

Countrywide Care Homes (2) Limited

Argyle House

Inspection report

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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

This unannounced inspection took place over two days on 28 and 29 June 2016.

Argyle House is registered to provide nursing and personal care for up to 87 people who may be living with physical disability or dementia. At the time of this inspection there were 61 people living in the home.

There was a registered manager in post at the time of our inspection. 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.

Staffing levels had been calculated to reflect the dependency levels of people living in the home. However, at times the number of staff on duty did not correspond to the number of staff required and there were not always sufficient staff to ensure that people's needs were met in the way that they chose.

People felt safe in the home and relatives said they had no concerns about people's safety. Staff understood the need to protect people from harm and abuse and knew what action they should take if they had any concerns.

Recruitment procedures protected people from receiving unsafe care from care staff that were unsuitable to work at the service. Staff received training in areas that enabled them to understand and meet the care needs of each person.

Care records contained individual risk assessments and risk management plans to protect people from identified risks and help to keep them safe. They provided information to staff about action to be taken to minimise any risks whilst allowing people to be as independent as possible.

Care plans were written in a person centred approach and detailed how people wished to be supported. Where possible people were involved in making decisions about their care. People participated in a range of activities and received the support they needed to help them do this. People were able to choose where they spent their time and what they did.

People were supported to take their medicines as prescribed. Medicines were obtained, stored, administered and disposed of safely. People were supported to maintain good health and had access to healthcare services when needed.

People were actively involved in decisions about their care and support needs. There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff had good relationships with the people that lived at the house. Staff responded to complaints promptly and in line with the provider's policy. Staff and people were confident that issues would be addressed and that any concerns they had would be listened to and acted upon. There was a stable management team and effective systems in place to assess and monitor the quality of service provided.

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.

Staffing levels did not always ensure that people's care and support needs were met in the way that they chose.

People felt safe and comfortable in the home and staff were clear on their roles and responsibilities to safeguard them.

Risk assessments were in place and were reviewed and managed in a way which enabled people to receive safe support.

There were systems in place to manage medicines in a safe way and people were supported to take their prescribed medicines.

Safe recruitment practices were in place.

Is the service effective?

Good 

The service was effective.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People received personalised care and support. Staff received training to ensure they had the skills and knowledge to support people appropriately.

Peoples physical and mental health needs were kept under regular review.

People were supported to access appropriate health and social care professionals to ensure they received the care, support and treatment that they needed.

Is the service caring?

Good 

The service was caring.

Staff had a good understanding of people's needs and

preferences and worked with people to enable them to communicate these.

People were encouraged to make decisions about how their care was provided and their privacy and dignity were protected and promoted.

There were positive interactions between people living at the home and staff.

Is the service responsive?

Good ●

This service was responsive.

People were listened to, their views were acknowledged and acted upon and care and support was delivered in the way that people chose and preferred.

People were supported to engage in activities that reflected their interests and supported their physical and mental well-being.

People using the service and their relatives knew how to raise a concern or make a complaint and a system for managing complaints was in place.

Is the service well-led?

Good ●

This service was well-led.

A registered manager was in post and they were active and visible in the home. They provided staff with regular support and guidance. They monitored the quality and culture of the service and responded to any concerns or areas for improvement.

There were systems in place to monitor the quality and safety of the service and actions were completed in a timely manner.

Argyle House

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 28 and 29 June 2016. The inspection was unannounced and was undertaken by two inspectors and one 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 the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law.

During this inspection we visited the home and spoke with seventeen people who lived there and spoke with four of their relatives. We also looked at care records relating to fourteen people. In total we spoke with fourteen members of staff, including care staff, team leaders, housekeeping staff, the cook, the registered manager and quality assurance manager. We looked at five records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service. We made observations about the service and the way that care was provided. We also used the Short Observational Framework Inspection (SOFI); SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

People were supported by a caring and dedicated team of staff. However, there were not always enough staff to meet people's needs as they wished and enable people to take part in their chosen activities. Some areas of the home were not consistently staffed at the levels required and people told us that this impacted on the care they received. People living in one particular area of the home told us that they often had to wait for support from staff at busy times. One person said "There probably are not enough staff. You see if I press my bell, someone will put their head around the door quite soon but then they don't come back for some considerable time, sometimes half an hour or more". Staff told us that they were able to meet people's choices and needs when the required levels were met but that too often they worked with less staff than this. We spoke to with the registered manager about the concerns raised and they told us that staffing levels were planned to meet the identified needs of people, but that these levels were not always met in practice; recruitment was currently taking place to ensure that there were always sufficient staff on duty.

