Care South

St Martins Grange

Inspection report

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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

This inspection took place on 5 November 2015. It was carried out by one inspector and one Specialist Advisor.

St Martins Grange is purpose built to accommodate up to 75 people. It has four individual units which are spread over two floors. The ground floor accommodation consists of Birch (20 beds) and Fern (12 beds) both of which provide residential care. Upstairs consists of Willow (18 beds) and Oak (25 beds) both of which provide nursing care. Some people living in the home had complex physical health needs and some people were living with dementia. On the day of our inspection there were 68 people living in the home.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

St Martins Grange opened in June 2015. It was established following a merge of two former care homes. There had been significant changes for people and staff. The registered manager took the lead to support people and staff in the changes that had taken place. They had taken steps to ensure people had a smooth transition.

Summary of findings

People had clear, person centred care plans however there were sometimes gaps in recording specific information. For example, staff did not always sign to say when cream had been administered or when a person had been repositioned to protect their skin. There were inconsistencies in people having their care plans reviewed.

There were insufficient quality checks in place which meant that these gaps were not picked up and no were actions taken.

There was regular use of agency staff to cover the shifts because of staff vacancies. The registered manager had advertised and recruited staff however they were unable to start employment as there were delays in the criminal records checks being returned.

People and staff told us staff had the right skills and experience. Staff told us they received supervision and appraisals and were encouraged to develop their skills through training such as apprenticeships. The training records were unclear as they were in the process of being put together. However the residential manager was able to talk us through the training requirements and the training that had been attended.

People were treated with kindness and respect. Staff were patient and courteous and responsive to people when they were distressed.

People had the opportunity to participate in social activities which included one to one time with staff. People's interests and hobbies were recorded and staff involved them in planning events and day to day activities. People living with dementia had some specific resources available for example memory boxes.

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

People were cared for by sufficient staff. However there was regular use of agency staff to cover the roster. The provider had taken steps to recruit new staff and was waiting for all the appropriate checks to be completed.

Medicines were stored and administered correctly.

People were at a reduced risk of harm and abuse because staff had received training and knew how to recognise signs of abuse. Staff knew how to report abuse.

The home was clean and tidy and the service was following correct infection control guidance.

Is the service effective?

Good

People received care from staff who had received appropriate training. However the training records for staff were in the process of being standardised as two staff groups had merged when St Martins Grange opened.

Staff understood the principles of the Mental Capacity Act (2005). The registered manager had made the appropriate DoLs applications to the local authority for people who had restrictions of their liberty.

People received sufficient food and drink and were able to influence the choices available on the menu.

People had access to healthcare and the service had good working relationships with healthcare teams.

Is the service caring?

Good

People were treated kindly and compassionately.

People were treated with respect and had their dignity and privacy maintained.

People were involved in making decisions about their care.

Is the service responsive?

Good

People had clear person centred care plans, with information about their likes, dislikes and preferences.

People were offered choices of social activity.

Summary of findings

People knew how to raise concerns and concerns were investigated by the registered manager.

Is the service well-led?

Requires improvement

The service was not always well led. There was insufficient quality monitoring systems in place. Quality checks on care plans did not always happen and therefore the service did not robustly identify when there were gaps in recording.

The management team were available and approachable. Staff told us they had good support and felt encouraged.

St Martins Grange

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 5 November 2015 and was unannounced.

The inspection was carried out by one inspector and one Specialist Advisor, who had experience in nursing and nurse education.

We did not request a Provider Information Return (PIR) from the service before the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, before the inspection we looked at information we had about the service, including notifications from the provider and information from the local authority. At the inspection we asked the provider to tell us about anything they thought they did well and any improvements they planned to make.

