HC-One Oval Limited

St Christopher's Care Home

Inspection report

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Date of inspection visit:
21 February 2018

Date of publication:
12 April 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 21 February 2018 and was unannounced. This was the first inspection for St Christopher's care home under the new provider HC-One Oval Limited. The provider changed in December 2017. HC One limited, purchased some Bupa Limited Homes including St Christopher's care home.

St Christopher's is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. They are registered to provide accommodation for up to 163 people for older people including people with dementia. At the time of our inspection there were 144 using the service.

St Christopher's care home accommodates 163 people across five separate units, each of which have separate adapted facilities. Two of the units specialises in providing care to people living with dementia. Three of the units provided nursing care.

The service had a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

Recruitment processes were not as robust as they could have been. Care plans in some areas needed better guidance and information for staff.

People felt safe living at St Christopher's Nursing Home. Staff were knowledgeable about how to keep people safe and reported and documented any incidents. However not all incidents had been reviewed and investigated appropriately.

Staff received regular one to one supervision from a member of the management team which made them feel supported and valued.

The atmosphere at the home was calm and people's needs were met in a timely manner by sufficient numbers of skilled and experienced staff.

People received support they needed to eat and drink sufficient quantities and their health needs were well catered for with appropriate referrals made to external health professionals when needed.

People and their relatives complimented the staff team for being kind and caring. Staff we spoke with demonstrated their knowledge about individuals' care and support needs and preferences.
People told us they had been involved in the planning of their care where they were able.

People were confident to raise concerns with staff or management and were satisfied that they would be listened to.

There was an open and respectful culture in the home and relatives and staff were comfortable to speak with the registered manager if they had any concerns.

The provider regularly monitored health and safety and the quality of the care and support provided for people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Recruitment processes were not as robust as they could have been.

People were kept safe by staff trained to recognise and respond effectively to the risks of abuse. However not all incidents reported were investigated appropriately.

Sufficient numbers of staff were available to meet people's individual needs at all times.

People were supported to take their medicines safely by trained staff .

There were systems in place to monitor infection control, this was appropriately managed by the provider.

Is the service effective?

Good

The service was effective.

People had their capacity assessed and best interest decisions completed to promote people's choice.

People's wishes and consent were obtained by staff before care and support was provided.

People were supported by staff that were trained to meet people's needs effectively.

People were provided with a healthy balanced diet which met their healthcare needs.

Is the service caring?

Good

The service was caring.

People were cared for in a kind and compassionate way by staff that knew them well and were familiar with their needs.

People and their relatives were involved in the planning, delivery and reviews of the care and support provided.

Care was provided in a way that promoted people's dignity and respected their privacy.

People's confidentiality of personal information had been maintained.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs and took account of their preferences and personal circumstances.

Detailed guidance made available to staff enabled them to provide person centred care and support.

People were supported to maintain social interests and take part in meaningful activities relevant to their needs.

People and their relatives were confident to raise concerns which were dealt with promptly.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Care plans required better information and guidance for staff in some areas.

Systems were in place to quality assure the services provided, manage risks and drive improvement.

People and staff were very positive about the registered manager.

Staff understood their roles and responsibilities and felt well supported by the management team.

St Christopher's Care 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 21 February 2018 and was unannounced. This was the first inspection for this location under the new provider HC-One. The inspection team was formed of three inspectors, a Specialist Nursing Advisor and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events, which the provider is required to send us.

During the inspection, we observed staff support people who used the service; we spoke with 16 people who used the service, 19 staff members, representatives of the senior management team and the registered manager. We spoke with relatives of seven people who used the service to obtain their feedback on how people were supported to live their lives.

We received feedback from representatives of the local authority health and community services and three visiting health professionals. We also 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 due to their complex needs.

We reviewed care records relating to 19 people who used the service and other documents central to people's health and well-being. These included staff training records, recruitment records, medication records and quality audits.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe. One person said, "The staff know what to do, I like it here, yes I feel safe I have no [family] locally so I depend on the home to take care of me and they do." Another person commented, "I feel safe because of the locks on the doors. I trust the staff to look after me."

Recruitment processes were not as robust as they could have been. Out of the four staff files we checked one had only one reference and for another one gaps in continuous employment had not been explored. All the other files had DBS checks in place and two references with full employment history in line with the provider's recruitment procedure.

