Wessex Care Limited

# Little Manor Nursing Home

## Inspection report

Manor Farm Road
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Date of inspection visit:
01 March 2016
02 March 2016

Date of publication:
19 May 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

Little Manor Nursing Home provides nursing care for up to 26 older people, some of whom may be living with dementia. At the time of the inspection there were 22 people resident at the home, of which eight people were in intermediate care beds. Intermediate care is a short term reablement service for people discharged from hospital and waiting to return to their own home. The home was last inspected in December 2013 and was found to be meeting all of the standards assessed.

The inspection took place on the 1 and 2 March 2016 and was unannounced.

There was a registered manager in post at 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.

People told us they felt safe living at the home. Staff understood their responsibilities and the actions they needed to take to keep people safe from harm and abuse. Risks to people's health and safety were identified and plans were in place to minimise these risks.

People's medicines were managed safely and they had access to health care services when required.

Staff knew people well and supported them with maintaining their independence. People and their relatives told us staff treated them or their relative with kindness and respected their privacy and dignity.

People were supported to have sufficient to eat and drink to maintain good health. People told us they enjoyed the food and that there was always plenty available.

The registered manager investigated complaints and concerns. People, their relatives and staff were supported and encouraged to share their views on the running of the home. Their views were taken into account in the planning of the service.

Health and social care professionals spoke positively about the care and support people received and praised the management team. They said they found the staff and management team approachable and told us they sought advice and guidance where appropriate regarding changes to people's care and support.

The provider had quality monitoring systems in place. Accidents and incidents were investigated and discussed with staff and at team meetings to minimise the risks of reoccurrence.

Arrangements were in place for keeping the home clean and hygienic and to ensure people were protected from the risk of infections.

Staff acted in accordance with the requirements of the Mental Capacity Act 2005. Where people did not have the capacity to make the decisions themselves, mental capacity assessments were in place and records showed that decisions had been made in line with best interests. Where required Deprivation of Liberty Safeguarding applications had been submitted by the registered
manager.

## 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

This service was safe.

Staff understood their responsibilities to keep people safe from harm. Staff knew the processes for reporting concerns and said they felt management would take appropriate actions where required.

The registered manager and provider carried out checks to assure themselves that staff were suitable to work with people who used the service.

There were systems in place to reduce the risk and spread of infection. People's rooms were cleaned daily.

### Is the service effective?

Good

This service was effective.

Staff told us they received training and support to provide people's care effectively.

People had sufficient to eat and drink to maintain good health and were supported to have their health care needs met.

Management and staff acted in accordance with the requirements of the Mental Capacity Act 2005.

### Is the service caring?

Good

This service was caring.

People were treated with kindness and compassion in their day to day care and support.

Staff knew the people they were caring for including their preferences for how they would like to receive care.

### Is the service responsive?

Good

This service was responsive.
People and/or their relatives said they were able to speak with

staff or the managers if they had any concerns or a complaint. People were confident their concerns would be listened to and appropriate action taken.

People had care plans that detailed how they would like to receive care and support.

People were supported to maintain important relationships. Activities were available within the home should people wish to take part.

## Is the service well-led?

Good

This service was well-led.

There was a registered manager in post who was supported by a senior management team.

The management team had a clear vision for the service and development plans were in place for improving the service.

The provider had systems in place to monitor the quality of service and identify improvements needed.

# Little Manor Nursing Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 1 and 2 March 2016 and was unannounced. The inspection team consisted of one inspector and a specialist advisor on the first day and one inspector on the second day. The specialist advisor had expertise in medicines administering and pressure ulcer care.

Before the inspection we reviewed previous inspection reports and all other information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us. The provider completed a Provider Information Return (PIR), which we reviewed. This 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.

During the visit we spoke with the registered manager, four people who use the service, two relatives, two care staff, two members of the senior management team, the welfare assistant and the cook. We also had an opportunity to receive feedback from a social worker, rehabilitation assistant and a GP who had contact with the service. We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for five people. We also looked at records about the management of the service.

Good

# Is the service safe?

## Our findings

People told us they felt safe living at the home, for example one person told us they used to feel anxious when being hoisted but now felt safe as staff provided reassurance and sought permission during hoisting, for example asking if the person was ready.

