Barchester Healthcare Homes Limited

Dudwell St Mary

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

Overall summary

This inspection took place on 15 and 16 July 2015 and was unannounced.

Dudwell St Mary is a residential care home which can provide personal and nursing care for up to 74 people. The home comprises two separate buildings, Dudwell House and St Mary's House.

There was a manager in post who was registered with the Care Quality Commission (CQC). They had overall responsibility for both buildings. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe at Dudwell St Mary. We found that enough staff were on duty to meet people's needs even though some people and staff had a different view of the level of staffing.

Staff had the required skills and abilities to meet people's needs. They received regular training, supervision and appraisals to maintain their performance and promote their development.

Summary of findings

Staff treated people with kindness and respect. Staff spoke with people in a dignified way and knew how people liked to receive care. People told us they liked the staff and were always treated with respect and dignity.

People received care that was responsive to their needs by thorough assessment and reviews of care plans, involving people or their relatives.

People had their health needs met quickly and staff had followed advice from health professionals that had improved people's well-being. People were given a choice of food and drinks and were supported to eat and drink sufficient amounts.

People were involved in choosing activities, menus and the décor of their rooms. Although activities were available and most people enjoyed these, a few people felt there was less to do. We have made a recommendation about this.

People and their relatives told us they could make a complaint and that the provider would address their concerns.

People were encouraged to comment on the service through surveys and questionnaires provided to influence how the service was developed.

Staff we spoke with had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). This legislation sets out how to proceed when people do not have capacity and what guidelines must be followed to ensure people's freedoms are not restricted.

Records showed that the Care Quality Commission (CQC) had been notified, as required by law, of all the incidents in the home that could affect the health, safety and welfare of people.

The manager understood when an application should be made.

Contingency plans were in place, including arrangements for alternative accommodation in the event of an emergency. People were risk assessed to ensure they received appropriate support to be safe in the event of an evacuation of the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

There were sufficient numbers of suitably qualified, skilled and experienced staff to meet people's needs.

People were protected from avoidable harm, bullying, harassment and abuse.

Risks to people's safety and wellbeing were assessed and managed.

Good

Is the service effective?
The service was effective.

Staff had the knowledge, skills and support they needed to carry out their roles.

People were asked for their consent, and when they were unable to make a decision the Mental Capacity Act 2005 had been complied with.

People were supported to eat and drink enough to meet their needs.

People were supported to maintain good health.

Good

Is the service caring?
The service was caring.

People were treated with kindness and compassion.

Staff treated people with respect and promoted their privacy and dignity.

Good

Is the service responsive?
The service was responsive.

People's care plans ensured they received care that was person-centred.

People were supported to take part in social activities.

Feedback from people's relatives was encouraged.

Good

Is the service well-led?
The service was well led.

Staff did not all feel that the registered manager had an open and inclusive culture or was always supportive.

People and their families were asked their views about the service and the feedback was used to improve care.

The registered manager used effective systems for checking that people received high quality care.

Good

Dudwell St Mary

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 15 and 16 July 2015 and was unannounced.

The inspection team comprised an Inspector, a specialist advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience's had experience of caring for people who live with dementia. A specialist advisor is someone who has clinical experience and knowledge of a particular field, in this case, medicines.

We gathered and reviewed information about the service before the inspection, including information from the local authority. We spoke with the commissioners of the service to gather their views of the care and service. We looked at notifications we had received from the provider. This is information the provider is required by law to tell us about.

We spoke with 24 people using the service and observed the care provided to people in communal areas. We spoke with eight staff. We spoke with six people's relatives to gain feedback about the quality of the care provided. We looked at care records and associated risk assessments for six people. We looked at management and staffing records.

Good

Is the service safe?