People were supported by a staff team that worked hard to maintain their safety. One person said "I do feel safe because the staff do whatever they have to do to keep us safe". People's relatives also said that they had no concerns about their family members' safety; one person's relative said "Yes, [Name] does feel safe. They are all very good and kind". We observed that people in the home were happy and comfortable with the staff supporting them and that people interacted freely with one another.

Safeguarding policies and procedures were in place and were accessible to staff. Staff were aware of safeguarding procedures and had received training in safeguarding. Discussions with staff demonstrated that they knew how to put these procedures in to practice and staff described to us how they would report concerns if they suspected or witnessed abuse. The registered manager had submitted safeguarding referrals when necessary, which demonstrated their knowledge of the safeguarding process.

People had individual risk assessments, which minimised the risk of harm and where possible they had been involved in the development of these; where this was not possible their representative had been involved. These guided staff how to support people to take part in the activities they enjoyed in a safe way and covered all aspects of their lives. Staff demonstrated an understanding of risk assessment and the need to adapt the level of support they provided depending on the person's support needs and identified risks. For example a member of staff described how people's individual risk assessments regarding falls, manual handling and behaviour helped them to understand how to keep people safe, whilst supporting them to be as independent as possible.

When accidents had occurred, the registered manager and staff took appropriate action to ensure that people received appropriate and timely treatment. Training records demonstrated that staff had received health and safety and first aid training and the staff we spoke to confirmed that this training had taken place. Accidents and incidents were regularly reviewed to establish if there were any incident trends and control measures were put in place to minimise the risks that had been identified.

People lived in an environment that was safe. There were environmental risk assessments in place and a list

of emergency contact numbers was available to staff. Contingency plans were in place in case the home needed to be evacuated and each person had a Personal Emergency Evacuation Plan (PEEP) in place to provide information to emergency services in the event of an evacuation. Health and safety matters were discussed regularly in staff meetings.

People's medicines were safely managed. All staff were trained in the administration of medicines and our observations confirmed that this training was followed in practice. Staff followed guidelines for medicines that were only given at times when they were needed, for example Paracetamol for when people were in pain. The medicines policy covered receipt, storage, administration and disposal of medicines.

People were safeguarded against the risk of being cared for by unsuitable staff. Recruitment files contained evidence that criminal record checks were carried out and satisfactory employment references were obtained before staff were allowed to work in the home. Staff we spoke with confirmed that these checks were carried out before they commenced their employment.

Is the service effective?

Our findings

People's needs were met by staff that had the required knowledge and skills to support them appropriately.

New staff received a comprehensive induction which included computer based learning, practical training and shadowing experienced members of the staff team. Each new member of staff had a 'mentor' who worked with them. Staff did not work with people on their own until they had completed all of the provider's mandatory training and they felt confident to undertake the role. The induction included key topics on moving and handling and dementia awareness. Newly recruited staff also undertook the Care Certificate; this is based on 15 standards that aim to give employers and people who receive care, the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff received mandatory training such as first aid, fire safety and mental capacity. Additional training relevant to the needs of the people they were supporting was also provided; this included training in challenging and distressed behaviours. One member of staff said "challenging behaviour training helped me to understand why people may behave in the way that they do and the importance of looking for the reasons for different behaviours, so we know how to support residents". There was a plan in place for on-going training so that staff's knowledge could be regularly updated and refreshed and training requirements were regularly discussed as part of supervision.

People's needs were met by staff that were effectively supported and supervised. Staff were able to gain support and advice from clinical lead staff and the registered manager when necessary and regular supervision meetings were available to all staff. The meetings were used to assess staff performance and identify on-going support and training needs. One member of care staff said "Regular supervision is helpful, if I have any concerns I can speak to [Supervisor], or the manager"

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. The registered manager and staff were aware of their responsibilities under the MCA and DoLS codes of practice. Care plans contained assessments of people's capacity to make decisions and when 'best interest' decisions had been made following the codes of practice. The registered manager had followed the legal process when applying for DoLS authorisations to place restrictions on people's liberty to leave the building unescorted in order to keep them safe. Staff that we spoke with knew where to find information relating to MCA and DoLS and we observed that they asked for people's consent before providing care.