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. For example, one staff member told us they observed another member of staff speaking to a resident in an inappropriate way. They reported this to their manager who responded by investigating the incident. Staff felt confident that the manager would listen to them and act on their concerns.

The manager told us they used a pre-admission dependency tool to determine staffing levels based on people's needs. They told us people were supported by sufficient staff with the right skills and knowledge to meet their individual needs. One person reported "Staff helped as quickly as they were able, however sometimes this took a while depending on the number of staff available and who else required help". Staff felt they had limited time to spend with people and if staffing were increased they would be able to sit down and talk to people more. Some relatives told us staff and the registered manager used to be more accessible. For example, relatives said they had the opportunity to speak with staff in the lounge; however now staff seemed rushed.

Care records showed that people's individual needs were assessed before admission into the home and where risks were identified appropriate guidance was in place to minimise potential risks. For example, the provider had carried out assessments in relation to falls prevention, malnutrition and the safe moving of people. Personal emergency evacuation plans had been completed for people using the service. Staff explained that where risks had been identified assessments still promoted people's independence whilst maintaining their safety.

Peoples' medicines were managed and administered safely. We observed the lunchtime medication round. It was noted that the nurse dispensing and administering medications had the home's cordless phone and was interrupted 3 times during the round. The nurse reported that it was not a problem for her and there had not been any medication errors. We discussed with the nurse that interruptions during the medication rounds increased the risk of medication errors occurring. Where people were prescribed 'as required' medicines (PRN), there were protocols in place detailing when they should be administered. We observed the registered nurse interacting with four different people concerning PRN pain relief. Compassion and kindness were demonstrated and the nurse took time to explain what medicines were for.

There were systems in place to monitor and reduce the risk of infection. Staff told us they had received training for infection control as well as The Control of Substances Hazardous to Health (COSHH). There was a maintenance team present who were responsible for the cleaning schedule and maintenance of the

premises. People's rooms were cleaned daily and the home had a deep clean once a month. We found there was an unpleasant odour in one of the sluices in the older part of the building. This had been reported as a drainage issue and the home were planning to get macerators which would reduce the odour.

The service followed safe recruitment practices. The manager told us the interview process was rigorous to ensure the suitability of nurses. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

Good

# Is the service effective?

## Our findings

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. Staff spoke passionately about the people they supported. One staff member told us "The people were the reason I came to work."

Staff had access to a range of training to develop the skills and knowledge they needed to meet people's needs. For example, mental capacity, health and safety, safeguarding, moving and handling and more condition specific training such as dementia awareness. Staff we spoke with were working towards qualifications appropriate to their role. Some staff were in the process of completing their Diploma in Health and Social care. New staff members received a thorough induction which included shadowing an experienced member of staff for a week.

People were supported by staff who had supervisions (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff told us they felt well supported by the registered manager and another told us they didn't always feel acknowledged by the registered manager when things were going well.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found people's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. People were involved in decision making and where people lacked capacity to consent to their care and treatment, associated mental capacity assessments were in place. People's mental capacity was reviewed and where people's capacity to make decisions changed then information was amended. People told us staff would ask for their consent before supporting with their personal care and also gave them choice, for example what they would like to wear or eat. One staff member gave an example of a person who was living with dementia and was not able to verbalise how they wanted their hair done. The staff member would look at photos with the person to see how they used to have their hair.

During the inspection, the manager told us where needed they had made applications for DoLS authorisations. Applications had been submitted by the provider to the local authority and they were awaiting a response.

People told us they liked the food and were able to make choices about what they had to eat. Comments included "The chef's food is excellent" and "The cakes are lovely." The kitchen assistant spoke to each person during the morning about the choices for lunch. People told us they would be offered an alternative if they did not like the food on offer. There was fresh water and squash available around the home, as well as bowls of fresh fruit, chocolate bars and crisps. There were also regular hot drinks offered. We observed the lunchtime meal and found that due to people's dependency levels and choice, most people received their meals in their rooms. Staff supported people if they needed assistance to ensure they had enough to eat and drink to maintain good health.

People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. For example, the chef told us about a person who was on a gluten free diet, which was a personal preference, but their choice was respected. The chef had knowledge about people's allergies and told us what process they would follow to prevent cross contamination. The kitchen was clean and tidy and had appropriate colour coded resources to ensure that food was prepared in line with food handling guidance.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. The GP we spoke to told us communication between them and the home was excellent and any recommendations made by them were followed by staff.

