Interhaze Limited

Minster Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 15 February 2016 and was unannounced.

Minster Lodge Care Home provides residential care for up to 27 people, some of whom have mental health needs or physical disabilities. The bedrooms are located on the ground and the first floor. At the time of our inspection there were 24 people who lived in the home.

A registered manager was in post. 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 their care and support needs were met by staff who were knowledgeable and knew them well. Staff had undertaken training relevant to the specific needs of people who lived at the home and staff told us they were supported within their job roles.

Everyone we spoke with said they thought Minster Lodge was a safe place to live and they were well cared for. Staff had a good understanding of how to report any safeguarding concerns. Staff understood how to keep people safe and were available at the times people needed them. The risks to people's health and wellbeing were assessed and action taken to minimise any identified risk.

People received their medicines as prescribed, and checks were undertaken to ensure people received them in a safe way.

People were supported in line with the principles of the Mental Capacity Act. The manager understood the importance applying for Deprivation of Liberty Safeguards (DoLs) when necessary. Staff ensured they maintained people's privacy and dignity and treated people with compassion and respect.

There were enough staff to support people who lived in the home. Recruitment checks were carried out prior to care workers starting work to ensure their suitability to work with people.

People had a choice of meals which met their dietary requirements and preferences. People were supported to maintain their health and attend healthcare appointment when necessary.

People had opportunities to pursue their hobbies and interests and maintain relationships with people important to them.

People and their relatives knew how to raise complaints and were confident actions would be taken in response to these. People had opportunities to put forward their suggestions about the service provided.

There were processes to monitor the quality and safety of the service provided and actions were taken to drive improvement in the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

This service was safe.

Staff were aware of how to identify risks to people and knew what actions to take to reduce these risks. People who lived at the home told us that they felt safe. People were given their medication safely. Staff were available at the times people needed them.

Is the service effective?

Good

This service was effective.

Staff received training to ensure they had the relevant skills and knowledge to support people who lived at the home.
Staff had a good understanding of the principles of the Mental Capacity Act and Deprivation of Liberty Safeguards.
Consent was always sought from people before providing care.
People were supported to eat a nutritional diet based on their needs and preferences and people's health care needs were met.

Is the service caring?

Good

This service was caring.

Staff communicated to people in a caring manner and ensured people's privacy and dignity was respected. People received care that was appropriate for their needs. People were involved in the planning and delivery of their care.

Is the service responsive?

Good

The service was responsive.

Staff knew, and responded to people's individual preferences. Activities were offered which were tailored to people's interests. The provider responded to complaints appropriately and people told us they

Is the service well-led?

Good

The service was well-led.

People who lived in the home, relatives and staff were asked to provide their feedback of the service. Staff felt supported by the management team. The provider had quality assurance systems in place to support them in maintaining a good quality of care for people who used the service.

Minster Lodge Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 15 February 2016 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience (ExE). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spoke with seven people who lived in the home. We spent time observing how they were cared for and how staff interacted with them so we could get a view of the care they received. We 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 also spoke with four relatives to gain their views about the quality of care provided.

We looked at information received from statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or the NHS.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The information provided by the provider reflected what we found during our inspection.

We spoke with the registered manager, three care workers, a senior care worker, three domestic staff and the cook. We reviewed seven people's care records to see how their support was planned and delivered.

We reviewed six staff files and training records for all staff. We reviewed records of the checks the staff and management team made to assure themselves people received a quality service.

Good

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe. People looked relaxed and there was a peaceful atmosphere in the home.

Staff had a good understanding of how to keep people safe and told us they felt confident in being able to recognise and respond to signs of abuse. They told us they were aware of how to report any concerns of abuse. We saw the phone number for the local safeguarding authority was displayed on a notice board in the manager's office which staff had access to. This meant that if staff had any concerns they could raise them with the relevant authorities.

The registered manager understood and followed safeguarding procedures. The registered manager had notified the CQC of incidents which had been referred to the safeguarding authorities and informed us of action they had taken to minimise risks of incidents re-occurring. For example, they had referred people for consultation to community psychiatric nurses (CPN's) and consultant psychiatrists.

