Blue Mar Limited

Colebrook Manor

Inspection report

Boringdon Road, Plympton Plymouth PL7 4DZ
Tel: 01752 343001

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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?	Requires improvement

Overall summary

The inspection took place on the 27 and 28 October 2015 and was unannounced. The last inspection took place on the 29 and 30 October 2014. At this inspection we were found there were not enough staff to deliver care safely and people who paid for their own care did not have contracts in place. We found both these concerns had been met on this inspection.

Colebrook Manor can accommodate a maximum of 65 people. Care is provided for younger and older adults who may have a physical disability. Nursing and residential care are provided. For people receiving residential care, their nursing needs were met by the community nursing team. There were 24 people living at the service when we visited.

There was a registered manager in place to manage the service. 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.

Colebrook Manor was owned and run by Blue Mar Ltd. They run two care homes in England. There was a nominated individual (NI) in place who is accountable at the provider level. There was no evidence of the provider ensuring the quality of the service. We spoke with the

Summary of findings

nominated individual who explained there had been a need to consolidate the finances of the service. This had been achieved and they were now in a position to facilitate stability and growth of the service.

At our last inspection, we found people who were paying in full or in part for their care did not have terms, conditions and contracts in place. We found terms and contracts had been developed but had not been implemented. We were advised they were to be implemented the week following the inspection.

The registered manager had some audits in place to measure the quality and safety of the service. There were gaps in these such as investigating people's falls to reduce this risk for others. Water temperatures were being taken to prevent scalding however, there was not a current legionnaire's check in place to ensure the water outlets were safe. The registered manager considered how to ensure the concerns raised could be addressed.

People and staff felt the registered manager was approachable. They also felt the registered manager had developed a culture which was open and inclusive. People and staff were asked their view of the service and felt they could offer alternative ideas on how the service was run. People's concerns were addressed early so they could be resolved quickly. The registered manager was looking at how they could use people's concerns to ensure the service improved for everyone.

People were looked after by staff who treated them with kindness and respect. The atmosphere in the home was happy with plenty of conversation and appropriate humour. Staff spoke highly of the staff and the staff spoke fondly of the people they were looking after. People said their dignity was protected at times of personal care. People said staff would always ask for their consent before starting care. People added that staff respected their decision and would come back later.

People felt safe living at the service. People were protected by staff who could identify abuse and would report their concerns. People and staff felt the registered manager would act on any concerns. Staff would contact the local authority or CQC if action was not taken. There were sufficient staff recruited safely to meet people's needs. Staff were trained to meet people's needs.

People were in control of their care and felt staff listened to them. People had their capacity to consent to their care assessed, as required. People had care plans and linked risk assessments in place to meet their needs. We identified some gaps but action was taken to address this through a new care planning process. For example, people on respite did not have care plans in place but this was addressed and started to be implemented on the second day of the inspection.

People's medicines were administered safely. Staff were following safe infection control policies.

People had their health needs met. People had access to healthcare professionals as required. People also had their nutritional and hydrations needs met. Action was taken when concerns were raised.

People were provided with activities to remain physically, cognitively and socially active. People's religious needs were met. The service employed an activity coordinator. There was a programme of activities developed with people which was flexible.

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?

Good

The service was safe. People told us they felt safe living at the service.

There were sufficient staff on duty to meet people's needs safely. Staff were recruited safely.

People were protected by staff who could identify abuse and who would act to protect people.

People had risk assessments in place to mitigate risks associated with living at the service.

Staff followed safe infection control procedures.

Is the service effective?

Good

The service was effective. People were looked after by staff trained to meet their needs.

People were assessed in line with the Mental Capacity Act 2005 as required. Staff always asked for people's consent and respected their response.

People's nutritional and hydration needs were met.

People had their health needs met.

Is the service caring?

Good

The service was caring. People were looked after by staff who treated them with kindness and respect. People and visitors spoke highly of staff. Staff spoke about the people they were looking after with fondness.

People felt in control of their care and staff listened to them.

People said staff protected their dignity.

