SA & JO Care Limited

Crouched Friars Residential Home

Inspection report

103-107 Crouch Street
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The unannounced comprehensive inspection of this service took place on the 3 May 2016. Crouched Friars Nursing home provides accommodation and personal care for to up to 56 people. Some people at the service are living with dementia. At the time of the inspection, Crouched Friars was home to 48 people.

A long standing registered manager was place. 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.

This service was rated as Good overall with Requires Improvement in the 'Effective' domain.

Relatives told us that the manager and care staff were extremely approachable, available, and willing to listen. People at the service told us that they were very happy with the care they received and their relatives told us the registered manager and staff team were excellent and provided people with the support they needed in a dignified and compassionate way.

The service ensured that staffing levels were adequate and enough staff were employed to meet people's individual needs. The service had retained a strong core team of staff who knew people at the service well. Staff told us that they enjoyed working at the service. The registered manager increased staffing when people health was deteriorating in health or at the end of their life. The service had safe and robust recruitment procedures.
Staff had received mandatory training and training updates. The registered manager also provided additional training to staff to meet the needs of people at the service.

The service worked collaboratively with health and social care professionals to meet people's health needs. Qualified nurses managed medicines safely. The deputy manager carried out regular checks of staff competency and medicine audits to ensure that they were being administered correctly.
Care plans, and risk assessments were individualised and updated regularly or when people's needs changed.
People received freshly prepared meals that considered their individual likes, dislikes and health needs. Relatives were enabled to join their loved ones for meals if they requested to. A variety of hot and cold drinks

were available throughout the day if people wanted these.

The service did not always carry out appropriate Mental Capacity Act (MCA) assessments on people and did not apply for Deprivation of Liberty Safeguards (DoLS) when people lacked the capacity to keep themselves safe.

This was a breach of regulation 11 (1) of the Health and Social Care Act. You can see the action we have asked the provider to take at the end of the report.

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.

Staff understood safeguarding procedures and how to keep people safe from harm.

The registered manager carried out thorough risk assessments and appropriately communicated risks to others so that they could be managed.

The service accessed appropriate equipment to keep people safe in the least restrictive way.

The registered manager and senior staff carried out regular supervisions of staff, including observations of staff care practices, taking action to improve care standards when the need was identified.

The manager accessed additional staff if these were needed. For example, existing staff sickness or high activity and need levels.

Medication was stored and administered safely by competently trained staff.

The service communicated well with health and social care agencies to ensure that people were kept safe.

However, we found two manual handling assessments had not been updated with current information.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not compliant with Deprivation of Liberty Safeguards.

However,

Recruitment process were robust and interviews were values based.

Staff received a good induction into the service and their roles and responsibilities.

Is the service caring?

Good

The service was caring

Staff treated people with dignity and respect.

Staff respected people's wishes and were sensitive to individual needs and personal preferences.

The registered manager held regular community meetings to include people in the running of the service.

People receiving end of life care were treated with dignity and compassion.

Is the service responsive?

Good

The service was responsive

People at the service were supported to access a variety of health services in a timely way to meet changing health needs.

People and relatives were involved with care planning to met their own individual needs.

Regular reviews of peoples needs were carried out and care plans adapted to reflect changes.

However,

People did not have a copy of their care plan.

Is the service well-led?

Good

The service was well-led

The registered manager and deputy were visible and approachable.

The registered manager consistently ensured that staff had the skills necessary to care for people in a safe and caring manner.

The registered manager listened to people at the service and used information to make improvements to the running of the service.

Crouched Friars Residential 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 the 3 May 2016 and was unannounced. This inspection was carried out by two inspectors, and an expert by experience. An Expert by Experience has personal experience of using or caring for someone who uses a health, mental health, and/or social care service. Our Expert by Experience had experience of supporting a person with dementia.

Before inspecting the service, we looked at all the information that we held about the service on our systems. This included notifications that the service had sent us.

During the inspection, we talked with 12 people who used the service and five relatives. We spoke with the local safeguarding authority and two social care professionals and interviewed six members of staff. We reviewed care plans, care notes and risk assessments for six people at the service. We also reviewed the services policies and procedures and any incidents that had been recorded in the last 12 months.

