Methodist Homes

Foxton Grange

Inspection report

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Date of inspection visit:
26 February 2019

Date of publication:
22 May 2019

Ratings

Overall rating for this service	Requires Improvement

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?	Requires Improvement

Summary of findings

Overall summary

About the service: Foxton Grange is a care home that was providing personal and nursing care to 27 people living with dementia aged 65 and over at the time of the inspection.

People's experience of using this service:
●There had been several different managers since our last inspection in 2016 which had impacted on the stability of the home and staff morale.
●Action plans to address shortfalls identified through the systems in place to monitor the quality and performance of the service, had not always been completed in a timely way.
●Care plans needed to be improved to enable staff to provide care in a more person-centred way.
●Complaints had not always been addressed within the timescales laid down in the providers policy.
●Staff were friendly, passionate about their work and caring; they treated people with respect, kindness, dignity and compassion.
●People developed positive relationships with staff.
●People were protected from the risk of harm and received their prescribed medicines safely.
●Staff were appropriately recruited and there were enough staff to provide care and support to people to meet their needs.
● Staff had access to the support, supervision and training that they required to work effectively in their roles.
●People were supported to maintain good health and nutrition.
●Staff knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005). The provider was aware of how to make referrals if people lacked capacity to consent to aspects of their care and support and were being deprived of their liberty.
●Information was provided to people in an accessible format to enable them to make decisions about their care and support.
●The service met the characteristics for a rating of "good" in three of the five key questions we inspected and rating of "requires improvement" in two. Therefore, our overall rating for the service after this inspection was "requires improvement".

More information is in the full report

Rating at last inspection: Good (report published 16 September 2016)

Why we inspected: This was a scheduled inspection based on previous rating.

Follow up: We will continue to monitor the service through the information we receive until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

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 Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was not always responsive Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led Details are in our Well-led findings below.	**Requires Improvement**

Foxton Grange

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by two inspectors, a specialist nurse advisor 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 instance their area of expertise was caring for family members living with dementia.

Service and service type:
Foxton Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Foxton Grange accommodates up to 36 people in purpose built single storied building. The building was divided in to two areas, one providing care for people living with dementia and had nursing care needs.

At the time of the inspection the service did not have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager had left the service and deregistered from 23 January 2019.The provider was in the process of recruiting a new manager who would then apply to be registered with the CQC. There was an area support manager and acting deputy manager managing the day to day running of the service overseen and supported by an area manager.

Notice of inspection:
This was an unannounced inspection.

What we did:
We reviewed the information we had about the service which included any notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law.

We contacted the health and social care commissioners who monitor the care and support the people receive.

Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send to us to give some key information about the service, what the service does well an improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection, we spoke with four people living in the home and five relatives. We also had discussions with 14 members of staff that included care and nursing staff, an activities co-ordinator, a housekeeper, a maintenance person, a cook, the acting deputy manager, support manager and area manager.

We observed care and support in communal areas including lunch being served. The people who used the service lived with a dementia related illness and so some of them could not describe their views of what the service was like; we undertook observations of care and support being given. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records of people who used the service, we undertook a tour of the premises and observed information on display around the service such as information about safeguarding, activities and how to make a complaint. We also examined records in relation to the management of the service such as staff recruitment files, quality assurance checks, staff training and supervision records, safeguarding information and accidents and incident information.

Following the inspection, the provider sent us details of a Quality Assessment of the home undertaken by the provider's Quality Directorate and a Service Improvement Plan which was in place following work with the local authority commissioners.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse:
●People continued to be cared for safely. There were effective systems in place which ensured people were safe.
●People told us that they felt safe. One person said, "I certainly feel safe living here. You don't get in here unless you are supposed to be here." A relative said, "I have never seen anything here that has upset or worried me."
●We observed that people looked relaxed around staff.
●Staff knew how to keep people safe from harm. They had regular training and described to us what signs of abuse they would look for. There was a safeguarding procedure in place for staff to refer to.
●The provider understood their responsibilities to keep people safe and we saw concerns had been raised appropriately with the local authority and notifications sent to the Care Quality Commission as required.

