Solent View Care Home Limited

Solent View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 5 February 2016 and was unannounced. The home provides accommodation for up to 19 people, including some people living with dementia care needs. There were 19 people living at the home when we visited. The home was based on two floors connected by a passenger lift; there were two lounges available for people to socialise and most bedrooms had en-suite facilities.

There was a registered manager in place. 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.

This comprehensive inspection was carried out to check on the service's progress in meeting the requirements made as a result of the previous inspection on 24 and 27 July 2015. Following that inspection, the service was rated inadequate and placed in Special Measures. This meant we started to use our enforcement powers to monitor and check the service and if no improvements were noted we could consider cancelling or varying the conditions of the provider's registration. We issued three warning notices to the provider and the registered manager; these were for breaches of regulations relating to safeguarding people from abuse, the governance arrangements and the failure to send us notifications of significant events. We also issued requirement notices for breaches of two further regulations; these related to safe care and treatment of people and the need for consent. The provider sent us an action plan stating how they were going to meet the regulations.

At this inspection, on 5 February 2016, we found action had been taken to meet the regulations, although some further improvements were identified.

Most individual risks to people's safety had been identified and were being managed appropriately, although further information was needed to enable staff to support two people to prevent pressure injuries developing.

Staff sought consent from people before providing care and the registered manager had assessed people's ability to make certain decisions. However, legislation designed to protect people's rights was not always followed as senior staff had not understand the process fully.

People told us they felt safe and their needs were met. Staff knew how to care for people effectively, although some had received initial or refresher training in key subjects, such as safeguarding people from abuse, food hygiene, medicines administration and dementia awareness. Therefore, they may not have been supporting people safely or in accordance with current best practice.

Effective systems were in place to assess, monitor and improve the service provided, although the system used to monitor staff training had not been kept up to date. Improvements had been made to fire safety

arrangements and concerns we had previously identified with the lack of restrictors on first floor windows had been addressed fully.

The arrangements for managing medicines were safe and an additional medicines round had been introduced to help make sure people received their medicines at the right time. There were sufficient staff to meet people's needs and recruitment practices were safe.

People were satisfied with the quality of the food and received appropriate support to eat and drink enough. They had access to healthcare services when needed.

People were treated with kindness and compassion in their day-to-day care. Staff knew people well and treated them with dignity and respect. People's privacy was protected at all times and they were involved in planning the care and support they received.

Staff empowered people to make choices about all aspects of their lives. They delivered care in a personalised way according to people's individual needs. Care plans contained comprehensive information about how people wished to be cared for and were reviewed regularly.

The provider sought feedback from people and had a process in place to act on issues raised. There was a suitable complaints procedure in place and people knew how to complain.

The service had an open and transparent culture and people had a positive relationship with the registered manager. Staff felt supported by management and worked well as a team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Most risks to people were managed effectively, although two people were not protected from the risk of developing pressure injuries.

People were protected from the risk of abuse and from the risk of falls. The environment was safe and suitable fire safety arrangements were in place.

Medicines were managed safely. There were enough staff to meet people's needs and recruitment procedures were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Senior staff did not always follow legislation designed to protect people's rights. Staff were knowledgeable about people's needs, but some had not attended all relevant training, as required by the provider's policy.

Suitable arrangements were in place to protect people's freedom. Staff were motivated and felt supported by the registered manager.

People were satisfied with the quality of the food and received appropriate support to eat and drink. They had access to healthcare services when needed.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by staff who knew them well. Their privacy was protected at all times.

People and their families were involved in discussing the care and support they received.

Is the service responsive?

Good

The service was responsive.

People were encouraged to make choices and remain as independent as possible. They received personalised care according to their individual needs.

Care plans contained detailed information about how people wished to be cared for and were reviewed regularly. People had access to a range of suitable activities.

The provider sought feedback from people and there was an appropriate complaints policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Effective processes were in place to assess, monitor and improve the service, although the system used to monitor staff training had not been kept up to date.

People liked living at the home and felt it was well-run. There was an open and transparent culture.

There was a clear management structure in place; staff enjoyed working at the home and worked well as a team.