Our findings

People told us they felt safe in the home. One person said, "I feel very safe here. I am one of the oldies." Another said, "I do feel safe. They use these, (bed safety rails) so I'm happy with that." One person said, "My door is left open, as I want. I can see people walking past." All the relatives spoken with felt that their loved ones were safe at the home. One said, "I do feel X is safe here." Another said, "I was so worried when X was at home, but it's much better now that they are here."

Staff knew how to identify different forms of abuse. They were able to tell us how they would respond and report it. Staff records confirmed that their training in the safeguarding of people from abuse was up to date. Staff told us about their knowledge of the procedures to follow that included contacting local safeguarding authorities and of the whistle blowing policy should they have any concerns. Staff knew where the policy related to the safeguarding of adults was located. This policy was up to date and included the correct local authority telephone numbers. The notice board held information about the provider's whistleblowing policy. Staff told us they would have no hesitation in reporting something they perceived as abuse. Because staff understood how to recognise and report abuse people were protected from the risk of abuse and harm.

There were comprehensive risk assessments in place for areas of people's needs such as mobility, mental capacity, communication, continence, eating, health and sight. For example, if people were at risk of choking, their risk assessment included how their food should be prepared and the level of support they required. Staff were aware of the risk assessments and followed them when supporting people to keep them safe. They also adhered to risk assessments in place to keep stairways and corridors clear to allow people to move about safely. Staff submitted a work request sheet for required maintenance works and this was signed off when the work was completed. There were two full time maintenance staff who ensured the premises were kept in a good state of repair.

There were action plans in place in relation to emergency evacuations and alternative temporary accommodation had been identified at a nearby care home. There were regular fire drills and all fire extinguishers, alarms and emergency lighting was regularly maintained and tested. Care plans contained individual personal emergency evacuation plans. All staff were trained in resuscitation techniques and were clear about the action they needed to take to respond to people's individual needs in the event of an emergency to ensure people's safety and wellbeing.

We saw that accidents and incidents were recorded and the staff discussed the reasons for any accident or incident and what they would do differently to prevent a recurrence. For example, for one person who moved around independently but had experienced falls there was a recorded action to "Move X's accommodation closer to the nurse's station. Staff to be vigilant whenever X exercises independently." These actions had been taken and as a result further falls had been prevented.

People and staff told us they felt that St Mary's House was less well served in terms of staffing levels than Dudwell House. One staff in St Marys House told us, "The staff numbers here aren't enough. There are people with varying levels of support, spread across four floors." One person told us, "I hardly see any staff." However, we found there were sufficient staff on duty and staff responded to people's needs and requests in a timely way in both the houses. The stroke rehabilitation assistants told us they did not have a problem finding staff, "They can generally spare a staff member to be with us." Rotas were planned using a dependency tool and showed appropriate levels of both nursing and care staff in both units to keep people safe. We saw that staff were always on hand and had time to spend with people.

Staff records showed that appropriate procedures had been followed to check their suitability for their role before they started to provide care for people. The records contained evidence of a check of their ID, a Disclosure and Barring Service (DBS) check, references and a full employment history. Staff had completed an application form and had been interviewed before being offered a post. Staff had been issued with a job description for their role and a code of conduct which outlined expected standards of behaviour and disciplinary measures which could be imposed if necessary. The registered manager monitored nurses' registration and ensured it was kept up to date.

Medicine systems were inspected during our visit by a pharmacist. They found that safe systems for ordering, checking orders received, disposal and administration were in place to manage people's prescribed medicines. Checks of medicines storage and equipment had been routinely

Good

Is the service safe?

carried out and recorded. The GP visited on a weekly basis to review people's medical conditions and medicine regimes. Records showed that any medicine dose changes following a doctor's visit were carried out as per instructions. Clear records were made in the care plan of outcomes from health professional's visits. Care plans contained information to give guidance to staff to manage people's treatment needs. The nurse on the medicines' round was seen and heard explaining patiently to people before dispensing their medicines. However, where medicines were prescribed to be given 'As required' there was a lack of instruction for staff detailing the circumstances in which these should be given.

