Bupa Care Homes (GL) Limited

St Mark's Care Home

Inspection report

1 Hartburn Lane
Stockton On Tees
Cleveland
TS18 3QJ

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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 1 September 2016 and was unannounced. This meant the registered provider and staff did not know we would be visiting. The service was last inspected in January 2014 and was meeting the regulations we inspected at that time.

St Mark's Care Home is a purpose built home situated in Stockton on Tees. It accommodates people over two floors and has communal dining areas and lounges. There are surrounding gardens and onsite parking available to the rear of the property. It is registered to provide accommodation and nursing and personal care for up to 39 people. At the time of our inspection 30 people were using the service.

There was a manager in place who was in the process of applying to be registered manager. 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.

Risks to people using the service were assessed and plans put in place to reduce the chances of them occurring. The premises and equipment were regularly reviewed to ensure they were safe for people to use. Accidents and incidents were monitored to see if improvements could be made to keep people safe. Plans were in place to provide a continuity of care in emergency situations.

Medicines were managed safely. Safeguarding policies and procedures were in place to help protect people from abuse. The manager monitored staffing levels to ensure they were sufficient to support people safely. Recruitment procedures were in place to minimise the risk of unsuitable staff being employed.

Staff received the training they needed to support people effectively and were supported through regular supervisions. Staff worked within the principles of the Mental Capacity Act 2005, but the registered provider's paperwork was not always effective at identifying people's capacity to make decisions. People were supported to maintain a healthy diet and to access healthcare professionals to maintain and promote their health.

People and their relatives spoke positively about staff at the service, describing them as kind and caring. Support was delivered in a kind and caring way. Staff stopped and talked with people as they moved around the building, which helped to create a homely atmosphere. People were treated with dignity and respect.

Advocacy services were advertised in communal areas throughout the service, and the manager told us how people would be supported to access these if needed. Procedures were in place to provide end of life care where needed.

Care was person-centred and based on people's assessed needs and preferences. Care plans were detailed

and contained information on how people wanted to be supported. The staff team was very reflective and all looked at how they could tailor their practice to ensure the care delivered was completely person-centred.

People were supported to access activities they enjoyed and procedures were in place to investigate and respond to complaints.

Staff spoke positively about the culture and values of the service. The service had a clear management structure in place, led by an effective manager who understood the aims of the service and made appropriate notifications to CQC.

The manager carried out a number of quality assurance checks to monitor and improve standards at the service. Feedback was sought from people and their relatives through monthly meetings.

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.

Risks to people using the service were assessed and preventative action taken.

Medicines were managed safely.

Safeguarding policies and procedures were in place to help protect people from abuse.

Staffing levels were monitored to ensure they were sufficient to support people safely.

Is the service effective?

Good

The service was effective.

Staff received the training they needed to support people effectively and were supported thorough regular supervisions.

Staff worked within the principles of the Mental Capacity Act 2005, but the registered provider's paperwork was not always effective at identifying people's capacity to make decisions.

People were supported to maintain a healthy diet.

Staff helped people access healthcare professionals to maintain and promote their health.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect by staff who knew them well.

Staff were kind and caring when delivering support.

Procedures were in place to arrange advocates and end of life care should they be needed.

Is the service responsive?

Good

The service was responsive.

Care was person-centred and based on people's assessed needs and preferences.

People were supported to access activities they enjoyed.

Systems were in place to investigate and respond to complaints.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively about the culture and values of the service.

The service had an effective manager who understood the aims of the service and made appropriate notifications to CQC.

The manager carried out a number of quality assurance checks to monitor and improve standards at the service.

Feedback was sought from people and their relatives through monthly meetings.

St Mark'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 took place on 1 September 2016 and was unannounced. This meant the registered provider and staff did not know we would be visiting. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

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, what the service does well and improvements they plan to make.

We contacted the commissioners of the relevant local authorities who worked with the service to gain their views of the care provided by St Mark's Care Home. Details of the feedback received are contained in the full version of this report.

During the inspection we spoke with four people who used the service and six relatives. People using the service were not always able to share their experiences with us so we carried out observations using the short observational framework for inspections (SOFI). SOFI is a tool used to capture the experiences of people who use services who may not be able to express this for themselves.

We looked at three care plans, medicine administration records (MARs) and handover sheets. We spoke with seven members of staff, including the manager, nursing and care staff, kitchen, maintenance and housekeeping staff. We looked at four staff files, which included recruitment records, as well as other

records involved in running the service.