The service provided 'intermediate care' for a number of people who stayed in the home for a limited period. For example, this could be whilst people were recovering from surgery to aid their rehabilitation before moving back home. A 'multi-disciplinary' meeting, involving the GP, physiotherapists, occupational therapists and social workers, was held in the home each week to co-ordinate people's care and ensure they were receiving the support they needed to aid their recovery. A visiting rehabilitation assistant told us they received good support from staff at the home and said the system worked well. The rehabilitation assistant said staff worked well to aid people's recovery and help them return home where possible.

Good

# Is the service caring?

## Our findings

People told us they were happy with the care they received. One person said they were very fond of the staff and they were all very good. Other comments included "The carers are terrific. I can't do any better" and "Carers always pop their heads around in the morning to say hello." People told us staff spoke to them in a kind and compassionate way. We observed a person getting upset at lunchtime and staff responding in a reassuring way. Staff who were supporting people with lunch, were sitting down having a talk and asking questions. For example, "How are you" and "Are your family visiting later today?"

We observed staff knocking on doors and waiting for permission before entering people's bedrooms. People told us they were treated with dignity and respect, for example staff closed the curtains and door when they provided personal care.

People's bedrooms were personalised and decorated to their taste. For example, one person had a desk in their room as they enjoyed writing a lot of poetry. The manager told us they did some "bumper" decoration for people who spent the majority of their time in bed and had bed rails in place. The manager told us they recognised the demand on staff and that they were not always able to spend time with people just talking. They had employed a welfare assistant who was able to spend time with people in the lounges and in their bedrooms, talking to them about their past, listening to music or talking about the war. The welfare assistant would sometimes have lunch with people to make it a more social occasion. People told us they had access to a garden area which had won an award, planted with sensory and edible plants. This was mainly used in the summer enabling people to sit outside.

Staff had recorded important information about people, for example, personal history, plans for the future and important relationships. People's preferences regarding their daily support were recorded. Staff demonstrated a good understanding of what was important to people and how they liked their support to be provided. For example people's preferences for the way staff supported them with their personal care needs. This information was used to ensure people received support in their preferred way.

People were supported to contribute to decisions about their care and were involved wherever possible. For example, people had regular individual meetings with staff to review how their care was going and whether any changes were needed. People were able to involve friends or family members in this process if they wanted to. Details of these reviews and any actions were recorded in people's care plans. People told us staff consulted them about their care plans and their preferences. There were also regular 'residents and relatives meetings', which were used to receive feedback about the service and make decisions about activities in the home.

People and their relatives were given support when making decisions about their preferences for end of life care. Where necessary, people and staff were supported by palliative care specialists. Services and equipment were provided as and when needed, for example specialist equipment such as pressure relief mattresses.

Good

# Is the service responsive?

## Our findings

People or their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. Care records were comprehensive and included details such as the person's likes and dislikes, life history, care summary sheet and an enablement plan. The enablement plan was written from the person's point of view and evidenced that the person and their relatives were involved in care. We found that the completion of some forms was variable and the communication care plan for people living with dementia did not always demonstrate a person centred approach. The focus was on peoples' inabilities rather than abilities to communicate. We found overall care planning required improvement. For example a person's enablement plan stated they could have challenging behaviour during personal care, however this was not translated into their care plan. This had been corrected by the end of the inspection.

We noted that where a person had a percutaneous endoscopic gastrostomy (PEG) feed, there was contradictive information recorded regarding the amount and timing of the feed. We discussed this with the registered manager who corrected this immediately and removed out of date care plans. We found there was no evidence of the use of 'colour coding' which was known to help people living with dementia as well as people with poor eyesight, for example coloured doors to help them find their way. This meant people's independence was not always promoted.

People's needs were reviewed regularly and as required. We saw that these frequently said 'no change' with little or no additional information in people's care plans. This was discussed with the registered manager and we asked the manager about what time was afforded to the nurses to complete paperwork. The registered manager reported that nurses cited lack of time as an issue, however, each registered nurse was now given up to 4hrs per week for paperwork and this should have led to an improvement. Where necessary health and social care professionals were involved, for example we saw referrals were made to speech and language therapy when people had swallowing difficulties.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored.