Staff were in the process of seeking people's advance choices and planning their end of life with them.

Is the service responsive?

Good

The service was responsive. People had care plans in place to reflect their current needs.

Activities were provided to keep people physically, cognitively and socially active. People's religious needs were met.

People's concerns were picked up early and reviewed to resolve the issues involved.

Summary of findings

Is the service well-led?

The service was not always well-led. There was no evidence of the provider ensuring the quality of the service, however, they were looking to address this.

People who paid in full or part for their care, continued to not have contracts in place. Contracts had been drawn up but not implemented yet. These were due to be implemented in the week following the inspection.

The registered manager had some audits in place to measure the quality and safety of the service. There were gaps in these such as investigating people's falls to reduce this risk for others. The registered manager started to address this.

People and staff felt the registered manager was approachable. Staff felt the registered manager had developed a culture which was open and inclusive. People and staff said they could suggest new ideas. People were kept up to date on developments in the service and their opinion was requested.

There were contracts in place to ensure the equipment and building were maintained.

Requires improvement

Colebrook Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 27 and 28 October 2015 and was unannounced.

The inspection team consisted of one inspector, a specialist nurse in caring for older people 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.

Before the inspection we reviewed previous inspection reports, the provider's action plan and CQC records, to ensure we had received all notifications as required. Notifications are specific information registered people have to tell us about.

We spoke with 10 people and five relatives. We sat with people at lunchtime on both days and spoke with them. We spoke with a group taking part in an activity and we observed how staff interacted with people. We looked at the care records of five people in detail and spoke to them where we could. This was to ensure they were receiving their care as planned. We also reviewed parts of two other people's care records to ensure parts of their needs were being met. We spoke with eight staff, read six personnel records and the training records of these staff. We also reviewed how training was planned. There were no current supervision or appraisal records for us to view. We spoke with nominated individual by phone. The nominated individual is someone who is accountable at the provider level.

We also reviewed how the registered manager was ensuring the quality of the service which included a number of audits, questionnaires given to people and complaints. We reviewed records held to ensure the maintenance and safety of the building.

We spoke with a specialist nurse, district nurse, physiotherapist and GP during the inspection.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service. People felt comfortable sharing any concerns with the registered manager and believed their concerns would be addressed.

There were sufficient staff to meet people's needs safely. At the last inspection In October 2014 we found there were not enough staff to meet people's needs safely. We reviewed staffing and we felt this had been addressed. The majority of people felt there were enough staff to meet their needs safely. Staff said staffing level had improved since the last inspection. One staff member commented this was still a concern they had. A visitor said: "They are short staffed occasionally, in particular at the week-ends" and one person said: "No [there are not enough staff], I can be a long time waiting for things to happen". We reviewed staffing with the registered manager who maintained a clear staffing ratio. In order to keep the numbers of staff at the right level, they used agency staff who had worked there often. In this way they tried to maintain continuity for people. The registered manager advised they were still looking for a way of evidencing people's dependency needs matched the number of staff looking after them.

People were looked after by staff who were knowledgeable about how to identify abuse and how to pass on their concerns. All the staff said they would report their concerns to the nurse in charge or the registered manager. All staff were confident that they would be listened to and action would be taken to make sure people were protected. Staff said they would speak to the local authority or CQC if they felt their concerns were not being taken seriously.

Staff were recruited safely and did not start work until all checks were in place. All staff underwent a formal application and interview process. New staff completed a three month probationary period in which time they were supervised and observed to ensure their continued suitability for their role.

People had risk assessments in place to mitigate their risk of falls, skin breakdown, malnutrition and when staff supported them to mobilise. These were clearly linked to their care plans and their dependency assessment to ensure they had the right staff to meet their needs. People were not having their individual needs risk assessed when there was a specific health, medicine or behaviour need which required a risk assessment to be in place. For example, people did not have risk assessments in place when they were diagnosed with diabetes of were prescribed warfarin. This meant staff were not aware of possible side effects or what action to take, if required. We discussed this with the registered manager who put systems in place to address this immediately. A template was developed before the inspection completed with staff detailed to complete this with people over the next few days.

