Ford House Care Home Limited

Ford House

Inspection report

140 St Neots Road
Eaton Ford
St Neots
PE19 7AL
Tel: 01480 472017

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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 responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

This unannounced inspection took place on 06 and 09 October 2014. The previous inspection was undertaken on 10 July 2014 and we found that the regulations were being met.

Ford House provides accommodation and nursing care for up to 46 people some of which have nursing needs. There were 41 people living at the home when we visited.

During the inspection we spoke to five people who lived in the home, two relatives, four staff and the registered manager. 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.

People told us they felt safe living at the home, that staff were usually kind and compassionate and that the care they received was usually good. People told us that they

Summary of findings

enjoyed the food and always had enough to eat and drink. People were supported to see health care professionals such as GPs and district nurses when needed.

People told us that there were usually enough staff on duty to meet their needs but that occasionally they had to wait far too long for assistance. They also told us that they would like it if staff had more time to sit and talk with them.

People confirmed and records showed that people received their medication as prescribed.

Staff were aware of and acted on the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which sets out what actions staff must take to ensure they uphold people's human rights.

Care plans were in place but these did not always contain the information that staff required in order to meet people's needs and people were not always involved with the development and reviews of their care plans. Risk assessments were in place which told staff what action to take to reduce risks to people.

The provider had ensured that the right people were working in the home by following a thorough procedure when recruiting new staff and dealing with any disciplinary issues appropriately. Staff received training during their induction to ensure they had the skills and knowledge they needed however this could be improved by ensuring that staff received regular updates to their training in a timely manner.

Staff attended team meetings and support sessions with their line manager where they could discuss any concerns. Staff knew how to reduce the risk of people suffering abuse and what to do it they thought someone was at risk.

There was a complaints procedure in place and people felt that they could discuss any concerns with the manager and that these concerns would be dealt with appropriately.

There were effective processes in place to audit the safety and quality of the service being provided and make continual improvements however this could be improved to include assessing the wound care charts to ensure dressings are being assessed or applied as stated.

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.

The risk to people of experiencing abuse was reduced because staff had a good understanding of what abuse was and how to report it.

Risks to people safety have been assessed and appropriate action had been taken to reduce risk where possible. People received their medication as prescribed.

Good

Is the service effective?
The service was effective.

People told us that overall they received good care.

Staff demonstrated a clear knowledge of the Mental Capacity Act (2005) when supporting people who lacked capacity to make decisions for themselves.

The service met the requirements of the Deprivation of Liberty safeguards.

Good

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

The majority of people we spoke with told us that they felt that they were well cared for and treated with dignity and respect.

Staff spent time supporting people and talking to them in a kind and gentle manner.

Staff did not always acknowledge and react appropriately and in a timely manner when people were feeling lonely and did not always provide people with the care that they required.

Requires Improvement

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

People were not always involved with the planning of their care.

Staff were usually aware of what individual support people needed but did not always respond to people's needs in a timely manner.

Complaints were dealt with appropriately

Requires Improvement

Is the service well-led?
People living in the home and their relatives were involved in assessing the quality of the service provided in order to drive improvement.

Staff felt confident to discuss any concerns they had with the manager and were confident to question colleagues practice if they needed to.

Good

Summary of findings

Staff understood their roles and what was expected of them and the manager provided them with appropriate support and guidance.	

Ford House

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 checked 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.

We visited the home on 6 and 9 October 2014. Both of these visits were unannounced.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications the provider had sent us since our previous inspection. A notification is important information about particular events that occur at the service that the provider is required by law to tell us about. We contacted local commissioners to obtain their views about the service.

During our inspection we spoke with six people who lived in the home, two relatives, four care staff and the registered manager. We observed care and support in communal areas, spoke with people in private and looked at the care records for three people. We also looked at records that related to how the home was managed including recruitment records, training records, health and safety records and audits.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe using the service. One person told us, “The staff are very nice to us.”

Staff told us and records we saw confirmed that staff had received training in safeguarding and protecting people from harm. A safeguarding policy was available and staff told us that they were required to read it as part of their induction. Staff were knowledgeable in recognising signs of potential abuse and were able to tell us what they would do if they suspected anyone had suffered any kind of abuse.

Assessments had been undertaken to assess any risks to the person and to the staff supporting them. The risk assessments included information about action to be taken to minimise the chance of harm occurring. For example, there was a risk assessment about a person who had recurrent chest infections so that staff knew what signs and symptoms to look for and what action they should take if they suspected the person may have an infection. Risk assessments were also in place where actions taken to help reduce risks could be seen as a form of restraint. For example, when people required bed rails to keep them from falling out of bed and people or their representative had been asked to give authorisation for their use.

Staff were aware of what action to take when accidents or incidents occurred and the reports that needed to be completed. The manager reviewed all accident and incident reports and carried out any investigations necessary to see if they could have been avoided and if any information needed to be passed on to the staff team during handovers, staff meetings or by updating people’s care plans.

