Minster Care Management Limited

Falcon House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 10 and 12 October 2017 and the first day was unannounced.

Falcon House Care Home was last inspected in August 2015 and was rated Good. At this inspection, the service remained Good.

The provider is registered to provide accommodation for up to 46 older people living with or without dementia in the service over two floors. There were 45 people using the service at the time of our inspection.

A registered manager was in post and was available throughout the inspection. 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.

Staff knew how to keep people safe and understood their duty to protect people from the risk of abuse. Risks were mostly well managed so that people were protected from avoidable harm, though falls risk assessments were not always accurately completed and the bedrails risk assessment required development to effectively consider all risks of the use of bedrails. Mattresses to minimise the risk of people acquiring skin damage were not always set to the weight of the person using them.

Sufficient staff were on duty to meet people's needs and staff were recruited through safe recruitment practices. Medicines were managed safely and staff mostly followed correct infection control practices.

Staff received induction, training, supervision and appraisal. People's rights were protected under the Mental Capacity Act 2005.

People received sufficient to eat and drink but their mealtime experience in one part of the service could be improved. External professionals were involved in people's care as appropriate and adaptations had been made to the design of the home to better support people living with dementia.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

People received care that respected their privacy and dignity and promoted their independence. People could receive visitors without unnecessary restriction.

People received personalised care that was responsive to their needs. Care records contained sufficient information to support staff to meet people's individual needs. A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunities to be involved in the development of the service. Staff told us they would be confident raising concerns with the management team and that appropriate action would be taken.

The registered manager and provider were meeting their regulatory responsibilities. There were effective systems in place to monitor and improve the quality of the service provided. New more detailed audit tools were to be introduced to further improve monitoring of the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains Good.

Is the service effective?

Good

The service was effective.

Staff received induction, training, supervision and appraisal.

People's rights were protected under the Mental Capacity Act 2005.

People received sufficient to eat and drink but their mealtime experience in one part of the service could be improved.

External professionals were involved in people's care as appropriate and adaptations had been made to the design of the home to better support people living with dementia.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Falcon House 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 10 and 12 October 2017 and the first day was unannounced.

The inspection team consisted of two inspectors 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.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed other information we held about the service, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law. We also contacted the commissioners of the service and Healthwatch Nottinghamshire to obtain their views about the care provided by the service. This information was used to help us to plan our inspection.

During the inspection we observed care and spoke with nine people who used the service, six visiting relatives or friends, two visiting healthcare professionals, the maintenance person, the cook, a cleaning staff member, a laundry staff member, the activities coordinator, four care staff, the deputy manager, the registered manager and a representative of the provider. We looked at the relevant parts of the care records of 10 people who used the service, three staff files and other records relating to the management of the service.

Not all of the people living at the service were able to fully express their views about their care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home. A person said, "Safe, yes well anybody if they've got any sense will keep an eye on you." A visitor said, "It is safe and free from bullying, I've not seen anything untoward." Another visitor said, "I know that [my family member] is safe and loved."

Staff were aware of safeguarding procedures and the signs of potential abuse. They knew what action to take if they suspected abuse. Two staff told us that they had reported concerns about individual staff members' behaviour to the registered manager and appropriate action had been taken. A safeguarding policy was in place and staff had attended safeguarding adults training. Information on safeguarding was available to give guidance to people and their relatives if they had concerns about their safety.

People were kept safe but not unnecessarily restricted. We saw that people walked round the home without unnecessary restriction. Some people were assisted to move by staff who used equipment to do this. We observed that this was done safely.

A visitor said, "[My family member] had a fall last week, we were informed, it was explained to us, [staff] dealt with it appropriately." Risk assessments were completed to assess risks to people's health and safety and to identify actions to be taken to minimise those risks. Risk assessments were reviewed regularly. Actions were taken to reduce these risks such as the use of a sensor mat and the involvement of external professionals, for example, the falls team.

However, we observed that three people's falls risk assessments were completed incorrectly. The registered manager reviewed these immediately and a new falls risk assessment was put in place on the second day of our inspection. We also saw that the bedrails risk assessment required development to effectively consider all risks of the use of bedrails. A new bedrails risk assessment was put in place on the second day of our inspection.

