St Helens And Knowsley Caring Association

St Bartholomews Court Nursing Home

Inspection report

Woodfield Road
Huyton
Liverpool
Merseyside
L36 4PJ
Tel: 0151 480 5505
Website: www.elaine.stbarts@btconnect.com

Date of inspection visit: 17 December 2015
Date of publication: 24/02/2016

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

Overall summary

This was an unannounced inspection carried out on 17 December 2015.

St Bartholomews is a purpose built nursing home. The service is a non profit making organisation and has registered charity status. The service is registered to accommodate up to 51 people. The service has 20 beds which are used to admit people from hospital that require intermediate and rehabilitation care. People receiving intermediate and rehabilitation care were supported by a multi-disciplinary team. These included occupational therapists, physiotherapists, social workers and the homes nursing and care staff.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality

Summary of findings

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 the last inspection in October 2013 we found that the service was meeting all of the regulations that we assessed.

Procedures were in place to protect people from abuse and staff had a good understanding of these procedures.

Systems were in place to ensure that medicines were managed appropriately and to ensure that people received their medicines when they needed them.

Procedures were in place that would enable people to be evacuated safely in the event of an emergency.

Sufficient numbers of staff were on duty to meet the needs of people who used the service. Effective recruitment procedures were in place that helped minimise the risk of people not suitable to work with vulnerable people being employed.

People's needs were assessed to ensure that the service had the facilities to meet their individual needs.

Health care professionals were available to support people with their specific health needs and to ensure that people received the care and support they required.

Systems were in place for the implementation of the Mental Capacity Act 2005 and to ensure that people's rights in respect of the Act were upheld.

People's dietary needs were catered for. Staff responsible for planning people's meals had a good awareness of individuals' specific dietary requirements.

People were supported by a staff team who received regular training and support in order for them to deliver safe and effective care.

Systems in place ensured that people received the care and support they wanted as they approached their end of life.

People's care plans were developed in a manner that promoted person centred care and they contained detailed information for staff as to how and when people's needs were to be met.

People had the opportunity to participate in activities at the service to help maintain their physical and psychological health and wellbeing.

A compliants procedure was in place and people were confident that any complaints they had would be listened to.

Effective systems were in place to monitor the service that people received. This helped ensure that any improvements needed to the service would be identified quickly and addressed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Medicines were safely managed. This helped ensure that people received their medicines when they needed them.

People were protected from the risk of abuse and staff had a good understanding of how to deliver care safely.

Staff were safely recruited, which helped ensure that only staff suitable for the role were employed at the service.

Good

Is the service effective?
The service was effective.

People's nutritional needs were assessed and monitored. People enjoyed the foods available to them.

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

People received care and support from staff that had received appropriate training for their role.

Good

Is the service caring?
The service was caring.

People felt that they were supported by caring staff.

People's privacy and dignity was respected by the staff that supported them.

People received the care and support they wanted as they approached their end of life.

Good

Is the service responsive?
The service was responsive.

People's care needs were planned for and reviewed on a regular basis.

People knew how to complain and they felt that any complaints they made would be listened to.

Activities were available for people to participate in.

Good

Is the service well-led?
The service was well-led.

The service had a registered manager.

The quality of the service people received was monitored and improvements were made when required.

The service worked in partnership with other organisations to provide safe and effective care to people.

Good

St Bartholomews Court Nursing 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 17 December 2015 and was unannounced.

The inspection team consisted of one adult social care inspector and a Specialist Advisor in nursing.

We looked in detail at the care planning records of four people who used the service. In addition we looked at records in relation to the management of the service, the recruitment records of five recently recruited staff, policies and procedures and staff rotas. We spoke with seven people who used the service and spent time with a further six people in a communal lounge. We looked at how people living with dementia or who were unable to talk to us were cared for. We did this by using our Short Observational Framework for Inspection (SOFI). SOFI allowed us to spend time watching what interactions took place around the service and helped us to understand if people had positive experiences. We spoke with seven staff and the registered manager.

Before our inspection we reviewed the information we held about the service including incidents that the registered provider had sent to us since our last inspection. We contacted the local authority who commissioned the service to obtain their views. They told us that they had no concerns about the service provided to people at St Bartholomews.

Good

Is the service safe?

Our findings

Everyone we spoke with told us that they felt that the service was a safe place to live. People's comments included "It's very safe here, I have no concerns" and "I feel safe and relaxed here". A visiting relative told us that they felt that the service "Was a safe place for their relative to live and be cared for".