Risks to people`s well-being were identified and effectively managed by staff. Risk assessments included areas like mobility, falls, nutrition, skin integrity and choking. Staff were knowledgeable and understood the measures in place to mitigate risks. Risk assessments in people`s care plans were up to date and clearly identified what actions were to be taken by staff to mitigate the risks further. For example, a person assessed at risk of choking had clear instructions for staff in order to help keep them safe.

However, we found that there were areas that needed improvement. For example, care-plans for people with diabetes whether on insulin or not, did not state the signs of hypoglycaemia or hyperglycaemia. . There was no guidance for staff on actions that need to be taken should the person experience low or high blood sugar levels. The care plans we looked at did not list the types of foods that should be encouraged, avoided or taken in small amounts. We also noted all care plans regarding catheter care we looked at needed to be consistent in providing the same information. For example, the catheter care-plans were varied, some mentioned what to do in the event of fever, pain and cloudy, urine and stated when the catheter should be changed. One mentioned recording the input and output daily. Two mentioned cleaning the meatus (the urethral opening). All care plans regarding catheter care should be consistent providing the same information. One resident had a supra-pubic catheter and there was no record of input and output of urine, however, we found that staff were knowledgeable about people's care needs and their dietary needs were managed appropriately. This meant that staff were providing appropriate care but the care plans required better information and guidance for staff.

Staff were knowledgeable about how to keep people safe from harm. Staff told us they received safeguarding training and they knew how to report their concerns internally and externally to local safeguarding authorities. They were able to tell us possible signs of abuse and how to document and report their concerns. However we saw that where staff recorded and reported unexplained bruising found on people`s skin these were not always discussed or reported by senior managers for an investigation to be carried out to establish the possible cause. A report to safeguarding authorities had not been made where a possible cause of these bruising could not be established. This was an area in need of improvement. We spoke with the registered manager and the deputy who assured us that changes would be made to ensure better communication and actions taken.

Staff were able to tell us that they used the correct amount of thickeners prescribed by the speech and

language therapy team (SALT) team for the person`s drinks and they provided the person with the correct type of diet. We found that the nursing staff had a white board in their station which listed every person on the unit with their date of birth, mobility needs, dietary needs, allergies and also if they had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place. This meant that staff had important information about people at hand to ensure people received care and support safely.

Actions were taken to help safeguard people because of incidents. For example, one person had experienced two falls; a note was made for the person's blood pressure to be taken every day for a week when they were lying down and then again, when they were stood up. The nursing staff told us that this was part of the investigations to understand why the person was falling and to ensure strategies were put in place to keep them safe.

People, their relatives and staff all told us that there were enough staff available to meet their needs. Throughout the course of the day, we noted that there was a calm atmosphere in the home and that people received their care and support when they needed it, and wanted it. We noted staff answered call bells in a timely manner and staff went about their duties in a calm and organised way. We saw a record of a compliment made by a relative on the day of this inspection that stated, "This home has been a god send. There are loads of staff all the time. I know my [relative] is well looked after."

Staff managed people's medicines safely. We saw that staff followed safe working practices while administering medicines and records checked were completed consistently. Medicines were stored appropriately in a temperature controlled room. Medicine administration records (MAR) charts were signed after staff gave people their medicines. There were PRN protocols in place to ensure staff had guidance in how and when to give people medicines prescribed on as and when required basis. A unit manager on one unit told us that they had worked closely with the GP to reduce the anti-psychotic medicines that had been prescribed for people. They told us this had a positive effect in people appearing more alert, people had stopped losing weight and the incidents of falls had reduced.

The environment looked clean and we saw housekeeping staff working on the floor cleaning people`s bedrooms and communal areas. There were no odours around and people seemed well groomed. Staff were seen using personal protective equipment (PPE) when delivering personal care to people or when serving meals.

We found that oxygen was managed safely and stored securely. The hospital and the provider liaised with the company who supply oxygen if someone living at St Christopher's required it. Oxygen cylinders were stored in the treatment room. Risk assessments were completed for each person requiring oxygen. The unit manager reported that oxygen cylinders were only used on Scott Unit in the event of an emergency because people used oxygen concentrators. (An oxygen concentrator takes in air and purifies it for use by people requiring medical oxygen due to low oxygen levels in their blood.)

Good

Is the service effective?