We spoke with seven people and two relatives. We also spoke with seventeen staff which included the registered manager, the operational manager and the residential manager. We looked at thirteen care plans and six staff files. We also spoke with two healthcare professionals and contacted a representative from the clinical commissioning group. We saw six weeks of the staffing rota, the staff training records and other information about the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

The registered manager was open with us and told us the service had a number of staff vacancies. They discussed with us how they managed to ensure the duty rota was covered. They used either agency staff to cover the gaps in the duty rota or regular staff worked extra hours. The duty rosters evidenced there were sufficient staff on duty.

Agency staff were being used regularly to cover care worker shifts on nights. The registered manager told us they aimed to use regular agency staff and booked staff one month in advance. Agency staff were provided with written information about people and their routines and an induction sheet with useful information such as telephone numbers. People and staff told us agency staff were caring however one person commented they found it unsettling having a strange face wake them up in the morning or help them to bed at night.

The registered manager was confident that staffing would improve once new staff were able to start work and the use of agency staff would reduce. The management team had taken steps to recruit new staff. 16 staff, which included 14 care workers and 2 kitchen assistants had been offered jobs. The provider had followed appropriate recruitment procedures and had requested criminal records checks. Unfortunately there were delays while certain checks were carried out which were beyond the providers control. The registered manager was following correct procedure and would not start new staff until they had received confirmation that they were safe to be employed to work in an environment with vulnerable adults.

Medicines were recorded on a Medicine Administration Record (MAR) and were administered correctly. There was a system for checking the MAR sheets to ensure people had received their medicines. Medicines were stored safely and at the correct temperatures. There were different suppliers of medicines on both floors; this had potential for causing some confusion for staff as there were different ordering and delivery systems. This was being resolved and as from January 2016 medicines were to be provided by one pharmacy.

Nurses did not use safety needles in accordance with Health and Safety guidance to protect staff from needle stick injuries. There were some available however, one nurse told us they were using up a stock of ordinary use needles first. The operational manager was aware of the guidance and they planned to fully implement the use of safety needles. These meant measures would be available to minimise the risk of needle-stick injuries to nurses.

People were at a reduced risk of harm and abuse. Staff had received training and were able to talk with us about how they would recognise abuse and what actions they would take if they suspected a person was at risk of harm. The registered manager knew how to report potential abuse. People told us they felt safe living in the home and one person told us they felt unsafe before moving from their own home into the service and they felt “reassured now.”

The service used standard documentation which included specific risk assessments. For example, there were risk assessments to identify if a person was at risk of falls, or weight loss and to identify if they were at risk of developing a pressure sore. When a person was identified as being at risk, the care plan provided guidance to staff to manage and minimise the risk For example, some people were identified at risk of developing a pressure sore. The care plans gave specific guidance on the use of pressure relieving equipment such as a pressure cushion and pressure mattress, which were particular to the individual. They also detailed the frequency of repositioning the person and staff were required to record this.

Healthcare professionals told us they gave staff guidance regarding how to safely manage people’s risks and they were confident that staff followed the advice given. For example, one person was at risk of skin damage, staff followed the recommendations and when the healthcare professional reviewed the person there was no longer any signs of skin damage.

There was a maintenance schedule which indicated which contractors conducted relevant checks or if these were carried out by the home. We saw that some of the assisted baths and hoists were overdue a service and this was raised with the registered manager, who followed it up with the contractors to take action. Other checks, for example the lift, fire and window restrictors had been carried out. The home employed a maintenance person and staff were able to report maintenance requests directly so that they were resolved promptly. They told us a new member of staff had been appointed who would provide them with some support.

Good

Is the service safe?

The home was clean, tidy and odour free. Personal protective equipment was widely available for staff use which prevented the spread of infection, for example use of disposable gloves and aprons. Staff received training in infection control, they followed the correct hand washing procedures and there were the appropriate waste disposal systems. People who required the use of a hoist had their own sling specific for their use which was cleaned as required. Multiple use equipment, for example ambulatory hoists were not labelled with anything to indicate they had been cleaned between each use, however staff told us they routinely clean equipment each time it has been used.