Solent View 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.

This inspection took place on 5 February 2016 and was unannounced. It was conducted by one inspector. Before the inspection we reviewed information we held about the service including previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

We spoke with six people living at the home, three family members and a doctor who visited people in the home regularly. We also spoke with the registered manager, the head of care, six care staff, a cook, a housekeeper, the maintenance person and a staff member responsible for arranging social activities. Following the inspection we received feedback from a social services care manager.

We looked at care plans and associated records for seven people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of accidents and incidents, and quality assurance records. We also observed care and support being delivered in communal areas.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection, on 24 and 27 July 2015, we identified that people's safety was compromised in some areas. We issued a warning notice and required the provider to make improvements. At this inspection we found the identified concerns had been addressed.

Plans were in place to minimise most individual risks to people. Some people who had been identified as at risk of developing pressure injuries had been given pressure relieving mattresses and cushions and the condition of their skin was monitored daily. However, there were no plans in place to protect two people who had been identified as being at 'high risk' of developing pressure injuries, using a nationally recognised tool. We brought this to the attention of the registered manager who reviewed the risks and took appropriate action to mitigate them.

The risks of people falling were managed appropriately. For example, one person often removed the laces from their shoes, making them unsafe. Staff looked out for this and supported the person to tie their shoes securely; they had also ordered more suitable footwear for the person that did not need laces. Staff maintained a log to record when and where people had had falls or accidents; this allowed the registered manager to monitor the incidence of falls across the home. Appropriate action was taken after each incident to prevent a recurrence. For example, a person had been injured by an electric chair malfunctioning and staff made sure the chair's control pad was kept in a safe place where it could not be operated accidentally. People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, staff encouraged people to self-mobilise, but made sure their path was clear of trip hazards, encouraged people to take their time and travel at their own pace.

People were protected from the risk of abuse. Clear plans were in place to protect two people who we had previously identified were at risk of abuse. Staff told us, and records confirmed, that the protection measures had proved effective and no concerns or allegations of abuse had occurred since. People told us they felt safe at the home. One person said, "Everything's OK and I feel safe." Another person told us, "I feel very safe and happy here; nothing troubles me." Staff we spoke with knew how to identify, prevent and report abuse and were confident the registered manager would take any concerns seriously.

Improvements had been made to fire safety arrangements since the last inspection. All outstanding fire safety deficiencies, identified by the provider's fire safety risk assessment, had been attended to and rectified. The means of escape from the rear of the building had been improved by linking a lock on an external gate to the fire alarm system; this meant people would be able to evacuate the premises more safely in the event of a fire. Staff had received training in fire safety; regular fire drills were conducted; and fire safety systems were tested on a weekly basis. Personal evacuation plans were in place for people, detailing the support each person would need in an emergency. Concerns we had previously identified with the lack of restrictors on first floor windows had also been addressed. Repairs had been made and all the windows we tested had suitable restrictors in place to prevent people falling through them.

Since the last inspection, changes had been made to the way medicines were administered. An additional

medicines round had been introduced to help make sure people received their medicines consistently and at the right times. One person told us, "The medicines are always on time now." The arrangements for managing medicines were safe. Medication administration records (MAR) confirmed that people received their medicines on time and as prescribed. Information was available to guide staff when most 'as required' medicines were needed, although this was not available for a sedative prescribed for one person. Consequently, the person may not have received this medicine consistently when needed. Staff had access to information to help them identify when people who were unable to verbalise their pain needed pain relief and had starting using a pain assessment tool for this purpose. One person looked after, and administered, some of their own medicines. A risk assessment had been completed for this and they were able to store their medicines securely in their room.

People said they were supported by sufficient staff to meet their individual needs, although two family members felt staffing levels in the evening were not always robust. One person told us staff were "always there if you need them". Staffing levels were determined by the registered manager based on people's needs and on feedback from people and staff. Without exception, all the care staff we spoke with felt they had sufficient time to attend to people's needs at all times. They said additional staff were brought in when needed, for example if a person needed one-to-one care.