We saw accident forms were well completed but did not identify what actions had been taken to minimise the risk of them happening again. The registered manager showed us the provider's incident form which would be used to record this information and told us that they would remind staff to use this form in addition to an accident form when appropriate.

Pressure-relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers; however the two mattresses we checked were set at too high a setting for the people using them. This meant they would not be effective in reducing the risk of pressure ulcers and may have increased risk. We asked whether checks were carried out on the mattress setting and the deputy manager told us they checked them weekly, however did not document this. The registered manager put a new mattress check form in place at the end of the first day of our inspection which was being used by staff to ensure mattresses were being checked by the second day of our inspection. Records were fully completed to show that people received support to change their position to minimise the risk of skin damage, in line with their assessed needs, as set out in their care plan.

We saw that the premises were safe and well maintained and checks of the equipment and physical environment were taking place. There were plans in place for emergency situations such as an outbreak of fire and personal emergency evacuation plans (PEEP) were in place for people using the service. This meant that staff would have sufficient guidance on how to support people to evacuate the premises in the event of an emergency. A business continuity plan was in place and available for staff to ensure people would continue to receive care in the event of incidents that could affect the running of the service.

People did not raise any concerns about staffing levels. A visitor said, "There are always staff available." A visiting professional said, "Staffing is normally covered, they don't like having agency staff and the regular staff usually provide cover for sickness." Staff felt that they had sufficient time to complete their work effectively. A staff member told us they thought there was sufficient staff rostered on duty to meet people's care and support needs. They said they sometimes experienced problems if there was short notice sickness, but the registered manager tried to find cover from other staff.

Systems were in place to identify the levels of staff required to meet people's needs safely. A staffing tool was used to inform decisions about staffing levels. The registered manager explained that people's dependencies were considered when setting staffing levels. Staffing levels were monitored closely to ensure that the correct level was maintained.

During the inspection we observed staff promptly attending to people's needs and call bells were responded to within a reasonable time. Staff were also present in lounge areas at all times in order to monitor those people who would be at risk if left unsupervised.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work. This helped reassure people and their relatives that staff were of good character and were fit to carry out their work.

People did not raise any concerns how their medicines were managed. Medicines were well organised and safely managed by staff at the service. Medicines administration records (MAR) contained a photograph of the person to aid identification, a record of any allergies and people's preferences for taking their medicines were recorded. We checked MARs and found they had been fully completed.

Medicines were stored securely. Temperature checks were recorded daily of the room and the refrigerator used to store medicines. Processes were in place for the ordering and supply of medicines. Staff told us they obtained people's medicines in a timely manner. Protocols were in place to provide additional information about how medicines should be given when they were prescribed to be given only as required, for example, pain relief medicine. Staff received medicines training and had their competency to administer medicines assessed regularly. That helped to ensure people received their medicines in a safe way.

People told us the home was clean. A person said, "It's very clean and tidy. [Staff] are very particular about that." A visitor said, "Bedding is changed every day, very clean, clothes changed every day." Another visitor said, "The laundry is always well done and never goes missing." A visiting professional said, "The home is always clean; properly clean." During our inspection we looked at some bedrooms, toilets, shower rooms and communal areas and found that the environment was clean and staff mostly followed correct infection control practices. We raised a couple of minor infection control issues with the registered manager who agreed to take action to address them.

Good

Is the service effective?

Our findings

Before our inspection visit we were notified of the outcome from a safeguarding investigation where it was concluded that the service's dementia and nutrition training needed improvement. It also concluded that the service's staff had not contacted 111 and 999 services until prompted by a person's family and had not taken appropriate steps to address a person's declining food and fluid intake which might have led to deterioration in the person's health. We are considering whether we need to take any further action in relation to the outcome of this safeguarding investigation. During our inspection we checked to ensure that training had improved, staff were clear on when they needed to contact professionals for advice and how nutritional and hydrational risks were managed. We found no concerns in these areas.

