Minster Care Management Limited

Attlee Court

Inspection report

Attlee Street
Normanton
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West Yorkshire
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Tel: 01924891144

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out this inspection on 25 April 2016. The inspection was unannounced.

Attlee Court is a nursing home currently providing care for up to a maximum of 68 people. The service has two floors and provides care and support for people with nursing and residential needs including people who are living with dementia. On the day of our visit there were 20 people living at the home and the provider had a voluntary stop on placements.

The service did not have had a registered manager in post at the time of our inspection, although there was a home manager who had been in post since August 2015 and had applied for registration. 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. The home manager was on leave on the day of the inspection and we arranged to give feedback upon their return.

Since the last inspection there had been significant improvements in the home. Renovations had been completed and there was more robust management of work being carried out within the home.

The environment was much more welcoming and homely than had previously been found at the last inspection, particularly for those people living with dementia.

The management of risk had improved in relation to the premises and for some aspects of individual people's care needs. There were some areas of concern in relation to accurately identifying risks from some equipment.

Standards of cleanliness in the home had improved and we found most areas to be visibly clean and free from odours.

Staffing levels ensured people's physical and social needs were met. There had been some staff changes since the last inspection and changes in senior management had helped to drive improvement.

Medicines were managed appropriately.

Staff were kind and caring, and the quality of interaction with people who were living with dementia had improved since the last inspection.
There were activities and improved resources for people to be meaningfully engaged.

There was improved management oversight in relation to the premises and to individual people's care needs. Better systems were in place to check the quality of the provision but these were not all robust

enough with regard to some aspects, such as safety checks.

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.

Some checks of equipment, such as beds and bedrails were not robust enough to ensure people's safety.

The premises had been refurbished to a safe standard.

Staff understood safeguarding procedures and what to do in the event of an emergency, although people's personal emergency evacuation plans required more detail.

Is the service effective?

Requires Improvement

The service was not always effective.
Staff said they felt supported to carry out their work

Staff understood the legislation around people's mental capacity, although information on people's care records was not always clear regarding decisions about their care.

Mealtimes were positive and social occasions and people were happy with the quality of food and drinks.

Is the service caring?

Good

The service was caring.

People had good relationships with the staff, who were kind and patient in their approach.

Staff understood people's rights to privacy and they respected their dignity when providing care and support.

People's independence was promoted and staff supported people at their own pace.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans had been re-written and provided clear information

overall, although some details were inaccurate and conflicting.

Resources and activities were available to all people so they were able to engage in purposeful occupation.

People understood how to complain if they felt unhappy about their care.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits had improved since the last inspection, although some checks were not thorough enough and documentation was not all securely retained.

Communication throughout the home was maintained well and there was high staff morale.

Management of the home was strengthened and staff were clear about their roles and responsibilities.

Attlee Court

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.

We had previously inspected this service in November and December 2015 and found there were multiple breaches in regulations. We proceeded with enforcement action and issued a notice of decision to close the service. The provider appealed against this decision because they felt the necessary improvements had been made.

This inspection took place on 25 April 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and two specialist professional advisors, one of whom specialised in nursing and dementia care and the other in governance, health and safety.

Before the inspection we reviewed the information we held about the service. This included looking at any concerns we had received about the service and any statutory notifications we had received from the service. We had received some concerns from members of the public and from anonymous sources that people's needs were not being met in a number of ways.

We used different methods to help us understand the experiences of people who lived in the home. We spoke with nine people who were living in the home and two visitors. We also spoke with five members of staff, the area manager, the deputy manager, the director and the home manager (during the feedback).

We looked in detail at nine people's care records and observed care in the communal areas of the home. We looked at two staff recruitment files and staff training records. We also looked at records relating to the management of the service including policies and procedures. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living in Attlee Court. One person said: "I feel very safe here". Another person said: "I know I'm surrounded by other people and that's why I feel safe". One person said: "Help is there when I need it, so that helps me to stay safe".

At the time of our last inspection the home was being refurbished and building work was underway. At this inspection we found the majority of the refurbishment was complete and where there was still work left to do, this was planned and controlled to ensure the areas being worked in were safe.

We had received recent notifications from the provider that there had been leaks to the plumbing, resulting in ceiling damage in parts of the home. We saw evidence that repairs to damaged ceilings had been carried out and we discussed with the provider their plans to repair areas, such as water damage in one person's bedroom. We saw there was an external contractor leading on the works required. The area manager produced a report from the contractor to show necessary work had been completed to prevent pressurised leaks or unsafe leaking water temperatures. We spoke with the contractor who stated the plumbing was safe and adequate for the number of people living in the home at the time of our inspection. This contractor was unable to give assurance that should the number of people living in the home increase to full occupancy, then the plumbing and heating system would be reliable. The contractor said they would need to carry out a full survey of the system to provide information about this and the director agreed this would be done.

