Countrywide Care Homes (2) Limited

St Martin's 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 the 26 February 2018 and was unannounced.

At the last inspection of this service on 2 November 2016 we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because equipment was not always used safely and requirements of the Mental Capacity Act 2005 were not always followed. Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to meet the requirements of the law. At this inspection we found the provider had followed their action plan and they were now meeting the requirements of the law.

This service is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service is registered to accommodate up to 42 people. At the time of the inspection 42 people were living at the service; some of whom were living with dementia and other chronic conditions. Of the people living at the service; 31 required nursing care and 11 required support with personal care.

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

People received effective, personalised care that was thoroughly planned and had been adapted to meet their needs. They directed and agreed to their care and the principles of Mental Capacity Act were being applied. People's end of life care was discussed and planned and their wishes respected.

People were supported to express their views, make choices about their care, and have maximum choice and control of their lives. People chose when to get up, what to wear, when to go to bed and how to spend their day. People had the opportunity to take part in group activities such as; painting, karaoke, bingo, visits from external entertainers, playing darts and using the in house 'bar'. Staff spent time with people on a one to one basis and encouraged people to stay in touch with their families and receive visitors.

People were encouraged and supported to eat and drink well and there was a varied daily choice of meals on offer. Health care was accessible for people and appointments were made for regular check-ups as needed.

People felt well looked after and supported. We observed friendly relationships had developed between people and staff. Care plans described people's preferences and needs in relevant areas, including communication, and they were encouraged to be as independent as possible.

Staff were supportive, caring and provided dignified care. They understood individual's preferences and supported people's lifestyle and social interests.

People's individual needs were met by the adaptation of the premises. Risks associated with the environment and equipment had been identified and managed. Technology, such as sensor mats, were used to alert staff if people at risk of falls got out of bed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

We found that a safe service was provided by a staff team who were appropriately recruited, trained and supported. Established systems were in place for preventing harm and abuse. Robust arrangements had been made to protect against risks, maintain health and wellbeing, and give medicines safely.

The service had an open, inclusive culture and was well managed. Feedback was sought and responded to. Complaints had been recorded and responded to appropriately. The governance of the service ensured regular monitoring of standards and the quality of care provided. Where shortfalls were identified action had been taken to make improvements.

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 was safe.

People were supported by staff who had a good understanding of how to keep them safe and manage identified risks.

People were supported by sufficient numbers of safely recruited staff.

People had their medicines when they needed them, with support from trained staff.

Is the service effective?

Good

The service was effective.

People were supported by staff that had the knowledge and skills to provide their care.

People were supported with maintaining a healthy diet and access the healthcare support they needed to maintain good health.

Staff had a good understanding of the need to obtain consent and worked in accordance with the principles of the MCA.

Is the service caring?

Good

The service was caring.

Peoples were involved in their care and made decisions about how they were supported.

People were supported by kind and caring staff who knew them well.

People's privacy and dignity was maintained and information about them was stored securely.

Is the service responsive?

Good

The service was responsive.

People's care needs had been assessed and planned for.

Person centred care was provided that was responsive to changes in the individual's needs.

Feedback about the service was obtained and a clear complaints procedure was in place.

Is the service well-led?

Good

The service was well-led.

People spoke highly of the management who they felt were approachable and listened to their views.

Systems were in place to identify shortfalls and drive improvement.

The registered manager was aware of their responsibilities.

St Martin's 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 was carried out on 26 February 2018 by one adult social care inspector, an inspection manager and a specialist advisor who was a nurse.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service. We also checked information that we held about the service and the service provider. We looked at any notifications received and reviewed any other information held about the service prior to our visit.

During the inspection we spoke with nine people who used the service, three people's relatives three visiting social care professionals, a maintenance person, an administrator, a cook, the registered manager, the providers quality assurance and compliance manager, an activities organiser, seven staff who delivered care including two registered nurses and a senior care practitioner.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We observed the administration of medicines in the morning and at lunch time. We also observed people's lunch time experience and the provision of a group activity in the afternoon. Records reviewed included: Seven people's care plans and daily records, staff rotas, policies and procedures, staff files covering recruitment, training and supervision, medicine administration records (MAR), accidents and incident records, complaints and audit documentation. We also looked at other areas of the environment including bathrooms, medication room, medication storage, communal lounges, people's bedrooms, the dining room, cleaning cupboards and sluice facilities.