People felt staff were competent in their role. A person said, "Staff are good, I seem to get on with them, they seem pretty efficient and even the ladies who've just come in – they soon pick it up." We observed that staff competently supported people throughout the inspection.

Staff felt supported by management. They told us they had received an induction which prepared them for their role and records confirmed that staff completed an induction process. A staff member said, "It was a very thorough and in depth induction. I shadowed three or four shifts before starting."

Staff also told us they had access to training to enable them to keep themselves up to date and they felt they had the knowledge and skills required for their role. Training records showed that staff attended training which included dementia, nutrition and equality and diversity training and was updated regularly. Staff also told us they received regular supervision and appraisal and records we saw confirmed this. This meant that staff were supported to maintain and improve their skills in order to effectively meet people's needs.

We saw that staff asked permission before assisting people and gave them choices. Staff did not always explain to people what they were about to do when moving them using a hoist. However, people did not appear concerned about this and staff thanked people after the moves had been completed.

Records we reviewed contained a consent form which people had signed to consent to the use of photographs within their care record and other decisions relevant to their care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

When people could not make some decisions for themselves, we found mental capacity assessments and best interest decisions were completed for some decisions, however, some care records did not contain mental capacity assessments for other decisions which were made, such as the use of bed rails, or the administration of their medicines. The registered manager agreed to review this.

Staff had an appropriate awareness of MCA and DoLS. DoLS applications had been made appropriately. We checked an authorised DoLS which had a condition in place. This condition was being met.

We saw the care records for people who had a decision not to attempt cardio-pulmonary resuscitation order (DNACPR) in place. We saw that DNACPR forms had been fully completed.

Care records contained some guidance for staff on how to effectively support people at times of high anxiety. However, they could be improved to provide guidance for staff on a more personalised approach to supporting people when in distress. Some staff had attended training on how to effectively support people with behaviours that might challenge others and the registered manager agreed to ensure that all relevant staff attended the training. Staff we spoke with were able to explain how they supported people during periods of anxiety.

Feedback on the quality of the food was generally positive. A person said, "The food is good, you get two hot meals a day." Another person said, "The food has changed, it's eatable and enjoyable, I've not got much to grumble about." A visitor said, "My relative is very particular about food, I'd know if there was a problem, they would tell me … if they don't like a meal I've seen staff say "What do you like?" and they have gone off and got them scrambled egg."

We observed the lunchtime meal on both floors. On the ground floor, tables were well laid and people were served promptly. Some people who had chosen their meal in advance were served with this, whilst others who were unable to remember or make a choice were offered the two options, either verbally or by showing them both meals. People were appropriately assisted by staff. Staff also offered a person, who had refused the main meal, a number of alternatives to the meal and continued to prompt them appropriately until they had eaten.

The mealtime experience on the top floor could be improved. Tables were not laid and food was not served promptly. A person required their food cutting up so that they could more easily eat it. Staff cut up some, but not all, of the food and we saw that the person struggled to eat the uncut part of their meal. No drink choices were offered, everyone was given the same flavour of cold drink. We discussed these issues with the registered manager who agreed to take action in this area.

Nutritional risk assessments were completed and care plans were in place to provide information about people's support needs, dietary requirements and preferences. People's weights were monitored on a monthly, fortnightly or weekly basis. When people had diabetes, this was not identified on their eating and drinking care plan, however, a diabetes care plan was in place which provided information on their dietary requirements.

Two of the people whose records we reviewed had lost weight over the previous nine months and a third person could not be weighed due to their condition but were nutritionally at risk. We observed two of these people were receiving nutritional supplements and staff were aware of their weight loss. Food and fluid intake charts were kept and indicated the people were eating well at meal times. We saw that people received regular drinks throughout the day.

Visitors told us their family members were supported with their healthcare needs. A visitor said, "Staff always call the GP before I need to ask. The optician comes in and the chiropodist." Another visitor said, "Staff brought up the issue of my relative's hearing, they arranged to have it tested and [my relative] now has a hearing aid – [staff] did that, not us." A visiting healthcare professional told us that staff contacted them appropriately when they were concerned about a person's health and staff were knowledgeable about the people they cared for.