People's medicines were administered safely. Medicines were managed, stored, given to people as prescribed and disposed of safely. Staff confirmed they understood the importance of safe administration and management of medicines. All medicines were administered by the qualified nurses, however, they were not currently up to date with training in administration of medicines or competency checked. We discussed this with the registered manager who put plans in place to address this. Medicines Administration Records (MARs) were in place and were completed correctly. Medicines were locked away as appropriate and where refrigeration was required, temperatures had been logged and fell within the guidelines that ensured quality of the medicines was maintained. Body charts were used to indicate the precise area prescribed creams should be placed and contained information to inform staff of the frequency at which they should be applied. Some of the records of the application of prescribed creams had gaps in them. The registered manager stated they would address this straight away with staff and reiterate the importance of keeping accurate records, in a staff meeting the week following the inspection.

People were protected by staff trained in infection control procedures. Staff followed these procedures when delivering personal care. People confirmed staff always wore disposable gloves and aprons during personal care. These were then disposed of safely. However, in the laundry staff were not wearing aprons when dealing with the contaminated or dirty laundry. There were also no clear guidelines describing how cleaning equipment, used to clean up spillages of bodily fluids, should be disposed of. Instead, they were being put through a very hot wash. We discussed this with the registered manager and staff member responsible for cleanliness and infection control

Good

Is the service safe?

within the service. The latest guidelines in dealing with infection control in care homes were reviewed. Systems were put in place to ensure good infection control was followed by all staff.

Good

Is the service effective?

Our findings

People were supported by staff who were trained to carry out their role effectively. People felt staff were well trained. One person raised a concern about the use of the hoist. This was reported to the registered manager who agreed to review the person to see what could be done better. The majority of staff were trained in the provider's core subjects which included safeguarding adults, infection control, manual handling, fire safety and food hygiene. Where there were gaps; training had been planned. Staff had been trained in first aid to ensure two trained staff were on each shift. Staff were trained in managing people's catheter or PEG feed (this is where someone is fed through the abdominal wall). Staff understood how to care for these specific needs. Staff were also knowledgeable about looking after people's skin to prevent pressure ulcers and about the needs of people with diabetes.

The registered manager advised most training had been via DVDs with little external training. They had their own manual handling approved trainer. They explained they intended to improve the training available to staff. In particular, training in dementia care and caring for people with specific diagnosis such as Huntington's and Parkinson's. Staff had written information available on these conditions however, the registered wanted to better meet everyone's needs by staff attending dedicated training. The registered manager explained they had not had a budget for training until recently, therefore, it had only just become possible to put this planning into place.

New staff underwent the service's induction programme and training. The registered manager was aware of the Care Certificate which is a new national initiative to train all staff, who are new to care, to the same standard. They were currently reviewing how to introduce the Care Certificate alongside the necessary information to work at the service.

The registered manager advised staff currently had one to one supervision on an "as needed basis". All new staff had supervision and time to ensure they remained suitable for their role. Staff were supervised more closely if concerns were raised. Their competency was also monitored. The registered manager was developing a process where staff in senior roles supervised the majority of staff with the registered manager supervising the senior staff and picking up any issues. Monitoring competency and appraisal were planned for, but had yet to take place as routine.

Staff were trained in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and understood how they applied in practice. Staff knew what actions they would take if they felt people were being unlawfully deprived of their freedom to keep them safe. For example, preventing a person from leaving the home to maintain their safety without the correct authorisation in place. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty

Staff were observed always asking for consent before continuing any offer of support and care. People said staff respected their choice. One person said: "The staff come and ask if I am ready to get up but they don't push you to get up". Everyone had MCA assessments in place to address whether they had the capacity to consent to their care and if not, a best interest meeting or discussion was considered. DoLS applications had been made but were awaiting authorisation. In the meantime, the registered manager considered how to ensure people were as free as possible while acting to keep them safe. For example, people with DoLS were still considered able to go out with staff but the situation was risk assessed to ensure this could be achieved safely.