Good

Is the service safe?

Our findings

At our last inspection on 2 November 2016 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that premises and equipment were always safe. At this inspection we found the provider had taken corrective action and was meeting the requirements of the law.

At the last inspection one person's door was being wedged open. This meant that in the event of a fire the automatic closing device would not be able to operate and placed the person at risk. At this inspection we found this issue had been addressed. At the last inspection one person did not know how to use their call bell in order to summon staff if they needed help. At this inspection we found this issue had been addressed and everyone knew how to use their call bells.

The provider had systems in place to protect people from abuse. We reviewed the services policies and practice around safeguarding and found them to be of a consistently good standard. Staff, when asked, were clear in their responsibilities to report any issue of concern and this included, if necessary, going outside of their service to The Care Quality Commission if they felt the response had not been adequate. Staff records confirmed that all staff regularly received updated safeguarding training. When incidents of potential abuse had occurred the registered manager had informed the local authority in line with local safeguarding protocols. We were able to view examples of good practice when staff had taken action to protect vulnerable people in their care.

Prior to the inspection we became aware of an incident that had resulted in a safeguarding concern and a police investigation. We looked into this issue and were satisfied that the home had done everything that could reasonably be expected of them to keep people safe and protect them from harm.

We looked at the staff rotas and saw that there was sufficient numbers of staff to provide a good standard of care and we observed that staff had the time to combine their tasks with time to sit and chat with people on a more informal basis. We were told that this was also the case when there was any absence due to sickness or holidays. A couple of people who lived in the home told us that they sometimes had to wait for care and support but most people were happy with the staffing levels provided. Some staff thought that the home would benefit from more nurses. We saw that there were two nurses on duty on week days until 2pm and that this was a recent improvement to enable the nurses to cover all the tasks that were required.

Recruitment practices were safe. Appropriate checks were completed to ensure new staff were suitable to work with vulnerable adults. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and adults. Recruitment files held a copy of the application form detailing the applicants full work history as well as notes from the interview, identification confirmation and copies of at least two references. We saw that references were followed up and checked for authenticity.

The provider had processes in place to protect people from infection. Staff had completed training in infection control and had access to personal protective equipment such as disposable gloves and aprons. Staff involved in the preparation of food had also completed training in food hygiene. We looked all around the premises and saw that it was clean and well maintained. We looked at the certificates relating to the safety of the building and the equipment in it and saw that all the safety checks were up to date and had been carried out regularly. Two sluice areas were observed; both had access via a door key code and were clean and tidy. Rooms next to both sluice rooms had cleaning products stored in line with Control of Substances Hazardous to Health (COSHH) guidance and were only accessible via a door key code.

There were systems in place for the safe management, storage and administration of medicines. Medicines were only administered by staff who had been trained to do so and whose competencies had been checked. Medicines were stored securely and at the right temperature in line with good practice guidelines. When medicines had been administered to people an entry had been made on a Medication Administration Record (MAR) to indicate this. The MAR for each person contained a photograph of the person and detailed any known administration difficulties or known allergies. The MAR also recorded each person's choice and preference around drinks, how they liked to have their medication and whether they required assistance to take their medicines.

Protocols were in place for the administration of 'as required' (PRN) medicines. These provided staff with guidance as to under what circumstances these medicines could be administered and for how long for before advice was sought from a healthcare professional. People who had communication difficulties or were living with dementia had evidence-based pain assessments/scales in place to enable staff to assess when they needed to take PRN pain relieving medicines. Where people had expressed a preference to manage their own medicines appropriate risk assessments had been undertaken to ensure it was safe for them to do so. Staff had access to up to date information about medicines and the contact numbers for the dispensing community pharmacy and GP practice were on display within the medication room.

Risks to people were managed effectively. Risks to people including those associated with the safety of the premises, equipment, wounds, medication, nutrition and skin integrity had been assessed. Risks to people had been mitigated in the least restrictive way to enable people to participate in their chosen activity with the relevant support from staff. Robust procedures were in place for monitoring and analysing accidents and incidents that had occurred at the service. When accidents had occurred these had been recorded and action was taken to reduce the risk of re-occurrence. People who had been identified as at risk of falls had sensor mats in their rooms to alert staff when they got out of bed.

