Nightingale Retirement Care Limited

Priors Mead Care Home

Inspection report

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Date of inspection visit:
02 June 2016

Date of publication:
29 July 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

This inspection took place on 2 June 2016 and was unannounced. At our previous inspection on 9 May 2014 we found the provider was meeting the regulations we inspected.

Priors Mead Care Home is a residential care home for up to 19 people over 65 years of age. At the time of the inspection there were 17 people using the service, who were all paying for their care privately.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission (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 2008 and associated Regulations about how the service is run.

People told us they felt safe living at the home and that care workers were friendly and kind towards them. They told us they were happy with all aspects of their care and if they had any concerns they were confident that the provider would listen to them.

People told us they enjoyed the food at the home. There was a menu in place and food was prepared using fresh, good quality ingredients. Food storage and preparation in the home followed the required food safety guidelines.

People had their healthcare needs met by the provider. Referrals and appointments were made with the GP and other professionals when required. Care records contained information related to people's health and there was evidence that the provider corresponded in a timely manner with other professionals when required. People were supported to receive their medicines from trained staff.

Care workers told us they were given time to get to know people which helped them when supporting them. They were aware of the importance of asking for people's consent and offering them choices. We observed this to be the case during the inspection, where we saw people being offered a choice of food and activities. Care workers respected people's choices.

There were thorough recruitment checks in place which helped to ensure care workers were safe to work with people. These included checking references and identity documents, and completing criminal records checks. Care workers also completed assessments prior to being offered a job which helped the provider to decide if they were suited for a role in care. Induction training for new care workers was based on an industry accepted standard called The Care Certificate and ongoing training was renewed every year.

People were given time to come to a decision about whether they wanted to live in the home and the provider completed an assessment when people first moved in. Care plans were developed based on people's needs. These were updated on a regular basis which helped to ensure that staff had access to current information to support people better.

Relatives told us the registered manager was approachable and managed the service well. They also said they were fully involved in their family member's care and were kept informed if there were any changes to their family member's needs.

The service was employee owned which meant that staff were committed to maintaining high standards within the home. There was also a programme in place to identify talented care workers within the organisation and to mark them as future potential managers.

Thorough quality assurance audits were in place which included weekly and monthly medicines audits, audits carried out by the owners which were based on CQC methodology, and feedback surveys sent to professionals.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe. Care workers had completed safeguarding training and knew who to speak to if they had concerns about people's welfare.

New care workers were assessed on their suitability for a role in caring. There were thorough recruitment checks in place.

People received medicines from trained care workers in a safe manner.

Is the service effective?

Good

The service was effective.

Care workers received a thorough induction based on the Care Certificate and shadowed an experienced colleague when they first started. They also received regular refresher training and one to one supervision.

The provider was meeting the requirements of The Mental Capacity Act 2005 (MCA).

People were provided with a varied diet and good quality food.

People's health needs were met by the provider.

Is the service caring?

Good

The service was caring.

People and their relatives said that care workers were kind.

Care workers were given time to get to know people and the provider supported people to maintain family relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

People were given time to visit the home over a number of weeks to see if it was suitable for them.

Care plans were individual to each person and reviewed on a monthly basis.

People were given details on how to complain if they were not happy.

Is the service well-led?

Good

The service was well-led.

Relatives told us the registered manager managed the service well and was always available to speak with.

A formal tool was in place to identify potential future managers and the company was employee owned which meant that staff were committed to providing a good service.

Quality assurance checks included visits from the provider, medicines audits and feedback surveys.

Priors Mead 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 checked 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 2 June 2016 and was unannounced and was carried out by one inspector.

Before we visited the service we checked the information that we held about it, including notifications sent to us informing us of significant events that occurred at the service. We asked the provider to complete a Provider Information Return (PIR) prior to our inspection. The PIR is a report that providers send to us giving information about the service, how they met people's needs and any improvements they are planning to make.

We spoke with three people using the service, four relatives and five staff members which included the registered manager, assistant head, the chef and two care workers. We looked at records including three care records, training records, three staff records, complaints and audits.

After the inspection, we contacted two health professionals to gather their views and received responses from both of them.

Good

Is the service safe?