Staffing levels were sufficient to meet people's needs. The numbers of people living in the home had reduced since the last inspection and the provider had agreed to a voluntary stop on placements in light of the concerns. The area manager told us they were confident staffing levels were currently enhanced due to the low numbers of people in the home. We looked at staff rotas which confirmed staffing levels were appropriate. The area manager told us, and we saw, agency staff were used to cover qualified nurse roles. There was an agency nurse on duty and we saw their identity and qualification checks had been carried out before allowing them to work in the home. We were told there had been changes to the leadership in the home and to the staff team since the last inspection which had improved the quality of the provision.

Staff we spoke with told us how they would recognise signs of possible abuse and they understood the safeguarding and whistleblowing procedures to follow to report any concerns about people or staff practise in relation to people's safety and welfare. Staff were confident to refer concerns to the local authority should they need to do so. We saw that where incidents needed to be referred to the local authority safeguarding team, this was done promptly by the manager.

Staff we spoke with were knowledgeable about some of the individual risks to people. For example, one member of staff told us about one person who was at high risk of choking because they ate their food too quickly and how the person's care was managed to minimise the risk. They also told us how they would recognise if a person was choking and the first aid steps they would carry out should the person need assistance.

We saw the individual personal emergency evacuation plans (PEEPs) stated people's individual mobility preferences but it was not clear how people would be helped to mobilise in the event of an emergency, such as the specific equipment they might need and how staff should support them. We saw there were detailed moving and handling risk assessments in people's files, along with risk assessments for mobility and falls.

We found accidents and incidents were recorded appropriately and monitored by managers to establish whether any patterns or trends occurred. We saw one recorded incident where a person had become trapped in their bedrails. The action taken was for the maintenance staff to check the bedrails, but it was not clear how the person's safety had been thoroughly addressed.

We looked at the care records for three people who had bedrails in place, but there was no evidence of how the decision to use these had been arrived at, whether any other methods had been tried, tested or discounted before installing bedrails and there was no evidence of best interests decisions having been made for these in respect of each individual.

We spoke with the member of maintenance staff who told us they carried out safety checks on beds and bedrails on a regular basis. We looked at the records to show regular checks had been carried out. However, the checks did not include measuring the height differential between the top of the mattress and the top of the bedrail, or the gap between each bedrail to prevent a person's hands, arms or legs becoming entrapped. The maintenance staff told us they had received some guidance by the previous maintenance staff with regard to checking electrical profiling beds, but no training had been done to give clear information about what to look for to ensure people's safety.

Mattresses and pressure cushions were checked, but again, the checks lacked rigour. For example, there was no evidence a water penetration test had been carried out. Records showed the last checks had been carried out on 16 March 2016, yet upon our checking of one of the mattresses during the inspection we found evidence of this 'bottoming out'. This meant that the efficacy of this mattress may have been compromised and therefore not adequately supported the person it was used for. We checked another bed and found the mattress was overhanging the divan base, which posed a risk to anyone who may have attempted to sit on the edge of the bed.

We looked at practice and care records for people who were identified as being at high risk of pressure ulcers. We saw people were seated on pressure cushions where these were required. One person's plan stated they used an alternating air mattress, but when we checked we found there was no such mattress in place. When we checked the person's repositioning chart we found there were gaps in the recording of the changes of position, which indicated the person may not have been helped with repositioning frequently enough for their pressure care needs. We spoke with the manager about this and they said this was more likely to be a recording omission than a practice issue and they would review the person's pressure care requirements.

We found a number of people required the use of hoists and slings for the purposes of moving and handling. Documentation to show thorough examination of lifting equipment was carried out by an external organisation. However, there were no documented internal checks of lifting equipment. We looked at the condition of some of the lifting equipment, such as the slings. We noted on one of the slings there was debris within the fastening, which may have impacted upon the efficacy of the equipment, with the potential to cause harm due to not being able to fasten securely.

During our check of the premises we noticed a free standing wardrobe in one person's room which was not secured to the wall to prevent the wardrobe falling forwards when opening the doors. This may have posed

a risk to the person or to staff. We saw there were sufficient first aid boxes on the premises. However, one located in the laundry had contents that had expired. There was no evidence of a check having taken place to ensure the correct or in-date contents were contained within the box.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(a)(b) because risks were not fully assessed and mitigated.