Clear recruitment procedures were in place to help ensure staff were suitable to work at the home. These included reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, on 24 and 27 July 2015, we identified that staff were not following the Mental Capacity Act, 2005 (MCA). We issued a requirement notice and the provider sent us an action plan outlining how they would meet the regulations. At this inspection we found improvements had been made but senior staff did not fully understand the MCA and its code of practice.

The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Where people had capacity to make decisions about the care and support they received, this was recorded in their care plan, together with signed consent forms indicating their agreement with the plan. Where people did not have the capacity to make such decisions, the registered manager had conducted an MCA assessment and made best interests decisions on their behalf. For example, a decision taken for one person, about restrictions to keep them safe from abuse, had been discussed with the person's family and documented in accordance with the MCA. However, the only decision that had been considered for other people was whether the person could "give consent to their care plan". When the MCA assessment indicated the person was not able to do this, the registered manager had made a decision "to sign the consent form on behalf of the person". This showed a misunderstanding of the MCA as a registered person is not able to give consent on behalf of a person, but should make a best interests decision. In addition, family members or other relevant people had not always been consulted about these decisions. Assessments of people's ability to make other key decisions, such as to receive medicines or to use bedrails to prevent them falling out of bed had not been assessed. We discussed this with the registered manager, who agreed to further review their procedures for making best interest decisions.

Staff were clear about the need to seek verbal consent from people before providing care or support and we heard them doing this continuously. They had received recent training in the MCA and carried advice cards with them for guidance. They acted in the best interests of people in the way they delivered care and support on a day-to-day basis.

At our previous inspection we identified that people were not protected against the risk of being deprived of their liberty unlawfully. We issued a warning notice requiring the provider to become compliant with the regulations. At this inspection, we found appropriate action had been taken. 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 are called the Deprivation of Liberty Safeguards (DoLS). One person was subject to DoLS and staff were clear about the action they would take if the person tried to leave the home. The registered manager had sought advice from the local authority DoLS assessor and was aware of the circumstances when DoLS applications should be considered. They had made applications for most of the people living at the home and these were being processed by the local

authority.

People told us their needs were met. One person said, "I'm very well looked after." A family member described the care as "excellent". Staff we spoke with were knowledgeable about people's needs and communicated with people effectively. For example, when speaking with people with cognitive impairment they used simple questions and gave people time to process the information and respond.

However, staff training records showed that not all staff had completed initial training or refresher training in key subjects, as required by the provider's policy. For example, all care staff prepared meals and supported people to eat, yet eight of the 11 care staff had not received food hygiene training. Most people at the home had dementia care needs, yet five of the 11 care staff had not received training in dementia awareness. The provider's policy was to refresh medication administration training every year, yet five staff who administered medicines regularly had not completed this training since September 2014 and one had not completed it since November 2013, over two years previously. The registered manager told us all staff should receive safeguarding training on a yearly basis; however, according to the training records, two staff members had not received this training; one last received it in 2007 and four last received it 16 months previously. Therefore, the provider was unable to confirm that all staff were suitably trained and up to date with best practice guidance. We discussed this with the registered manager who took action to arrange additional training for staff.

Staff new to the home received suitable induction training and completed the Care Certificate if they had not worked in care before. The care certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. We spoke with a newer staff member who told us they had completed a formal induction and shadow shifts where they worked alongside experienced staff before being allowed to work unsupervised.

Staff told us they felt supported by the registered manager. They received regular supervisions and yearly appraisals. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. One staff member said, "I identified [a particular course] that would be useful and will be doing it soon." Another told us they had supervisions "often enough" and could speak with the registered manager at any time as "their door is always open".

People were satisfied with the quality of the food. One person told us, "The porridge was nice and I had jam in it, which they know I like." Another person said, "The food's good and they give me [suitable food for my diet]. You can ask for snacks and I've only got to ring and they bring me up a coffee." Care records included nutritional plans, which the cook was aware of and followed. For example, they fortified some people's food with cream or cheese to increase their calorific intake. Alternatives were offered if people did not like the menu options of the day. For example, one person told us, "I don't like fish, so they're doing jacket potato and cheese for me today." A choice of drinks was available throughout the day; people had access to a range of drinking vessels suitable for their needs, including spouted beakers, and staff prompted people to drink often. People were encouraged to eat and staff provided appropriate support where needed, for example by offering to help people cut up their food. Staff monitored the body mass index (BMI) of people and took appropriate action when people experienced unplanned weight loss.