People had their needs for good nutrition and hydration met. People had regular opportunities to access food and fluid throughout the day. People who could make their own hot or cold drinks could do so freely. For others, staff offered drinks regularly or responded to requests from people. People had fresh water or juice in their rooms. Relatives and visitors could also access hot or cold drinks for themselves or their family or friends. Snacks were available with drink rounds and people could ask for extra as needed. Eating and drinking was seen as a social occasion. Meal times were a time for people, visitors and staff to eat together. People could have their food of choice. Everyone was very complimentary about the standard of the meals.

Comments were received about the food included: "The food is nice, I like the puddings especially"; "On the whole the food is very good and the chef is also very good as he

Good

Is the service effective?

does everything very well"; "The food is excellent"; "The food varies, I would like more plain food – edible; not bad" and "The food is alright, I am not very fussy". A relative said, "The food is lovely, I always have lunch when I visit".

People had their dietary needs met. There was clear communication between the registered manager and the kitchen to ensure people's food was prepared as needed. People's nutritional assessments were discussed with kitchen staff, who also had information on people's preference and allergies. People whose food and fluid intake was causing a concern was clearly monitored. Each person had been seen by a dietician or Speech and Language Therapist, as required. This ensured people's food was prepared according to their needs. People had monitoring charts in place to review this. Some of the recording on the monitoring charts lacked necessary information such as how much people had eaten. The registered manager had begun to address this before we finished the inspection.

People had their health needs met. People said they could speak to their GP as required. People felt staff helped them to understand their individual health needs. One relative said: "They explain everything and take time to make sure my parent understands". People could see an optician, dentist and podiatrist as required. The registered manager confirmed people always had their annual health care checks and medicine checks with their GP. The recording of this was not always consistent, which the registered manager advised they were addressing. The GP, district nurse and physiotherapist we spoke with were positive about the staff in meeting people's health needs. All commented that staff were up to date with people's needs so they could respond to them. Staff would contact them appropriately to visit and for advice. They felt staff always followed advice through and would feedback on this.

Good

Is the service caring?

Our findings

People told us they were happy living at Colebrook Manor and staff treated them with kindness and were caring. Comments we received included: "It's friendly here and I enjoy meeting the other people"; "It is open and friendly here; we don't squabble and there is no bullying or shouting"; "The home is friendly, people chat away and we can choose what we do"; "It's good here, all of us get on well".

One person's relative said: "My parent [had tried two other homes]. This one is so much better [for them] and they are happy, smiling and comfortable. They keep saying 'I'm happy being here'". Another relative said: "I find the home to be friendly and so full of life, the staff are always cheerful". All relatives told us they felt welcomed. People said their visitors were welcomed at any time of day or evening and offered refreshments. Relatives confirmed this and one said that in view of the distance they travel they always booked a lunch. On one occasion the chef offered them an extra alternative from the items on the day's menu, which they were pleased to accept.

People were observed to be happy in the company of staff. The atmosphere in the service was full of conversation, laughter and a constant buzz of activity. People freely moved about the building. Staff support was given to those who required assistance. Staff were observed to stop and talk to people as they walked around. People were always greeted by their chosen name and with warmth. Appropriate humour was heard often. People were encouraged to develop friendships and met in the lounge, dining room or while doing activities, to continue their acquaintances. People asked about people who were poorly or not at lunch. They were also supportive and caring to people who were forgetful and gently reminded them what they had been talking about.

People were in control of their care and staff listened to them. We observed staff always included people in any discussion about them and included them in planning what was going to happen next. People said they could choose how to spend their day. People could take part in an activity in the home or have time on their own. People said they went to bed and got up when they wanted to. They could eat in the dining room or their bedrooms. People could go out into the community when they wanted. For example, one person could use their disability scooter. Staff booked taxis for people. Staff supported trips out or people could book their own carers from other registered services if that was their preference. People said they could have a shower when they liked. People were choosing not to have a bath. The service had been without a bath for some time and the registered manager was going to see if people would like to give the new bath a try. This was to find out if not having a bath had become a habit but they would like to have one once they tried it.