Staff told us that they were aware of the provider's whistle blowing policy and staff told us they felt confident that any concerns they reported would be acted on appropriately. A whistle blower is a person who discloses any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

Risk assessments were in place for people who lived in the home and were updated monthly to reflect the person's changing needs. A risk assessment is an assessment that identifies any risks to a person's health, safety, wellbeing and ability to manage daily tasks.

Staff were aware of people's individual risks associated with their care and support and were able to describe how these were managed. For example, one person's behaviour meant they could potentially put others at risk. Staff had discussed this risk with the CPN and a risk management plan was put in place to reduce the chances of their behaviour impacting negatively on others. The person had also moved bedrooms to a room on the ground floor to reduce the risk of falls.

We checked whether medicines were managed safely. A person told us, "Staff look after them for me, they always give me them when I need them." We saw that medicines were stored safely and procedures were in place to ensure people received medicines as prescribed. Regular medicine audits were undertaken which ensured staff administered medicines correctly and at the right time. The provider had protocols (medicine plans) for medicines prescribed 'as and when required', for example medicines for pain relief or medicines for people who sometimes had difficulty sleeping. These protocols gave staff clear guidance about what the medicine was prescribed for and when it should be given. Staff who administered medicines received training and had their competencies in this area regularly assessed by the registered manager.

Staff were available at the times people needed them. Staff told us staffing levels were, "Generally alright but this week it is a bit tight." This was because a care worker had left the organisation the previous week and a

new one had yet to be recruited., The provider had arranged for a member of staff from a different home to be available to help provide cover until a new care worker was recruited. We spoke to staff members who told us "We all pull together." The registered manager told us the provider used a dependency tool to calculate staffing levels based on the needs of people who lived there. Staffing rotas' showed that the staffing levels were in line with the dependency tool calculations.

The registered manager told us that there were occasionally times when agency staff covered shifts where the provider's staff were not able to. Staff told us the registered manager tried to ensure they used the same agency staff each time as they would be familiar with the home, and know the needs of the people who lived there. The registered manager told us they were recruiting to fill their two vacancies and this would reduce the number of agency workers used. A member of staff spoke about their recruitment process which included an interview, references from previous employers and a DBS (Disclosure and Barring Service) check. The checks were completed to ensure people who were employed were of good character and to check whether they had a criminal record which might mean they were unsuitable to work as a care worker. This was in line with the provider's recruitment policy.

The provider had produced a business continuity plan which staff were aware of, and was available in the office. This provided staff with details of people to contact if there was an emergency. For example, if the water, gas or electric supply was disrupted. This meant staff had the information to deal with emergency situations without delay.

Personal emergency evacuation plans (PEEP's) which provided essential advice to staff about how to move each individual person in the event of an emergency such as a fire, were completed for all people who lived in the home. Copies of the PEEP's were hung in a folder near the exits of the home which meant staff could get to them easily in an emergency. Each PEEP was colour coded to show what level of support a person needed to help leave the building; this meant that staff could effectively support people without having to read a lot of information.

Audits on people's spending money were completed to ensure the correct amounts were accounted for. The registered manager ensured that if a person did not have capacity to manage their finances a power of attorney was in place to help plan purchases in the person's best interest.

Good

Is the service effective?

Our findings

We asked a person who lived at the home if staff offered them the support that they needed and we were told, "The support is good. Staff take me to the doctor, the dentist, the optician whenever I need it"

Health records showed that people saw health professionals when necessary. People who lived at the home were supported to visit a local GP, and during our inspection visit staff supported a person to attend a routine appointment at a hospital to review their on- going health needs. Records showed that regular referrals were made to community psychiatric nurses and consultant psychiatrists. If a person's health needs changed staff were able to contact health professionals immediately so that their care could be reviewed.