Good

Is the service safe?

Our findings

Risks to people who used the service were assessed and plans put in place to reduce the chances of them occurring. When people started using the service an assessment took place that considered risks to them in a number of areas, such as medicine support, mobility, skin care and falls. If a risk was identified a care plan was developed to minimise the chances of it happening. For example, one person was identified as being at risk of falling out of bed and injuring themselves. This led to a crash mat being placed next to their bed to reduce the chances of injury if they did fall. Another person was assessed as being at risk due to them liking to spend a lot of time in bed. As a result, staff incorporated exercises recommended by the physiotherapist when they were supporting the person to get dressed. The service used recognised tools such as the Abbey Pain Scale and Waterlow to assess risks to people. The Abbey Pain Scale is used for the measurement of pain in people who cannot verbalise it. Waterlow gives an estimated risk for the development of a pressure sore. Risk assessments were regularly reviewed to ensure they reflected people's current support needs and risk levels.

The premises and equipment were regularly reviewed to ensure they were safe for people to use. A fire risk assessment was completed in December 2015, and the manager said remedial action had been taken where issues were identified. Regular checks were carried out in areas including fire doors, emergency lights, fire-fighting equipment, fire alarms and staff call alarms to ensure they were still safe to use. Fire drills took place on a regular basis, which meant staff understood how to support people in emergency situations. Required maintenance and safety certificates were in place in areas including electrical equipment, gas safety, fire-fighting equipment, hoists and fire alarms.

Accidents and incidents were monitored to see if improvements could be made to keep people safe. The manager reviewed accidents and incidents on a monthly basis, and sent a report to the registered provider on the number of falls that had occurred. The manager told us, "Every time I get an accident form and it is a fall I put it on my spreadsheet. It records where it happened and the time, so I can figure out any patterns. It helps me to see if I need any more staff."

There was a business continuity plan in place. This gave staff guidance on how to provide a continuity of care in emergency situations that disrupted the service, such as water damage or staff shortages. The service also had a 'residents register'. This contained a colour-coded overview of people's mobility needs and could be given to emergency services if an evacuation of the building was needed. However, there were no specific personal emergency evacuation plans (PEEPs). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. We discussed this with the manager, who agreed on the benefit of introducing PEEPs. The day after our inspection the manager sent us evidence that they were introducing PEEPs.

Medicines were managed safely. We found that there were appropriate arrangements in place for obtaining medicines; checking these on receipt into the home and storing them. We looked through the medication administration records (MARs) and it was clear all medicines had been administered and recorded correctly.

All staff who administered medicines had been trained and completed regular competency checks to ensure they were able to safely handle medicines. We spoke with people about their medicines and they told us that they got their medicines when they needed them.

We found that information was available in both the medicine folder and people's care records, which informed staff about the protocol for each person's 'as required' medicine. We saw that this written guidance assisted staff to make sure the medicines were given appropriately and in a consistent way.

Arrangements were in place for the safe and secure storage of people's medicines. Room temperatures were monitored daily to ensure that medicines were stored within the recommended temperature ranges. We saw that there was a system of regular audit checks of medication administration records and regular checks of stock. We spot checked some medicine stocks and saw they matched the levels recorded. This meant that there was a system in place to promptly identify medication errors and ensure that people received their medicines as prescribed.

Policies and procedures were in place to help protect people from abuse. There was a safeguarding policy in place, providing guidance to staff on the types of abuse that can occur in care settings and the steps they should take if they suspected it was occurring. The policy had recently been amended, and staff had signed the back of it to confirm they had read and understood it. Staff we spoke with were familiar with safeguarding procedures and felt confident to report any concerns they had or to whistleblow. Whistleblowing is when a person tells someone they have concerns about the service they work for. Where issues had been raised, records confirmed they had been investigated and lessons learned to help keep people safe.

The manager monitored staffing levels to ensure they were sufficient to support people safely. Day staffing levels (during the week and at weekends) were two nurses, one senior care assistant and five care assistants working across both floors. Night staffing levels (during the week and at weekends) were one nurse and three care assistants. Four people at the service received one-to-one support from dedicated staff in addition to those staffing levels. The manager used a 'dependency review' every month to review what level of support people needed. This was monitored by the manager and registered provider, and any changes in support levels led to changes in staffing levels. The manager told us one person had recently been re-assessed as needing nursing support, which led to an increase in staffing levels. An additional care assistant was deployed on night shift once a month when medicines were received into the service to assist in organising these.