We looked at the medicine administration record (MAR) sheets of all the people in the home. We looked closely at a sample of five previous records and found these were all correctly filled in, with individual photographs and allergy status clearly noted. There were also protocols in place for PRN (as required) medicine and people were asked whether they required any pain relief.

We looked at the systems in place for the storage of medicines. We saw medicines were stored securely and at an appropriate temperature. Room and refrigerator temperatures were checked and recorded daily. We saw the nurse supported people patiently with their medicine and made observations to make sure medicine had been taken by each person before recording this on their MAR. There were appropriate explanations given to people about the medicine they were given. The morning medicine round took longer than we were told was usual and was not completed until 11.15am. The nurse understood the required interval between doses, however, to ensure people's medicine was safely spaced out.

We saw the environment was clean and free from unpleasant odours, with evidence that cleaning staff were busy throughout the day. Cleaning staff were aware of the procedures they followed to minimise the spread of infection. We saw staff used personal protective equipment (PPE) such as gloves and aprons. However, we noted in one kitchenette area the floor was dirty where the flooring met the skirting of the cupboards. Sweeping brushes and mop heads were seen to be visibly clean. One person commented their room was 'always spotlessly clean'. One relative we spoke with said they were happy with the standard of cleanliness in the home.

Requires Improvement

Is the service effective?

Our findings

Some people we spoke with told us staff cared for them effectively, although we received mixed views. One person said: "They know what I need and I get what I need here". Another person said: "I trust they know their job. I think I'd know if they weren't doing it right". One person told us the service was not effective. They said: "This place is past it's sell-by date, they've made some things better but it's not enough. In my view they don't really know what they're doing".

Staff we spoke with said there had been improvements in the level of support they received to enable them to carry out their work. Staff told us the manager supported them to complete training. Staff said, they had regular supervision meetings in which they were able to discuss their development and identify where training may be required. Records showed there had been regular staff meetings and staff training. Communication throughout the home had improved with more regular meetings involving more staff, people and relatives. Staff we spoke with said there were better relationships with each other than during recent months.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The manager showed us evidence of where Deprivation of Liberty Safeguards had been authorised or applied for with regard to people living in the home. There were nine DoLS applications in place for people living in the home.

Staff had an understanding of mental capacity and how decisions might be made in someone's best interest if they lacked capacity. Staff encouraged people to make decisions within the daily routine, such as where to sit, what to do and what to eat or drink. Staff supported people's ability to make decisions in a manner appropriate for each person.

We looked at nine people's care plans. We saw some mental capacity assessments had been carried out in detail and in keeping with the legislation. For example, one person had a decision specific mental capacity assessment for every aspect of care they received. However, we also saw one person's record contained a single capacity assessment for all areas of care. Another person's care record stated the person lacked capacity, and important decisions had been discussed with the person's relative, yet there was no capacity assessment in place or evidence the person's relative had legal authority to make such decisions.

We saw staff patiently offered people choices of meals and used visual techniques, such as showing two plated up meal choices. This was carried out effectively and enabled people living with dementia to make informed choices. We saw two people looking at a menu together and they discussed what they might like to eat.

We spoke with people about the food and everyone we spoke with said they were very happy with the choices and quality of the meals and snacks. One person said: "The food here takes some beating", and

another person said: "It's lovely". They told us they had a good choice of food and if they did not like what was on offer they could choose something else. We saw there were sweet and savoury snacks accessible to people in communal areas along with cold drinks. In addition, staff regularly offered people hot and cold drinks throughout the day. We saw there was a laminated list on the drinks trolley about people's food and drink requirements and preferences, with a reminder to staff about ensuring people were given choices at every occasion.

We spoke with the cook who told us they had a list of people's dietary needs and staff communicated constantly with them about people's particular choices and requirements. We saw menus were varied and nutritionally balanced, with choices available. We saw the cook chatted to people in the lounge and discussed what they were making for lunch, and what people might like to eat. Staff we spoke with understood people's dietary requirements and the level of assistance they needed.
Staff we spoke with told us they had no concerns about people's weight loss and they were monitoring people's weight in line with their care needs. We saw care records recorded people's weight regularly and appropriate advice was sought where there may be concerns. One relative we spoke with said their family member had gained weight steadily in the home.

We saw the local authority food safety inspection had resulted in the service being awarded a five star rating which was displayed.

Staff told us they sought medical advice and where a GP was needed, they were involved in people's care. One person told us they were going to hospital for a routine appointment and we saw staff facilitated this. People's involvement with other professionals was noted on their care records and in the diary for staff to be aware.

Good

Is the service caring?