Staff received relevant training which gave them the skills and knowledge to effectively support people. The registered manager told us the provider employed a training manager to provide regular training opportunities for staff. Staff told us the training was useful and it helped them provide better care to people who lived at the home. One member of staff told us they had attended training about Huntington's disease, and this had given them a better understanding and knowledge of how to support a person who lived in the home who had been diagnosed with this. Staff also attended training considered essential to meet people's health and social care needs, and training to refresh their skills and knowledge.

New staff employed by the service had an induction period in which time they completed training to provide them with skills to support people. One member of staff told us this had included manual handling, fire safety awareness and health and safety training. Staff told us that during their induction they shadowed (worked alongside) other members of staff and this enabled them to understand how to support people in the home. The care certificate was used to provide training during the induction. The Care Certificate is a set of minimum standards which staff have to achieve to demonstrate they have the skills, knowledge and behaviours expected of a care worker, and should be covered as part of an induction for new care workers.

Staff told us that they had regular one to one meetings with their manager. They told us this gave them the opportunity to discuss their training and development needs. One member of staff told us they had completed their NVQ level three for health and social care. This is a nationally recognised qualification that assesses competence and application of knowledge in regards to health and social care.

We looked at the meals provided to people who lived at Minster Lodge. People were positive about the food choices they received, one person told us, "There's always enough food, and my favourite is curry." Another said, "I like the breakfasts." The meals provided met people's dietary needs. We saw information displayed in the kitchen about people's allergies and medical conditions which required special diets and preferences. This enabled the cook to refer to individual people's needs when planning meals for people.

People were offered a choice of meals and if they did not like the meal or an element of the meal they were offered an alternative. For example, the cook saw that a person did not like the potato croquettes served with lunch and offered them mashed potatoes instead, which the person preferred. Another person had said

that they did not want lunch because they were not hungry, a care worker offered the person a lighter choice and they requested toast instead which they ate. One person, who wanted to lose weight, was following a diet plan, and they were offered a salad which met this eating plan instead.

The menus were discussed at 'residents' meetings which enabled people who lived in the home opportunity to make suggestions for meals.
Drinks were available to people throughout the day and a person who lived in the home told us "I can always get a hot or a cold drink." People regularly went in to the kitchen to make themselves a drink and staff offered drinks to people during the day.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us that some of the people who lived at the home did not have capacity to make their own decisions. This meant they needed support to make decisions. Care files showed that their mental capacity had been assessed, and clearly stated what decisions the person could or could not make for themselves. Where a person lacked capacity, family members and professionals who knew the person made decisions in their best interest, and which reflected what was felt would have been the wishes of the person. These decisions were recorded. We checked whether the service was working within the principles of the MCA. When we asked staff about their understanding of the MCA they demonstrated a good understanding of the principles of the Act. A staff member told us, "People here have different levels of capacity, for example it's safe for some to go out alone and they will go shopping but for some it's not safe. If we don't think it's safe we have to assess their capacity, if they don't have capacity we have to act in their best interest to support them to live their life in a way that they want." We observed that staff asked people for their consent before supporting them with tasks.

Where DoLs authorisations were in place, these included best interest decisions. We saw input in one DoLS authorisation from an Independent Mental Capacity Advocate (IMCA). An IMCA is a legal representative for a person who lacks the capacity to make specific important decisions, and who has no 'appropriate' family or friends who can represent the person. In other DoLs authorisations, family members and health professionals were involved in making the best interest decisions. The DoLS authorisations were reviewed regularly and this ensured that people's freedom was not being deprived unnecessarily. This showed that the provider was following the correct procedures if a person's liberty was restricted.

Not all people who lived in the home were able to communicate verbally. We observed staff used a range of ways to communicate with people. In one person's care file it stated that they could understand verbal communication but not complex sentences. It was recommended that staff speak in short sentences of five words of less. We heard staff spoke to this person using simple sentences which enabled them to understand the information given. It was recorded in a care plan that another person needed people to speak slowly and clearly to them and if they showed signs of confusion to "be patient and allow [Name] time to understand what you have said." Staff told us that if it was necessary they would repeat the information to allow the person to understand it and that by doing this it "stops [Name] getting confused or angry."

Good

Is the service caring?

