V & V Care Limited

St Mary's Residential Care Home

Inspection report

Market Place
New Buckenham
Norwich
Norfolk
NR16 2AN

Tel: 01953860956

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

St Mary's Residential Care Home is a residential care home that provides accommodation, care and support for up to 29 older people, some of whom live with dementia. It is registered to provide accommodation for persons who require nursing or personal care but nursing care is not provided. At the time of our inspection there were 19 people living in the home.

People in care homes receive accommodation and 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.

St Mary's Residential Care Home accommodates people across two floors. People are accommodated in single rooms, and there are communal toilet and bathroom facilities for people to use. This was the first comprehensive inspection carried out for this organisation.

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.

At this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Care plans did not always contain enough guidance for staff to mitigate risks to people. There were some risks associated with people's environment which had not previously been identified by the provider.

People's food and fluids intake was not always monitored and recorded appropriately. People were not always referred for a review for their swallowing, and care plans did not always have enough detail about people's diets.

Mental capacity assessments had not been carried out for people with variable or limited mental capacity in order to ensure that decisions were made in people's best interests. Staff sought consent from people wherever possible, before delivering care.

Care records were not always written in a person-centred manner, and did not always contain full information about people's health and care needs, their preferences and their histories.

Improvements were needed in the overall governance systems in the home, to ensure they assessed, monitored and improved the quality of the service provided. There were plans in place for improvements to be made.

Staff had received some training relevant to their role, such as manual handling, but further training was needed in areas such as mental capacity and dementia.

There were plans in place to address the above concerns, as the provider was working with the registered manager and a consultant on a service improvement plan.

There were enough staff to keep people safe and meet their needs. They knew how to report any concerns they had, and there were safe recruitment systems in place. People received their medicines as they were prescribed, and people felt safe living in the home.

People told us they enjoyed the meals in the home and people were supported to engage in activities in the home.

People had access to healthcare and staff supported them to see the doctor or occupational therapist if they needed. Staff provided compassionate care to people and respected their privacy, dignity and independence. People had choices of where to spend their time and were supported to eat a healthy balanced diet.

The registered manager was available to people, and people felt listened to. The registered manager demonstrated team work and staff were positive about their roles.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks assessments were not always properly carried out so that staff could mitigate risks to people, and there were some environmental hazards within the home which had not been identified.

There were enough staff appropriately recruited with systems in place which contributed to keeping people safe.

Medicines were administered as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's food and fluid intake was not always monitored as needed.

Mental capacity assessments had not been carried out where needed, but staff sought consent from people before delivering care.

People had access to healthcare services.

Is the service caring?

Good

The service was caring.

Staff knew people well and were thoughtful towards people and their families.

Staff provided compassionate care to people and respected their privacy, dignity and independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans had not always been completed to guide staff in respect of individuals' health and care support needs.

There were activities on offer, however these were not always carried out in line with people's preferences.

There was limited planning and staff training or guidance around end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The organisation had identified some areas for improvement and had put in place an action plan to address these.

There was good leadership within the team and staff were positive.

St Mary's Residential 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 checked 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 20 November 2017 and was unannounced. The inspection team consisted of one inspector 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.

As part of the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also completed 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.

During the inspection, we spoke with five staff members including two senior care staff, the cook, the activities coordinator and the registered manager. We also spoke with a management consultant involved in improving the home, and the owners of the organisation. We looked at three care plans in detail, as well as a sample of daily records kept about people's care.

We looked at records relating to how the service is run and monitored including a sample of recruitment files and quality assurance records. We also checked a sample of Medicines Administration Records (MARs).

Requires Improvement

Is the service safe?

Our findings

Care plans did not always contain detailed assessments of risks for individuals such as those associated with dysphagia (swallowing difficulties), high blood pressure and diabetes. For example, for one person, it was recorded in their care plan that they had problems with swallowing and should be on a soft diet. However, it was also documented that the person ate foods such as oranges, and in a note written in February 2016, it said, 'soft diet but able to swallow normal food.' This statement was contradictory, and staff were not able to see what the risks to the person were, and how to mitigate them.

