Country House Care Limited

Spetisbury Manor

Inspection report

Spetisbury
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The inspection took place on the 12 June 2017 and was unannounced. The inspection continued on the 13 June 2017 on an announced basis. The previous inspection had been carried out in April 2015.

Spetisbury Manor is registered to provide accommodation for up to 26 people who require personal care. At the time of our inspection there were 16 older people living at the service. The home provides single room accommodation over two floors with the facilities to provide shared accommodation when required. Rooms have en-suite facilities and there is also a specialist bathroom on each floor.

The service had 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 were at risk of not having their topical creams administered safely. Cream prescription labels were not always clear, medicine administration records did not always match the creams prescribed, had not always been completed by staff and information was not available on where or how to apply creams to people. Medicine audits had been completed and included all other areas of medicine administration but had not included checking the recording and administration of topical creams. Where improvements had been identified an action plan had beencompleted, discussed with staff and better outcomes had been achieved for people. The registered manager agreed this was an area that required improvement and told us they would review the topical cream process and medicine audit tool immediately.

People and their families felt the care was safe. Staff had been trained to recognise signs of abuse and knew how to raise concerns. People were involved in decisions about their assessed risks and staff understood their role in minimising identified risk whilst respecting people's freedoms and choices.

People were supported by enough suitably trained staff to meet their assessed needs. The registered manager told us they would source a staff dependency tool to assist in calculating staffing levels based on the changing needs of people and new admissions. Staff had been recruited safely with checks made to ensure they were suitable to work with vulnerable people. Induction and on going training provided staff with the skills to carry out their roles effectively. Staff received support through supervisions and appraisals with opportunities for professional development.

People had been supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People and their families described the staff as kind, caring, friendly and willing to help. Staff had a good knowledge of people, their interests, likes and dislikes and family and friends important to them. This was reflected in positive interactions between staff and people. People were involved in decisions about their

day and felt their dignity, privacy and independence was respected. People's individual eating and drinking needs were met and the mealtime experience was relaxed and at the persons pace.

People had their care and support needs assessed and reviewed regularly. Staff understood their role in supporting people whilst respecting the persons wishes and promoting independence. People had access to healthcare when it was needed. A range of activities was available to people including events linked with the local community.

The service was well led. Staff had a good understanding of their roles and responsibilities. Interaction between staff and the management was professional and communication effective. Feedback from people, their families and staff was had been used to review and improve outcomes for people. A complaints process was in place that people were aware of and felt if they used they would be listened to. The registered manager was pro-active and responsive to ideas and continual development 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?

Requires Improvement

The service was not always safe.

People were at risk of not having their topical creams administered safely. Other types of medicines were stored, administered, recorded and monitored ensuring risks to people were minimised.

People were supported by enough staff who had been recruited safely to meet their assessed needs.

People had their risks assessed and actions put in place to minimise harm.

People were supported by staff who knew how to recognise signs of abuse and the actions they needed to take if abuse was suspected.

Is the service effective?

Good

The service was effective.

Staff had completed an induction and on-going training that gave them the skills to carry out their roles effectively.

The principles of the Mental Capacity Act were followed ensuring people's rights were upheld.

People's eating and drinking needs were understood and met.

Is the service caring?

Good

The service was caring.

People were supported by staff that knew them and understood their communication styles.

People described staff as kind, caring, friendly and patient.

People had their dignity, privacy and independence respected.

Is the service responsive?

Good

The service was responsive.

People were involved in their individual care and support plans which were holistic and clearly explained what actions were needed to support their assessed care needs.

A complaints process was in place that people and their families were aware of and felt if they used they would be listened to and actions taken.

Is the service well-led?

Good

The service was well led.

Staff understood their roles and responsibilities.

The culture was positive and open enabling people, their families and staff opportunities to share feedback, ideas and any concerns. The registered manager was pro-active and responsive to ideas and continual development of the service.

Quality assurance processes were in place and when improvements were identified prompt actions were taken to improve outcomes for people.

Spetisbury Manor

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.

The inspection took place on the 12 June 2017 and was unannounced. It continued on the 13 June 2017 and was announced. The inspection was carried out by one inspector.

Before the inspection we looked at notifications we had received about the service and we spoke with social care commissioners to get information on their experience of the service. We also looked at information on their returned PIR received in March 2015. 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 our inspection we spoke with six people who used the service and three relatives. We spoke with the registered manager, activities co-ordinator, four care workers, the chef and a housekeeper. We reviewed five people's care files and discussed their accuracy with them and care workers. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Requires Improvement

Is the service safe?