People had mixed views on the variety and quality of the food provided at main mealtimes. Some people were happy with the food on the menu, however others said that it lacked variety and was sometimes bland. We observed lunch being served in the home and people were provided with a choice of meal and an alternative to this if they did not like what was on the menu. The food served at mealtimes had been discussed at residents' and relatives meetings and in response to feedback the menus had been changed; the manager said that the success of the new menus would continue to be monitored. Drinks and snacks were readily available to people living in the home and staff supported people with eating and drinking as needed.

Staff were knowledgeable about people's food preferences and dietary needs and menus were available in pictorial and written formats to enable people to make choices. People were referred to the speech and language therapy team if they had difficulties with swallowing food and, if required, referrals were made to the dietician. People who were at risk of weight loss or gain were weighed regularly and their dietary intake monitored. Care plans contained detailed instructions about people's individual dietary needs, including managing diabetes and food allergies.

People's healthcare needs were monitored and care plans ensured that staff had information on how care should be delivered effectively. People had prompt access to health care support, as the doctor attended the home weekly as well as visiting people for acute health problems when needed. One person said "The doctor comes out every Tuesday, but if you ask the staff they'll get him out a different day". We saw instances recorded in people's care records when staff had promptly contacted health professionals in response to any deterioration or sudden changes in people's health and acted on the instructions of the health professionals. We saw evidence of regular health checks taking place and people were supported to access a range of healthcare professionals such as the chiropodist, diabetic services and community mental health team.

Is the service caring?

Our findings

Staff supported people in a kind and caring way and involved them as much as possible in day to day choices and arrangements. Staff had good relationships with people, one person said "The main word to say about them is kind; they are all very, very kind" Another said "This is a wonderful place, the staff are very good".

People told us that their family could visit whenever they liked and were offered refreshments such as a cup of tea or a meal when they visited. We spoke with people's relatives who told us they were very pleased with the care and support provided for their family members, one relative said "They are very good to us here". We observed that staff were open and warm towards the people they were supporting, interaction was often light hearted and we observed that people enjoyed having a laugh and a joke with staff. Staff told us that they worked hard to enhance people's well-being; one member of staff told us "I love to see genuine happiness, real joy". We observed staff supporting a person with eating their meal and they followed the information provided in the person's care plan as they spoke to the person in a soft voice and used gentle reassuring touch to encourage them.

Staff knew about people's life histories and the people and things that were important to them. We saw people chatting with staff about their families and interests, and people gained a lot of enjoyment from this. We heard staff talking to one person about a therapy doll that they cared for and were very proud of; the person gained a great deal of comfort and reassurance from this. In some areas of the home people's photos were displayed on their bedroom doors; these pictures reflected their past experiences, hobbies and interests. There was information in people's care plans about their past life, including their past employment, hobbies, and important events.

People were encouraged to express their views and to make choices. There was information in people's care plans about their preferences and choices regarding how they wanted to be supported by staff and we saw that this was respected; staff described to us how they supported people to dress in their personal style. The registered manager was aware of how to access advocacy services on behalf of people and information was available regarding people who had a lasting power of attorney or an advocate in place.

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. People's dignity and right to privacy was protected by staff. One person said "When I have a bath they wash my back. They do respect my dignity, using a towel to cover my private parts". Staff were able to explain how they upheld people's privacy and dignity by taking into account their personal situation and needs and attending to these in a person centred way. For example, one member of staff spoke about supporting people with personal care and described how it was important to "Keep doors shut and curtains drawn, put a towel around the person". Staff also described the importance of knocking on people's doors, asking people what they wanted and allowing people the time they needed to do things. We observed that staff knocked on people's bedroom doors and waited to be invited in before entering the room.

Is the service responsive?

Our findings

People's care and support needs were assessed before they came to live at Argyle House to determine if the service could meet their needs. This assessment was carried out by the registered manager who shared the outcomes of the assessment with staff. Initial risk assessments and care plans were produced and these were monitored and updated as necessary.

People were cared for by a team of staff that knew them well and that had an in-depth understanding of their care and support needs. There were good verbal communication systems in place to support staff and to ensure they were aware of any changes in people's care or support needs. Relatives were contacted promptly if staff had concerns about the wellbeing of the person.