Our findings

Staff told us that they had received training to support them to be able to care for people safely. One staff member said, "I think we are providing good care for people." One relative commented, "My [relative] is a resident here in the home, I can't say enough about this home, I'm here all the time breakfast, dinner and tea, so I know how well everybody is looked after, the standard of care is excellent."

Staff were knowledgeable about capacity, best interest decisions and how to obtain consent from people with limited or restricted communication skills. We noted that 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, it was clear that people had been involved with making the decisions and, where appropriate, their family members as well. Best interest decisions had been made on behalf of people who did not have the capacity to make decisions themselves. For example, in relation to the use of bedrails to help prevent people falling from bed. We noted that families and health professionals had been involved with making these decisions in people's best interests.

Staff explained to people what they were doing and obtained their consent before they provided day-to-day care and support. For example, we saw a staff member supporting a person to put a clothing protector on at lunchtime. The staff member said, "It's just to stop food dropping down and spoiling your clothes."

However we found that the way staff described the care and support they offered to a person who was reluctant to accept support around their personal care could have been unlawfully restricting the person`s liberty. Staff told us they gave reassurance to the person constantly and that the provision of personal care was in the person`s best interest. However the care plan had not been detailed enough around this process and the deprivation of liberty application made by the management to local authority had no detail of the way the care was been delivered. The registered manager had rectified this and resent the DOLs application with relevant details to ensure the persons best interest. They later confirmed that the care plan had been updated and the DOLs assessor had reviewed the application.

We observed breakfast in two of units and saw that staff supported people in a calm and unhurried way. There was a good selection of foods on offer for people to enjoy a cooked breakfast as well as cereals and toast. One person said, "They [staff] make sure I eat and drink well, the foods great." Another said, "I think the food is alright here there's an alternative available, so I always have a nice meal."

We noted that most people opted to eat in the communal dining room and some chose to eat in their rooms. We observed the lunchtime meal served in all units. We noted that staff provided people with appropriate levels of support to help them eat and drink. This was completed in a calm, relaxed and patient way that promoted people's independence as much as possible. We heard staff interacting with people in a kind and considerate manner indicating that nothing was too much trouble. Tables were nicely laid with cloths and condiments were on the tables to support people to be independent. However, on one unit this was not the case. We observed very little interaction taking place between the staff and the people who used the service. We saw one staff member supporting a person with their food had not engaged in any communication whilst supporting them.

The provider employed hostesses that supported staff by serving during meal times and supporting people to have snacks and plenty of fluid throughout the day. We noted staff were monitoring people`s nutritional intake. If people had specific dietary needs these were known to the staff on the units as well as the kitchen staff who appropriately prepared the meals to meet these needs.

People were weighed regularly and where a weight loss was identified staff involved the person`s GP and a dietician to ensure they had specialist advice in meeting people`s nutritional needs. Food and fluid charts were completed. Fluid charts had a target amount people should have had over a 24 hour period. The amount of fluid people had over 24 hour period had been totalled and staff knew who they had to encourage to drink more in case the person had not met their target. Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. We noted that these assessments were kept under review and amended in response to any changes in people`s needs.

We saw a record of a compliment made by a relative in response to the care provided. They had said, "I have nothing but the highest praise for [Nurse] and her staff. The care and support given to my [relative] and our family has been outstanding. Always working towards the best possible outcomes in a very difficult situation."

Staff told us they received training that helped them keep up to date with care practices. They told us they had an induction when they started working for the provider and before they worked alone they shadowed a more experienced staff member until they felt comfortable working on their own. Staff told us that the current induction provided to newly employed staff was better structured and supported new employees to work a day on the floor part of the induction process. This gave staff a clear understanding about what responsibilities they were taking on and they could make an informed decision if they felt able to deliver care and support to people.

We saw a recent letter of compliment received from relatives of a person who used the service. They had said, "My [relative] came here from hospital with only days to live. [Relative] has now been here seven weeks (At the time of writing), thanks to the great care here will make their 80th birthday. Thanks." The unit manager told us that the person had made a significant recovery and was now able to sit up and eat independently. This showed that people received the care they needed.

We saw that staff involved health care professionals in people`s care when required. Care plans evidenced involvement from GP, dieticians, chiropodists and opticians. We spoke with three visiting healthcare professionals during the course of this inspection and all gave us positive feedback about the service provided. One professional said, "Staff are knowledgeable and responsive, we have no concerns." A further professional said, "They are very good and very caring. The unit manager really knows people well. If she tells us someone is not right then we listen because she is always right. [Unit manager] runs a tight ship." One person commented, "If I'm poorly they call the doctor or the nurse looks after me."