Our findings

People were at risk of not having their topical creams administered safely. One person had four creams in their bathroom. The label on one had become illegible. This meant it was not possible to determine whether the cream had been prescribed for that person, whether it was in date or the directions for application. The person told us staff administered the cream every day. The second cream stated apply three times a day but had been recorded on the Medicine Administration Record (MAR) as only twice. Care staff explained the person only liked it twice a day as it was greasy. The MAR had not been completed to reflect the person was declining an application a day and records did not indicate this had been discussed with the persons GP. The third cream had 'use as directed' on the label. Staff were able to tell us the area of the body the cream was applied but this was not reflected in their medicines care plan. The fourth cream was an over the counter cream but had not been recorded on the MAR sheet. Another person had a cream prescribed for application twice a day but the MAR sheet had not always been signed to reflect this. We spoke with a care worker who told us "Sometimes we radio (to senior) 'What's this cream for'. Don't know where to apply so it doesn't get applied". This meant that people were not consistently being protected from the risk of deteriorating skin or health conditions due to prescribed creams not being managed and administered appropriately. We discussed our findings with the registered manager. Medicine audits had been completed and included all other areas of medicine administration. Where improvements had been identified an action plan had been completed, discussed with staff and better outcomes had been achieved for people. They agreed that the medicine audit had not highlighted shortfalls in topical cream administration and told us they would review the topical cream process and medicine audit tool immediately in order to ensure people received their creams safely .

People told us they felt their medicine was managed safely. Each persons MAR had a photograph of the person and details of any allergies. One person said "Wherever you are they come and find you. You get them at the right time". We checked medicines that were time limiting and they had been signed to reflect the date they had been opened and were being used within the time parameters. When medicines were prescribed as 'when required', protocols were in place to ensure they were given appropriately. An example was a person who had been prescribed a laxative. A bowel chart was included with the MAR to support decisions on administering the medicine. Some medicines needed to be stored in a fridge. Records had been completed showing the fridge temeperature had been checked twice a day ensuring medince had been stored safely. Some people had been prescribed controlled drugs which are medicines that require additional storage and administration safeguards. We found that the storage and recording of these medicines were providing the additional safeguards to keep people safe from harm.

People and their families described the care as safe. One relative said "I would describe the care as safe but not restrictive". People told us they felt safe and well cared for by the staff. Staff had undertaken safeguarding training and understood the types of abuse vulnerable people were at risk from and how to recognise signs of abuse. A care worker explained the actions they would take. "I would contact CQC or the local authority if concerns were not being dealt with. We've the telephone numbers in the staff room".

Assessments had been completed that identified risks people experienced. When a risk had been identified

actions had been put in place to minimise the risk and these had been regularly reviewed.

People were involved in decisions about how risks they lived with were managed. One person had no history of falling from bed but felt unsafe. In response a risk assessment had been completed. It included a discussion with the person and their family who had agreed that bed rails would be fitted to ensure the person felt safer. Another person had a risk of choking. They were involved in decisions about how to reduce the risk of harm. We read an incident report where the person had choked on a meal. It had been discussed with the person and they had declined a swallowing review by the Speech and Language team (SALT) but preferred to make adjustments to their meal options. We discussed this with a care worker who told us "(Name) has a soft diet. They gave up meat for a weekend but as still coughing decided to have meat again. They have capacity to make their own choices and understands the risk". Another care worker said "(Name) has a risk of choking so we have to watch (name) very closely". We read care records that confirmed what we had been told. This meant that people's risks were assessed and understood and actions to reduce risk had respected their freedom and choices".

One person had been assessed as at risk of skin damage. To reduce the risk an air mattress had been fitted to their bed. The air mattress needed to be set to the persons weight to ensure maximum protection. The mattress was set correctly. During our inspection the registered manager created a form for staff to sign each time they helped the person into bed which confirmed the mattress had been set correctly. This meant the person was protected from potential risk of harm.

Accidents and incidents were recorded and reviews had been carried out to establish cause and any actions needed to minimise a further event. For example, one person had fallen and actions had included a change in equipment and footwear to reduce the risk of a further fall.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency. A business contingency plan was in place in the event of the home not being able to operate the service.