People had access to ongoing support and healthcare from visiting professionals such as the rehabilitation team, opticians, and chiropodists. However, recording of this involvement of this was not always easily found in the person's care records. The registered manager told us they would remind staff to ensure that this external professional involvement was more clearly documented.

The premises were suitable for the people using the service. Adaptations had been made to the design of the home to better support people living with dementia. Bedrooms, bathrooms and toilets were clearly identified. Directional signage was in place to enable people to move around the home independently where possible.

The first floor lounge windows were large which meant that the lounge area was bright. However, when the sun was shining the temperature in the room increased and it became very warm. There were no curtains or blinds to provide shade. The registered manager agreed to address this issue immediately.

A representative of the provider showed us the plans for refurbishment of the home. This refurbishment was planned to include the whole home and would considerably improve the internal and external environment of the home.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. A person said, "Staff are always lovely." Another person said, "[Staff] are very considerate." A visitor said, "[Staff] are brilliant, we were all traumatised [when family member first went into the home] but within a week there was a complete transformation. They [staff] showed care and concern to us as a family as well. After a month my relative said, 'Thank you for bringing me here, I'm really happy.' It's not just the physical needs, it's the mental needs and the caring, it is not a show home, it offers the emotional care my relative needed, it's outstanding."

People told us they were comfortable with staff. A person told us they had good social relationships with staff and they could chat and laugh together. Another person said, "Staff are good, I seem to get on with them." A visitor said, "The staff are lovely, genuine and open. [My family member]'s face lights up when staff talk to her." Staff had a good knowledge of the people they cared for and their individual preferences. We observed staff interacting well with people and visitors and talking in a kindly, friendly and polite manner.

Views were mixed on whether people or visitors had been involved in the care planning process. A person said, "I've not been involved in the care plan, I haven't seen one, I know they write things down." However, A visitor said, "I've gone through the whole care plan with them."

Care plans indicated that people or their relatives were involved in the development of their care plans and in their review. Care records contained information regarding people's life history and their preferences. The registered manager told us that regular care reviews took place where people and their relatives, where appropriate, were invited to discuss the quality of care provided and whether they wanted any changes to that care.

When people were unable to communicate easily, care plans provided information about the gestures or body language people used to communicate with and how staff could better understand them. We observed staff clearly communicated with people and gave people sufficient time to respond to any questions.

Advocacy information was available for people if they required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

Visitors felt that people's dignity and privacy were respected by staff. A visiting professional described a situation they had observed, in which a person's dignity was in danger of being compromised and staff had acted quickly to ensure the person was covered quickly. We observed staff knocking on bedroom doors and respecting people's privacy by closing doors during personal care. A staff member told us they would close the bedroom door and the curtains when they were providing personal care to preserve the person's privacy and dignity.

The language and descriptions used in care plans showed people and their needs were referred to in a

dignified and respectful manner. We saw that staff treated information confidentially and care records were stored securely.

A visitor told us staff encouraged their family member to do things if they were able to. Staff also told us they encouraged people to do as much as possible for themselves to maintain their independence. We observed people using adapted crockery at meal times to assist them to eat independently.

People could receive visitors without unnecessary restriction. A visitor said, "I'm always welcome, I visit every other day, any time at all." Another visitor said, "I pop in at different times, I don't announce my visits." Information on visiting was in the information provided for people who used the service.

Good

Is the service responsive?

Our findings

People raised no concerns regarding whether they received support that was responsive and personalised to their needs. A staff member said, "People get up when they want to and people stay up late if they want to as well. We ask people what they want to do." Another staff member said, "People are asked whether they would like a shower or a bath and we are able to respect their wishes."

People gave mixed feedback on activity provision. A person using the service said they preferred their own company but would have liked the opportunity to go out of the home individually with staff. Another person said, "It's boring." A visitor said, "They do activities, [my family member] tells us about it, they are smiling." Another visitor said, "There are lots of activities. [My family member's] room is full of things she's done here. Staff take her to the church for a coffee morning each Thursday." A member of staff said they felt there could be more activities for people. However, they said the activities coordinator did facilitate some activities.