People felt staff protected their dignity. We observed staff offered support to people in the lounge and dining room discreetly. For example, one person was supported to eat in their own time and the staff member spoke with them often. The person was asked if they wanted more, a drink or a break at regular intervals. The timing of what happened was the person's own. Conversation about everyday life, such as the weather, was also part of the scenario. One person said: "They always knock on the bedroom door and also close the bathroom door and curtains [at times of personal care]". One person raised a concern about an incident when a staff member caused them a concern about their dignity, which was shared with the registered manager who spoke with staff in handover to remind them it was important people's dignity was respected at all times. People said new staff were introduced to them and then shadowed an established member of staff before looking after them on their own.

Staff spoke about the people they were looking after with fondness. Staff identified the atmosphere had improved since we were last at the service. One staff member said: "It has most definitely changed; I love the home and feel part of a family. The registered manager has encouraged the staff to be a team and staff communicate with people now; we think outside the box for them". Another new staff member said: "It feels like a happy atmosphere; It's lovely here." They added, they had been welcomed by people and staff and made to feel very welcomed.

People's end of life choices were not currently being recorded consistently, however, the service were addressing this. A member of staff was to become 'End of Life Champion' and another was working with people to complete their 'This is me' booklet which would look at all aspects of their life. It would also begin the process of encouraging people to think about their advance decisions in respect of their end of live. The registered manager explained they had been on training through the local

Good

Is the service caring?

hospice and were working with the end of life champion to build this learning into how the service and staff responded to peoples' end of life choices. The district nurse and GP confirmed they had no concerns about how the service had met people's end of life.

Good

Is the service responsive?

Our findings

People felt confident they were receiving the care appropriate to their needs. People had care plans in place. This was a great improvement since we last inspected the service. We found all the people who were at the service long term had clear care plans in place. These were person centred and reflected how the person wanted their care delivered. There was a gap in the recording in respect of specific conditions such as diabetes or those which required warfarin (a blood thinning drug), and ensuring staff had enough information to meet these needs and what to do in the event of something not being right. Some people's daily records also lacked enough detail about how people passed their time. The registered manager had recently reviewed the care planning process and felt this could be improved. The new care planning process was being trialled with a person who came to live at the service on the second day of the inspection. The new style of care plan addressed the issues we raised.

There was no evidence in peoples' records that their care plan had been discussed with them. People had some knowledge of a care plan which they said was discussed with them. Relatives were familiar with the care plans and said they had been involved in the planning and making decisions about their relative's care. Relatives felt they were kept up to date with their relative's needs. They were always spoken to in person or by phone. The new care planning process would ensure staff were evidencing people or their representative were involved in the care planning and review process.

People on respite did not have adequate care plans in place to ensure staff had the right amount of detail available to them to deliver care appropriately. The goals of the person being placed with them was recorded. However, there was no information on how staff could support that person to reach their goal. For example, one person was with them to rehabilitate following a fall which resulted in a fracture, but there was no detail on what staff would do to support that person to rehabilitate. The physiotherapist we spoke with stated that the most important thing for most people who were rehabilitating to go home was to show the person could use stairs, go to the toilet by themselves (even if this was a commode) and to mobilise safely. The person we reviewed had none of this detail in place. We discussed this with the registered manager who immediately developed a new shorter care plan for people on respite and started to review this with the person we reviewed. They advised they would ensure this was the case for all people on respite who were currently residing at the service and for any new admittance.

People were provided with activities to remain physically, cognitively and socially active. People's religious needs were met. The service employed an activity coordinator. There was a programme of activities developed with people but this was flexible. People were involved in making Halloween decorations but could also have their nails painted or chose another activity to do alongside the main activity. The activity coordinator was also involved with supporting people to fill in their 'This is me' folder. People were heard discussing their past lives together. There was appropriate humour for happy times and support when sadder times were shared. The activity coordinator visited people when they first came into the service and people who chose to stay in their rooms. They understood the need to support people emotionally when they first came to live at the service. The activity coordinator gained trust from people to allow them time to become familiar with the idea of activities. For example, one person was supported through one to one conversations with the activity coordinator then encouraged to visit the lounge. They were now eating their lunch in the dining room and taking part in activities.