People were supported by enough staff to meet their assessed needs. Staff rotas showed that at weekends care staff had additional duties of cleaning, laundry and supporting with evening catering duties. We discussed with people, relatives and staff whether this impacted on care. One person told us "The staff are quick at coming if I need help. As far as my experience there are enough staff at the weekends". A care worker stated "We normally get the work done; people don't miss out". Another told us "Sometimes weekends can run smoother than the week days". A relative we spoke with described staffing was a little stretched at weekends. We discussed this with the registered manager. They told us they would source a staff dependency tool. This would assist them to calculate staffing levels based on people's dependency needs, reflect people's changing needs and new admissions.

People were supported by staff who had been recruited safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults. When agency provided care staff a profile had been sent to the service providing details of employment checks and training.

Good

Is the service effective?

Our findings

Staff had completed an induction and ongoing training that provided them with the necessary skills to carry out their roles. A process had been developed which recorded what training staff had completed and when they were due for a refresher. Induction included completion of the Care Certificate. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. The registered manager explained that recently recruited staff had care experience. Induction had included a self assessment competency check linked to the Care Certificate. People described the staff as well trained. One person said "The staff all seem well trained,. they all know what they are doing".

Staff told us they felt supported and had supervision every six to eight weeks with an annual appraisal. Recent training had included diabetes and end of life training. One member of staff told us "I feel supported. Anything at all I can go to (supervisor), they always have time for me".

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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.

Care files contained records of people signing and consenting to their care, medicines, sharing information, nights checks and the right to withdraw their consent at any time. The principles of the MCA were displayed on the office wall as a prompt to staff. Staff were aware of how to support people to make decisions. We observed staff explaining to people how they would like to support them and waiting for consent. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf. One person had deteriorating mental health and a meeting had been arranged with their family and GP to consider whether a DoLs application was required. This meant people were having their rights upheld and their needs met.

People and their families described the food as really good with plenty of choice. One person told us "The food is very good. They will always do something different to the menu". Another said "Quite often I have a cheese omelette; they are lovely. I am very pleased with the food". A relative told us "The staff know what to order for (relative). They know what they like. (Relative) doesn't always want to eat and the staff spend a long time encouraging them". Specialist diets were catered including diabetes and gluten free options. We

observed people using modified crockery to support them remain independent at meal times. This included specialist beakers and coloured crockery.

People had access to healthcare and records showed us this had included opticians, dentists, GP's, district nurses, chiropodists, community mental health team and dieticians. Feedback from people and healthcare professionals reflected that staff responded appropriately to both on going healthcare needs and health emergencies.

Good

Is the service caring?

Our findings

People and their relatives all described the staff as kind and caring. One person said "The staff are very nice, willing and helpful". A relative described staff as kind, efficient and friendly. Another told us "Staff are stars on an individual basis".

Staff had a good knowledge of people and this was reflected in practical actions. One person had experienced bereavement. The community mental health nurse had recorded in their review 'Staff recognised (name) needs extra support through this period". A relative described how the service had provided equipment to their (relative) in their own home prior to admission to Spetisbury. They said "Prior to admission they really cared, they understood we were struggling at home and over a weekend they lent us equipment. It really made the difference".

We observed positive relationships between people and the staff. Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. People were supported by staff in a relaxed and unhurried way that provided support at the person's pace. Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example talking with people at eye level and using hand gestures and facial expressions.

People were involved in decisions about their day to day lives. One person explained "I'm involved in decisions about my care; it's teamwork". One person's care review had included a record of a discussion about their night routine. It demonstrated that the person had been listened too and their view and need for independence respected. People who needed an independent representative to speak on their behalf had access to an advocacy service.

People had their privacy, dignity and independence respected. One person told us "Staff give me enough time in the bathroom. They are respectful of my dignity". Another told us "Staff are respectful; they don't take liberties". People were supported to retain and develop their independence. We saw that staff encouraged people to undertake the tasks they were able to do for themselves. Staff described how it was important to involve people in day to day tasks. Examples included encouraging people to carry out as many personal care tasks as possible for themselves, getting involved with planning celebrations and events in the home and planning how they would like to spend their day.

The home was registered with the Gold Standard Framework for end of life care. The Gold Standard Framework is a standard of care that people can expect when they are near the end of their lives. It is designed to meet the physical, spiritual and emotional needs of people who are dying, with a focus on the management of symptoms, comfort, dignity, and respect.

Good

Is the service responsive?

Our findings

People's care was provided in response to an assessment of their needs. Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. A relative told us "Prior to admission they carried out an assessment. They were interested in what (relative) could do food they liked. We felt quite involved in the process".