People told us that there was normally enough staff on shift to meet their needs in a timely manner. One person told us, “I don’t have to wait for long.” Another person told us that they had complained as they felt that had to wait too long to be assisted with personal care on some occasions but that it had improved since raising their concern with the manager.

The manager completed dependency levels assessments to ensure that there were enough staff working on each shift to meet people’s assessed needs. Staff confirmed that there were enough staff on shift to keep people safe but would sometimes like more time to be able to sit and talk to people. The manager stated that she was aware of some staffing issues at weekends and as a result they were carrying out spot checks at weekends to ensure people were being cared for appropriately. During this inspection we saw care staff taking time to sit with people, call bells were being responded to in a timely manner and care staff did not rush people.

Staff told us that when they had been recruited they had completed application forms and attended interviews. References and criminal records checks had been completed before they were employed to ensure they were suitable to work in home. When staff had not followed the correct procedures in the home they had been subject to the provider’s disciplinary procedure and any appropriate action had been taken.

People confirmed that they received their medicines on time. We looked at the administration of medicines records and saw that they were accurate and reflected what people had told us. We also checked the stock levels of medication and saw that the correct amount was held in the home. Staff told us that they had completed administration of medicines training and that as part of this training, the manager had watched them administer medicines and asked them questions to check their knowledge.

Good

Is the service effective?

Our findings

People told us they thought that the staff had the skills and training they required to meet their needs. We found that people were supported by staff who had the right skills. Staff told us what people's individual needs were and how they should be met. Staff confirmed that they regularly attended training including safeguarding vulnerable people, Mental Capacity Act, infection control and administration of medicines and if they requested extra training this was normally provided. Two members of staff had completed train the trainer moving and handling training in June 2014 so that they could provide moving and handling training to the rest of the team. We did note that that not all of the nurses had received catheter care training and competency assessments in a timely manner. At the time of the inspection only one nurse working in the home had been trained to carry out this task for males living in the home.

The manager, nurses and care staff told us that they received regular supervisions (a meeting with their line manager) and that they could discuss their progress and issues they wanted to raise during these session. They felt that this enabled them to support people effectively.

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack capacity to make decisions are protected. We discussed the MCA with the manager and staff. They showed that they were knowledgeable about how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected. We looked at care records which showed that the principles of the MCA Code of Practice had been used when assessing an individual's ability to make decisions. The manager and staff were knowledgeable about the Deprivation of Liberty Safeguards (DoLS). We were told that no one living at the home at the time of inspection required an application to be made under the DoLS, as there was no one who was subject to a level of supervision and control that may amount to deprivation of their liberty.

People told us that they liked the food and said that they were given a choice of meal. We saw that snacks were available for people throughout the day, such as fruit, cakes and biscuits. One person said, "The lamb hotpot today was lovely." We saw people being supported at mealtimes and noted that that support was given in a relaxed manner. When supporting people staff members explained what they were doing and responded appropriately to the people they were supporting. During our inspection we saw that people were provided with enough to eat and drink. There was a choice of two main meals and if people did not want either of the main meals offered, they could choose an alternative. Where people were identified at being as risk of malnutrition, staff took appropriate action. This included people being weighed weekly and provision and access to fortified food (food where the amount of calories is increased through cream and cheese).

People told us that when they needed to see a doctor or other healthcare professional this was always organised for them in a timely manner. Records also showed people had regular access to healthcare professionals and had attended regular appointments about their health needs.

Requires Improvement

Is the service caring?

Our findings

One person we talked with told us that they sometimes got upset due to staff not always supporting them with their continence needs in a timely manner or providing the right continence aids. They told us, “It’s embarrassing, I hate it.” We looked at the person’s care plan to see what guidance there was for staff about what support they needed and the information had not been included. We also talked to the member of staff who had written their care plan. The staff member was aware that the person needed help to remain continent. They confirmed that not all of the information was in the care plan and that they were being supported in different ways by different staff. They stated that there needed to be a further assessment completed to ensure that all staff were aware of the person’s needs and how they should be met. This meant that the person was not receiving consistent care from the staff and was sometimes left with wet or soiled clothes or bed linen and this left them feeling embarrassed.

One person told us, “Some staff are kind and compassionate.” Another person told us they thought they were treated with dignity and respect and that staff sometimes supported them to go shopping and that this made them feel, “Bloody lovely.” Another person told us that staff were “fantastic” but they would like it if they had more time to sit and talk to them. One member of care staff told us, “I treat people as if they were my nana or granddad in a caring and loving way.”

People recognised the staff and responded to them with smiles. Staff were not rushed and were able to take the time needed to assist people with their care. However, during the inspection a member of staff informed a nurse that someone receiving end of life care wasn’t feeling well. The nurse went to check the person and came back and told us that “they are just lonely there’s nothing I can do about that”.