Another person's care plan did not contain a full risk assessment for the person's diabetes. The care plan stated that the persons' blood glucose level should be maintained, but there was no guidance as to what this figure should be and no plan as to when it should be taken. We saw that the person's blood sugar had been taken on 16 October 2017 and not since. The care plan also said that the person was on a 'normal' diet, having been updated on 17 November 2017. There was no further information about why this was or that the risks around this had been discussed or mitigated.

One person who had been living in the home for three weeks did not have written care plans in place. This had not been completed in a timely manner. The person had complex health conditions and associated risks, and was cared for in bed. There was no guidance in place for this person in respect of risks to their safety or wellbeing. The person's pre admission assessment stated that they were mobile with a stick, and this had changed since being in the home. The registered manager told us that staff verbally shared the information with each other. We saw that the person was supported with repositioning every two hours as they were cared for in bed, as this had been recorded. However, other potential risks to the person had not been identified and mitigated. Lack of written guidance for staff put the person at risk of receiving care and support that was not appropriate to their needs.

We identified some risks associated with the environment. For example, we saw that hazardous substances were left unsecured around the home, such as aerosol solvent air fresheners and alcohol hand gel. This posed a risk to people living with dementia due to the potential of accidental ingestion. We also found that there were hot radiators where people were at risk of falls, and therefore the risk of scalds or burns was evident. We discussed these with the provider and they said they would risk assess the environment and cover radiators where needed.

Where prescribed creams and lotions were kept in people's rooms they were not stored securely. They were in lockable cabinets but three cupboards we tried in the home had been left unlocked with the keys in. We also saw some hazardous substances unsecured in the home, such as air fresheners and cleaning products. These concerns posed a risk of inappropriate use, as there were people who may be disoriented due to living with dementia in the home. The registered manager assured us they would ensure these were locked.

These concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection visit, we identified three care plans which required referrals to a speech and language therapist for a review, and these were completed promptly.

Some further risks associated with people's environment were actioned promptly following our inspection visit. There were hot pipes exposed and a steep staircase which was accessible to people. We told the providers about these concerns and they immediately took some remedial action, such as boxing in pipes and ensuring a stairgate was placed in front of the staircase to mitigate these risks.

One person said, "I feel safe here, there's never been a time when I've felt frightened or scared."
Staff understood how to protect people from harm and what types of abuse there were, and had received training in safeguarding adults. The registered manager of the home had referred concerns to the appropriate safeguarding authorities where necessary. Some staff we spoke with were unable to tell us how they would report concerns to outside agencies. We spoke with the registered manager about this, and they informed us following the visit that they discussed safeguarding in a team meeting. They also told us they were planning face-to-face training in safeguarding, rather than solely e-learning as they felt this would be more effective. Staff told us they felt comfortable to raise concerns to the registered manager if they felt they needed to. This was supported by appropriate safeguarding policies which contributed to promoting people's safety.

We found that equipment for detecting, preventing and extinguishing fires was tested regularly. Lifting equipment was serviced as required and environmental maintenance and risk assessments were in place. However, there had not been any recent safety checks such as portable appliance testing for electrical equipment. This had been identified and organised.

People's risk of developing pressure ulcers was assessed, regularly reviewed and preventative measures were taken by staff. Pressure relieving equipment was in place where needed. Staff told us what risks to look for and prompt preventative action was taken when they had concerns about people's skin.

There were enough staff to ensure a safe standard of care was maintained. One person said, "I like that there's always someone around to help if I need it." People and their relatives told us that staff attended quickly when they pressed the call bell. Staff told us, "We're always happy to do extra." The registered manager told us they did not use a dependency tool to assess people's needs in order to assess how many staff were needed. However, staff and people told us they felt there were enough staff and we saw that staff were available to people throughout our inspection visit. Staff reported that the registered manager often worked with them on the floor so they knew what staffing levels were.

We recommend the service regularly assess, monitor and audit staffing levels to ensure they are meeting people's individual needs.