Care and support plans focused on people's abilities and were reviewed at least monthly. Reviews had captured feedback from staff, observations and information recorded in the daily records. One review we read had noted a person favoured certain staff. This had been reflected in care planning and led to the person being more receptive to support with personal care. Another person had changes in mobility following a fall. Reviews over three months reflected both the decline and then steady improvement until their mobility had returned to normal.

Staff had a good knowledge of people's care and support needs and told us they were kept up to date with changes. Files contained information about a person's personal history and support network. One person told us "We have an open house for our families". Arrangements had been made for the service to have internet connection around the home. This had enabled people to keep in touch face to face with family and friends via Skype.

People had the opportunity to participate in activities both in the home and the local community People spoke positively about trips out although at the time of the inspection there was a vacancy for a driver. One person told us "Most days are quite full. Mornings are easy, get dressed and have breakfast and then it's 11ish. Coffee comes around and then there is entertainment. If it's nice you can sit outside". Activities included pamper afternoons, exercise classes, musical entertainers and quizzes. The Activities Co-Ordinater described how they used quizzes as an opportunity for opening discussions about people's lives. They gave an example of a question being about cooking. "We get talking about how people were brought up, what their mothers did, chats about school days. We can be talking for half an hour and try and include the gentlemen as much as possible". Some people told us they preferred spending time in their room and had belongings that reflected their interests such as music, TV, reading, word games and looking at photographs with staff.

Photographs had been displayed on noticeboards showing outings into the local community, events and celebrations. People had access to the village newsletter which detailed local events taking place. The grounds had been used for village fetes and car rallies. This meant that people had the opportunity to be involved in what was happening in their community.

People and their families were familiar with the complaints process and felt if they raised a concern appropriate action would be taken. One person told us "I feel able to talk with (registered manager) if anything was worrying me". Another person explained that residents meetings provided an opportunity to raise issues. They told us "We had a residents meeting recently and were asked if any think could be made

better. We are able to air our views. One person suggested better garden paths and it's being looked in to".

Good

Is the service well-led?

Our findings

There were quality assurance systems in place that were largely effective in securing improvements in the quality of service in relation to peoples safety, health and well being. However the medicine audits had not identified issues with topical creams identified at this inspection. Audits had been carried out for medicines which had highlighted some areas where practice needed improvement such as missing signatures on medicine administration records. Records showed us that when improvements had been identified an action plan had been completed which had led to improvement. Actions and any learning had been shared with staff in supervisions. The audit tool used for auditing medicines had not included checks on the ordering, storing, administration and recording of topical creams. We discussed this with the registered manager who agreed this was a shortfall in the medicine audit process. They told us they would immediately review the audit tool and ensure it captured all medicine related activities.

Audits had been completed on people's care and support plans. We saw that audits had identified that daily recording needed to reflect people's choices and consent in their day to day life's and link to care and support plans. When we read people's daily notes actions from the audit had led to improved record keeping which had then been used to support reviews of people's care. The found the registered manager responsive to ideas and continual improvement and development of the service.

Meetings had been held with residents and relatives and the staff team to gather feedback and share information. Actions identified at the last resident meeting included providing garden paths, Wi-Fi around the whole home and a change to supper time. Records and discussions with people demonstrated all actions were in progress. This demonstrated a commitment to monitoring and improving outcomes and service delivery to people.

Staff had a good understanding of their roles and responsibilities. Senior staff had taken on a lead role in key areas such as medicine and infection control. At the start of each shift care staff were allocated people they were supporting and a senior took responsibility for the management of the shift. Staff told us that they felt able to express their views and ideas with the registerd manager and owners of the service. One said "The home runs well. Overall this home is very good". We observed relaxed, friendly, professional interaction between staff and the Registered Manager. The registered manager had provided care on a night shift three days before our inspection and had been able to share with us a knowledge of the care and support people received. The registered manager was pro-active and responsive to ideas and continual development of the service.

Staff described communication as effective. One care worker explained "Communication has got better. They have introduced a file and if a carer reports something about a resident it's written down and that means things are actioned. Also there now is a board and it shows who is in hospital".

The registered manager had a good understanding of thier responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any

changes to their regulated services or incidents that have taken place in them.

The registered manager told us they felt supported by the provider who visited the service at least once a month and they felt if there was a problem they could talk to them. The provider visit included discussions in relation to staffing levels, occupancy, issues with the service, maintenance and the environment.

The registered manager had just completed a level 5 diploma in leadership for health and social care. They were in the process of setting up a group meeting with three other homes in order to share knowledge on how to achieve an outstanding rating.