Good

Our findings

Recruitment processes were robust. Potential staff had to complete an enhanced criminal records clearance and provide two references from previous employers, before they could commence work. One relative told us, "The registered manager is brilliant; she makes sure that she has the proper people for the job."
Staff we spoke with were confident in describing what constitutes abuse and how to protect people from harm.

Care staff received safeguarding vulnerable adults training as part of their mandatory training from the registered manager at yearly intervals, and was able to describe what the whistleblowing procedures entailed. The registered manager had investigated safeguarding concerns raised against the home thoroughly. The registered manager and deputy manager carried out risk assessments of people's needs. People's assessments were reviewed at six monthly intervals, or earlier if a person's needs changed. These were individualised and identified varying levels of risk.

However, we found that whilst these covered all areas of risk, they did not always include most current information. For example, two people's manual handling assessments stated that they were not at risk of falls, but evidence for other parts of their care plans and records indicated that they were. One person had a body map, where they had received bruising to the face from falling and who walked with the aid of a walking frame were short distances. We did not see evidence that the person had received a falls assessment, or had, had appropriate professional input following the fall.

The service had good systems in place for assessment of manual handling equipment such as specialist high low beds and sensor mats for people identified as having a risk of falls. Staff had appropriate training to safely move people, and we observed them using the manual handling equipment appropriately.

The service also carried out monthly bedrails assessments, including capacity assessments for the use of bedrails for people at risk of falling out of bed. These were reviewed monthly so that the least restrictive option could be considered. When people lacked capacity to consent to the use of bedrails, options were discussed with their next of kin who held power of attorney for health care and were legally able to make these decisions.

On the day of the inspection the service was adequately staffed and staff were available to meet people's needs. The registered manager and deputy manager also provided assistance throughout the day and

people told us they were always available to lend a hand if needed. We saw that when the needs of people were high, the registered manager was able to get an extra member of staff. They service rarely used agency staff, preferring to offer regular staff overtime. Rotas demonstrated that staffing remained constant.

The service had robust policies, procedures and practices in managing medicines. Staff had appropriate training in medicine management, and the registered manager and deputy undertook regular observations of staff providing medicine administration every three to four months to ensure that they were competent in this task. Medications were stored appropriately in a clean and organised clinical room. The service had a good relationship with a local pharmacy who was within two minutes walking distance, and staff could contact them for advice when needed. Most medicines were dispensed in blister packs, but we saw that staff checked these against the medication administration record (MAR) to ensure that people received the correct medicines. District nurses attended the service to support people at the end of their life, who might require more specialist medicine administration such as syringe drivers to be managed.

Staff monitored fridge and room temperature's where medicine was stored. Fridges were defrosted monthly in line with the medicine policy. All medications were audited monthly by the pharmacy, and the deputy manager carried out medicine audits to ensure that staff were administrating medications! safely. When staff had queries over medicine, they obtained professional advice appropriately and acted accordingly.

Staff had access to appropriate protective wear, equipment, and appropriate waste disposal. Cleaning duties were in place and audited regularly and the environment was clean. Staff were trained in infection control and we saw that staff adhered to infection control preventative measures.

Our findings

Staff had received mandatory training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The 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. However, the staff, including the registered manager who provided the training, did not have a good understanding about how DoLS was implemented to safeguard people and had felt that it was a restrictive practice.

Whilst the service had carried out a variety of capacity assessments appropriately they had not carried out appropriate capacity assessments for people around leaving the home alone when they suspected that they did not have capacity to do so safely. This meant that they had also not or applied for a Deprivation of Liberty Safeguard (DoLS) to keep the person safe. DoLS provide legal protection for people aged 18 and over who are, or may become, deprived of their liberty in a hospital or care home.