Good

Is the service effective?

Our findings

At the last inspection on 2 November 2016 we identified a breach of Regulation 11 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that they always worked within the principles of the Mental Capacity Act (MCA). At this inspection we found the provider had taken the action needed to meet the requirements of the law.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had followed the requirements in the DoLS. Where appropriate to do so, applications had been submitted to the 'supervisory body' for authorisations and the provider had properly trained and prepared staff in understanding the requirements of the Mental Capacity Act in general, and the specific requirements of the DoLS.

Since the last inspection improvements to staff practice in relation to gaining lawful consent in line with the MCA had been made. Consent to receive care and treatment had been obtained from either the person or a person with the legal authority to give consent on the person's behalf. Where people did not have the capacity to give consent a best interest decision had been made and recorded within their care records. Three external health and social care professionals told us they had attended a meeting with a person and a registered nurse from the service to review the person's care and capacity to consent. They also told us as part of the review the person had been consulted in relation to their choices and preferences.

People received support from competent and skilled staff. Staff received the training and support needed to undertake their role effectively and provide safe and responsive care. All new staff completed an induction to the service before working unsupervised. This included shadowing experienced staff which helped them to familiarise themselves with people's routines and care needs before caring for the person themselves. We reviewed staff training and found there to be a comprehensive approach to ensure that all staff had the same foundation of learning that was updated every 12 months. This training was defined as mandatory by the registered provider and included: moving and handling; infection control; safeguarding; food hygiene; health and safety; mental capacity and DoLS.

Staff also completed specialist training in to meet people's individual care needs such as tissue viability care and PEG feeding [Percutaneous endoscopic gastrostomy is a tube that is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not possible

or adequate]. Staff also accessed dementia awareness training which was useful as many people were living with dementia type conditions.

Staff had regular access to support and supervision. Supervision provides staff with the opportunity to discuss any training and development needs they may have. All staff that had been employed for 12 months or more had received an annual appraisal of their performance. Most staff also held a nationally recognised qualification in care such as a Health and Social Care Diploma or a National Vocational Qualification (NVQ). Staff new to care were supported to complete the Care Certificate. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should be covered for staff 'new to care'. Staff told us that they felt supported and were able to raise concerns if they needed to. Comments we received included "The manager is great. She is very approachable" and "The manager is always asking us how we feel and if we are ok."

People's health care needs were identified and met. People were supported to maintain good health and had on-going healthcare support. Care staff monitored people's health and recorded their observations. They liaised with health and social care professionals involved in their care if their health or support needs changed. People's care plans documented people's health conditions and provided staff with information on their medical history. People received the support they needed to access support from health care professionals such as GP, SALT and dieticians. Care plans also indicated involvement of podiatrists and the need for dentist and optical input. Care records confirmed people had received routine health checks and medication reviews when needed. Information regarding the outcome of people's healthcare appointments were documented and any advice given had been followed.

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. We observed lunch. It was relaxed and people were considerately supported to move to the dining areas or could choose to eat in their bedroom or the lounge. People were encouraged to be independent throughout the meal and staff were available if people required support or wanted extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. All the time staff were checking that people liked their food and offered alternatives if they wished. People were complimentary about the meals served.

People's individual needs were met by the adaptation of the premises. Hand rails were fitted throughout the service, and other parts of the service were accessible. There were adapted bathrooms, wet rooms and toilets and hand rails in place in these to support people.

Good

Is the service caring?

Our findings

People felt staff were consistently kind and caring. One person told us; "I'm quite happy to be here. The staff are lovely. They knock on my door if it's closed; I appreciate that". Health and social care professionals all felt the service was caring. They told us they felt the staff were "really engaging", "caring" and "help make the residents feel that it is their home". One healthcare professional told us "As soon as you come into the home you get a really positive feel for the home". They told us in their experience people were always treated with dignity and respect and stated they had no concerns about people's care or about the staff who worked at the service.

All of the interactions we observed between staff and the people were kind and caring. We saw that people were supported at their own level and pace and were encouraged to make clear choices in how they wished to be cared for. We saw many examples of people making choices about the time they got up, how they chose to spend their day, and where they wished to eat their meals.