Sickness and holiday leave were covered by staff working additional shifts, which the manager said was preferable to people having to be supported by staff they had never met before. Staff told us they thought enough staff were employed to support people safely, and that sickness and holiday leave were covered. Throughout the inspection we saw that people were supported promptly and that there was no undue delay in staff responding to call bells.

Recruitment procedures were in place to minimise the risk of unsuitable staff being employed. Applicants were required to submit an application form setting out their employment history and experience of working in the care profession. Recruitment records confirmed that gaps in employment history were explored with applicants. Interviews took place at which applicants were asked a series of care-based questions to assess their suitability for the role. Written references were obtained, proof of identify and address sought and Disclosure and Barring Service (DBS) checks carried out before new staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting

decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. The manager carried out monthly checks on the registration of nursing staff with the Nursing and Midwifery Council (NMC). The NMC is the professional regulatory body for nurses and maintains a register of nurses and midwives allowed to practise in the UK, including any restrictions that have been placed on the individual's practice.

We saw that personal protective equipment (PPE) was available around the home and staff explained to us about when they needed to use protective equipment. We spoke with the housekeeper who told us they were able to get all the equipment they needed. We saw they had access to all the necessary control of hazardous substances to health (COSHH) information. COSHH details what is contained in cleaning products and how to use them safely.

Good

Is the service effective?

Our findings

Staff received the training they needed to support people effectively. Mandatory training was given in a number of areas, including food safety, behaviours that can challenge, fire safety, infection control, medication awareness, moving and handling, pressure ulcers, the Mental Capacity Act 2005 and safeguarding. Mandatory training is training the registered provider thinks is necessary to support people effectively and plans were in place to ensure all staff completed this training. The manager used a chart to monitor and plan staff training. This showed that 90% of staff had completed mandatory training, and where they had not plans were in place for them to do so. Staff refreshed their mandatory training annually to ensure it reflected current best practice.

Specialist training was also provided to ensure people with particular care needs could be supported effectively, for example in PEG care. PEG (percutaneous endoscopic gastrostomy) is a system used where people having difficulty swallowing foods and fluids. Nursing staff were supported to completed their re-registration with the Nursing and Midwifery Council (NMC) and received additional training relevant to their role. Staff told us they received the training they needed to support people using the service. They also said they would feel confident to ask the manager for additional training if they felt they needed it.

Staff were supported through regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Staff received four supervisions a year, a mid-year review and an end of year review. In addition, the manager also carried out observations of staff practice. Records of supervisions confirmed that staff were encouraged to raise any support needs they had. For example, one member of staff raised a welfare issue in their supervision and the manager took steps to support them with this. The manager had been in post since June 2016, and said they were waiting 12 months before carrying out any staff appraisals. The manager said, "Nobody has had an appraisal but I've said I can't do it until I get to know them [staff]." Staff had received appraisals under the previous manager.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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.

We found that, in line with the MCA code of practice, assessments were only completed when evidence suggested a person might lack capacity. When people had been assessed as being unable to make complex

decisions, there were records to confirm that discussions had taken place with the person's family, external health and social work professionals and senior members of staff. This showed any decisions made on the person's behalf were done after consideration of what would be in their best interests.

At the time of the inspection we found that applications for DoLS authorisations had been made where appropriate. The manager explained that most people would need this form of authorisation and they had submitted the applications but the supervisory body had not yet processed them. They confirmed that action was being taken to chase this up and none of the people actively sought to leave the home.

Staff had a good understanding of DoLS and why they needed to seek these authorisations. We found that they had recognised that people may have disabilities, but were able to retain the capacity to make decisions about their care.

However, we did find that the registered provider's capacity assessment paperwork was sometimes confusing. It did not always correctly direct staff on when a best interest decision was needed or record whether lasting powers of attorney had been appointed. Staff were able to work around the registered provider's standard templates, and the manager recognised this deficit and told us that the registered provider was redesigning the templates and ensuring adherence to the MCA guidance.