Assessing risk, safety monitoring and management:
●Risks to people had been identified; people had individual risk management plans in place which gave detailed instructions as to how staff should manage the identified risk effectively. For example, staff had instructions to monitor the fluid intake of one person and ensure that they were regularly repositioned to mitigate the risk of developing pressure sores. We saw fluid charts were consistently maintained and the person was repositioned every two hours as instructed.
●There were regular maintenance checks around the building including weekly fire alarm checks, equipment checks and testing the quality and temperature of the water.
●Staff knew what to do in the event of a fire and each person had a personal emergency evacuation plan in place which was updated as people's care needs changed.

Staffing and recruitment:
●People were safeguarded against the risk of being cared for by unsuitable staff because there were appropriate recruitment practices in place, which were consistently followed.
●Staff had been checked for any criminal convictions and satisfactory employment references had been obtained before they started to work at the home.
●There was sufficient staff to provide the care and support people required at the time of the inspection. Staff had time to spend with people. We saw staff talking with people and supporting them with activities.
●The provider assessed people's care needs and adjusted the level of staff to ensure that people's needs could be met in a safe and timely way.

Using medicines safely:
●Medicines were overall safely managed. The provider had systems in place to monitor the administration

of medicines and any shortfalls were addressed.

●People received their medicines as prescribed. One person said, "I get my pills in a little pot and they watch me take them. I know what they are for."

●Staff received training in the administration of medicines and their competencies were tested.

●We found where medicines were being given to people disguised in food, best interest's decisions had been made appropriately. However, advice from a pharmacist as to what food the medicines could be taken with had not always been sought. We spoke to the provider about this, they were aware of this and were in the process of seeking the appropriate advice and ensuring that this was always done if medicines were given in food.

Preventing and controlling infection:

●People were protected by the prevention and control of infection. There were up to date policies and procedures in place.

●People who required a hoist to assist them move had their own sling which reduced the risk of cross infection.

●Staff were trained in infection control and had the appropriate personal protective equipment to prevent the spread of infection.

●We saw that all areas of the home were clean and tidy, and that regular cleaning took place.

Learning lessons when things go wrong:

●Accidents and Incidents were monitored and action taken to address any identified concerns.

●Any lessons learnt from incidents were discussed with staff and action plans put in place to ensure similar incidents did not happen again. For example, following an incident where a person was found to have unexplained bruising, all staff had been booked on to a bespoke training session on moving and handling older people.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
●People's needs were assessed prior to them moving into the home to ensure the service could meet their care and support needs. A relative said, "The pre-assessment was comprehensive and I visited unannounced twice, morning and afternoon and was well received both times."
●Care plans detailed people's care needs and support plans were in place which gave guidance to staff how to meet people's needs.
●The level of information about people's preferences, choices, history and likes and dislikes was limited. However, we saw that the provider had identified that care records were not always consistently completed and an action plan was in place to address this.

Staff support: induction, training, skills and experience:
●People received support from staff that were competent and had the skills and knowledge to care for their individual needs.
●People told us staff looked after them well. A relative said, "I think the Staff are well trained and very patient with residents, especially those who have challenging behaviour and there is a fair few here. They [staff] really know them well."
●Staff training was relevant to their role and the training programmes were based around current legislation and best practice guidance.
●Records confirmed that staff refreshed their training such as health and safety, safeguarding and infection control regularly.
●New staff completed an Induction which included online training and shadowing more experienced staff.
●Staff told us they had regular opportunities to discuss their performance and training needs and we saw all staff had annual appraisals planned.

