Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Morton Grange

Stretton Road, Morton, Alfreton, DE55 6HD

Tel: 01246866888

Date of Inspection: 21 January 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Inverhome Limited
Registered Manager	Mrs. Shancimol Mathew
Overview of the service	Morton Grange is located on Stretton Road in Morton, Derbyshire. The home provides nursing and personal care for up to 66 people, including people with dementia.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 21 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

There were 62 people using the service at the time of this inspection. We spoke with three people in the home, four visiting relatives, four staff and the manager. Some people in the home were unable to tell us their views of the service. We were able to observe their mood, behaviour and interaction with staff.

People and their relatives told us they were pleased with the care provided. One person told us the home was, "Doing a good job" and, "You go out and do what you want." A relative said, "The care here is second to none. The staff are very good with Mum and she's much more settled now." We observed a good rapport between people in the home and staff. We saw staff helping people in a kind and sensitive way.

We found that people were protected from abuse, or the risk of abuse, by the policies in place and staff awareness. Relatives told us they felt people were safe in the home.

We found there were suitable measures in place in relation to the security and maintenance of the home. Prompt action was taken where repairs or improvement were needed.

People in the home, their representatives, and staff were regularly asked for their views of the service provided. Their views were taken into account in making changes and improvements to the service.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at the care records for six people in the home. We saw that assessments were carried out before the person was admitted to the home to ensure their needs could be met. On admission to the home, a holistic nursing assessment was carried out, looking at all aspects of the person's needs and abilities.

The care plans we saw had details of the person's needs and clear guidance for staff about the care required to meet those needs. We saw from daily records and observation that care was delivered in line with the care plans.

Care was planned and delivered to meet people's individual needs and to ensure their safety and welfare. We saw that people's care plans covered all aspects of their care. The care plans included information about people's individual preferences regarding daily routines and the support they required. Risks associated with their care needs were identified and assessed. There were plans in place to manage the risks. For example, one person was identified as being at risk of inadequate nutrition. They had a risk assessment in place that was reviewed and updated monthly. They had a care plan showing how the risk should be managed. Their records showed that they were weighed weekly and that their weight had increased.

Care was planned and delivered to meet people's emotional and social needs. People were offered a wide range of activities, in and out of the home, to promote their wellbeing. One person told us about going to see a pantomime they had clearly enjoyed. We saw records and photographs of activities including live entertainment in the home, social evenings, art projects, and reminiscence.

We saw that people in the home and their representatives were provided with information about end of life care. People's care plans included their wishes regarding end of life care. The provider had put into place the Gold Standards Framework (GSF) for end of life care

and they were awaiting accreditation for this. GSF is a systematic, evidence based approach to ensure the highest quality of care for people nearing the end of their lives.

One person told us the home was, "Doing a good job" and, "You go out and do what you want." A relative said, "The care here is second to none. The staff are very good with Mum and she's much more settled now." Another relative told us about the action taken by staff to make sure the person was safe and comfortable in a chair.

There were arrangements in place to deal with foreseeable emergencies. The provider had a comprehensive business continuity plan. This covered a range of possible emergencies and had details of the action to take for each contingency. We saw that the majority of staff were up to date with fire safety and emergency first aid training.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

The provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We saw the provider's policy for safeguarding vulnerable adults. This had information and clear guidance for staff to follow, including a copy of the local authority multi-agency procedures. Staff we spoke with were aware of the policy and knew the correct procedures to follow if abuse was suspected or alleged.

We saw that there was information available to people using the service, and their representatives, about abuse and safeguarding. Three relatives we spoke with told us they felt the person was safe at the home. One relative said, "I know I don't need to worry about her, they'll make sure she is safe."

People using the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. There were some people using the service whose behaviour could present a risk to themselves or others. We saw that the risks were identified and documented in people's care plans. The care plans had details of how to manage the risks whilst maintaining the person's dignity and independence. We observed a person being assisted by a care assistant to eat lunch by putting food on their fork and then handing it to them. The person started to become agitated, shouting at the staff. The care assistant quietly handed the person the fork and left the table for a few minutes before returning to assist the person again. This was patiently repeated a few times before the person calmed down.

We saw that two people in the home had Deprivation of Liberty Safeguards (DoLS) authorisations in place. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home or hospital only deprives someone of their liberty in a safe and correct way. This should only be done when it is in the best interests of the person and there is no other way to look after them. We saw that correct procedures had been followed to establish and act in accordance with the best interests of people in the home.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

The home was generally of a suitable design and layout. The home was divided into three units, The Willows, The Poplars and The Beeches. The Willows and The Poplars were in a modern, purpose built part of the building. The Beeches was an older building that had been converted many years ago for use as a care home. The provider had made improvements over the years, including adding a large lounge. Some people in The Beeches were able to use the staircases. We saw that there was a door leading directly onto the top of a staircase with a small step immediately on opening the door. The provider should note that people were not alerted to this potential hazard as there was no warning on the door or any marking on the step.

There were appropriate measures in place in relation to the security of the premises. We saw that entry to the home was restricted by use of a code lock so that any visitors not aware of the code would have to be admitted by staff. Visitors were asked to sign in and out so staff could check who was in the building. There were security lights and closed circuit television to the outside of the building.

The premises and surrounding grounds were adequately maintained. There was a full time maintenance person working in the home and a gardener to maintain the grounds. Staff told us that anything they reported as needing repair was promptly dealt with. We saw that some areas of the home had been recently redecorated. We saw that there were regular checks of the buildings and action was taken to address any issues found.

We saw records of regular checks and maintenance of systems and equipment in the home. This included checks of the fire alarm system and the emergency lighting, and checks and maintenance of wheelchairs.

We saw that safety and improvement issues regarding the premises were discussed at weekly management meetings. Action was planned and followed up. The provider was looking at how to ensure the safety of people on stairways by restricting access wherever possible. We saw that the provider had considered the needs, safety and independence of people in planning the appropriate action to take. We saw that there were plans for an enclosed garden that ensured people's safety and privacy.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

There were systems in place to ensure the quality of the service provided was regularly assessed and monitored. People in the home, their representatives, and staff were regularly asked for their views of the service provided. This was done using questionnaires, meetings and suggestion boxes. The feedback was analysed and was reported on in the home's newsletter. The results of quality monitoring were discussed at the weekly management meetings and also at staff meetings. Action was taken to address any issues raised. One example was that people had raised issues about the laundry, such as finding other people's clothes in their wardrobe, or not getting their own laundry back. The provider had introduced a system of weekly checks by staff to ensure that people had their own clothes in their bedrooms. The manager told us that the issue had improved and that people had made positive comments about the new system.

Risks to the health, welfare and safety of people using the service and others were identified, assessed and managed. We saw that people had individual risk assessments in place where there were issues that may affect their health or wellbeing. The risk assessments were regularly reviewed and updated. We saw that potential hazards in the home were identified, assessed and managed. Examples of this were the use of cleaning chemicals, the use of hot water boilers in kitchen areas accessible to people in the home, and the risk of Legionella bacteria in the water supply.

We saw that accidents and incidents in the home were recorded and appropriate action taken to reduce the risk of recurrence. Accidents to people in the home were analysed every month. Where it was identified that people had several falls, they were seen by their GP for review and possible referral to the local falls prevention service.
We saw the provider had regard to appropriate professional and expert advice when required. They had sought advice from Derbyshire Fire and Rescue service regarding the proposed new devices to keep fire doors locked until the fire alarms sounded.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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