Our findings

Everyone told us staff were caring. One person said "The staff are lovely."

Staff spoke with people with dignity and respect. They knew all the people they cared for by name and addressed people in the manner they preferred. Some people preferred the use of their names or nick names whilst others preferred a more formal address. We heard one member of staff knock on a person's bedroom door and asked "Sir, is it okay for me to come in before entering." Another member of a staff called a person 'darling' whilst speaking with them. The person smiled and showed that they were happy with this term of endearment and did not feel uncomfortable by the familiarity.

Staff considered people's needs before approaching them. For example, we observed one care worker sat down next to a person who was blind and explained who they were before speaking with them.

Each person's care plan had a detailed life history section. Staff had a good understanding of people's lives prior to coming to live at Minster Lodge and told us that they used these histories to understand why people may behave in particular ways or exhibit certain behaviours. A member of staff told us "By understanding why someone behaves the way they do, means we can help them in a way they want and help them to feel happier."

The registered manager told us that care plans were reviewed each month and each person had a worker who knew them well, and who would discuss any changes they wanted to make to their plans. A person told us "I'm always asked what I want and they [staff] write it down. I check it afterwards and agree if it is right." In the records we reviewed we saw that people had signed to say they had read and agreed their care plan. This showed that people were involved in making decisions about their care needs.

Staff told us it was important to them to maintain people's privacy and dignity when they were supporting people. Staff told us they would make sure doors and curtains were closed before assisting people with personal care. One member of staff said, "If I'm helping someone shower I always make sure that I have everything I need with me when we go to the shower. This means they do not have to wait partially clothed whilst I go to get things." This showed that staff worked in a way that respected people's dignity.

Staff told us they respected people's confidentiality by keeping their records secure and not discussing people's care needs in front of other people. We saw that care records were kept in lockable cupboards which were not accessible to members of the public or other people who lived in the home.

Staff supported people to be as independent as they wanted to be. During our inspection visit people left the home to go shopping and attend other social activities in the local community. One person who was not able to go to the shops on their own was accompanied by a member of staff who supported them to take part in activities they enjoyed and maintain their safety.

We saw staff encouraged people to maintain their independence with daily living. For example, one person

was offered a piece of cake and given a fork to eat it with. A member of staff sat with this person whilst they ate the cake. The person put the fork down and the staff member asked if they would like help. The person indicated that they did and the member of staff helped them to eat the rest of the cake. The member of staff did not rush the person and allowed them time to finish each mouthful before offering more. This showed that staff supported people to be independent but offered additional support when necessary.

Staff and people told us that relatives could visit at any time they wanted however no relatives visited during our inspection visit. By not having restrictions on visiting times this helped people to maintain relationships that were important to them.

Good

Is the service responsive?

Our findings

People received individualised care and support. Each person who lived at the home had an individual care plan which detailed their health needs, likes, preferences and personal histories including people that were important to them. Staff told us that they would read the person's care plan if they had not previously supported them so that they understood their individual needs.

People told us activities were planned which took these preferences into account. For example, in one person's care file it stated that their physical appearance was important to them. A member of staff offered this person a choice of hair clips which would match their outfit and later in the day a member of staff assisted them to paint their nails. This showed that staff were aware of what was important to each person and supported them with this.

Another person enjoyed music and taking photographs. We saw this person walked around the home listening to music with headphones. The person told us they had gone out of the home in the morning and showed us photographs they had taken. In this person's care plan it was recorded that the person had an interest in both photography and music. This showed that people were encouraged to pursue hobbies that they were interested in.

An activity schedule was displayed in a communal area which included daily walks, arts and crafts and a take away evening. There were also photo's on display of trips to Blackpool and Norfolk which people told us they had enjoyed.

In one person's care file it stated they enjoyed going to church and they had positive relationships with people at a local church. This person told us that they had attended church on the morning of our inspection visit. In the dining room a member of staff was overheard discussing the visit with the person and what they had enjoyed. This showed that staff supported people to follow their chosen faith.