Good

Is the service effective?

Our findings

People were supported by staff who had the appropriate skills and experience. When St Martins Grange opened the staff from the two previous services amalgamated. Staff told us the training requirements were different and this meant the existing team at St Martins had experienced different methods of training and assessment of their skills. One member of staff told us it created some difficulties as "different staff had different ways of doing things." The registered manager was aware of these issues and was working to standardise practices and training requirements throughout the service. The training records were in the process of being updated to reflect the new team.

The essential training covered a range of subjects, including infection control, health and safety and dementia awareness. The methods of delivery were either face to face or by e-learning. The registered manager told us the team were in a transitory phase however was able to demonstrate to us that staff had received the required training or were booked to complete it. For example, some staff had attended moving and handling training the week of our inspection, further staff were booked to do it the following week. Some staff had not received refresher training in fire safety however this was booked for December 2015. The residential manager told us staff had received on site induction in fire safety.

Staff told us they had a comprehensive induction and had opportunity for further learning. They told us they were actively encouraged to develop and enhance their skills. One care worker told us "I have personally had a lot of training." Another care worker told us they had signed up to do an apprenticeship. The service had signed up for the Care Certificate for new staff which would involve a three month induction period. This provided a standard, minimum level of training for care workers.

There was a system for ensuring staff received supervision in keeping with the supervision policy. Staff had one observational supervision session followed by two one-one sessions and then an annual appraisal, Staff told us they felt this was sufficient and they could request support in between planned sessions.

Staff understood the principles of the Mental Capacity Act (2005) and how it applied to their work. . They sought people's consent as part of the care planning process and when carrying out day to day care. For example, we saw staff approach people, greet them and explain what they planned to do and ask permission. We checked with staff what they would do if people declined and staff were able to describe various responses. For example one care worker told us they would check the person understood and they would offer choices, such as another care worker/ alternative time.

Some people lacked mental capacity to make some decisions; we saw that decisions had been made in their best interests. For example one person was a high risk of falls and did not have the capacity to understand the risks they were facing. There was a best interest's decision relating to the safety of the person and the use of specialist equipment. Relatives had been involved in the decision making process. Some people who lacked capacity had their liberty restricted in some way and appropriate applications for a Deprivation of Liberty Safeguard (DoLS) had been made to the local authority. One person had a DoLs authorisation granted .There were some applications waiting to be assessed.

People told us they enjoyed the food. One person told us "it's good, I always enjoy it." Changes to the menu were made to reflect choice for example the person had requested pork chops. The chef was enthusiastic and told us they aimed to visit each unit and speak with people individually. They told us they like to get to know people and who they are cooking for, they were able to describe to us, peoples individual likes and dislikes, for example one person liked a particular type of breakfast cereal, and another person liked omelettes.

People had their nutritional needs assessed. If they required a special diet this was provided. The chef was aware of specific dietary needs; there was a folder in the kitchen with people's nutritional screening. People's meals were prepared accordingly, for example some people required fortified diets because of concerns about weight loss or poor diet. The chef described how they would ensure food is fortified.

The chef told us they wanted to be more integrated with the staff team and gave examples of how they achieved this. For example, the kitchen staff ensured all the kitchen areas were stocked up in the evenings, ready for breakfast the next day, this meant care workers did not have to keep

Good

Is the service effective?

"running back to the main kitchen." The chef was also making Christmas cakes the following week for each unit. They planned to do the preparation with people so that "they get a chance to stir it".

People had access to drinks during the day and there were snacks available. We observed lunch being served. People were offered a choice and were unhurried. One person told us "Lunch is good."