Polices and procedures were in place in relation safeguarding people from abuse and whistleblowing. Staff had signed to confirm that they had read these policy statements. Staff explained what actions they would take in the event of them suspecting or witnessing abuse taking place. Their explanations were in line with the registered providers policy and procedures. Training records demonstrated that all staff had received safeguarding awareness training. In addition, the majority of staff had attended a 'safeguarding alerter workshop.' Staff confirmed that they had attended safeguarding training and they felt any concerns would be identified and reported appropriately.

Staff knew about the registered providers whistleblowing procedure. None of the staff spoken with had used the procedure, however they felt confident that if needed any whistleblowing concerns raised would be managed appropriately by the registered manager.

People received their medicines safely. We observed the administration of medicines twice during our inspection. On both occasions registered nurses followed best practice guidance in preparing and administering people's medicines. For example, whenever possible people were asked to confirm their name and date of birth at the time the medicines were being administered. In the event of a person not having the capacity to confirm their information staff referred to the photograph displayed on the person's medicines records. This helped ensure that people received the correct medicines prescribed for them.

Medicines administered were recorded on medication administration records (MAR). These records contained details of any allergies that people may have and full details of all treatments prescribed for the individual. We looked at people's individual MARs and saw that all medicines had been recorded appropriately. Medicines prescribed for use on an 'as and when required' basis had been recorded fully. This helped to ensure that clear records were maintained of when a person had been administered or offered medicines prescribed for them.

All medicines were stored securely in lockable trolleys and a secure storage room which was clean, tidy and well organised. The temperature of the fridges in use to store medicines were monitored on a regular basis. However, the medicines storage room was very warm and could, if not addressed had had an impact on the correct storage temperature for medicines. This was brought to the attention of the registered manager who addressed the concern immediately by arranging for a cooler to be made available for the room.

We saw that sufficient staff were on duty to meet the needs of people. Rotas demonstrated that a set number of staff were on duty throughout the day. Staff explained that in the event of further staff being needed for additional support the registered manager would make arrangements for this. People told us that they felt sufficient staff were on duty and that they didn't have to wait long if they needed assistance. We saw that when a person used their personal call bell to request staff attention, these calls were answered quickly. This meant that people did not have to wait for a long period of time to get the assistance they required.

The environment was clean and tidy. Training records demonstrated and staff confirmed that they had received training in infection control. Personal protection equipment was available throughout the service. For example, gloves and aprons were readily available for use when required. Regular monitoring of health and safety within the service took place. Systems were in place to ensure people could be safely evacuated in the event of an emergency. Personal Emergency Evacuation Plans (PEEPS) were available for each person who used the service. We looked at these plans and saw that clear information was available in relation to individual's mobility, senses and communication. This information would help anyone assisting a person to evacuate the building in the event of an emergency as they would be aware of the person's needs.

Detailed recruitment procedures were in place to ensure that only staff suitable to work with vulnerable people were employed. We looked at the recruitment records of the five most recently employed staff members. The information

Good

Is the service safe?

demonstrated that appropriate recruitment procedures had taken place. For example, there was evidence of a completed application form, proof of identify, an interview assessment and two written references. In addition, we saw that Disclosure and Barring Service (DBS) checks had been completed.

Risk assessments were in place to ensure that identified risks to people were minimised. For example, falls experienced by people were closely monitored and wherever possible minimised. Clear guidance was available to staff on how to minimise the risk from people falling. This guidance included considering people's foot care, appropriate footwear, sensory needs, memory; sleep patterns and motivation. A register of all falls was maintained and when a person had been identified as being at risk from falls the risks were assessed and care was planned to minimise any further falls.

Accidents and incidents were recorded. We looked at these records and saw that once an accident or incident report had been completed the information was reviewed by the registered manager or the deputy manager. Any actions required to minimise the risk of the accident re-occurring were recorded and care planning records were updated. This demonstrated that issues relating to accidents experienced by people were addressed by a robust monitoring system.

Good

Is the service effective?

Our findings

People told us that they enjoyed the food served within the service. Their comments included the food "Was better than hotel food. Its something different every day. I like it because we have a light snack at lunch time and our main meal at tea time. This does not give you the bloated feeling of eating too much" and "The food is excellent. If you don't like something you can always have something else".

Prior to a person moving into the service an assessment of their needs was carried out. The purpose of this assessment was to ensure that the service had the facilities to meet the person's individual needs. In addition, the information gained during the assessment helped to develop the person's individual care plan.