We saw evidence in incident logs that one person who lacked capacity due to dementia had left the home to find their friend. Staff had contacted the police when the person was found to be missing and they were brought back to the service by an ambulance. It was not documented if the person had consented to return to the service. However, staff told us that the person had often tried to leave, although they could be distracted to remain. Following this incident the registered manager had taken measures to ensure that people could not leave the service without staff knowledge. This meant that potentially people would be restricted from leaving the service. We looked at the records we held and care plans and care notes of people at the service, and found that although the service had a number of people in residence that lacked capacity, some of who did make requests to leave the home, the registered manager had not applied of any Deprivation of Liberty Safeguards (DoLS). At the time of inspection, no one who lacked capacity had been referred for a DoLS assessment and should they have tried to leave the home had limited powers to prevent them to do so.

This is a breach of Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014, Need for consent.

However, all care files we looked at did contain mental capacity assessments around every day decisions, such as washing and dressing. These supported staff to be aware of what decisions a person was able to make. We saw that staff asked people for their consent before providing care and support. Daily care notes

documented that staff requested peoples consent and people at the service confirmed this.

Staff underwent good induction processes, receiving all mandatory training during a two-week induction period. The registered manager provided most of the staff mandatory training and had gained a certificate in adult training to help them develop their skills to do so. Mandatory training included moving and handling, medication training, health and hygiene, safeguarding vulnerable adults, fire training, basic first aid and infection control. Senior staff carried out observations to new staff completing care tasks to ensure that they were competent.

The registered manager and deputy manager carried out group and individual supervisions every other month. During these meetings staff would discuss what had gone well and what had been learnt from incidents. They also discussed training needs and other issues to support staff in their roles.

We observed that staff provided care and treatment in line with the services policies and procedures. The registered manager carried out observations of staff providing care to people to ensure that they were able to able to carry out care competently. We checked staff files and could see that these observations had taken place and that when needed the registered manager took action to support staff to improve their practices, for example, providing additional training, or training refresher courses.

Staff had received additional training to support people at meal times if they required. This included feeding each other with a variety of foods, including foods and drinks that had been thickened. Staff told to us that this had been a helpful exercise in understanding what it was like to be fed by someone else and how this could impact on a person's dignity and ability to enjoy their food. We observed staff engaging with people throughout meal times and this made the dining experience enjoyable for people. Staff were particularly sensitive to the needs of people who had dementia and required support with eating.

One person with dementia was observed to keep leaving the table. Staff gently encouraged the person to engage with the mealtime experience and this demonstrated to us that they knew the person's needs well. We observed staff watching carefully to see if anyone needed assistance. Staff appeared to know who needed more assistance than others. We saw that meal times were calm and unhurried. Where people required support to eat, staff seated themselves next to them appropriately.
People who used the service and their relatives described the food as good. There was always at least two choices and additional snacks and meals could be offered if requested. One person told us, "The girls know what food I can eat, the staff always cater for my needs." The staff serving meals were aware of people's preferred portion size and preferences. Meal times were observed to be a social occasion and people were sitting with each other and chatting whilst eating.

Staff received training in, and carried out nutritional risk assessments using the Malnutrition Universal Screening Tool (MUST). This is a recognised method to assess people's nutritional state. The registered manager told us that people's weights were monitored monthly; however, whilst this was mostly the case, we did observe that in all files reviewed there was no recording for the previous month prior to the inspection.

When people's weight had deteriorated, we saw that staff had made appropriate referrals to the dietician for a nutritional assessment. The registered manager knew how to make referrals to the dietician for a nutritional assessment, for example, when people experienced difficulty with their swallowing.

The registered manager worked closely with GP surgeries, the local pharmacist, social workers and other health and social care professionals to advocate for people's physical and mental health needs. They had

also arranged for training talks to be delivered to staff, for example on insulin delivery and blood sugar monitoring for people with diabetes. Staff told us that this had enhanced their understanding and knowledge of the condition and how to support people with it. Qualified nursing staff had undertaken a yearlong part time course in diabetes management.

Referrals were made quickly to appropriate health and social services when people's needs changed. However, it often depended on the waiting lists of the other agencies on how quickly people would be seen. When referrals were taking longer than planned for initial assessments we saw that the registered manager and senior staff would follow these up and record the responses. Care plans were updated so that staff could try and manage potential risks.

The registered manager ensured effective management of the needs of people at the service with sensory impairment, such as sight problems and hearing loss. For example, if a hearing aid broke, or went missing, the registered manager followed this up with the audiology department at the local hospital in a timely way to minimise effects of the impairment on the person.