Our findings

People using the service told us they felt safe living at the home. Relatives also did not raise any concerns about the safety of their family members. Care workers had received safeguarding training and told us, "Safeguarding is about making sure people are safe" and "Anything of concern needs to be reported to the manager or to the local authority." They were able to identify different types of abuse and the tell-tale signs which may indicate people were at risk.

Risks to people and to the home were managed effectively which helped to ensure people were safe living in the home.

An initial assessment carried out before people moved into the home identified any major areas of risk but a more formal and thorough assessment was carried out within the first week of a person moving into the home. The provider used standard risk assessments to identify risk. For example, Falls Risk Assessment Score for the Elderly (FRASE), a nutritional risk scoring tool, Waterlow and Maelor score which are two of the most commonly used tools when it comes to assessing pressure sore risk, dependency profile, continence, geriatric depression scale which is a screening test for depression symptoms for older people, Long Term Care (LTC) dehydration risk assessment and a self-medication assessment. People were risk assessed against these areas and where a person was identified at high risk, the support that they needed to be given such as more frequent monitoring was in place.

Risk plans for emergency evacuation of people were in place. Individual risk assessments for each person were based on their room location and their mobility. Regular test evacuations took place which helped to ensure that care workers were familiar with what to do in the event of an emergency. We saw fire risk assessments for individual areas of the home such as the kitchen, conservatory, lounge and staff office, along with actions to reduce the risk to remove the probability of an event occurring were also present.

Equipment at the home was serviced regularly which helped to ensure it was safe for people to use and the environment safe for people to live in. We saw up to date certificates for electrical safety, gas safety, Portable Appliance Testing (PAT), fire equipment and emergency lighting. We also saw certificates which showed that the water had been tested for legionella and service reports for the passenger lift and bath hoists. Water temperatures were tested weekly which helped to protect people from scalding when receiving personal care.

People told us that there were enough care workers to meet their needs. One person said, "There is always someone around to help if needed." Call bells were in place in people's bedrooms and we did not notice a delay in care workers responding to these when they were used. Care workers told us there were enough of them on duty to meet people's needs and they did not feel rushed or understaffed when supporting people.

The registered manager told said there were three shifts at the home. The morning shift was between 08:00 and 14:00 during which there were three care workers. The afternoon shift was between 14:00 and 20:00 during which there were two care workers and a waking night shift between 20:00 and 08:00 was staffed with

two care workers. During the day there were additional staff on duty such as the chef, activities co-ordinator and the registered manager and an assistant head. We checked the staff rota for the week of the inspection and the following two weeks which confirmed that the required number of care workers were allocated to each shift.

New care workers were subject to robust recruitment checks such as evidence of identity, proof of address, written references and Disclosure Barring Service (DBS) checks. The DBS provides criminal record checks and barring functions to help employers make safer recruitment decisions.

Potential care workers completed online tests prior to interview to assess their suitability for a role in care work. These recruitment assessments and tests included psychometric, behavioural, attitude and personality tests, and assessments that helped the provider to recruit care workers with an affinity and aptitude for a role in social care. Following these tests, new care workers were invited for an interview and further assessment. This meant that the provider only recruited people which were suited for a role in social care.

People were supported with their medicines in a safe manner from trained care workers who were competent in undertaking these tasks. There was a trained member of staff available at all times to administer medicines, they had completed a level two certificate in Understanding the Safe Handling of Medicines. The registered manager had achieved level three accreditation.

An up to date record of people's medicines was kept in their care records. Risk assessments were in place for people that were able to administer their own medicines. Guidelines for Pro Re Nata (PRN) medicines were in place giving staff information on which situations to offer these to people (These are medicines to be taken on an 'as required' basis). Patient information leaflets were available for all the medicines currently in use at the home.

The majority of people received their medicines in a blister pack. Medicines were stored securely in a locked cupboard which only staff had access to. Medicine Administration Record (MAR) charts were completed accurately. Medicines were counted when they were delivered and quantities documented when staff administered medicines. All MAR charts were signed by care workers correctly.

Good

Is the service effective?

Our findings

Care workers told us that the training they received was good and helped them to carry out their roles effectively. They said, "Training is good, I recently did moving and handling, fire safety and health and safety", "[The registered manager] makes sure our training is up to date", "We have to complete some training every month" and "The training is good, it's useful to be reminded about things you've learnt before."