The provider's recruitment policies and induction processes were robust, and so contributed to promoting people's safety. Appropriate checks were made before staff were recruited, such as disclosure and barring services (DBS) checks and references. This showed that only people deemed suitable, in line with the provider's guidance were working at the service.

We found that medicines were administered by trained staff as they had been prescribed. There were no protocols for medicines that were taken on an 'as required' basis (PRN), which guided staff on when to give them. There was therefore a risk that these medicines may not always be given appropriately and safely. However, we saw that staff administering these medicines had remained consistent and knew people's needs well. One person said, "I don't have regular medication but if I wanted something for a headache I just

ask and they'll give me paracetamol." The registered manager told us they would put in place PRN protocols as a matter of priority, and that this had already been identified within the service improvement plan. People's allergies were identified and preferences were adhered to when staff administered medicines. We observed that staff stayed with people whilst they took their medicines to ensure they were appropriately taken. Oral medicines were stored securely, however the temperature had not always been recorded to ensure they were kept at a safe temperature. Medicines that are exposed to inappropriate temperatures may not work effectively.

There were good infection control practices in the home. One person told us, "I have been pleasantly surprised by the cleanliness of my room, they keep it very clean." During our inspection visit we found the home was kept clean.

If there was an incident or accident, staff knew how to report this and took action to resolve and mitigate further risk. Whilst there was not an overview of reportable incidents, the service had taken steps to include the reduction of potential risks. These were outlined in an action plan which outlined improvements they were planning to make to the service. This included health and safety and the management of hazardous substances training planned for staff.

Requires Improvement

Is the service effective?

Our findings

People's needs were assessed prior to coming into the home, so that the registered manager could be assured they could meet the person's needs. These assessments outlined people's basic support needs, such as those for their mobility and personal care. Equipment, such as manual handling and mobility aids were provided if needed.

People and their relatives had confidence in the competence of the staff. One relative told us, "They seem to know what they're doing, I haven't got any complaints." Staff received training which was deemed mandatory by the providers. This training included first aid and manual handling. Most of the training was computerised, and some staff told us they would prefer more face to face training. All of the staff told us they would benefit from further training in dementia care. We saw from the service improvement plan that the provider's consultant had worked with the registered manager to put into place further training in dementia awareness and nutrition, as well as training in the Mental Capacity Act 2005 (MCA).

People's fluid intake was not always monitored so that staff could be assured they were drinking enough. There was not enough guidance in place for staff to effectively support people to drink enough to meet their needs. For example, in one person's care plan it stated 'ensure adequate fluid intake', yet there were no records kept of this for staff to monitor. For another person who was being cared for in bed, staff were keeping a record of what drinks they were having, but the information was not being totalled. We looked at these records and saw that the person had drunk only 225 mls on 18 November, and 450 mls on 19 November 2017, which could put them at risk of dehydration. There was no guidance in place for staff to say how much the person should be given on a daily basis. We fed this back to the registered manager who agreed to take further action in this area to improve.

Everyone we spoke with said the food was good. One person said, "Although there's one main at lunchtime, we can always have something different and there's always a choice for tea." A visitor told us, "They have lovely food, lots of vegetables." We spoke with the cook, and they told us how staff communicated with them about people's needs, for example, those who required a diet with extra calories, or a diabetic diet.

We saw on the menu there was one meal option at lunch time, however people told us they felt they were given a choice because they asked for something else if they wished. Staff knew people's preferences and dislikes, and consulted people about the menu. People chose what they wanted for breakfast each day. The kitchen staff were knowledgeable about how to provide different diets to people, and communicated with care staff about people with special diets, such as diabetic diets. They also had guidance in the kitchen about how to prepare meals of different consistencies, such as pureed or fork mashable. We observed staff assisting and encouraging people to eat at lunchtime in a discreet and patient manner. There were pleasant interactions during the meal. Staff who were supporting people with their meals explained what was on the fork and gave them enough time to eat.

We found that people were referred to healthcare professionals such as occupational therapists (OTs) when required. The home worked with local healthcare organisations to ensure people received support if

needed, for example, with equipment to mobilise. However, people were not always referred to a speech and language therapist (SALT) for review when needed.