Good

Our findings

People told us that they felt that their opinions were important and that they mattered. Four people we spoke with told us that the staff were really caring. One person told us, "I am very happy here, and I can do what I want." One person told us that they had been offered a bigger room and they "loved it."

People looked well cared for, clean and presentable. We saw that some female residents wore jewellery and had been supported to put make up on. Staff told us, "Some people are very proud of their appearance and we try and support this."

We observed staff using a hoist to move people from one chair to another. Staff explained what they were doing throughout and paused when needed to ensure that people's dignity was maintained, For example, readjusting their clothing to maintain their dignity whilst they were being lifted from their seat.

People's dignity and privacy was respected. One person told us how they liked to remain in their bedroom and how staff respected this and always took time to pop in and check on them, they told us, "I don't ever feel I have to do something I don't want to. The staff really respect my privacy."

Staff behaved in a caring and compassionate manner to people at the service. We observed a member of staff comforting a lady with Dementia, walking beside her and gently massaging her hand to comfort her. When people were nursed in their bedrooms, we observed staff regularly checking them to make sure they were comfortable.

One person said, "The manager is a lovely lady, she always comes into my room to have a chat." A relative told us, "Staff show great affection for people here. My [person] used to come home for visits but now they do not want to. They love it here so much. It is their home. When I do manage to take them home they just ask me when they can go back."

People were supported to express their views in monthly resident meetings. We saw minutes of the meeting were people were involved in the running of the service, for example what food they liked to eat and activities they enjoyed. Feedback people gave during the meetings was positive and staff acted on it when suggestions were made such as changes to the menu.

The registered manager told us that they were committed to supporting people at the service to maintain relationships with loved ones. A relative told us, "They are really good here. If I come at meals times I always

let the registered manager know and they offer me a meal so I can sit with my [Person]. It's really lovely that we can enjoy it together, it's really important." The registered manager told us how important it was for them that people at the service could eat with loved ones as they would be able to do in their homes before. She told us, "This is their home after all."

Staff at the service supported people receiving end of life care with compassion. One person spent long periods nursed in bed. They no longer were able to verbally communicate, but we saw from observations and care notes that staff regularly checked in with them and spoke to them gently and sensitively. We saw that soft music was being played in their bedroom and the person seemed relaxed. Staff told us, "The music helps to give them some stimulation." We saw that staff assisted the person to eat in a sensitive and caring way. This demonstrated that staff knew people well and how to support and comfort them.

Good

Our findings

People at the service told us that they felt their needs were being met and that they received an individualised service that supported them to remain as independent as possible. One person told us, "I can come and go as I please." Another person liked to have an evening alcoholic drink every evening. Staff made sure that they could facilitate this and the alcohol was stored in the locked medicine room, and staff had to sign it in and out. This was reflected in the person's plan of care and we saw that staff respected this.

The registered manager talked to people at the service and, where appropriate, their family members about care plans and encouraged them comment and review the suggested care interventions.

Care plans detailed people's needs and risks, taking into consideration their preferences, likes, and dislikes. Monthly reviews looked at any changes to people's daily routine, their mobility, pain relief and any other changes affecting them. We spoke with staff who knew people very well. One person told us "I don't leave my room very much, I prefer it in here, but I love talking to people. The manager went out of her way to look into different services that would help me. This included contacting the befriending service."

However, people did not have a copy of their care plans. The registered manager told us that this was because people in the past had written on them and they had been mislaid. People we spoke with who had capacity told us that they knew they had care plans but did not know what was in them.

The service employed an activity co-ordinator who worked week days and some weekends. The activity care co-ordinator did provide some assistance with people's care tasks if needed, but also provided one to one time and social interaction for people. These interactions included art, puzzles, and group activities if people wanted to do this. People were supported to follow their own interests and make choices about their care, treatment, and everyday lives. One person told us, "I wanted to keep my own hairdresser and it wasn't a problem." Another told us, "I really enjoy colouring and the staff support me to do this. Sometimes they do it with me." A relative told us, "Staff always encourage social activities." Five people told us that they could join in activities, as and when they wanted to.