We recommend that the provider seek best practice guidance on managing and administering medicines prescribed to be given 'As required' in care homes for older people.

Good

Is the service effective?

Our findings

People told us that the staff understood what care they needed. Their relatives told us that people were well supported by staff who had received all the necessary training. People told us their health needs were met. One person's relative told us, "They always phone if X is unwell, and tell us what the doctor said."

Staff told us they felt equipped to carry out their role effectively because of the training they received. They all completed an induction when they started work at the home. Induction included shadowing experienced staff until they were competent to work independently. They also completed the Care Certificate which covers training in fundamental standards of care. They were introduced to people, their care plans, the homes policies and procedures and undertook all essential training. Most staff spoke positively about their induction. Staff had regular supervision and annual appraisals to ensure they were working effectively and felt supported in their role.

Staff told us they received regular training to carry out their roles effectively. Staff told us, "The training here is very good." Training included first aid, the Mental Capacity Act 2005, safeguarding and dementia care. Nurses were required to maintain their professional registration and undertook refresher training to keep up to date with best practice in areas such as wound or pressure sore care, medicine administration and catheterisation. The home was affiliated to the Brighton University scheme for student nurse attachments, which kept staff abreast of latest best practice guidance and promoted an atmosphere in which learning was valued. Staff had all completed a relevant health and social care qualification or were part way through the process. This meant that people were supported by staff that had the skills and knowledge to meet their needs.

Staff were able to demonstrate a good working knowledge of the Mental Capacity Act 2005. They put this into practice effectively, and ensured people's human and legal rights were respected.

One person at the home had an advocate who represented them in important meetings to make decisions about their care or finances. Care plans showed evidence of many best interest meetings. Where people had difficulty making decisions the registered manager assessed their capacity to make the decision and, if they were unable to do so, held a best interest meeting to make a decision on their behalf. This had involved staff, family members and health and social care professionals. The appropriate procedures had been followed to ensure that people's rights were upheld. People in the home who were not able to manage their own finances had either a family member acting for them with Power of Attorney (POA), or a solicitor looking after their finances.

Staff asked people for their consent before providing care and support, for example making sure people were ready to move from their bedroom to the lounge when they required support or if they were happy to take their medicines. People's choices were respected, for example one person preferred to eat their meals in the privacy of their own room and this was facilitated. People were offered choices in relation to their personal support, such as when to get up or go to bed and whether they wanted a bath or shower. Staff were familiar with people's needs and their personal preferences.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The registered manager understood when an application should be made and was aware of the Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. DoLS applications had been made as required for people to ensure they were not deprived of their liberty unnecessarily. We saw several records of DOLs applications. One authority was already in place for one person and an application had been submitted in relation to the use of keypad door entry systems. This meant people were not deprived of their liberty or restrained unlawfully.

People were pleased with the food at the home. The menu was on display in the dining area, showing the choices available. One person said, "The food has been delicious, and you can easily ask for more." Another person said, "The food is quite good, generally hot and a choice of two everyday here." Relatives were very complimentary about the food. One said, "Great food, and always a choice of at least two." The meals always had fresh vegetables, there was a choice every day and people could always ask for something else. One person said, "If there is something I don't like, I see the cook, who is very kind and does me something else, for example smoked salmon and salad."

Good

Is the service effective?

People told us they were able to have breakfast when they wanted. There were plenty of drinks, both available for people to help themselves and offered and encouraged by staff. Every person seen had a drink nearby and staff were often seen to offer more. Staff were heard to frequently ask people for their choice of drinks, saying, "Tea, coffee or something cold to drink."