People were supported to access other healthcare services when needed and they were seen regularly by doctors, nurses, chiropodists and other specialists. A doctor told us staff highlighted people who needed to be reviewed by them; they said, "They are giving patients medicines and treating them with respect and seeking consent." A senior member of staff had developed a new form to record essential information about

people that would be needed if they were admitted to hospital. This would help medical staff communicate with the person and understand their needs.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "I like [the staff], they're lovely. We get on well and have our little jokes." Another person said of the staff, "They treat me very well; they're kind and caring." A family member told us, "[Staff] are marvellous with [my relative]. [One staff member] in particular treats her like a long lost friend."
When medicines were being administered staff took time to explain what the medicines were for and allowed people to take them at their own pace.

When supporting people with visual impairments, staff approached people in a reassuring way and used touch to reassure them. They took time to explain things the person was unable to see clearly. For example, at meal times, staff described the food and named the people who were sat around them. One person had been given a talking clock so they knew the time. This showed consideration and understanding for people.

All interactions we observed between people and staff were positive, showing that staff understood people's individual needs and knew them well. People and staff freely shared stories about their lives including holidays and their families. When a person became upset, they were reassured warmly and staff tried to identify the cause of their distress. They offered the person some pain relief, but they declined and continued to show signs of distress. Staff discussed this amongst themselves, in private, and suggested a different staff member talk with the person. This approach worked; the person accepted the pain relief and became visibly relaxed.

Staff ensured people's privacy was protected by speaking quietly, closing doors and curtains when delivering personal care and making discreet use of towels, so people's dignity was not compromised. When people received treatment from visiting health professionals, this was carried out in the privacy of their rooms. All bedrooms had locks which people could use if they chose to and staff knocked on people's doors and waited for a response before entering. Some people needed assistance to go to the bathroom and were then left in private. When the staff member returned, they knocked on the door to check whether the person was ready and needed any further assistance.

People were treated with dignity and respect. A staff member told us, "I always get people to pick their own clothes. One person sometimes looks a bit 'mix and match' because that's what they've made their mind up to wear." People had been asked whether they preferred to receive personal care from a male or female member of staff; their preferences were known to staff and respected.

When people moved to the home, they (and their families where appropriate) were involved in discussing and planning the care and support they received. They were also consulted and involved in decisions about resuscitation. People's care was reviewed on a monthly basis and those who had capacity to make decisions were consulted when changes in their care were needed. Family members told us they were always informed of any changes to their relative's health.

Good

Is the service responsive?

Our findings

People were empowered to make choices and have as much control and independence as possible. One person told us "I like to stay in my room but can go elsewhere if I want company." Another said, "I like to have a bath on a Sunday; I enjoy that." A third person said, "I can please myself what I do each day." We heard staff routinely offering people choices with questions such as, "Where would you like to go? Would you like to go to the coffee lounge or stay here?" "Would you like tea or coffee?" A staff member told us this was important and said, "It's their home; it's their choice."

Care and support was delivered in a personalised way. A staff member told us "You have to get to know people. Like [a named person] gets hot and doesn't like many layers [of clothing], but [another named person] is tiny and wears loads of layers." One person said, "I'm happy with the way [staff] look after me." We noticed another person was unshaven and he told us this was his choice. He said, "I'm anti-shave at the moment." One person had a set daily routine and described everything staff did to support them to follow it consistently. They finished by saying, "I go to bed after I've had my medicines in the evening; but I could stay up if I wanted to."

Care plans were detailed and reflected how people wished to receive care and support and recorded people's preferences and choices. For example, they contained clear information about how people wished to receive personal care, the order in which they preferred to dress and the support they needed with their continence. Care plans also encouraged staff to promote people's independence by allowing them to do as much as possible for themselves. When people's needs changed, staff responded appropriately and care plans were reviewed to ensure they reflected people's current needs.