The registered manager told us they had recently introduced the Care Certificate for new staff. Six staff that had been hired after May 2015 had started working through the modules with the registered manager verifying the workbooks that they completed. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training for new caregivers and was developed jointly by Skills for Care, Health Education England and Skills for Health. There are 15 different standards that are covered as part of the Care Certificate.

The first day of induction for a new care worker included going through policies and procedures, the care planning software, first aid and health and safety. The registered manager told us that all new care workers did three initial shadowing shifts with an experienced care worker, one in the morning, afternoon and night to "Make sure they know what is expected and the difference in tasks for the different shifts."

Ongoing training for existing staff consisted of e-learning in the following areas, first aid, moving and handling, health and safety, fire safety, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), person centred care, nutrition and diet, medicines, safeguarding, dementia, Control of Substances Hazardous to Health (COSHH) and fire safety. These were all renewed every year, each month care workers were required to cover a specific module which meant over a year they covered all 12 modules.

Staff were supported in their roles through regular supervisions during which key outcomes were identified and followed up.

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 this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Throughout the day of the inspection we saw that people were not restricted and were observed leaving the service with relatives or staff. The provider had followed correct procedure and applications had been submitted for legal authorisation to deprive some people of their liberty under a DoLS to ensure people were kept safe. At the time of the inspection the provider was waiting to hear back from the authorising

authority.

Care workers demonstrated an understanding of the MCA and how it was implemented. They told us, "Some people lack capacity and others have full capacity to make decisions" and "If people lack capacity, decisions need to be made by speaking with their power of attorney and have meetings with family members."

They also said that they were careful about offering people choices when supporting them and said they respected the choices they made. One care worker said, "We respect their decisions if they refuse but at the same time you have to be wary they are not being neglected."

Care records were documented electronically and people's consent was recorded in this way as well. We saw that in some cases accurate records were not maintained. For example, some people were not able to consent to their care and treatment and had a Lasting Power of Attorney (LPA) in place, however in the electronic records it stated that consent was given by the person rather than the LPA. The paper records were signed by the appropriate person and we pointed this out to the registered manager who told us she would ensure that accurate electronic records were maintained regarding consent.

People had their healthcare needs managed by the provider. They told us, "The GP and dentist do visits when needed" and "Staff take me to hospital appointments." A relative told us, "They measure [my family member's] sugar levels a few times a day and give the results to the diabetic nurse."
Care records included medical information such as people's medical history, prescribed medicines and current health concerns.

The registered manager told us they worked closely with community matrons for care homes. This was a community support service used to boost the competence of care home staff to manage people's needs and to cut avoidable hospital admissions. The matrons were used in an advisory, supportive and facilitative approach to assist care home staff in developing their competence and confidence in managing people's care.

People were given the choice to register with a GP surgery of their choice but they generally chose to register with one of three local surgeries. The GP carried out home visits if necessary and contact details for GPs, district nurses and hospitals were on display in the staff office for staff to refer to if needed.

Health care plans were in place which included correspondence related to health such as follow up appointments and discharge summaries after admission to hospitals. We saw evidence that people were supported to attend appointments and that reviews with GPs, psychiatrists and community services such as the memory clinic took place where appropriate. We also saw appropriate referrals were made, for example to the occupational therapists when there were concerns that needed specialist input.

People using the service told us, "Food is excellent, it's presentable" and "It's tasty, we get offered a choice." Relatives told us, "We are satisfied with the food, we sometimes stay for lunch" and "Food is fine, no complaints."

There was a six week rolling menu in place. A cooked breakfast was available every day and 'smoothie of the day' was also offered to people. The main cooked meal was served at lunch and included meals such as roast beef, pies and fish in sauce. The evening supper was a lighter meal and consisted of things that care workers could prepare or heat such as soups, nuggets, fish fingers or sausages. Menus were available on tables in the dining room. The chef told us, "There are no restrictions on what people can request. I like to be offered a choice and it's the same for the people living here."

Fresh fruit and drinks were available on each table during lunch and care workers offered these to people. The food looked appetising and portions were sufficient. Some people had gone out to lunch with families.

Good infection control practices was being followed. Opened food in the fridge was covered and labelled with the date it had been opened or made and when it was to be used by. Fridge, freezer and cooked food temperatures were taken which helped to ensure people were served food that was safe to eat.