We observed staff chatting with people whilst supporting them with their day. It was obvious that staff knew people well and were able to talk to them about the things that they were interested in. We also noted that staff made sure to treat people with respect regardless of their capacity to consent. We saw that staff explained what they were going to do and asked people how they wished to be supported.

People were provided with emotional support. We were able to view how staff communicated with people throughout the day and observed their interactions. They were respectful, encouraging and were heard to be offering people choices about activities and food. Our observations were that the relationships between people and the staff supporting them were warm, respectful and dignified. We saw one person was getting agitated and a bit anxious. The staff member in the room noticed this quickly and spoke with the person, laughing and joking with them and then got them a cup of tea and quickly diffused their agitation. They then sat with them and had a conversation and talked about films that were on the television. Visitors were welcomed and relatives told us they were able to visit at anytime.

We saw that people's well-being was considered and supported. Some people were supported by handling dolls and soft toys. We could see that this significantly had a positive impact on their mood and they appeared happy and contented. We observed one person happily singing to the dolls and enjoying the activity.

We heard the registered manager on the telephone to a relative. The registered manager was reassuring and described to the relative how they were supporting their family member. We saw that the registered manager had very positive interactions with the people and was very involved in all aspects of their care, role modelling good care practice to the staff members.

People were supported to retain their independence and make their own choices. People told us they could get up and go to bed when they wanted. One person commented "I like to do what I like to do and I can do that. I'm not one for staying up late". Another person commented "I go to bed early and watch my

programmes in bed. I like the door open at night so I can wave at people as they go by". At lunch time we saw that people were provided with the equipment and support they needed to enable them to eat and drink independently. For example some people were provided with beakers with handles and spouts or straws. Other people were provided with plate guards or had their food cut up into smaller pieces. We also observed a foot plate of one person's wheelchair had been removed. Staff explained this was so the person could use their leg to propel their wheelchair without staff support.

People were supported to make their own decisions and their wishes were respected. At lunch time we heard staff asking one person if they wanted thickener in their dink. When the person refused staff reminded the person of the risk of not having the thickener but respected their decision. The person later confirmed to us they had been advised by a healthcare professional that they should have their drinks thickened to reduce the risk of choking but they did always follow this advice. They also told us they had signed documentation confirming they were aware of the risks of not having thickened drinks and staff always asked their preference before serving them a drink.

People told us their privacy was respected and had been consistently maintained. One person's relative told us their loved one was "definitely" treated with dignity and respect. Peoples' equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs and preferences. There were individual person-centred care plans that documented peoples' preferences and support needs, enabling care staff to support people in a personalised way that was specific to their needs and preferences. For example care plans provided details of the clothes people preferred to wear such as 'likes to wear a skirt and blouse'.

Information was kept confidentially and there were policies and procedures to protect people's personal information. Records were stored in locked cupboards and offices or on password protected computers. For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available. The registered manager was aware of who they could contact if people needed this support.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. There were systems in place for the needs of anyone considering using the service to be assessed before a service was offered. This allowed the person and the registered manager to assess whether or not the service could provide the support the person needed. Assessments were comprehensive. A social worker highlighted that as part of one person's pre-admission assessment staff at the service had identified a need that the local authority assessment had not identified. This was because the person was very tall and required a larger bed. They told us an appropriately sized bed had been obtained and was in place ready for when the person moved into the service.

Pre admission assessments were holistic and gave detailed information on people's likes, dislikes, preferences and health care needs. The assessments had been used as a base to compile care plans which detailed people's health needs, social contacts, previous jobs, family background and how each person needed and wanted their care to be delivered. Feedback from people, relatives, care staff and visiting health and social care professionals was that care plans were regularly updated and reviewed to reflect changes to people's care needs. This ensured staff had access to the guidance they needed to provide people with safe and effective care in line with people's preferences.

Peoples' end of life care was discussed and planned. Where people refused to discuss this, their wishes had been respected. Where possible people were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes, with regard to their care at the end of their life, had been sought and documented.