Staff supported people to access regular healthcare. One person told us, "If I need a doctor the staff know, about a week ago I didn't feel very well, they got the nurse to come and see me." The registered manager told us they had a good relationship with the local GP, and called them whenever they needed. There were also regular appointments for a chiropodist to visit people.

One visitor told us what they thought about the home environment, "It's lovely and warm and spotlessly clean." They said the staff had supported their relative to move downstairs as this was more appropriate. Another told us they felt it was homely. We pointed out some areas for improvement in the safety of the environment, and concluded that some updating was necessary in order to adapt for people living with dementia. The providers told us they planned to complete these updates.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

Staff were able to explain how they sought consent from people before delivering care, and we saw that they did so. They knew about people's mental capacity and what types of decisions people could make. However, when people had varying levels of capacity, the registered manager had not carried out decision-specific mental capacity assessments. They explained how for one person, they had sought the support from their social worker who had completed an assessment. There was not a thorough understanding of MCA and DoLS, and best interests' decisions had not been formally made in respect of how people were being cared for. This had been identified and the registered manager was working closely with the consultant on this area in order to improve knowledge and systems around this.

Good

Is the service caring?

Our findings

People were complimentary about the care they received, one saying, "[Staff] are marvellous, even when they're busy they're really good." We saw that staff interacted with people in a warm, reassuring manner, and used humour with people where appropriate.

People felt that staff listened to them. One person said, "If I was worried I would talk to a member of staff. I know I can say something and it would be sorted out." Another said, "Well they listen to me, if there's something I want done in a certain way, they do take notice of what I have to say." We also observed several examples of staff giving people choices and listening to their response. We saw that when one person became distressed and started to cry in a communal lounge, staff were compassionate, discreet and reassuring and offered to talk in a private area. They then accompanied the person back to their room to talk in private. One person said, "There isn't one of them who isn't patient and considerate, they are all very good."

People told us they were involved in decisions associated with the care they received. One said, "I only have to ask, the staff are very obliging so yes, I am involved in my care." Another confirmed, "It's up to me really, if I want to be involved then I can be. I can have my room the way I want it or if I want to go out, I can." We saw that people's rooms were personalised with their own pictures and ornaments, and had a homely feel to them.

Another explained how they were involved in their care, but preferred to be as independent as possible, "Well I suppose in a way, even if that is me deciding that I don't need a lot of care." A relative told us how staff had supported their family member to walk a few steps with a frame since being in the home. This was an improvement in their mobility. We observed during our inspection visit that people were supported to maintain independence, as staff supported and encouraged people to walk where possible, and to improve their mobility. A staff member talked about how they supported one person to regain their confidence with their mobility. Another staff member also explained how they encouraged people to remain as independent as possible during personal care, through prompting and assisting only when needed.

Staff were thoughtful and accommodating to people's families when they visited. One relative gave us an example of how staff at the home had supported their family member to get them a present for an anniversary and surprise them with it. All of the family members we spoke with said they could visit when they wished and were welcomed.

People told us they were treated with respect and dignity. We saw that staff offered opportunities to talk with people in private when they were upset, and were available to people for emotional support. Staff demonstrated to us that they knew people well.

Requires Improvement

Is the service responsive?

Our findings

Care plans were written in a way that failed to understand people's individual needs and used language that was not always respectful.

We saw one care plan where the directions on the front about whether the person was to be resuscitated in the event of a cardiac arrest were not clear. The impact of this was potentially serious and this information needs to be immediately clear and accessible to staff and visiting emergency services.

Staff did not always have enough guidance included in care plans about people's preferences. One person told us, "The first time [staff] said to me, it's bath time, I thought to myself, good, I like a bath. Then they sat me on a chair under a shower. I would much prefer to have a bath; that was quite disappointing." We saw that this type of information was not always included, and fed this back to the registered manager and the consultant. They said they were planning to review all of the care plans. Staff told us that they got to know people as they lived in the home and became aware of their preferences, and would try and meet them as much as possible. We concluded that staff did not always provide individualised care to people because there were not always enough details gathered of how people wanted to receive care.