There was a welfare assistant in post who supported people to be involved with a range of activities. , For example chair based exercises, bringing in animals for people to stroke and painting ornaments. People were able to choose what activities they took part in and suggest other activities they would like to complete. Some people told us they did not like to take part, however enjoyed watching and listening. The welfare assistant spent one-to-one time with people who were unable to leave their rooms, talking to people about their past, listening to music or talking about a subject of their choice. The welfare assistant told us she was planning to do a hand and nails massage course, so she would be able to provide that service to people to enhance their wellbeing. The welfare assistant also supported people with their shopping and would accompany people on shopping trips. People also had access to a visiting hairdresser, priest and chiropodist.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. Complaints were regularly monitored, to assess whether there were any trends emerging and whether suitable action had been taken to resolve them. Staff were aware of the complaints procedure and how they would address any issues people raised in line with it. Complaints received had been thoroughly investigated and a response provided to the complainant. Complaints were not closed until the registered manager had reviewed the response and all actions with a director of Wessex Care as part of their supervision process.

There were regular feedback forms given out to people every three months. The issues raised were used to plan agendas and discussion points for the residents and relatives meetings. The results of this feedback were collated and actions planned to address any issues or concerns that were raised. Some relatives told us they were unable to attend the relatives meetings as they were held too late in the evening. The manager told us they also offered a lunch time meeting to enable as many relatives as possible to attend. An example of an issue that was raised by relatives during a meeting was that they were not keen on seeing staff smoking outside on the premises during their break. This was acted on and a trellis screen was put in place to give staff privacy during their break.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post and they were available throughout the inspection. In addition to the registered manager, the management team included service managers, a quality assurance, training and safeguarding manager and the directors of Wessex Care. The provider had clear values about the way care should be provided and the service people should receive.
They told us they wanted to create a homely feeling to Little Manor Nursing home and did not want it to appear clinical.

The provider acknowledged there had been some challenges, for example the lay out of the building. It had numerous staircases, a number of different floors and narrow corridors. Staff told us it was time consuming to get from one end of the building to another. The building's decoration and the lay out of the building also had an impact on people in the intermediate care beds as there was not sufficient space for people to receive physiotherapy. A health and social care professional told us they had limited level surfaces for people to walk on. The registered manager told us they also had a challenge with peoples and their relatives' expectations of the intermediate care service.

The provider told us there were development plans in place to make the building fit for purpose. Plans included having a nurse's station on all floors, installing overhead hoists in all bedrooms, having en-suite facilities for people and a mini kitchenette on all floors for people and their visitors to access tea and coffee at all times. There were also plans to create facilities for relatives and friends to stay overnight if they wished to do so.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. This included an assessment of the service by the registered manager and one of the directors. Information from the reviews was used to develop an action plan to address any shortfalls and to promote best practice throughout the service. The development plan was reviewed and updated as part of the registered manager's supervision sessions. This ensured actions were being implemented where necessary. For example the quality assurance team identified that care plans focussed more on things people couldn't do, instead of the things they could. As a result of this enablement plans were put in place.

Satisfaction questionnaires were sent out every three months asking people their views of the service. The results of the surveys were collated and actions were included in the overall development plan for the service. Regular audits were completed by the quality assurance team to identify any risks within the service, for example falls and tissue viability audits to identify any patterns.

There were regular staff meetings, which were used to keep staff up to date and to reinforce the values of the organisation and how they expected staff to work. The management team also had weekly meetings to discuss any incidents, accidents, safeguarding or any other issues which arose that week. Any updates on policies and procedures were cascaded down from the management team to staff.

The service worked in partnership with other organisations to make improvements and ensured best

practice, for example the provider met with the manager of another care provider to learn about staff deployment and time management. The provider told us they were constantly striving to provide the best care possible and were always looking for ways to improve. They told us they had also developed links with Sight for Wiltshire to support with communication aids for people with sensory loss.

People had been supported to maintain links with the local community through the local schools visiting during special celebrations, such as Easter and Christmas. Duke of Edinburgh students visited the service to provide one to one voluntary work with people and school students completed their work experience by supporting people with activities and serving lunch and tea.