Staff were flexible in where they provided people's meals. Most people ate in the dining rooms with staff on hand to support them if necessary. Staff did not rush people and chatted with them to create an enjoyable mealtime experience. Others chose to eat in their rooms. One person said, "I prefer to stay in my room. Here, it's not a problem." Another said, "I prefer to eat on my own. They do respect that, but they try to see if I have changed my mind." There were clear eating and drinking assessments within people's care plans including consistency, size of portions, allergies, and any specialised cutlery or crockery needed and staff were familiar with these. We also saw in care plans that people who experienced difficulty swallowing had been referred to the Speech and Language Therapy (SALT) team. Kitchen and care staff were aware of their recommendations regarding quantities, texture and supplements and implemented them. For example, thickener for some people's drinks was kept in their rooms and staff were seen to be using it carefully as they brought round the drinks. Care plans outlined the support people needed to eat their meals and we saw that staff provided this. Staff understood how to meet people's dietary needs, for example those with health conditions such as diabetes. People were supported to eat and drink enough to meet their needs.

People, and their relatives, felt that healthcare was managed well at the home. A relative said, "If X even sneezes, the doctor comes quickly, and they phone us. We are very happy with it all." A relative noted that, "If I have any queries about X's medication, the head nurse is very helpful. They did phone me when X wasn't well, of course, and someone sat with X all the time." One person said, "They put you on a list for the doctor to see if you're not well, and the nurse from here comes as well." Another said, "There's always a nurse to see to my swollen feet." Care plans included monthly records of vital signs including temperature, pulse, respiration and blood pressure and catheter changes were managed by the nurses. People's health was monitored and any need for medical intervention was acted upon in a timely manner.

Specialist health support was arranged for people when necessary. The mental health team provided good support to the people living at the home with regular visits from the Community Psychiatric Nurse and a consultant. We spoke with members of the stroke rehabilitation team who said that they had been visiting one person, "Three times a week for about three months now." The dietician from their team was meeting with the person's relative on the day of our visit and their physiotherapist was due to come again soon to review their progress. They told us that staff were 'very receptive' to learning and keen to help. For example, two staff brought in a standing hoist and used it safely at their request. They also told us that the person was weighed monthly, as they had requested, and this had helped their rehabilitation programme. People had health action plans that ensured their health needs were identified and met.

The premises were maintained in a way to make it as easy as possible for people to move about with uncluttered corridors and hand rails. There was level access for wheelchairs to the garden which was flat and included decking areas for people to use. One person's door was decorated with butterfly pictures to help them easily identify their own bedroom. The upstairs dining room contained many old black and white pictures, dolls for therapy and racks of dressing up clothes for people to use. These were appropriate for the needs and interests of the people using the service.

Good

Is the service caring?

Our findings

We saw that staff were kind and caring towards people. People were called by their names, or in the case of at least one person, the name that they preferred. Staff who had spent some time helping a lady with a crossword left her and said that when she returned, she would bring a dictionary and she was later seen to have done so. One person, who wished to be taken upstairs in the lift to their room, was taken cheerfully by staff, even though lunch was about to be served. A nurse, who was trying to soothe a distressed person, spent time holding their hand and talking quietly. One person said, "There is nothing they won't do for you." Another person said they wanted to open "My own window in my room." This was clearly respected, as was another person's wish not to have their curtains pulled back, even though their room was quite dark. The staff offered to open them, but they declined and this was no problem. A relative said, "It's just like a hotel here, with excellent care as well. They take care of the little things, like making sure you can reach your coffee or whether you are warm enough."

Staff understood people's needs well. They knew what was important to them as individuals and provided us with accurate information about people's interests, needs, daily routines and preferences. Every care plan included a life history and information about people's interests, likes and dislikes and preferred routines. One person's care plan stated that they liked to spend time on their own in their room each day. Staff told us this was their preference and we saw the person was attended to regularly by staff so that they did not become socially isolated. At lunchtime, one member of staff was observed for part of the meal, helping a person in bed to eat. They had been raised into a good position and covered to protect their clothing. The staff and the person were cheerful throughout the meal, with the staff, who clearly knew the person well, taking to them and answering their questions. The person was not rushed, and time was taken to clean them afterwards, with re-assurance given when the person asked, "Am I all smart and tidy?"