People had access to a range of healthcare. For example a GP, opticians, dentist, chiropodist and community mental health team. All medical interventions and visits were clearly documented in the care plan. People were registered with one of two GP practices and the registered manager told us they had very good links with both. One GP visited the home fortnightly and reviewed each person individually, which ensured people's health problems were picked up quickly .There was a monthly visit by a psychiatrist for people who had mental health problems. During our inspection a community mental health nurse called into the home and there was a good rapport with staff. One healthcare professional told us staff work closely in partnership with them and are always helpful and responsive when they visit.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. One person told us "I am very happy here, they are very nice people, and they take very good care of me." Another person told us "I'm being well looked after- they are very good."

Staff were committed and motivated in their work. One care worker told us "I love caring for people." Another care worker told us "people here have given to the community-it's our job to give back and help them." One healthcare professional described staff as "kind and considerate."

Staff responded to people with patience and understanding. For example, one person kept asking the same member of staff the same question repeatedly, the member of staff responded kindly and with patience each time. We saw numerous examples of staff talking with people and ensuring they used appropriate body language so that they could listen and be heard, for example kneeling down, or pulling a chair up and facing people. Staff gave people time to express themselves. One person became distressed and staff reacted compassionately.

People were involved in planning their care. The care plans identified specific information about people, for example a brief history of their lives, family, hobbies, and employment and general life experiences. Staff were able to talk with us about people and showed us that they knew people well as individuals.

People's privacy and dignity was respected. Staff told us how they support people to maintain their privacy and dignity. One care worker described how they respect people have their own rooms and it is "their home." They told us it was important to be respectful and knock before entering a room. People told us staff "always close the door." People were approached discreetly by staff when they needed assistance.

Laundry provision was on the premises and there was a system to ensure peoples clothes were taken care off. Laundry staff were conscientious and talked to us about ensuring they took good care of peoples clothing. This demonstrated respect for the person and their belongings. One person told us it was important for them to "look and feel good," and their clothing was important to them. They were positive about the care taken.

People were asked about their cultural and spiritual needs and staff were able to describe to us how they met one person's particular cultural needs, which included consideration of diet and end of life care.

People had been asked about their preferences regarding end of life care. Some people gave specific instructions which were clearly documented, for example one person had requested the television was kept on and the door was left open.

Good

Is the service responsive?

Our findings

People received personalised care that was tailored to their individual likes, dislikes and preferences. For example the registered manager told us about one person who liked to be out in the garden, they provided them with a garden shed for their personal use. One person told us staff know "what I like They told us staff knew their routine and knew what was important for them, for example in which order they like to put their clothes on. People's room doors had a picture on, which was chosen by them for example a television character or a pet. Staff told us this helped people find their rooms.

The service was able to accommodate some married couples. They demonstrated understanding of each person's needs. They were able to be flexible to ensure that each person had their needs met and they were responsive to the needs of both people as a couple. For example, sleeping arrangements were specific to the couple; one couple had separate arrangements at night but were able to spend time together as a couple during the day. The service also provided separate dining facilities for couples so that they could have some privacy at mealtimes.

People were offered opportunity to be involved in social activities. There were three dedicated staff employed to organise activities. There were some scheduled events which were on display at reception. However on a day to day basis staff told us they did not have a rigid time table, they took a flexible approach and talk with people each day and check their care plans. They told us they asked people what they would like and planned activities around this. There were less activities taking place at weekends, although there was a regular church service. One member of staff told us there were plans to appoint a fourth activity person to provide more comprehensive cover across the week.

Activities included outings, movie clubs, baking and jig-saws. Staff told us they aim to ensure peoples have opportunity to engage in activities they like for example one person liked watching sport; staff provided them with the sport sections from newspapers and supported them to watch sport on television.

Some people were provided with one to one time, for example hand massages. Each care plan contained an activity sheet and this was a record of what activities people had been offered or participated in, for example there were several care plans which had a record of hand massages.

One member of staff told us that there were resources available in each unit for staff to offer people living with dementia activities, for example a memory box and memory cards. One care worker told us how these help generate conversations with people. Another member of staff told us that with current staffing levels in the unit they worked in, there was sufficient time for staff to spend one to one time with people. We saw staff engaged in one to one time with people during the afternoon.