People had access to a range of activities. An activity coordinator supported people to engage in activities on weekdays. They had identified people's individual interests and tailored activities to meet their needs. Group activities, such as hoopla, skittles, were organised for some people, together with word games to keep their minds active. In addition, one-to-one activities were arranged for people who preferred to remain in their rooms. A person with a visual impairment told us they enjoyed playing games with the activity coordinator, "like putting your hand in a bag to feel what's there". Another person said they enjoyed "having my nails done and having a foot massage". They added, "If I wanted to do more [activities], I could."

The provider conducted quality assurance surveys twice a year to obtain people's views about the service. The activity coordinator supported people to complete the surveys, where needed, and reported the results anonymously to the registered manager. Comments from the latest survey showed people and their families were satisfied with the service provided and identified no improvements that could be made. The registered manager explained how they responded to feedback and made changes when needed. This had happened following previous surveys where issues had been raised.

A complaints policy was in place and people told us they knew how to complain. One person said, "I've not had to complain; I just talk to [the registered manager] if I've any concerns." Records showed one complaint had been received in the past year, which had been resolved promptly and appropriately.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, on 24 and 27 July 2015, we identified that the provider had not notified us about some significant events and their quality assurance system had not been effective in ensuring regulations were met. We issued a warning notice and required the provider to make improvements. At this inspection we found most concerns had been addressed, but quality assurance systems were not robust.

The systems designed to assess, monitor and improve the service were not always effective. For example, the registered manager told us they maintained a 'training matrix' to monitor staff training, but this was not up to date. They sent us an updated version of the training matrix after the inspection, which identified that some staff had not received refresher training in accordance with the provider's policy. The quality assurance system in place had not identified this, so action had not been taken to address it.

Care plans were reviewed and updated by a staff member on a monthly basis. A senior staff member then dip-sampled these to make sure they reflected people's current needs, although they had not identified the lack of information in relation to the management of pressure injuries for two people.

A new system had been introduced at the end of each shift to check that medication administration records had all been signed. This had helped ensure that people received all their medicines as prescribed. However, the provider's medication policy, which we had identified was not up to date at the time of the previous inspection, still did not reflect the latest guidance. The policy had been reviewed in November 2015 by a senior member of staff who had not received any training in medicines management since 2007. The policy referred to a previous regulatory body that ceased operating in 2010. It did not refer to guidance issued by the National Institute for Health and Clinical Excellence (NICE). It did not reflect current staff practices in relation to storing medicines brought into the home by community nurses or the use of a pain tool to assess the need for analgesia. We brought this to the attention of the registered manager, who reviewed the document and sent us an updated version after the inspection.

Other systems to assess and manage the quality and safety of the service were effective. For example, the maintenance person conducted environment audits weekly to check the safety of the premises and equipment, including fire safety equipment and the settings on pressure relieving mattresses. This had identified that one person's mattress could not be adjusted for the person's weight, so they had liaised with the community nursing team to obtain a more suitable mattress. The head of care described 'spot checks' they conducted. These included checking that staff knew when to wear protective equipment and used effective hand hygiene techniques.

People liked living at the home, had a positive relationship with the registered manager and felt the service was well-led. One person said, "They do their best to keep the place up together; it's run alright." Another person told us, "[The registered manager] is very good. If you've got any problems he helps you; it's run very, very well." A family member described the management as "excellent".

The service was open and transparent. The provider had notified us promptly of all relevant incidents. The

previous inspection report was prominently displayed in the entrance lobby. Visitors were welcomed, although we noted there were no links with the community other than through friends and family members.

There was a clear management structure in place consisting of a registered manager, a head of care and a deputy head of care, who had individual responsibilities. In order to keep up to date with current practice, the registered manager attended meetings of the local care homes association; accessed circulars distributed by them; and sat in on training being delivered to staff. Staff enjoyed working at the home, felt supported by management and worked well as a team. Comments included: "[The management] are brilliant; they are approachable and have an open door policy"; "I love it here; there's a homely atmosphere and I enjoy coming to work"; "We've got a great team"; and "We are listened to, get praised and feel valued".