People were supported to maintain a healthy diet. People who used the service had an 'eating and drinking' care plan. This set out their dietary needs and preferences, and guidance to staff on how they could be supported with any specialist nutritional support needs. For example, a person who used PEG to consume food and fluids had a detailed care plan in place setting out their individual diet and how their equipment should be maintained. People were weighed regularly to monitor their nutritional health. Kitchen staff we spoke with were knowledgeable about people's dietary needs and preferences, and these were also displayed in the kitchen. This helped ensure people received appropriate food that they enjoyed. There was a set menu in place, but kitchen staff said people were free to ask for anything they would like to eat and this would be arranged.

People we spoke with said food at the service was good. A relative told us, "The food is excellent." Another relative said, "[Named person] has never eaten so much in their life since coming here." We saw that people were offered drinks and snacks throughout the day. A daily menu was displayed on the wall each day and the people had a choice over what they wanted to eat. The food appeared nutritious, well balanced and appetising. People were encouraged to sit at tables of four, which helped to create a welcoming and friendly atmosphere at mealtime.

People were supported to access healthcare professionals to maintain and promote their health. Care records contained evidence of regular visits and appropriate referrals to a range of external professionals, including GPs, dieticians, PEG nurses, occupational therapists and district nurses. This meant people were supported to access the healthcare they needed whenever it was required.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about staff at the service, describing them as kind and caring. One person we spoke with said, "It's a nice place to live" and "I think the staff are good." A relative we spoke with said, "Staff are very supportive of the family, and very good with [named person]." Another relative said the service had, "Very friendly and caring staff." Another relative told us, "They are good in here and we really rate the care."

Support was delivered in a kind and caring way. Staff knew the people they were supporting well, and were able to talk with them about things they found important, their families and their interests. For example, we saw staff reassuring one person who was distressed by reminding them a relative was visiting later that day and discussing things the person and their relative did during a previous visit. A member of staff sat down next to the person and used appropriate touch to comfort them, describing the relative's car so the person could look out for it. This led to the person relaxing, smiling and talking about how much they were looking forward to the visit. On another occasion, staff were able to reassure a person who was anxious about eating lunch by reminding the person how much they had enjoyed the same dish previously. A staff member then sat with the person continued to talk with them, with the result that the person relaxed and ate their meal.

A relative we spoke with told us how a person living with a dementia had previously worked in the catering industry and thought the kitchen at the service was their own business. The relative said, "They let [named person] in to have a look around and make sure everything is as it should be."

Staff stopped and talked with people as they moved around the building, which helped to create a homely atmosphere. For example, a member of staff was walking through the communal lounge and stopped to tell a person sitting near a doorway that a sideboard would be arriving soon. The conversation developed and soon involved other people sitting in the lounge and also people passing the doorway. The member of staff adapted their communication to involve people living with a dementia, pointing to areas of the lounge where furniture would be moved to and describing maintenance staff who would assemble it by reference to their tools.

People were treated with dignity and respect. Throughout the inspection we saw staff delivering support in an unhurried way and at people's own pace. Staff asked people for permission before entering their rooms or assisting them, and spoke with them politely. Where people indicated that they needed support staff approached and asked how they could help in a quiet and discreet way. Where staff wanted to discuss a person's support needs amongst themselves they moved to a quiet part of the building so they could do so quietly. For example, we saw two staff members ask if they could use the manager's office to have a private conversation about whether a person was distressed and what they could do to help with this.

The service used a feedback book to collect comments from people and their relatives. We saw this contained several compliments about the care provided by staff. One relative wrote, 'I visit [named relative] regularly and always find them happy and settled. This is down to the dedication and care of all the lovely staff.' Another relative wrote, 'I love the way all of the staff give genuine care to anyone who needs it.'

At the time of our inspection no one at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. Advocacy services were advertised in communal areas throughout the service, and the manager told us how people would be supported to access these if needed.

No one was receiving end of life care at the time of our inspection. The manager told us how this would be arranged if appropriate, describing how relatives and other professionals would be involved.

Good

Is the service responsive?

Our findings

Care was person-centred and based on people's assessed needs and preferences. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person.

Before people started using the service their support needs were assessed. Assessments involved people, relatives and staff. Where a support need was identified a care plan was put in place to provide care in the way the person wanted. We observed care plans in place covering a wide range of support areas, such as lifestyle, safety, skin care, moving around, washing and dressing and eating and drinking.