Activities within the home included playing bingo, skittles and quizzes. However, there was no information within people's care plans about their life history or what their hobbies and interests had been prior to moving into the home. There was no evidence that activities were organised around peoples' choices and preferences. This was mitigated to some extent by having a consistent staff team who got to know people well. The activities coordinator explained how they got to know people through talking to them, and family members, and gave an example of one person who enjoyed playing cards.

The activities coordinator explained that they did not always have time to spend one to one with people who preferred to spend time in their rooms. The registered manager and the providers told us they planned to finance additional hours for activities for people. One person who used the service told us they enjoyed knitting, colouring and drawing as they did this with minimal support. During the inspection we saw that a staff member got people involved in a game of skittles in the morning, in the afternoon there was a quiz. There was some visiting entertainment regularly throughout the year, such as singers and regular exercise classes. We concluded that although activities were on offer, they were not always tailored around specific preferences. People were able to engage in their own activities independently, such as knitting, but activities with staff were not always person-centred.

Staff were responsive to people's ongoing needs throughout the day. We overheard one staff member ask a person who used the service, "Oh, your hands are very cold, would you like me to get you a blanket, are you warm enough?" We also observed a staff member walking past a person sitting in a chair and noticed they did not look very comfortable. The staff member stopped and offered to help the person into a more comfortable position. We did see some missed opportunities for meaningful interaction however, as staff who were supervising the communal area at times stood to one side of the room without interacting with people. On some other occasions through the day, staff huddled together at the side talking to each other

and did not always take opportunities to interact with people.

All of the people we spoke with reflected that they chose where to spend their time and what to do. One person said, "I have choices, for example if I want to go to bed a bit earlier than I usually do then I can, it's up to me." Another said, "I like to spend time in my room. I come out for lunch and I'll eat in the dining room but I'm happy with my own company. The people here know that. They used to try to get me to go to the lounge but they know me now." People ate their meals where they wished.

Staff had not undergone training in end of life care, and the details of people's end of life wishes and preferences was not always recorded in people's care plans. This was an area that required improvement.

Requires Improvement

Is the service well-led?

Our findings

All of the people we spoke with were complimentary about the registered manager. One person told us, "The manager is very nice." All of the people we spoke with knew who the registered manager was, one saying, "Yes, I know who the manager is, they're very good, I see them most days." When we arrived we saw that the registered manager was working delivering care alongside the care staff. We saw that the staff worked well as a team and there was a good atmosphere within the home.

Two people told us they would be told any information about what was going on in the home if they asked, one saying, "They tell me what's happening if I ask." The registered manager said they had organised a meeting for people living in the home in order to give them information and ask for their views and ideas about the home.

One person said, "I don't think they're constantly striving for improvement." They said they had not seen many changes in the home. We identified that the providers had employed a consultant to support the registered manager, as they wished to implement some improvements in the running of the home. We found that most of the areas where we identified concerns, had already been picked up. The registered manager was transparent about areas where they knew they needed to make improvements. Auditing and governance systems were lacking, so the registered manager had not previously identified where there were gaps in records and areas which needed improving. Where they had identified some gaps previously, these were not always used as an opportunity to improve the service.

Whilst current systems in place to monitor and improve the service were lacking, the registered manager and the consultant were able to explain plans they had to improve the oversight they had of the home, and therefore make improvements. The provider was also responsive to our feedback about areas requiring improvement, immediately putting into place some suggested changes.

Some systems were in place to monitor the quality of the service delivered, such as questionnaires for the people living at the home. We looked at a sample of these and found that feedback was consistently positive, although some people felt the environment was not suitable. The provider was planning some refurbishment across the home at the time of our inspection visit, which demonstrated they were using this feedback to improve the service.

The registered manager had begun working with the consultant to develop a service improvement plan, which outlined important areas where there were gaps. The plan included improving staff training, reviewing and updating care plans, ensuring people were referred to SALT if needed, improving medicines storage and competencies, and creating further audits to oversee the running of the home.

The registered manager understood what notifications they were required to send CQC.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always properly assessed and mitigated and there were hazards associated with the environment.