Supporting people to eat and drink enough to maintain a balanced diet:
●People who were at risk of poor nutrition and dehydration had plans in place to monitor their needs closely and professionals were involved, where required, to support people and staff.
●Food was specifically prepared for people on specialised diets such as pureed or mashed food for people with swallowing difficulties and fortified food for people to maintain a healthy weight.
●Staff supported and encouraged people to eat and spent time with people during mealtimes.
●There was a choice of meals each day and snacks and drinks were available throughout the day. One relative said, "The staff do watch their [people] fluid levels well."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support:

●People were supported to access various health professionals such as a GP, District Nurse, chiropodist and dietitian. Records confirmed when health professionals had visited and the guidance they had given which staff had followed.

●People told us if their relative could not assist, staff would accompany them to appointments with health professionals.

●A relative told us that as their loved-one's condition had worsened the staff had sought further advice from a specialist team.

Adapting service, design, decoration to meet people's needs:

●The home had recently been refurbished which ensured that people were living in a well maintained and bright environment.

●People and their families had been encouraged to provide personal items to put in a memorabilia cabinet which were outside some people's rooms and there was some signage around the home to direct people.

●People had access to a courtyard area and gardens and there were areas, other than their bedrooms, where they could meet with families and friends.

Ensuring consent to care and treatment in line with law and guidance:

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

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

●We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. We were satisfied that the provider understood their responsibilities and saw best interest decisions had involved the relevant people and been documented.

●People told us staff asked them before they did anything for them. One person said, "The staff always ask if they can do things for you."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity:
●People were cared for by staff who were kind, caring and empathetic. One person said, "The staff are very kind and good at their job." A relative said, "[Loved-one] seems very happy here and the carers certainly understand their needs and meet them well."
●People were relaxed with staff and interactions were positive. Staff offered people reassurance when needed.
●Staff who had worked at the home for several years knew people well and understood their likes and dislikes and preferences as to how they were cared for. Relatives commented agency staff did not always seem to know people but that the permanent staff did. One relative said "The staff are very good, they have a lot to cope with my [relative] but they have managed them well and things are a lot calmer now with them."
●Staff understood the need to respect people's diversity and ensure people were treated equally.
●People were supported to celebrate their religious beliefs. There was a regular church service held at the home and people were supported to attend their local places of worship.

Supporting people to express their views and be involved in making decisions about their care:
●People told us they were involved with their care. One person said, I choose exactly what I want to do. I can stay in bed, get up, do nothing or do something." Another person said, "I can have a shower or a bath anytime I want."
●Staff asked people what they wished to do and offered people a choice in what they ate or where they wished to spend their time.
●The provider was aware of the need to involve an advocate if someone had difficulties in speaking up for themselves and had no family to represent them. There was no one at the time of the inspection being supported by an advocate. An advocate is an independent person who can help someone express their views and wishes and help ensure their voice is heard.

Respecting and promoting people's privacy, dignity and independence:
●People were free to come and go as they pleased and those with restrictions in place were supported to access the community if they wished.
●Staff spoke to people politely and referred to people by their chosen name.
●Bedroom and bathroom doors were kept closed as people were supported with their personal care and staff knocked on doors before they entered a person's room.
●Care records were stored securely and staff were aware not to discuss people in front of other people. We saw that when a health professional visited people were given the space and privacy to meet with them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

- Care plans did not contain detailed information around people's life history, preferences or interests, nor the type of dementia people were living with which would have ensured their care was delivered in a more person-centred way.
- Staff who were new or were relief staff from an agency did not have the information to fully support and interact with people in a meaningful way. For example, we observed some staff entering communal areas where several people were sitting, complete a task, but have no interaction with the people in the area. One person sat, following their meal, for over half an hour in the dining area before anyone came and supported them.
- People's experience of living at Foxton Grange would be enhanced if all staff had access to the full information about the person. A relative said, "There are quite a few new or agency staff, mostly because of all the management changes I think. The agency staff they use now seem to be just sit in the lounges with the residents while the regular staff get on with all the work."
- People told us there was plenty of things to do. One person said, "There is always something going on here. We had a singalong yesterday which was good. We have been out on trips to Rutland Water and a Garden Centre, that was nice. A change of scenery is good for you."
- The activities co-ordinator told us they looked for activities which stimulated and encouraged people. For example, music therapy, singing for the brain and hand massaging.
- We saw people taking part in an exercise session with a balloon; we heard the staff member say, "It's not like weightlifting, use your feet if it [balloon] falls to your feet." People were well engaged and seemed to be having fun.
- The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard. People's communication needs were identified, recorded and highlighted in care plans. These needs were shared appropriately with others. We saw evidence that the identified information and communication needs were met for individuals; for example, menus including pictures of the food available.