Care and support was planned and delivered in line with people's individual preferences, choices and needs. We observed that one person, who wanted to access the garden independently had been given a call pendant that they could wear around their neck. They told us how important it was to them that they could choose to go in the garden whenever they wished and that they were not reliant on staff to accompany them. They said "It has increased my confidence to go in the garden as I know that I can call the staff at any time".

Person centred care plans were up to date, reviewed as needed and contained information about people and their preferences. They covered areas such as personal care, eating and drinking, mental capacity and skin integrity. Risk assessments and care plans were linked together and cross referenced to give a full picture of people's needs and people received care that corresponded to their care plans. Where people were at risk of pressure ulcers, their care plans recorded the equipment and support they required to help prevent them. People's pressure relieving mattresses were set to the correct pressure for each person's weight and people were helped to change their position to relieve their pressure areas regularly as detailed in their care plans. People were involved in planning their care as much as they were able and people or their representatives had signed their care plans to consent to care and support.

The assessment and care planning process considered people's hobbies and past interests as well as their current support needs. Staff supported people to do the activities that they chose and were knowledgeable about people's preferences and choices. One person said "The staff take me on the bus to feed the swans, I love that". People living in the home were provided with a plan of organised activities and we saw that these activities took place as scheduled and were enjoyed by many people living in the home. Activities on offer included board games, musical bingo, quizzes, arts and crafts, baking and carpet bowls. Individual activities were available to people at times and staff were able to describe the things that people enjoyed, such as hand massages, reading newspapers and sensory based activities.

There was a complaints policy and procedure in place and complaints were logged and investigated promptly and thoroughly by the registered manager. The importance of reflecting on and learning from complaints was emphasised. People and their relatives told us that they knew who to speak to if they were unhappy with any aspect of the service. During residents and relatives meetings, people were asked if they

had any concerns that they wanted to share, there were also regular opportunities for people to speak in private to staff or the registered manager. Staff were knowledgeable about how to respond to complaints, one member of staff said "If anyone made a complaint to me I would do what I could to help and tell the manager".

Is the service well-led?

Our findings

People said that the registered manager was approachable and they had confidence in their ability to manage the home. They said that the registered manager had made many improvements to the service provided by the home and that these improvements had impacted positively on the quality of care provided. One person said "I get the care I need, she gets things done". The registered manager demonstrated an awareness of their responsibilities for the way in which the home was run on a day-to-day basis and for the quality of care provided for people in the home.

Staff were clear on their roles and responsibilities and there was a shared commitment to ensuring that support was provided to people in the best way possible. One member of staff said "We all work as a team and we're all here for the residents". Staff were confident in the managerial oversight and leadership of the registered manager and found them to be approachable and friendly. They told us that they felt able to ask for support, advice and guidance about all aspects of their work. We observed that the registered manager had an open door policy and was accessible to staff and people living in the home.

Policies and procedures to guide staff were in place and had been updated when required. We spoke with staff that were able to demonstrate a good understanding of policies which underpinned their job role, such as safeguarding people and mental capacity. Staff were aware of the whistleblowing policy and were able to explain the process that they would follow if they needed to raise concerns outside of the company.

Regular staff meetings took place to inform staff of any changes and for staff to contribute their views on how the service was being run. The content of staff meeting minutes demonstrated a positive, open culture, with discussions about staffing levels, care issues, health and safety and feedback from residents' and relatives' meetings. One member of staff told us that as a result of discussions during a staff meeting, work had commenced in the garden to make it a more inviting space for residents.

The provider had a process in place to gather feedback from people, their relatives and friends. Regular residents' and relatives' meetings took place and any concerns raised during these meetings had been addressed. For example; the manager had introduced a new labelling system and documentation to improve the laundry service provided. Care staff who worked in different areas of the home had attended these meetings so that relatives could address any comments or concerns to the staff directly involved in the care and support of their family member.

The provider carried out regular surveys of the views of people living in the home, their relatives and staff. We saw that questionnaires completed by residents and relatives had been analysed by the provider and action taken in response to comments made. At the time of the inspection a survey of staff views was ongoing and staff that we spoke with had taken part in this.

There were arrangements in place to consistently monitor the quality of the service that people received, as regular audits had been carried out by the provider and manager. The quality assurance manager visited the home regularly and spoke with people living in the home, relatives, health professionals and staff. Their

audit also covered areas such as the environment, complaints and documentation. The registered manager carried out a monthly audit covering areas such as medicines, infection control and health and safety. We saw that actions required as a result of these audits were taken in a timely manner.