The environment in the units for people living with dementia were welcoming, clean and free from clutter so that people could walk around. Corridors were decorated with pictures and tactile artwork also handrails were painted in different colours from the wall so people could easily recognise their ways and how to keep safe. We noted on one unit near their bedroom doors people had memorabilia boxes with familiar photographs and important items which triggered memories for people and helped them recognise their bedroom. However, we also saw that there were large mirrors on the corridors and in each bedroom, which is not in line with current best practice in regards to the environment people with dementia live in. We spoke to the registered manager about this and they confirmed they would look at ways of improving this.

Good

Is the service caring?

Our findings

A relative told us, "I think the home is efficiently run, very caring staff. You can have all the fancy equipment you like but without caring staff, it is worth nothing. They look after [person] really well and they have a lovely room." One person said, "The carers are very good here. They come in and get me up any time after 6am, as they know that I like to get up early."

People received care from staff in a kind, caring and respectful manner. Staff were friendly, courteous and smiling when approaching people. We observed sensitive and kind interactions between staff and people who used the service. The way people related to staff demonstrated good relationships between them based on respect and trust. One person said, "The staff are really very nice here and look after me well and keep me safe. I have my buzzer here if I need to use it and they're normally quick to come and see me, they are gentle with me."

The environment throughout the home was warm and welcoming. People's individual bedrooms were personalised with many items that had been brought in from their home such as cushions and pictures. On one unit, we noted that each person's room had been decorated specifically to match their individual likes and wishes. For example, one person was fond of horses so a wallpaper mural had been put on their wall making the space individual for them. Another person's room had a mural of a woodland scene making the room a green and tranquil space.

We observed staff interact with people in a warm and caring manner listening to what they had to say and taking action where appropriate. For example, on one unit a person had become distressed whilst talking to us about a personal experience they had. The unit manager came and comforted the person and reassured them that they would look into their concerns personally. The person calmed down immediately and it was clear to see that they had trust in the unit manager's response to them. A relative commented, "There are lovely staff here, they've got to know [relative] very well now. I know that [relative] is being well looked after, and I am so content with them being here. When they first came here, around two years ago, the doctors told me that they wouldn't last a month, but the staff here have been so good they've got her up and walking I think it's all down to the dedication of the staff."

Staff took action to relieve people's discomfort. For example, we heard staff ask people if they were warm enough and saw them fetch a blanket for a person who said they felt a bit chilly. Another staff member noted a person fidgeting in their chair towards the end of lunch service. The staff member asked, "Are you alright [Person's name]? Do you want to go back to your soft chair?" The person indicated that they did want to move so the staff member supported them back to their armchair.

Staff addressed people using their preferred names and it was clear that staff knew people well. They were knocking on bedroom doors and greeted people when they went in. People`s privacy and dignity was promoted. People looked presentable and well groomed. People`s hair looked clean and combed. There was a relaxed and happy atmosphere in the home. The relaxed manner staff were approaching people with created a sense of calm and a warm homely feel in the home where people were smiling and seemed happy.

Input from people in their care plan was demonstrated by the, `My day, my life, my portrait` which gave a short overview about people`s likes dislikes and family background. Consent forms were signed by people or where appropriate by their relatives.

There were numerous compliments received by the unit from relatives of people who used the service. These were very complimentary about the care and support people received and praised staff for their caring attitude. One compliment said, "Thank you so much for the excellent care, love and compassion that you gave to our [relative]." Another compliment said, "We would like to thank you for the wonderful care you gave to our [relative]."

Good

Is the service responsive?

Our findings

People and their relatives where appropriate, had been involved in developing people's care plans. People's care plans were reviewed regularly to help ensure they continued to meet people's needs. We saw that people's relatives were invited to attend monthly review meetings where appropriate.

Care plans contained information about people`s medical conditions, personal care needs, medication, risks to their well-being, MCA and also records when other health or social care professionals visited, and care reviews. Staff were knowledgeable about what people liked and disliked and what their preferences were.