Improving care quality in response to complaints or concerns:

- There was a complaints procedure in place but the feedback received from people and their relatives was that if issues had been raised they had not always been responded to. We spoke to the area manager about one complaint which had not been responded to by a previous manager. They agreed to look at it and ensure it was responded to.
- There were regular meetings held with relatives which gave people the opportunity to raise any concerns. However, a relative said, "I do come to the regular relative's meetings, and we do speak up, but to be honest, nothing changes as a result."
- People said they would speak to one of the staff if they had any concerns.

●The provider needs to ensure that complaints are responded to within set timescales and any outcomes which improve the quality of care shared.

End of life care and support:

●The home continued to care for people at the end of their lives.

●People were asked about their wishes in relation to end of life care. If people were happy to discuss this, a care plan had been developed. At the time of the inspection although there were people receiving end of life care the care plans had not been fully completed and feedback we received suggested that families were not always being listened to.

●Staff received training in end of life care and the home liaised with other health professionals which ensured that people had a dignified and pain free death.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Requires improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility:

- At the time of the inspection there was no registered manager. There had been several managers in post since the last inspection; two had completed their applications to be the registered manager but had not stayed, the last registered manager left 23 January 2019. Interim arrangements were in place;an area support manager and acting deputy manager were managing the day to day running of the service overseen and supported by an area manager.
- Feedback from relatives and staff indicated low morale amongst staff and staff feeling undervalued.
- One relative said, "So many changes of management have meant that they [the service] have lost a lot of really good staff. They [provider] need to be careful."
- Staff expressed concerns that there had been so many changes with each manager having their own ideas they did not always feel listened to and some felt unable to express their concerns.
- The provider was aware of some of the concerns being expressed and was actively looking to recruit a new manager; there were arrangements in place to try and support the service. This had only been in place for a few weeks so we were unable to assess how effective this was.
- Staff knew how to whistle-blow and knew they could raise concerns with the local authority and the Care Quality Commission (CQC) if they felt they were not being listened to or their concerns acted upon.
- The provider had systems in place to ensure compliance with duty of candour. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had established audits in place relating to the running of the service. These included care records, staff training and medicine administration. However, the actions to address any shortfalls had not always been completed in a timely way due to the changes in management.
- Staff were clear about their roles and responsibilities towards people living in the home. They had supervisions and attended regular staff meetings. One member of staff said," We have staff meetings and managers have listened but then nothing happens."
- The provider had notified CQC about events they were required to by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

- There were regular meetings with staff and relatives. Feedback suggested however, that although people

had raised issues things had not changed.
●The provider, although aware of some of the issues being raised, needed to ensure that action was taken and that they developed a more open culture where staff felt able to raise issues without fear of repercussions.

Continuous learning and improving care:
●The provider had completed a quality assessment of the home in June 2018 and an action plan had been put in place to address the shortfalls identified, which included care plans not being detailed and consistently maintained and reviewed. However, with the changes in management this had impacted on the timescales to address the shortfalls. The temporary managers in place were beginning to address some of the issues identified.

Working in partnership with others:
●The provider worked closely with the local authority and health commissioners to ensure the service developed and people remained safe.
●Local schools attended the home to partake in activities. This provided the opportunity for the different generations to come together.