We observed a residents meeting. People were being consulted about events during the Christmas period. They were given an opportunity to make any other suggestions, for example one person requested the menus were displayed in advance and two people requested there was less "angel delight" on the menu. Minutes of the meeting were taken and the residential manager told us they would follow up on people's comments. We spoke with the chef who confirmed they knew about the issues raised in the meeting.

People told us they knew how to raise concerns. There was a complaints policy and we saw that the registered manager had investigated any complaints which had been received. For example one relative complained their loved one was in bed when they visited late morning. The registered manager investigated and was able to feedback to them that the person had received a bed bath and had breakfast in bed in accordance with their care plan. The care plan indicated the person needed periods of best rest. The investigation report stated the relative was reassured by the response.

Requires improvement

Is the service well-led?

Our findings

The service was not always well led. There were consistently gaps in recording which had not been picked up in the quality checks (audits) which were carried out by senior staff. There was a system for quality checks which included a monthly audit of the care plans; however they were not always completed. One person had not had their care plan audited since July 2015- the same person was overdue reviews of their care plan and had gaps in their personal record. For example it was unclear if they had received cream as prescribed to them. They were due to have cream applied twice a day, during October 2015 there were seven occasions when it was signed for once and on two occasions it had not been signed for at all. There were some inconsistencies in the completion of charts which recorded if a person required repositioning. We saw three examples of when the charts were not correctly completed, however people's skin remained intact. This would indicate it was a recording issue not a practice issue. The lack of robust quality checks meant that there was not adequate recording of all care being carried out. It also meant that there was a risk of the right care not being given.

Staff told us they were still becoming familiar with the new paperwork which was required since the opening of the service. However the lack of robust checks meant gaps in recording were not identified so that actions could be taken to make improvements to recording and reviews took place as required.

There was a registered manager who was supported by a residential manager for Birch and Fern and a nurse manager for Willow and Oak. The residential manager told us the registered manager was responsible for checks which affected the whole unit and the nurse manager and residential manager carried out checks of care plans and medicines. Where there had been an audit we saw actions were taken. For example in a health and safety audit in September 2015 it was identified that staff were using a bathroom for storage. One of the actions was to discuss in a staff meeting, this took place and was recorded for October 2015. During our inspection the bathrooms were not being used for storage.

The registered manager was supported by the operational manager who visited the home once a month. The registered manager had worked well to ensure the people who lived in the home had minimal upheaval during the transition period of the opening of St Martins Grange. For example, some people were required to move from downstairs to upstairs, the registered manager ensured the same décor was replicated to ease people into their new surroundings.

People and staff told us the registered manager was approachable and supportive and had a presence in the home. People knew who the registered manager was and we saw people interacted in a familiar way which supported that they knew them. One member of staff told us they chose to work in the home because they knew the registered manager "is really good." Another member of staff told us they had health problems and had been supported to continue working by the registered manager who made some changes for them.

People and their families were asked for their views on the service through annual quality questionnaires. There had not been any for St Martins Grange as the previous questionnaires had been sent out prior to the opening and concerned the previous service. The next questionnaires were due to be sent in January 2016. People were able to express their views in the resident's meeting and people told us they could approach the registered manager easily about any suggestions or concerns.

Staff meetings were held on a monthly basis and staff felt they could contribute ideas or suggestions during these meetings. Staff told us they felt comfortable approaching the registered manager with any concerns or suggestions.

There was a system for reporting accidents and incidents and the registered manager kept an overview of the reports to enable them to identify any trends. For example, some people had increased incidences of falls and this led to a review of their care plan.

The registered manager conducted spot checks out of hours, for example there was a spot check in October 2015, the registered manager identified that domestic staff were busy during the weekend period and took action to review the staffing in order to forward plan.