People's meal preferences were recorded in their care records. The chef was familiar with the dietary requirements of people using the service, such as those who were diabetic and needed an appropriate diet. A visual 'traffic light system' Malnutrition Universal Screening Tool (MUST) chart was available in the kitchen giving the chef a quick snapshot of people who were at risk of malnutrition. People highlighted in red were at most risk and were therefore provided with fortified meals to ensure their nutritional needs were met.

Good

Is the service caring?

Our findings

People using the service told us that care workers were friendly and kind towards them. They said, "I'm very happy here", "Everybody helps me", "They are so polite and respectful" and "They are extremely helpful." A relative told us "She's settled, happy", another said "Yes it's a good home, absolutely."

We saw some positive, caring interactions between people using the service and staff. We observed the chef going round after breakfast asking people what they would like for lunch, offering them a choice. She did this in a kind, unhurried manner and explained the choices available in more detail when asked. We also observed this during lunch, staff supported people in a caring manner asking "Are you OK?", "Do you need any help", and "Do you need more gravy" People were given time to finish their meals and were offered drinks throughout the meal.

There was an informal, relaxed atmosphere at the home. Relatives that we spoke with said that this was one of the main reasons why they chose the home. They said, "It's got a lovely homely feel to it", "Really friendly staff, it's an uplifting atmosphere", "It's not institutionalised" and "When I first came to visit, the staff were so welcoming and made [my family member] feel at home."

Care records contained details about people's history and also their preferences regarding meals and personal care. This meant that the provider was able to deliver person centred care. The registered manager told us they encouraged care workers to build caring relationships with people and one of the ways they facilitated this was by asking them to spend 30 minutes of quality time every day speaking with people. One care worker told us that one of the reasons why they liked working at the service was, "We have a manageable number of clients which means we get to know them and their families." Another said, "They are all happy, we get time to sit and talk to them."

People were also supported to maintain family relationships and we saw relatives visiting the home and spending time with their family member, either in the home or taking them out. One person told us, "I see my family all the time." An iPad was available for the people to use to skype/facetime their relatives when they were not able to see them in person.

People lived in single bedrooms which were en-suite. We looked at some rooms which were all fully furnished and provided with a telephone and a TV. People were given the choice to bring in their own furnishings and memorabilia if they wished, the registered manager told us "We try and accommodate all requests, we want people to feel like this is their home."

Good

Is the service responsive?

Our findings

People's care records were documented and reviewed and updated every month. This meant that staff had current information available which allowed them to support people in the most appropriate manner. One relative said, "The care plan has changed but it is current and reflects [my family member's] needs."

Following an initial enquiry or referral, the registered manager completed an initial assessment of a person's needs, usually in their home. She told us, "It's an opportunity to introduce myself, give them a brochure and have a discussion with the person and their family about their needs and to see if there are any issues such as mobility." People and their relatives were given time to make a decision and the provider facilitated ways to do this, for example by allowing people to come initially for a two week respite period for both parties to get to know each other and see if people were happy. Relatives told us, "They were very thorough with the move" and "Staff have been great, allowed [my family member] to settle"

A more formal and thorough assessment was carried out within a week of a person first moving into the home and care plans were developed. All care plans were recorded on a software system. Care plan reviews were mainly carried out by the assistant manager or the registered manager but with input from care workers.

Care records were split into two main sections, general and care. The general section included details related to people's admission, personal information, discharge information, a one page profile, important contacts and complaints information. The care section consisted of two sub sections, care planning and care delivery. Care planning included assessments, care plans and risk management plans. Care delivery contained information related to daily records, accidents, medicines and body maps.

Care plans were in place for a number of areas related to activities of daily living (ADL) which is a term used in healthcare to refer to people's daily activities. These included finance, mental capacity, activities, medicines, personal care, nutrition and cultural needs amongst others. All the sections we saw contained a good level of detail apart from the one page profile which was not always completed in the examples that we saw.

Care workers completed care delivery notes which were daily records completed in relation to meals, personal care and bathing. These were completed in a timely manner, for example notes were seen for the morning of the day of the inspection when we looked at records in the afternoon.

