on 26 February 2015. Staff told us that they had attended a meeting during which the contents of the published inspection report was shared with them. However, people and a health care professional told us that they had no knowledge of the ratings of the home and were unaware of the summary report that the provider was to share with them. Minutes of a residents'/relatives' meeting showed that the findings of the inspection were not shared with those people present. On arrival to the home there was no public display of the ratings of the home. Representatives of the provider told us that the provider's website did not show the ratings for The Malting's Care Home.

This was a breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they knew who was responsible in managing the home and were able to tell us their names. The registered manager was supported by a senior nurse manager who was responsible for ensuring that staff were supported to do their work. An RGN told us that there had been an improvement in the management of the service. They said, "[Name of senior nurse manager] is brilliant. The team is a lot better (since the last inspection). And we've settled with more support." A health care professional told us that they considered the senior nurse manager to be one of the best managers in the Peterborough area.

The senior nurse manager told us that they had delegated some of their work to senior care staff and registered nurses. They advised us that this had enabled them to take action to improve the standard and quality of people's care. This included the monitoring of staff at work and how people were looked after. A member of senior care staff told us that they had an increased understanding of what was expected of them. They said, "We are better organised as I know more about my role and responsibilities. I feel more confident now." Minutes of staff meetings provided evidence that staff were reminded of their roles and responsibilities in looking after and valuing people.

Improvements had been made since the last inspection of 03 February 2015. Action had been taken to ensure that people's medicines were kept secure and staff had been assessed to be competent in the management of people's medicines. In addition, people's mental capacity had been assessed and people's decisions about how they wanted to be looked after were now respected.

Action was taken in response to audits where minor deficiencies had been found in the management of people's medicines and staff were aware of these. These included maintaining accurate records and labelling of people's medicine containers. Deficits in people's dining experiences had been identified and the provider had decided that action was to be taken by 31 May 2015 to improve this area. The deficits included staff standing over people when they were being supported with eating their food.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments How the regulation was not being met: Information was not publicly made available in relation to the ratings of the home. Regulation 20A (1) (2)(3)(4)