We did not observe many activities taking place during the morning of the first day. A group of ten people took part in an exercise session on the first floor while on the ground floor people were sitting in chairs looking out of the window or dozing. However, in the afternoon staff facilitated a game of skittles in the lounge on the ground floor. We also observed staff sitting and chatting with some people about things the people were interested in.

We spoke with the activities coordinator who had recently taken over the role. She showed us the most recent weekly activities timetable and described the group and individual activities offered by the service. This included regular trips out into the local area and regular visitors coming into the home to provide activities. The activities told us of their plans to further improve the range of activities available at the home.

Care records contained documents with information about people's life history and interests in a range of forms including the Alzheimer's Society, "This is me" booklets. Care plans provided information about people's individual care and support needs and were evaluated and reviewed monthly. Some of the original care plans had not been re-written for over a year which meant that up to date information regarding people's needs was sometimes found in the evaluation of care plans not the care plan itself. This meant that there was a greater risk that up to date information on people's needs could be missed by staff when looking at care plans.

Care plans were in place to provide information on people's care and support needs, including healthcare needs. Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs. A visitor told us that any preferences for same gender care staff when their family member receiving personal care were respected.

Visitors told us they knew how to make a complaint. A visitor said, "I'd go to the nurse in charge if it was a small complaint. I'd go to the [registered] manager and be confident it would be dealt with quickly and properly." Another visitor said, "I'd be totally happy I could raise anything with [staff]."

Complaints had been handled appropriately and responded to promptly. Guidance on how to make a complaint was displayed in the home and in the information provided for people who used the service.

There was a clear procedure for staff to follow should a concern be raised. Staff were able to explain how they would respond to any complaints raised with them.

Good

Is the service well-led?

Our findings

A visitor told us that they had attended a meeting for relatives where they were comfortable that they could comment on the quality of the service. We saw separate meetings for people and for relatives took place where comments and suggestions on the quality of the service were made. Comments were generally positive and the registered manager was documented as having taken action in relation to any identified issues. We saw completed surveys were very positive on the quality of the service being provided. These surveys were completed by visiting professionals, people using the service and relatives and other visitors.

A whistleblowing policy was in place and staff told us they would be prepared to raise issues using the processes set out in the policy. The provider's values were displayed and staff were observed to act in line with them during our inspection. These values emphasised privacy, dignity, rights, independence and fulfilment.

A visitor said, "When I come here, it's like a second home." A staff member said, "It's a friendly atmosphere." Another staff member said, "Everyone's like a family and gets on." We found the home to be calm and relaxed, staff were warm and friendly.

People told us that the registered manager was approachable and listened to them. A person said, "[The registered manager] helps out, she'd sort things out if there was a problem." A visitor said, "[The registered manager] remembers everyone's name, and knows about them, I know things are dealt with quickly and properly." Another visitor said, "It is well led, it comes from the top." A visiting professional told us the service was well led. They said, "The management is very good; there's a good command structure. If there is a problem you always know who to go to." They said the service was, "Well organised."

Staff told us that the registered manager and deputy manager were very supportive and approachable. A staff member said, "You couldn't wish for a better manager. If you have any problems, they will sort things out straight away."

We saw that regular staff meetings took place and the registered manager had clearly set out their expectations of staff. Staff told us that they received feedback in a constructive way. A staff member told us the registered manager would speak to them on a one to one basis if there was an issue. A clear management structure was in place and staff were aware of this.

A registered manager was in post and was available throughout the inspection. They told us that they felt well supported by the provider. The current CQC rating was clearly displayed. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required.

The provider had a system to regularly assess and monitor the quality of service that people received. We saw that regular audits had been completed by the registered manager and representatives of the provider. Audits and checks were carried out in a range of areas including infection control, medicines, catering and

care records. A representative of the provider showed us new more detailed audit tools that were to be introduced to further improve monitoring of the quality of the service. Actions had been taken where issues had been identified by audits or from inspections by external organisations.