In the event of a person needing to access the service in an emergency, for example to receive intermediate care and rehabilitation, an emergency admission pack could be developed on the service's electronic care planning system. This system enabled staff to instantly create care planning and risk assessment documents at any time of the day or night when required. People accessing the service for intermediate care were supported by a multi disciplinary team (MDT) of health and social care professionals when required. For example, the service had ready access to occupational therapists, speech and language therapists, physiotherapists and social workers whose role it was to plan people's rehabilitation and assist people to return to their own home. Regular MDT meetings were held to plan and support people's discharge from the intermediate care service.

Equipment was seen around the service to assist people with their rehabilitation. For example, we saw equipment to assist people in using stairs and a rehabilitation kitchen was available to assist people to regain or develop independence within the kitchen for when they returned to their own home.

In addition to the multi disciplinary team the service had access to the services of a tissue viability nurse and when required an admiral nurse. A admiral nurse is a registered nurse who is specially trained in supporting people living with dementia. Having access to specialist care and advice helped ensure that people received the care and support they required.

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 people lack mental capacity to make particular decisions, any decisions 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 received care and treatment when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked that the service was working within the principles of the MCA 2005 and found that they were.

The registered manager demonstrated a clear understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. She was able to tell us of all the applications that had been submitted for authorisation on behalf of people and the reasons for the applications. Each time that an application had been granted the registered manager had informed the Care Quality Commission, as they are required to do so by law.

Policies and procedures were in place in relation to the implementation of the Mental Capacity Act 2005 and staff had read and signed to say that they understood the five statutory principles of the Act. In addition to the registered provider's policy and procedure staff had access to other professional guidance. For example, from the Care Quality Commission and the Department of Health and this further informed staff of information relating to the Mental Capacity Act 2005 and what the Act meant for the people they supported.

Staff demonstrated a good understanding of best interest decisions made of behalf of people who were unable to make a specific decision themselves. Care planning documents demonstrated that people's ability to make decisions had been considered, assessed and recorded.

Two dining rooms were available for people to have their meals. We saw that tables were set with cutely, napkins and condiments. Mealtimes were unrushed with staff taking time to explain to people and remind them what the choices of meal where. One person did not eat their meal as they did not like it and a staff member offered an alternative which was delivered within a short time.

Good

Is the service effective?

We spoke with the cook who explained that the menus were changed twice a year. They demonstrated a good awareness of people's needs and wishes in relation to choice of foods and portion size. The cook explained that meals were prepared to meet people's personal preferences and medical needs. For example, for people requiring low sugar, low salt and for people living with diabetes. They told us that whenever possible, meals were fortified for added nutrition by using cream and butter.

The cook demonstrated that they used alternative foods to thicken certain foods to gain the appropriate level of consistency required, for people requiring a diet of a specific consistency. For example, as opposed to used gelling agents, bread was used to thicken certain meals as it increased the amount of carbohydrate in the meal for people and enhanced the flavour. The cook demonstrated by photographs a number of deserts they had developed and made using pureed foods. The deserts photographed looked colourful and appetising and aimed to encourage people to choose food which would enhance their mealtime experience.

Throughout the inspection we saw people being served drinks, biscuits and snacks which included home made cake. People told us that they could ask for a drink at anytime if they wished.

People's hydration and nutrition needs were monitored on a regular basis. Risk assessment tools were used to measure if a person was at risk from a lack of hydration or nutrition. In addition people's weight was regularly monitored. When a person had been identified as at risk, a system for monitoring people's fluid and food intake was in place. This involved keeping regular records of what people had had to drink and eat. From regular assessment of these records appropriate health care professionals were contacted for their advice. For example, a referral to a speech and language therapist or a dietician was made when concerns about a person's swallowing or weight loss were identified.

Systems were in place to measure people's potential skin pressure area damage. A number of people were at high risk of pressure area damage following their assessment. The registered provider had, following these assessments taken action to ensure that people's pressure areas were managed appropriately. For example, pressure mattresses had been provided, pressure relieving cushions had been made available and people's care was planned so that they changed position on a regular basis. Effective risk assessment and review of people's skin helped ensure that any risks were minimised with appropriate treatment and the provision of pressure relieving equipment.

Records demonstrated, and staff confirmed that they received regular supervision for their role. Registered nurses received annual structured clinical supervision sessions and they told us that the registered manager and the deputy manager were always available to talk to for advice.