All of the relatives we spoke with felt welcome in the home. One said, "You can pop in at any time." Another explained, "'Most staff know me well now and I can come in anytime, which is so nice." Another said, "I have come in at all different times and it is so homely here, it suits (my loved one) down to the ground." We saw one person was distressed. Staff were holding her hand and reassuring her. One person told us they liked the care and the staff's sense of humour.

The hairdresser was clearly popular, with one relative saying, "She gets her hair and nails done every week", and one person noting, "I get my hair done every Monday as well." Another lady showed us her manicured nails, clearly very pleased with them. At lunch time we observed gentle support and encouragement from staff when people were eating. Staff were speaking on the same level as people, either sitting with them or crouching down so they were at face to face. There was old time music playing which added to the relaxed, happy atmosphere. People were cheery and reassured by this.

Staff were respectful and mindful of people's dignity. One person told us, "They always knock on the door here, before they come in." All rooms in Dudwell House had en-suite wet rooms and those in St Mary's had ensuite facilities which further promoted people's dignity and independence as personal care was provided in private. People told us their dignity was respected by staff. Staff were discreet when discussing people's needs and were aware of the provider's confidentiality policy. Staff spoke to people respectfully.

People had been involved in compiling advanced directives and living wills including funeral arrangements and these were held within care plans and familiar to staff. People told us this was important to them.

Good

Is the service responsive?

Our findings

People told us that they were supported to do the things they enjoyed. One person said, "If you want a bath, someone will help you. There are no problems and you have only to ask and someone will help you here." People told us that they were able to take part in many activities. Staff ensured people were able to celebrate their birthdays. We saw that staff delivered care that met people's individual needs and preferences.

Care plans included comprehensive pre- admission assessments which included people's mental capacity, health history and current condition, their medicine regime, communication level, and continence so that their care needs could be properly and individually assessed before they moved in. People's care plans were personalised. They included life stories and assessed needs which were reviewed monthly. They gave staff information about the way the person preferred to be supported, for example when they preferred to go to bed and get up and whether they preferred to take a shower or bath. Staff were aware of people's preferences and were able to tell us who liked which particular activity and who would rather stay in their rooms. People's choice regarding the gender of the staff providing personal care was recorded and adhered to. One lady told us that she was asked about whether she was happy with male carers. She said, "Oh yes, I was asked. They are lovely."

There were detailed guidelines for staff to follow in relation to people's moving and handling needs and the use of equipment. Staff were familiar with these and had received appropriate training to support people in moving around the home. We saw examples of this throughout our visit.

Visiting physiotherapy team members told us the staff always asked when they were coming in next, the details were diarised and any requests, such as the person being washed and ready on their bed, were complied with. When people had to go to hospital they were accompanied by staff who took transfer notes. These included Do Not Attempt Resuscitation (DNAR) orders, where in place, lists of medicines, Medication Administration Records (MAR) sheets and risk assessments about the person's mobility, mental capacity, communication and continence and ensured that their particular support needs were made known to hospital staff.

Activities provided for people were discussed at monthly residents' meetings to ensure they were important and relevant for them. These included baking, arts, bingo, trip to garden centre, exercise and age appropriate music. The current weekly plan of activities was displayed in several places, and there were photos of activities. The one scheduled for the morning took place in the older building. A lady there said, "I joined in with the bingo today"' and another, upstairs, said, "I do go down for some of the activities." However, another person told us, "There's not really much to do."' Only limited activities were observed in the newer building, one person was doing a crossword in their newspaper, another person had been given some colouring and there was a bookcase full of large print books and films in a lounge area. One person said, "I go to some activities. I love the outings but the last two have been cancelled. We went to the fish farm in the mini bus, I enjoyed that." One person said they enjoyed the regular Monday Extend exercise activity. Another said, "They take me for walks," and added, "And they always ask me if I want to come when they are having an activity, but I don't usually join in." Her family had added bird feeders to the garden area outside of her window, and she enjoyed watching the birds feeding there. Some relatives felt there were not enough external activities. The registered manager told us there were plans in hand to address this and was looking into acquiring suitable transport to make it possible. This showed that the provider and registered manager were listening and responding to people's wishes.