Our findings

People we spoke with said staff were caring. One person told us they had lived in Attlee Court for a number of years. They said: "They are all so kind". Another person said: "They care about everyone, they really do". Another person said: "I am treated like an individual here". One relative we spoke with said they had no concerns about the staff attitude towards people and found staff had a 'caring manner'. We spoke with a visitor who had come from a local church. They told us they had always found there to be good care and said: "The staff have always been interested in the people".

We saw people's personal appearance was appropriate and indicated staff had taken time to offer support with personal care. One person told us: "I can manage most things for myself, but I like to look my best and staff help me if I need them to". Another person told us: "They [the staff] helped me get ready today. This is one of my favourite jumpers".

Staff interaction was mostly supportive and attentive to people's needs and staff showed empathy and kindness to people. Where people were unable to communicate verbally, staff regularly offered explanations and commentaries about what was taking place. We saw staff observed people's non-verbal cues and acted accordingly. For example, one person looked at their cup but could not reach it, so a member of staff brought this closer for the person. One care plan we looked at stated the person would be unable to verbalise to staff if they felt hot or cold and so staff should look for signs that might show they were not comfortable. Staff we spoke with had a good understanding of people's communication skills and where additional support and observation was required.

On one occasion we observed a member of agency staff interacted only in a limited way with the person they supported. We saw they assisted the person with their meal, but stood to the side of the person, so that when food was presented, the person did not always see this coming and there was no explanation given about what the person was being offered. The member of staff appeared disengaged and spent time looking round the room instead of providing attention to the person. We discussed this at feedback with the area manager and the home manager who said they would monitor this. They said they were confident through their observation of staff practice that Attlee Court staff engagement with people was supportive and appropriate.

On the dementia care unit we saw there was a calm, happy atmosphere and staff engaged well with people in a person-centred way to ensure their individual needs were met. Staff had a clear focus on people's needs and interaction was patient, positive and enabling. People showed they felt happy by smiling, laughing and singing. Daily notes in people's care plans illustrated people had been content and relaxed.

Where people living with dementia needed support with tasks we found staff were patient and respectful. One person gestured to packets of sauce on the table and asked staff how they could put these on. Staff explained what they were and offered to help if the person wanted sauce on their meal. Where one person became confused about which cutlery to use, staff supported them patiently whilst enabling them to retain their independence. We saw staff used good eye contact and gave people plenty of time to process

information and to respond when they asked any questions.

Staff were respectful of people's privacy and dignity when they provided personal care. Staff discreetly asked people if they wanted help with their personal care and they knocked on people's doors before entering. Staff liaised with one another about people's care in areas where they could not be overheard, to ensure people's privacy and confidentiality of information. We saw on one occasion one person on the ground floor was unable to summon help in time for the toilet which compromised their dignity.

There was some information in people's care records about end of life discussions. One relative we spoke with said they were confident staff would sensitively enable their family member to have such conversations when this was appropriate.

Requires Improvement

Is the service responsive?

Our findings

People told us they were happy with the way their needs were responded to. One person said: "I've been here a really long time, so I know what's going on. They know me well in here". Another person said: "They try to do things the way I like them doing. I never have to wait long for some help if I need any". Another person said: "When I call for help, they come to see what I need". One relative we spoke with said they thought the staff knew their family member's care needs well.

Information in people's care plans was easy to locate, clearly written and contained depth of information. The area manager told us care plans had been re-written for every person in the home. Staff we spoke with said they knew how to find the information they needed and they ensured care documentation was kept up to date. We saw evidence of reviews in people's care plans.

However, although care records had improved, we found there were some contradictions in the information within these and some of the information was not always accurate or followed up. For example, on one record it was identified a person was at high risk of malnutrition and to refer if they continued to gain weight. Yet in another part of the record it stated the person was gaining weight, but with no evidence of referral. Another person's care record said they had lost weight, yet this information did not correspond with weight audits and staff said they were not concerned about weight loss for any of the people in the home. We spoke with the area manager who said this was more a recording issue than a practice issue and agreed to check the documentation. There were also inconsistencies in the recording of people's capacity and choice.

Activities for people throughout the home were much improved since the last inspection. We saw evidence of recent St George's Day celebrations in the home. There were plentiful interesting resources accessible to people and these were seen in use during the day. For example, we saw drawers on the dementia unit for people to rummage in, some people chose to cuddle baby dolls or look at books. We saw one person looking at a book with old photographs in and they told us how much they enjoyed being able to sit in a quiet area to do this. One person told us they looked forward to a seaside trip. We saw staff offered to paint people's fingernails and they chose which colour they liked.