There was an activity coordinator employed for each unit. There were activities scheduled in each unit and we saw that when an activity coordinator was not present the other activity staff from different units gave people the opportunity to join activities outside their own unit. We heard people singing and having conversations with staff but they were also given the opportunity to participate in arts and crafts session. Activity records showed that events were celebrated, Burns night and birthdays, various games were played such as dominoes, quizzes and bingo, and external entertainers were brought in to play music and sing for people. We spoke with one of the activity coordinators and they said, "Everyone gets seen we visit people in their room, we use aroma therapy, give hand massages and do their nails. We find out what people like and don't like to do. One person said, "I get involved with the activities they're really good girls and they ask me to get involved which is good. I've always liked artwork; I did all the daffodils on the walls in the lounge. I like to draw and paint and I'm doing more for St Patrick's Day and Easter is coming up. I enjoy it."

During our inspection, we were told that two activity staff were on leave and we saw on one unit this did have an impact and one person told us they felt bored. We spoke with the registered manger about this and they told us there are plans to employ another activity co-ordinator to help improve cover and ensure activities staff were available to people when required.

People received end of life care from staff that had appropriate training and knowledge to provide effective support to people nearing the end of their life. Care plans were developed to capture people`s wishes of where and how they wanted to be cared for in their final days. We saw a compliment card from a relative of a person who had used the service. The card said, "Thank you for making [relative's] final days peaceful and dignified."

Concerns and complaints raised by people who used the service or their relatives were appropriately investigated and resolved. People who used the service and their relatives told us that they would be confident to raise any concerns with the registered manager. A staff member told us of a complaint that had been made about the care they had received from a member of agency staff working at the home. The concern had been escalated to the registered manager who was investigating the concern with the agency.

Requires Improvement

Is the service well-led?

Our findings

St Christopher's had recently been taken over by HC One and the registered manager had started working at the service in December 2017. Documentation from the previous provider such as care plans were still in place however, we were told by the registered manager that this would be changing to HC One documentation. We found that the care plans needed more personalisation and in some areas better guidance and information for staff. For example, better guidance and information was needed in care plans for people with diabetes and people who had catheters in place. Documentation found in recruitment files needed to be more robust and one DOLs application needed better detail to ensure the person received appropriate support and evidence that the care provided was in their best interest. This required further improvements.

Staff were a little unsettled regarding the change of ownership. Whilst they felt their employment position was not in question, there was some concern about what the changes would mean in practice. There had not been the opportunity for staff to have their questions and concerns addressed by HC One. Staff said that there had been little change at the moment but that two members of HC One senior management team had visited the service in recent weeks to introduce themselves.

Staff understood their role and responsibilities one staff member said, "I recently had manual handling training. I had safeguarding, infection control and other trainings. I feel knowledgeable in my role." Staff felt that the new registered manager was approachable. A staff member commented, "The manager is the best out of the four I met in the last three years. She is firm but fair". Another said, "The managers are very approachable. I saw a few managers in my time working at this home and this one is by far the best".

Staff told us that the management team was approachable and that they could talk to them at any time. They said that the management was always open to suggestions from the staff team and that they listened to everybody and always provided them with opportunities for improvement. Staff told us that there was regular staff meetings held to enable them to discuss any issues arising in the home.

The registered manager felt supported by the provider they told us that they could contact their manager at any time if they needed. They also said, "I find all departments in HC One helpful." They had good relations with the local authority. Other managers completed monitoring visits to ensure best practice.

The unit managers demonstrated an in-depth knowledge of the staff they worked with and people who used the service. They were familiar with people's needs, personal circumstances, goals and family relationships. We saw them interact with people who used the service, relatives and staff in a positive, warm and professional manner.

There was a range of checks undertaken routinely to help ensure that the service was safe. These included such areas as water temperature checks, safety checks on bedrails, inspection of the call bell system, and fire checks. We noted that where issues had been identified they were passed on to the relevant person to address.

There were various audits done in each unit. These included medicine audits, environmental audits and care plan audits. Audits identified areas in need of improvement; however, actions were not always signed off by a responsible person to evidence completion. There were also weekly clinical risk meetings where the managers from different units together with the manager and the clinical manager analysed the care and support people received and if the risks to people`s well-being was effectively mitigated. These meetings looked at people who were at risk of losing weight, had swallowing difficulties or were at risk of developing pressure ulcers.

The registered manager also attended daily meetings with representatives from each unit and this also included housekeeping, kitchen staff and maintenance. This meant that the registered manager was up to date with any issues or changes. The registered manager and the deputy manager completed daily walk about on all units to ensure best practice any issues found including issues with the environment, resulted in action plans implemented.