Care plans were detailed and contained information on how people wanted to be supported. For example, one person's moving around care plan identified that they could be anxious when being assisted into their wheelchair. Staff were reminded to offer the person reassurance when this was taking place to help the person relax. Care plans were regularly reviewed to ensure they reflected people's current preferences.

We saw that the staff team were very reflective and all looked at how they could tailor their practice to ensure the care delivered was completely person centred. Staff said, "We are encouraged to look past a person's condition and to really make sure we get to know them. I make sure that I treat people as individuals and tailor the way I work with individuals so they always feel valued. The manager encourages and really wants us to work in person-centred ways."

Daily notes and handover meetings were used to ensure all staff had the latest information on people's support needs. Throughout the inspection we observed staff working together closely as a team and passing information about people's needs amongst themselves. This helped to ensure all staff were informed of any changes in how people wished to be cared for.

People were supported to access activities they enjoyed. Activities were promoted in communal areas at the service. A timetable of future activities was also on display, and examples of planned activities included pet therapy, flower arranging, singing and visits to a local park. Most activities were group based, but we saw that staff also spent time with people who preferred to do things on their own. People were playing games during our inspection, which they clearly enjoyed.

People told us they enjoyed the activities on offer, with one person saying they particularly liked the pet therapy. Relatives also spoke positively about the activities provided. One relative told us one of the main attractions of the service was the various activities on offer.

The manager and staff were able to explain what to do if they received a complaint, but commented that they rarely received complaints. The manager showed us the complaints policy which was in the office on each floor. We looked at the complaints procedure and saw it informed people how and who to make a complaint to and gave people timescales for action. We saw that when complaints had been received the manager had followed the registered provider's policy and procedures.

We found that visitors' comments were actively sought and read a number of comments recorded in feedback book located in the reception area. These included, "Home feels organised," "Very attentive staff," and "[Relative] came to your home during a difficult time in their life but during visits I was always impressed with the way staff looked after them and made life a little easier for them."

Good

Is the service well-led?

Our findings

Staff spoke positively about the culture and values of the service. Staff we spoke with said they were committed to providing high-quality care that was focussed on people's individual needs and preferences. One member of staff told us, "I love my job." Another member of staff said, "I really enjoy working at the home."

Staff told us the morale was excellent and that they were kept informed about matters that affected the service. They told us that team meetings took place regularly and that they were encouraged to share their views. They found that suggestions were warmly welcomed and used to assist them constantly review and improve the service. We looked at staff meeting records which confirmed that staff views were sought.

The service had a clear management structure in place led by an effective manager who understood the aims of the service. The previous registered manager left the service in August 2016, and the current manager was appointed at that time. The manager was in the process of applying to be registered manager. We found that the manager had a detailed knowledge of people's needs and explained how they continually aimed to provide people with a high quality service. Staff spoke positively about the manager, who they said had supported them through recent changes following the departure of the last registered manager.

Relatives also spoke positively about the manager. One relative told us about an issue they had raised with the manager and said it was, "handled very quickly and effectively." Another relative said the new manager had helped to create a "relaxed" atmosphere at the service.

The manager carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. Daily, weekly and monthly checks and audits were carried out in areas including the care plans, medicines, clinical care, environmental health, nutritional care, DoLS referrals and infection control. Where an audit identified an issue an action plan was developed to plan and monitor remedial action. For example, a medicine audit in August 2016 had identified an issue in recording one person's medicine. This led to a member of nursing staff redesigning the MAR chart to more easily record that medicine. In another example, a care plan audit found that a member of staff had not properly completed a falls risk assessment. This led to the manager speaking with the staff member and offering them guidance on how to complete such assessments.

The manager sent the results of the quality assurance checks to the registered provider on a monthly basis and also kept their own record of the monthly results. This meant the manager and registered provider had a clear overview of the support needs of people using the service and could take any remedial action if needed. For example, in the nutrition care monthly audit from July 2016 four people were identified as being in need of additional nutritional support as a result of changes in their health.

Feedback was sought from people and their relatives through monthly meetings. Minutes of meetings

confirmed that people and their relatives were able to discuss any issues they had with the service, including the laundry service, the lounge area and maintenance around the building. A feedback book was also used to obtain feedback, and the manager said they regularly reviewed this to see if any compliments or complaints had been received. We reviewed the feedback book and saw it contained positive feedback on the service and support delivered by staff.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The manager had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that appropriate action had been taken.