Several people told us they were supported to attend a local church, which was important to them. This meant that their religious needs were met.

We recommend that the provider seeks and follows guidance in providing activities that suit every person's needs and wishes.

Rooms were personalised to allow people to express their individuality. People had their own furniture in their room and one person had their own computer set up to keep in contact with family. Relatives told us that they knew how to make a complaint if they needed to and felt confident they would be listened to. One relative said, "Any problems are sorted out quickly by the manager." They gave an example of their loved one's room being flooded a while ago, and said the staff had handled it all well, giving them another temporary room while redecorating and replacing everything. Another stressed that there hadn't been any

Good

Is the service responsive?

problems and that any queries had been sorted out. A third said, “We feel we can go to any of the staff here.” The provider listened to people’s concerns and dealt with them in a timely manner. Relative surveys had been sent out and the results analysed. These indicated that people and relatives felt there was an improvement in staff availability, activities, respect for privacy and being treated as an individual.

Good

Is the service well-led?

Our findings

There was a mixed experience of leadership between the two units. Staff in St Mary's house felt they were not listened to by the manager and that the unit was the 'poor relation'. People also told us they felt that St Mary's House was less well served in terms of staffing levels and activities than Dudwell House. Although staff and people felt St Mary's house was less well staffed, we did not find evidence that this impacted on people's care.

The provider sought the views of people and their relatives. A 'fast' response feedback questionnaire for residents, relatives and visitors' was available in the porch of the older building and also in the reception area at Dudwell house. This included the the registered manager's name on it so people would be clear about who they could approach with feedback. It was a satisfaction survey and covered the care, the staff, the welcome received, the cleanliness, the complaints procedure and other issues with yes/no questions. There was also a box for other comments. The notice board had dates for 'relatives and residents meetings', which were quarterly. One relative noted, "I attend the meetings, they can be useful." The survey did not return any indication that relatives felt St Mary's was less well served than Dudwell House.

The registered manager was known to all the relatives we spoke with. One said, "The manager is very approachable." Another told us that the registered manager had visited her loved one at home prior to their placement and reassured them.

Many of the people spoken with also knew her. One person said, "I know her but she doesn't say much", and another said, "The manager knows us all and is very friendly. We are all family to her."

The last CQC report was on display in one of the porches so people and relatives had access to the latest evidence in relation to the service they used. The registered manager understood their legal obligations including the conditions of their registration. They had correctly notified us of any significant incidents and proactively shared identified risks and plans for improvement.

Care plans were reviewed regularly. In this way the registered manager was able to measure and review the delivery of care. We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities both to people and to the registered manager.

The registered manager had actively sought the views of others. This included an annual survey and questionnaires to relatives and health professionals. There were regular staff meetings. The home's nurses had meetings on their own and then held meetings with the other staff to share information and any new guidelines about best practice.

Staff were confident about their roles and generally felt well supported by the registered manager. They were all familiar with relevant policies and procedures and where to locate them. However, there were some concerns raised about a culture of favouritism. Some staff also felt they would benefit from more support from the registered manager to deal with the personal impact of working with people who displayed behaviours that challenged. The registered manager told us that they were always available to provide support to staff, if asked.

There was a programme of quality assurance audits carried out on a weekly and monthly basis. This included audits by the provider. The registered manager visited each part of the home daily to check the standards of care. This included speaking with people and staff to review the effectiveness of the support provided. We saw that improvements that had been recommended at the previous audit had been made.