We spoke with the activities co-ordinator who told us they planned an activities schedule every two weeks which was left on the dining tables so that people could have a look at it. The activities for the day of the inspection included knitting club, ball exercises and crossword puzzles. She said that activities were a mixture of one-to-one and group sessions and they tried to do one-to-one activities at least twice a week with people. There was also an allocated shopping day for people who wanted to take part in this. A volunteer came in on the weekends to do some reading with people. The chef also ran some of the activities within the service such as the knitting club. A new conservatory had been built leading out onto well

maintained gardens. Staff told us the garden was used throughout the summer for barbeques.

Every four months an activities review was carried out with each person which included which activities they had done, activities they would like to do in future and what the activity coordinator needed to do to make it happen. She told us, "I sit with their families when they first come to get an understanding of what their interests are." This helped to ensure that people were able to take part in activities of their choice.

Residents meetings were held, we reviewed the minutes from meetings held in February, April and May 2016. These were well attended and some of the topics discussed included safety, staff, menus and activities. We saw people's suggestions were recorded and followed up by staff.

There had been no recorded complaints received by the provider from people, relatives or other visiting professionals. The registered manager said they always tried to resolve complaints before they escalated to formal complaints.

People told us, "I will go in and tell staff if I am not happy about anything" and "They do listen. In the past when I've had a grumble they have sorted everything out." A relative told us, "Never had any complaints."

People were able to raise any concerns through residents meetings in which they were asked for their views or if they were unhappy about anything.

We reviewed the provider's complaints policy which included the contact details of the owners that people could speak to if they were not happy. Also included were the details of the Local Government Ombudsman (LGO) and the Care Quality Commission (CQC) in case people were not happy with the response from the provider and wanted to raise their concerns to an independent external organisation.

Good

Is the service well-led?

Our findings

Relatives told us the service was managed well and they had confidence in the registered manager. Comments included, "[The registered manager] is approachable, makes time for you", "[The registered manager] has been good, she knows what's going on" and "They keep us informed, call us with any issues."

There was an open culture within the service. The main office was next to the front door and we observed people, relatives and staff approaching the registered manger or assistant head and asking questions without being ignored. A monthly newsletter was produced which was given to people and relatives telling them some of the events that had taken place for example, activity dates, any new staff appointed and details of regular clubs. This was done to keep relatives informed about any changes within the service. General staff meetings were held every four months and management meetings every week which helped to ensure that staff were kept up to date with any changes within the service.

The registered manager had been with the organisation for eight years and had progressed through the company before taking on the role of registered manager in July 2015. She spoke to us about the 'management pool' which was in place and used to identify potential future managers or senior staff. The current registered manager had been identified via this method and told us about some of the staff that she herself had identified from the current staff team that she felt were capable of being a registered manager in the future. Care workers said they felt well supported by their peers and the senior team. They said, "I love it here", "We work well together", "It's a good place to work" and "The manager always gives me whatever I need, I get a lot of support."

Since July 2014 the provider became employee owned, the registered manager told us this changed the whole ethos around the home. Employee owned businesses are totally or significantly owned by their employees. Some of the benefits of this had been an opportunity for staff to raise their own employment standards and recruit and retain talented, committed staff. It also encouraged staff to be more committed to the company. The registered manger said, "Employees input care and thought into their work."

New employees were automatically enrolled onto the employee ownership arrangement at no extra financial cost to them. Bonuses were paid out every year and a share of the profits based on earnings and length of employment. Employees were given access to the company accounts to see the financial footing of the company and were given training in finance and how to understand figures. Employees were also involved in the budget for the upcoming year and attended partners meetings.

The provider also encouraged referrals of new staff, if an employee was referred and stayed with the organisation for six months they were given a financial bonus.

The registered manager told us the quality audits had been amended to reflect Care Quality Commission (CQC) methodology. Internal audits were carried out by the owners of the home. These audits covered the five areas that are inspected as part of CQC inspections. Each month one of the five key questions was audited against.

Weekly medicines audits completed which covered whether medicine administration record (MAR) charts were completed correctly, dated, allergies recorded and signed by care workers. More detailed monthly medicines audits took place looking at storage, stock levels, disposal practices and information sheets. A national commercial pharmacy company carried out an audit in September 2015 covering policies and procedures, ordering medicines, storage, controlled drugs, disposal, medicines administration, recording, homely remedies and training.

Questionnaires were sent to six professionals in April 2016. Although only one had been returned and we saw that the feedback was positive. Staff questionnaires were sent out in September 2015 and we saw evidence that the provider responded to feedback received.