Since our last inspection the service had revised the induction programme for newly recruited staff members. The recently introduced induction was carried out by a senior member of staff who carried out an internal induction plan over a two week period. This helped ensure that new staff were fully aware of their role prior to working unsupervised .

People's care and support was delivered by a staff team that received regular training for their role. Training records demonstrated that staff had received training which included moving and handling; health and safety; food hygiene; communication; continence care; infection awareness; dementia care; safeguarding first aid; Gold Standard Framework for end of life care and medicines management. A number of staff had also received training in spirituality, massage and relaxation for when working with people who challenged the service.

Registered nurses had received additional training which included wound care, urinalysis, use of syringe driver and end of life care. Having appropriately trained staff helped to ensure that people received the care and support they required in a safe manner.

Good

Is the service caring?

Our findings

People told us that they felt that the staff were caring. People's comments included "Staff are kind and they look after us well" and "The staff are very nice and respectful".

Staff were caring in their approach to people. For example, we saw staff addressing people in a gentle quiet manner whilst being close to them and maintaining eye contact. It was evident that staff knew people well and that relationships had formed between people and the staff that supported them.

Comment cards completed since our previous inspection contained positive information from people who had used the service. These comments included "I have found the staff very caring and considerate. I have enjoyed the food and on the whole I have no complaints and have enjoyed my time here", "Very kind staff", "My father has been welcomed here and is very happy. The staff are friendly, caring and always treat him with dignity and respect", "I am very happy with my care" and "Staff are very caring and treat residents with dignity and respect. The environment is very hygienic".

A hairdresser visited the service on a regular basis. We spoke with four people who were waiting to go to the hairdressing salon. They told us that they visited weekly to keep their hair as they wanted it. One person told us "I always feel better when my hair is done. You've got to keep on top of these things to look presentable".

A mobile pay telephone was available that could be taken to different areas of the service. This enabled people to access the telephone in a area of their choice to make private personal telephone calls.

A member of staff was a designated dignity champion whose role was to disperse information to their colleagues in relation to dignity issues. Information was available in the foyer area for people and visitors to read in relation to dignity and its place within the service. Information was also available that explained the Mental Capacity Act 2005 and what people should expect from the implementation of the Act. This demonstrated that people and their visitors were provided with information as to what service they could expect from the staff team.

People's care plans contained information relating to their needs so that the care and support they required was managed appropriately. For example, one person's care plan stated in relation to their rights "Required full assistance to access the services Statement of Purpose and residents guide. Information written in these documents will allow him to take advantage of all the facilities the service had to offer." The record stated that staff were to help remind the person to access this information on a regular basis. This helped ensure that people were made aware of the service they should expect.

Care planning documents contained, where relevant, the personal wishes of people for when they approach their end of life. For example, one person's care plan documented that they had made advanced decisions and had discussed their preferred priorities for care. This information helped staff understand people's wishes in relation to what specific care and support they wanted.

We saw evidence that the registered provider actively participated in the Gold Standard Framework for End of Life Care. Four End of Life nurses attended regular locality meetings regarding changes and improved practice changes to End of Life Care. Staff were proud of the work they carried out around End of Life Care and they demonstrated that all staff received cascaded learning in relation to this area of care. The registered manager told us that all staff took an active part in delivering End of Life Care and staff were supported following the death of a person they had been caring for.

The registered provider held an annual service for people who had died. Relatives and friends were invited to join the staff at the service to remember their loved ones. A memory tree was created during these events.

Good

Is the service responsive?

Our findings

People told us that they knew who to speak to if they wanted to make a complaint about the service and they felt that they would be listened to. People commented that activities were available and one person told us; “There are things to do if you want to join in”.

The registered provider had recently introduced a new electronic care planning system. We looked at the care planning records of four people. Care plans demonstrated that individualised and person centred care for people had been planned and was reviewed with the input of the individual and where appropriate, family members.

Care planning documents considered all aspects of people’s day to day care needs. Once a need relating to a person’s health, safety and wellbeing had been identified a risk assessment had been carried out with the outcome of these assessments being included in people’s care plans. For example, risk assessments and care plans were in place in relation to personal care; mobility; eating and drinking; decision making; medicines management and social needs. In addition, information in relation to people’s sensory needs, sight, hearing and touch were recorded. The documents gave clear information as to what actions staff needed to take to ensure that people received the care and support they required. Each person had a care needs summary that gave a brief outline of a person’s needs and overall health. This information was useful to find out what support individual’s needed in the event of an emergency. Members of the multi-disciplinary team involved in people’s health and care planning had access to the electronic records, enabling them to update them efficiently.