People were supported to participate in their chosen activities and social events which they enjoyed. The activities organiser told us that they provided group activities as well as spending time with people on a one to one basis. Our observations confirmed what they told us. We saw the activity organiser spent time with people reading the newspaper and doing crosswords and facilitated a painting session which a six people took part in. We saw this was a very social occasion with people chatting and laughing with each other. People told us there was a range of other group activities on offer including bingo and Karaoke which some people said they particularly enjoyed. Another person told us "The school came in the other day. The children played games and read to us. One of them was teaching me how to play draughts. They've been before singing. We've got a choir coming in on St Patrick's Day, we're having a party". A visitor told us their relative preferred to stay in their room and listen to their favourite radio programmes. They confirmed that staff knew what these programmes were and made sure the radio was turned on at the right time and was tuned to the right station. They also told us that sometimes their relative liked to attend the 'men's club'. Staff told us the 'men's club' was set up to encourage the gentlemen to come out of their rooms and socialise more. They told us this was held in one of the communal lounges where a bar and dart board had been installed. One person told us that sometimes they went to the 'men's club' to take part in the darts competition and have a shandy and that they enjoyed this.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012.

Services must identify record, flag, share and meet people's information and communication needs. Although staff had not received AIS training they had ensured people's communication needs had been identified and met. People were communicated with verbally and with written information some of which was illustrated with pictures to aid people's understanding. People's care plans provided information on how to communicate effectively with them. For example one person's care plan stated they were 'able to answer closed questions e.g. would you like a cup of tea?' and 'Staff to allow enough time to talk and answer questions'.

People and their relatives were asked to give their feedback on the care through reviews of the care provided and through quality assurance questionnaires which were sent out. We saw that the service had also received a number of compliments from relatives giving praise and thanking them for the care that their family members had received.

People and their relatives told us they felt comfortable in raising any concerns and knew who to speak to. The provider had a complaints policy and processes were in place to record any complaints received and address them in accordance with their policy. We saw that the complaints procedure was displayed in communal areas. Since the last inspection improvements had been made in relation to the recording of complaints. We looked at the complaints log and saw that formal complaints were robustly investigated and responses given to complainants in a timely manner. We also saw that complaints were audited monthly to ensure that they were properly responded to.

Good

Is the service well-led?

Our findings

The registered manager had been registered since January 2018 but had been in post since August 2017. They understood their responsibilities in relation to the service and their registration with CQC and had updated us with notifications and other information as required.

From April 2015, providers must clearly display their CQC ratings. This is to make sure the public see the ratings, and they are accessible to all of the people who use their services. The registered manager had ensured the ratings were appropriately on display in a clear and accessible format, at the entrance to the service.

We found that the registered manager had a good knowledge of the people who used the service and of the staff team. We saw that there was clear leadership which set the tone for the service and that this was based around wanting to provide good quality care for everyone who lived there.

We looked at the arrangements in place for quality assurance and governance. Quality assurance processes are systems that help providers assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. We reviewed several audits and checks and these included checks on health and safety, infection control, staff records, care records, medicines, accidents and incidents amongst other areas. We saw that these checks were carried out regularly and thoroughly and that any action that had been identified was followed through and completed. We could see that the registered manager had made good progress since they commenced in post and had made improvements to the service.

People, their relatives and staff all felt the service was well-led and would recommend it to others. Health and social care professionals told us they would refer people to the service without hesitation. They also told us they felt the registered manager was very approachable and engaging.
People and their relatives confirmed they were asked for their opinion of the service and had contact with the management team on a regular basis including through one to one meetings and resident and relative's meetings.

Staff felt supported by management and listened to. Staff told us that the provider, registered manager and deputy manager were supportive and understanding of any personal or emotional needs they had. This helped to promote a positive and inclusive culture within the organisation. There was also good staff retention within the service with many staff having worked at the service for many years which helped promote good continuity of care. Staff highlighted they believed the management always had people's interests at the forefront and were always looking at ways to improve.

Staff told us they would not hesitate to raise concerns if they witnessed poor practice and were aware of the providers 'whistleblowing' policy. They were also aware of the need to escalate concerns about people's welfare both within the organisation and externally.

The provider had good community links with other organisations involved in people's care such as health and social care professionals and worked in partnership with them to ensure the best outcomes for people. They also had links with the local school who were encouraged to visit the service on a regular basis. We viewed comments from the recent survey carried out by the service and saw that the responses were positive.