People were provided with the service's 'Philosophy of Care' and complaints policy. This was so they could raise concerns if they were not receiving the expected standard of care. No one said they had made a formal complaint and none were recorded to review since the last inspection. The registered manager explained people were encouraged to share their concerns no matter how small. They added, they aimed to deal with issues quickly to prevent them becoming larger. The nurse in charge generally dealt with people's concerns with anything serious passed to the registered manager. People were then kept up to date and were spoken with to ensure they were happy with the outcome. People felt comfortable sharing their concerns with staff and their needs would be addressed. They would ask to speak to the registered manager if needs be. The registered manager advised they were looking at recording people's concerns to ensure they were identifying any themes or learning which could be applied to improve everyone's experience of living at the service.

Requires improvement

Is the service well-led?

Our findings

Colebrook Manor was owned and run by Blue Mar Ltd. They run two care homes in England. There was a nominated individual (NI) in place who is accountable for the service at the provider level. A registered manager was employed to run the service locally. They had a team of people to support them in this process. There was a clinical lead, nurse in charge of each shift and carers who were senior in role. These staff took responsibility for some aspect of running the service. The registered manager explained they were trying to empower staff to take lead roles.

We spoke with the NI during the inspection as there was no evidence of the provider acting to ensure the quality of the service. The registered provider was not currently carrying out quality audits of the service to ensure the standard of the service was appropriate. The registered manager also expressed concerns the provider was not providing adequate support to enable them to carry out their role fully. We spoke with the nominated individual who explained they, and those investing in the service, had spent March to September 2015 consolidating the finances of the service. They explained they had reports from the registered manager on the progress of the service. They were now in a position to facilitate the quality, stability and growth of the service. Further investment had been put into the service. Budgets had been developed and Colebrook Manor should now receive dedicated attention from the NI. The NI stated: "This is people care and we don't just look at the bottom line". The NI also told us they were going to review the management of the service the week following the inspection during a planned visit. This would offer the opportunity for the registered manager to discuss the management needs of the service. They would then look to develop the appropriate management of the service. This would include a clear quality audit process by the provider.

The registered manager had a number of audits in place to monitor the quality of the service. This included the administration of medicines, care plans and infection control. Water temperatures were being taken to prevent scalding however, there was not a current legionnaire's check in place to ensure the water outlets were safe. There was also no audit of people's falls to see if there were lessons which could be learnt for all people living at the service. Also, there was no regular check to ensure the fragment of the building was safe. The registered manager started to look at putting these in place straight away with key staff best place to complete these audits. They showed us audits they had developed or sourced.

People, relatives and staff spoke positively about the registered manager who they felt was approachable. People said they saw the registered manager often. For example, one person said: "I see the manager when we have something we want to talk about" and another. "The manager eats with us sometimes. She is very nice". The registered manager confirmed they walk round the service regularly, work alongside staff sometimes and attend staff handovers to see if there is anything they need to follow up on.

People were asked to contribute ideas to the service through regular meetings. They had been asked often about the food/meal planning. The service was still undergoing a programme of refurbishment. People had been consulted about this. People were only moved to other rooms with their permission and kept up to date on the progress. They were consulted how they would like 'their room' to look.

Staff also felt they could volunteer ideas about how the service could run better. Staff said they felt this had improved since we last inspected the service. They felt the registered manager had brought a sense of order to the service and openness in culture. Also, staff felt their roles were now clearly defined and they felt confident to carry this out as a result.

The registered manager understood their role in relation to the duty of candour. That is, they understood the requirement to act in an open and transparent way with people and their families if things go wrong. The registered manager explained they would sit with people and their family and explain what had happened, apologise and put an action plan in place to everyone's satisfaction.

There were contracts in place to ensure the utilities and equipment were maintained. Clinical and domestic waste were removed by appropriate contractors.