The registered manager looked for opportunities to enhance the quality of people's lives. They had developed good relationships with a local charity organisation called FUNS who helped to raise money for additional activities such as trips to the cinema, theatre and the seaside. Regular staff were paid for their time to support people on these outings and relatives were also encouraged to come along. This meant that people could access a variety of different activities in the wider community.

People at the service were able to get involved in fund raising for different community projects, such as Help the Heroes. The registered manager told us about a recent activity where people made cupcakes with staff and were able to sell these to their relatives and the staff. She told us it gave people a sense of purpose. We saw photographs of the day and people appeared to be enjoying themselves.

People had six monthly care reviews and when appropriate relatives were invited to these. For example if a person wanted them at the review or when a person lacked capacity and a relative had taken on the responsibility of their Power of Attorney.

People told us that if they had any complaints they would speak to staff. People told that us they could always speak to the registered manager and she would follow up any concerns. One person told us, "I can always speak to the manager she is very kind to me." Four relatives told us, they could speak to the manager at any time and she would deal with any issues they had. We saw that the service had a formal complaints procedure which set out how a complaint would be dealt with.

The service did listen to and investigate complaints appropriately, in particular to complaints by relatives of people who used the service. However, the service did not always agree with the complainant, and this at times had caused for relations between relatives and the registered manager to become strained. In the complaints we reviewed we found that the service had acted in the best interests of people at the service and had advocated for people in conjunction by seeking appropriate advice from other health and social care professionals.

Good

Our findings

The registered manager and deputy manager provided visible leadership within the service. Staff told us that managers were approachable and available at all times and led by example. One relative told us, "The manager is very good she knows everything that is going on with the residents." Another told us, "The [manager] really knows what is going on and is always on the floor checking that people are being looked after well." One member of staff told us, "The manager's priority is always the quality of care that our residents receive."

We observed the registered manager and the deputy manager interacting with people in a caring and compassionate manner. Relatives and people who used the service knew the managers by name and told us that they were visible and approachable. One person told us, "The manager is really approachable, I can speak to her about any worries I have."

The registered manager told us if when needed, they worked alongside care staff and lead by example. This included times when staff had phoned in sick and in emergencies. Staff told us, "The managers are really good, if I don't know what to do or need additional help and it's out of hours, one of them will come in to support us to keep people safe."

The service had regular resident and relative meetings. Minutes taken from these meetings demonstrated that people were involved in the day-to-day running of the service, from issues such as food choices and activities, to what colour carpets would be laid. There was a clear plan of improvement for the service and the manager told us how they were updating the bathrooms one by one.

Staff told us they enjoyed working at the service, "I enjoy working here. Morale is good and the manager is approachable." We saw evidence of meeting minutes where staff had been able to raise concerns or make suggestions for improvement. An example of this was practical teach sessions when staff could practice how to support people, such as feeding each other.

Regular meetings, supervision's, and daily handovers kept staff informed about service changes and expectations. We saw that staff received one to one supervisions from senior staff every two months, or sooner if the need arose. For example, to address staff performance issues. Staff told us that they found supervisions useful as they discussed areas of good practice, improvement, and any training needs. We saw evidence in staff files that the manager investigated these thoroughly to ensure that people and colleagues were safe and that appropriate performance management took place. All staff we spoke with told us they

could speak to senior staff at any time they wanted, they were always available for support and advice. Senior staff carried out regular care observations to ensure that staff were providing care competently with respect and dignity.

We saw from meeting minutes that staff had not been getting along. The registered manager and deputy had not ignored the issue and had spoken to all staff concerned to remind them of their responsibilities and expectations of the service and people they cared for.

The manager carried out a range of audits to monitor quality within the service. These included health and safety checks, monitoring the management of medicines, care plans, and risk assessments, and infection control monitoring. The service learnt from incidents and accidents and we saw that the registered manager had investigated these thoroughly to understand how they had occurred and developed actions to minimise future risks.

The service carried out a yearly satisfaction survey or people living in the service and their relatives. At the time of inspection, these had been collected in and were due for review.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The service did not apply for deprivation of liberty safeguards when people lacked capacity to keep themselves safe.