A number of staff had received training in the ‘House of Memories’ which was a training programme that promoted engagement, stimulation and participation for people living with dementia. Two activities workers were employed to deliver daily activities around the service. Our inspection took place prior to Christmas and we saw that activities had been planned around this Christian festival. Activities took place at the service and in the community. These included; a Christmas show by staff; a Christmas party; Christmas tea dance; a mass; bingo; karaoke and a trip to the Royal Court Theatre.

Wifi hotspots were available around the service which enabled people to access the internet if they wished. In addition people had access to a desktop computer. These facilities enabled people to send personal emails and access the internet during their stay.

We saw photographs of theme nights that had been arranged in which people were able to invite their family and friends. For example, Greek; Russian and Chinese meals had been prepared to celebrate those particular countries and their dishes. Photographs were available of people celebrating national parents day; American independence day and Burns night. The cook explained how he researched and prepared foods that were eaten on VE day to ensure that the VE celebrations were as close to how people remembered them as possible.

A complaints procedure was available around the service. The procedure gave clear information as who complaints could be made to, the timescale in which complaints would be responded to and how any actions required following the complaint investigation would be managed. No formal complaints had been made about the service and the Care Quality Commission had not received any complaints regarding the service. People’s care planning documents contained information in relation to what support a person required in the event of them wishing to make a complaint. For example, one person’s file stated “[X] requires an advocate to raise any complaints about the home as [X] is unable to access the home’s complaints procedure himself. [X] advocate should be given a copy of the home’s complaints procedure to enable concerns to be raised”.

The registered manager explained that any complaints from people receiving intermediate care services about the care they received would be managed by herself. Details of all complaints would be shared with other agencies involved in the service, for example, the Clinical Commissioning Group as a learning exercise for all parties.

People’s views were obtained about the service informally during the reviews of their care and in addition, questionnaires were circulated to gather people’s views on a regular basis. A plan for improvement would be developed if required from people’s views and responses. The most recent satisfaction survey took place in June 2015.

Good

Is the service well-led?

Our findings

The registered manager was registered with the Care Quality Commission in January 2011. People who used the service were able to identify the registered manager.

The registered manager's role was to oversee the service provided for people residing at the service and people in receipt of short term intermediate care. During discussion and throughout the inspection process the registered manager demonstrated an excellent awareness of legislation relevant to providing safe, effective care for people. Professional best practice guidance was available around the service to inform staff of any recent changes in relation to delivering a safe service to people. For example, we saw that information had been made available from the Department of Health and the Care Quality Commission.

Staff spoke positively about the support and leadership they received from the registered manager. There was a clear line of accountability and staff had a good understanding of their role. All staff spoken with were proud of their role and the service that they delivered to people.

By law services are required to notify the Care Quality Commission of significant events. For example, when a Deprivation of Liberty Safeguard has been authorised for an individual or when a person dies. Our records showed that the registered manager informed the Commission of notable events in a timely manner.

A number of internal audits were carried around the service on a regular basis. For example, we saw that audits were completed in relation to infection control; medicines; the environment and care planning documents. The purpose of these audits was to ensure that systems in place for the delivery of safe care and support were effective. In the event of improvements being identified action was taken to address the issues.

In addition to the internal monitoring systems in place the registered manager also reported on a monthly basis to the Clinical Commissioning Group who purchased the intermediate care services. We saw that these reports included the results of audits in relation to the number of falls people had experienced; pressure area care; Deprivation of Liberty Safeguards applications; the number of registered nurses in post; the number of agency staff used; and medical conditions experienced by people who used the service. The audits were completed in detail and the registered manager told us that these audits were used as a way of monitoring the quality and efficiency of the service provided to people.

The most recent infection control audit of the service by the local infection control team resulted in the service being awarded a gold certificate of excellence in infection prevention and control for achieving a score of 97% following the assessment. The most recent inspection by the local council in relation to food hygiene saw the service awarded with a maximum score of five stars. This further demonstrated that effective systems were in place for monitoring the service provided to people. The registered manager and the staff team were proud of their achievements in maintaining high standards in these areas.

The service had achieved Beacon status for their active participation in the Gold Standards Framework for End of Life Care. Beacon status is awarded when a service demonstrates that they are progressively learning and delivering good standards of care for people approaching their end of life. The registered manager and the staff team were proud of their achievements in maintaining high standards in these areas