We saw an organised activity session in which an external entertainer visited the home and did a seaside themed event with a singalong and a reminiscence activity quiz. All the people in the home were invited to join in and where people in the dementia unit needed encouragement, staff were very supportive. We heard one person was not sure if they would like to watch and staff said: "Let's go see what it's like eh? You might like it". Some people joined in with the entertainment but others chose not to. There were mixed opinions amongst the people about whether they had enjoyed this and staff engaged with people to discuss their views afterwards.

Furniture in the dementia unit was arranged into small seating areas and we saw this created space that encouraged people to engage in smaller groups. The area manager told us that as there were only five people on this unit, there had been discussions about whether these people should be relocated downstairs so that they were with more people in the home. We saw evidence in meeting minutes that this had been

discussed at length to consider whether such a move would be feasible. Staff had used their knowledge of people's individual needs to inform a decision that people would not benefit from moving from their familiar surroundings and this was given careful consideration with the needs of the people at the centre of the process.

People told us they knew how to make a complaint if they wished to. One person told us they were unhappy because they wanted to move out of the home to live independently and they said they had told this 'to the boss'. We discussed this with the peripatetic manager and found arrangements were being made by management to facilitate this person's request to move out. Another person said: "This place has come on in recent weeks, I might have complained before but not now, it's much better". Another person said: "I am happy with everything and I have no complaints. If I was unhappy I would speak with the manager". One relative we spoke with was happy about the changes that had been made and thought the home looked 'smarter than before'. Another relative said there had been 'massive improvement', particularly with regard to the décor in the home. However, another relative we spoke with said that although changes were noticeable, they felt this was 'too little too late'. They reported there had been a number of problems which they had reported to management that had not been resolved, such as problems in their family member's room.

The complaints procedure was available to people and the area manager told us there had been no complaints received since the last inspection. They said they were working closely with people and their relatives to address any concerns with the building and arrange refurbishment of people's bedrooms.

Requires Improvement

Is the service well-led?

Our findings

People, staff and relatives told us they thought the home was managed well. One person said: "It's loads better now the ones at the top know what they're doing". Another person said: "It's turning around at last, it needed to". One relative we spoke with said they were encouraged to approach managers and they had been involved and informed in the progress of the home since the last inspection.

The home manager was waiting for completion of their registration with the Care Quality Commission at the time of the inspection. They were on leave on the day of the inspection and the running of the home was done by the area manager who had been in post supporting the improvements since March 2016. We found the area manager had a clear understanding of the issues at the last inspection and the direction the home was moving in to achieve improvements. There had been an administrator appointed to assist with the clerical aspects of running the home and a senior member of staff had been promoted to the deputy manager.

We were told by the area manager and the director 'major lessons had been learned' from the last inspection and measures had been put in place to ensure the safety and well being of the people whilst the refurbishment was completed. They identified that there had been a lack of communication from the head office which had resulted in poor standards within the home and they demonstrated how they had improved communication at all levels. They told us in the event of a situation arising again they would have a formalised plan with a clearly identified project manager. The area manager showed us written communication that had been put into place whilst work was undertaken to inform visitors of any disruption and to assure them of safety. We saw risk assessments were completed when unexpected situations occurred, such as the change in the pressure of the hot water.

The maintenance staff told us the home was 'getting better' and the manager 'makes things happen, gets things done'. Staff we spoke with said there were noticeable improvements and a lot of hard work had gone into improving the home. One member of staff said: "Everyone has worked really hard to make things better". Another member of staff said: "We know there are changes for the better, it's much better than it was".

We saw staff and relative satisfaction surveys had been carried out in January 2016 and these reported positive changes.

We saw evidence of more robust auditing within the home than had been identified at the last inspection, with ongoing assessment and monitoring of the quality of care. There were quality assurance visits from senior managers in the organisation. We saw monthly managers' reports with clear actions identified and addressed. The home manager and the area manager had implemented audits in respect of quality indicators, such as weights, pressure care, dining experience, care plans and medication. Where audits identified action points, these were clearly noted and addressed. However, some key audits lacked rigour, such as internal audits of documentation to identify inaccuracies, checks of premises and equipment, such as bed rails, hoisting slings and mattresses.

Care documentation that was regularly in use was filed securely and not on view. However, we saw in an unused room on the dementia unit, there was a store of archived documentation relating to people's care. This room was not locked and could be accessed by anyone. We brought this to the attention of the area manager who agreed to address this immediately. However, we saw this was still unlocked later in the day.

The provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17(2)(c) because records were not maintained securely or accurately.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not fully assessed and mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not maintained securely or accurately.