We saw that people were treated with dignity and respect and that staff supported them in a caring way. We observed staff responding to how people were feeling. For example, one person wasn’t eating much and a member of staff came up to the person. They talked with the person and asked how they were. They gave time for the person to talk and engaged with them by talking about things that interested them. We saw one member of staff sitting with people in the dining room and asking them to choose which music they would like to listen to. They then sang along to the music with them. The nurses and care staff used people’s preferred names and we saw warmth and affection being shown to people.

We saw several thank you cards that had recently been sent to the manager and staff. One stated, “We are so thankful mum was with you and grateful for the kindness and care she received and also for the kindness and support you gave us a family, especially during the last few weeks and days.”

Requires Improvement

Is the service responsive?

Our findings

One person told us that had not seen their care plan and stated, "I would like staff to read the care plan to me". The nurse who had written the person's care plan told us, "I think the family have read and signed the care plan". However there was no signature of either the person or a family member to say that had seen the care plan. One person told us that at a recent hospital appointment they had been advised that with staff assistance they should go for a short walk each day but that this had not been happening. We discussed this with the manager and deputy manager and they stated that they were not aware of this and would update the person's care plan to reflect this and would ensure that staff were aware. Two people told us that they would rather have a double bed rather than two singles beds in the same room. We raised this with the manager who stated that they would talk to the couple about it and discuss the options.

Two of the three care plans we looked at provided staff with the guidance and information they needed to support people in the way they preferred. One person told us, "Most carers know me well". The care plans were individualised and included important information for the staff about how people liked to be cared for. They also contained clear information about people's history and what their likes and dislikes were. There was no separate end of life care plans. We discussed this with the manager who showed us that the end of life information was included throughout the care plans rather than a separate care plan. One care plan contained detailed information about how the person communicated and what staff should do if they were showing signing of being unsettled. Any changes to care plans were communicated to staff during the handover of staff from one shift to the next one so that they were aware of what support people needed.

Staff we spoke with knew people's needs well and were able to describe the care and support people required. At the time of the inspection, there was a vacancy for an activities coordinator but this did not impact upon the activities and hobbies and interests that people were able to take part in. We saw a member of staff giving a person a manicure and another person was listening and singing to music with a member of staff. One person told us that they preferred to stay in their room but that staff always put their music on or a talking book on for them to listen to.

One person told us if they had any complaints they would, "talk to the staff or manager, I feel confident to talk to her". Another person told us if staff weren't kind they would, "talk to the manager". People we spoke with told us they if they had any complaints about the home they would talk to the manager about it. One person told us they had made a complaint and that it had been appropriately dealt with. There had been two complaints in the last year and both had been dealt with appropriately and in line with the homes procedure. This showed us that the service responded to complaints as a way of improving the service it provided.

Good

Is the service well-led?

Our findings

The service had a registered manager who was available to people, relatives and staff. We were told by people who used the service and staff that the manager was approachable. The manager told us that they encouraged people to see them and their door was "always open" so that people living in the home, their relatives and staff could discuss any concerns with them at any time. The relative of one person told us if they were unhappy with anything in the home they felt that they could "go and talk to the manager".

There were systems in place to audit the quality of care provided and to identify risks. The manager completed regular audits including accidents and incidents, pressure ulcers, infection control and weights to see if there any changes need to be made or any action taken to ensure people were receiving a good quality service. The regional manager had also carried out monthly visits to the home and their own audits. We saw the manager had implemented improvements as a result of these visits such as organising the testing of portable appliances to ensure they were safe to use. The manager also regularly observed staff working and carried out competency assessments to ensure that they had the right skills and knowledge to meet people's needs.

We saw there were plans for dealing with emergencies, such as an outbreak of fire and that a personal evacuation plan for each person was available and fire drills had been carried out.

The manager had implemented a variety of methods to communicate with staff, which included formal processes such as supervision, handover and regular staff meetings. Staff told us, and we saw evidence, that there was good communication between all staff within the home. Staff said handovers gave them current information to continue to meet people's needs and that they could discuss any concerns they had during staff meetings or supervisions. There was also a whistle blowing procedure (this is where staff can raise concerns about poor practice) that staff were aware of and could use if they needed to raise any concerns. One member of staff told us, "I feel supported by the management".

The Provider Information Return (PIR) detailed improvements that they planned to make. These included staff receiving training about nutrition and individual care planning.

The style of leadership in the home had resulted in a staff group who understood the management structure, the purpose of the service being provided and their role in achieving that.

The manager stated that she sends out quality assurance questionnaires to people who live in the home and their relatives each year and uses the feedback to improve the service. The manager had also held meetings for people living in the home and relatives meetings so that any issues could be discussed or suggestions made for improvements to the service. We saw from these meetings and our observations that this was the case.

There was a process for recording staff training and the provider had an expectation of what training staff should complete when they commenced working in the home and on an annual basis.