We observed a staff 'hand over' of information about each person between one staff team finishing their work for the day, and the next team on duty. Records of these meetings were kept and we saw they included information about people's changing care needs. During the hand over, information was shared that one person had requested an optician's appointment and during the afternoon a member of staff contacted the opticians to arrange this. Another person stated that they wanted to buy new shampoo and a member of staff accompanied this person to buy this. This showed that people's needs were effectively communicated throughout the team and requests for support were acted upon.

A person who lived at the home told us, "If I had any complaints I would speak to the staff." In the care files we saw copies of the provider's complaint policy and a document called "residents rights" which detailed what people could expect from the staff and what was expected of them. These were available in an easy read format for people who had difficulty understanding the written document. Easy read is a way to provide information using pictures and short, simple sentences. Posters of information about how to raise complaints were on display in communal areas of the home in an easy read format.

We reviewed the record of complaints held at the home and found they had been responded to in a timely way in line with the provider's complaints policy. Meetings with the registered manager were offered for people to discuss their complaint and response letters confirming actions taken following a complaint were sent.

No complaints had been made to the service in the 12 months prior to inspection. The registered manager analysed any complaints received and included information in the response which included what steps would be taken to improve standards in the home.

Good

Is the service well-led?

Our findings

People we spoke with knew the registered manager and one person told us they thought they were, "Very nice"

The registered manager had good knowledge of people who lived in the home and was actively involved in the day-to-day running of the home. Staff we spoke with had a good understanding of their roles and responsibilities and told us that they could approach the manager if there was anything they were unsure of. One member of staff described the registered manager as an, "Almost perfect manager."

The provider's policies and procedures were clear and comprehensive. The policies were updated regularly and included latest research so that best practice was delivered in the home. The registered manager told us that staff were updated of any changes in policies during their one to one meetings or during staff meetings. This ensured that staff were aware of any new ways of working. Staff told us that the manager or team leader would observe them whilst they worked to ensure the standard of care they provided was in line with policies and training.

A range of audits and checks took place to assess the quality and safety of service provided. This included checks on the premises to ensure it was safe, and. checks on the quality of care people received. We saw actions were taken to address any shortfalls. For example, the provider had previously identified that people's money and bank cards were not always stored safely. To improve this a new safe had been bought and new procedures were put in place.

Staff meetings took place regularly. Staff told us these helped to promote positive team working and they felt supported in their job roles. Staff told us they were invited to complete an annual survey to provide their opinions about the home and to suggest improvements. One quote from a staff feedback survey stated "I really enjoy coming to work in such a comfortable and hardworking team. It's enjoyable to come to work and is such a rewarding and lovely place to be." They told us they could raise any concerns on an ad hoc basis, as well as at staff supervision and team meetings.

People told us they had opportunities to put forward their suggestions about the running of the home. Weekly 'resident' meetings were held which gave people opportunity to provide feedback. One suggestion had been to have a "take away evening." We saw on the activity schedule and menu's that this had been implemented.

Service satisfaction surveys were sent to people and their relatives. We reviewed the results of the most recent surveys and found they indicated high levels of satisfaction with the home. The results of the surveys had been analysed and were fed back to staff and people during their meetings. This meant the registered manager involved staff and people who lived in the home in considering how the service could continue to improve.

The registered manager stated that she booked people onto relevant training and refresher courses when

necessary and that this was factored into the rota's which means that staff had the opportunity to enhance their skills and knowledge without affecting the number of people available to support people in the home. This ensured that training did not impact on care provision.

All incident reports, audits and training records were recorded on a computer system. This enabled the provider to assess the information and feedback any actions necessary during meetings with the registered manager. We were told the provider met with the registered manager each month and during this time, staff training needs and other issues such as incidents and accidents were discussed. This showed that the provider was involved in assessing the quality and safety of the service provided.

A service commissioner had recently recommended the provider record informal verbal complaints to see whether there were any trends or emerging themes. The registered manager had put a system in place to record these complaints although none had been made at the time of our inspection. This showed that the registered manager acted on suggestions to improve the quality of service provided.