Naseby Care Home Limited

Naseby Care Home

Inspection report

8 Avenue Road
Christchurch
Dorset
BH23 2BY

Website: www.agincare-homes.com

Date of inspection visit:
24 May 2018
25 May 2018

Date of publication:
11 July 2018

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

Naseby Care Home is a residential care home for 21 older people; some of which live with dementia. At the time of our inspection 18 people were living at the service. Accommodation is over two floors with lift access to the first floor. Two rooms have an en-suite wash basin and toilet. Three rooms on the first floor are not accessible from the lift or suitable for a hoist. There are three shower rooms and a bathroom providing specialist bathing facilities.
At the last inspection the service was rated 'Good'. We found at this inspection the service had maintained a rating of 'Good'.

People were receiving safe care provided by a staff team that understood how to recognise signs of abuse and the actions needed if abuse was suspected. People's risks had been assessed and staff were able to explain their role in minimising people's risk of avoidable harm. Risks had been managed whilst respecting people's rights and choices. Improvements had been made in assessing and managing environmental risks.

Staff had been recruited safely with checks ensuring they were safe to work with vulnerable adults. Staff had completed an induction, ongoing training and had the support which enabled them to carry out their roles effectively. A dependency tool had been used to ensure staffing levels met the assessed needs of people.

Improvements had been made in medicine administration including a more robust medicine auditing system. People were having their medicines ordered, stored, administered and recorded safely. Staff had completed infection control training and followed procedures that ensured people were protected from avoidable infection. Positive, responsive relationships with health and social care professionals had enabled effective care outcomes for people.

Prior to admission assessments had been carried out to establish people's care needs and choices. The information gathered had been used to create person centred care plans that recognised people's diversity. Activities were an integral part of each day and included group social gatherings, entertainers, visiting animals and for some people one to one time in their rooms. Limited information had been gathered about people's past interests and hobbies but Naseby Care Home had begun completing life histories for people with help from families.

People and their families described the staff as caring. We observed staff demonstrating kindness and patience and providing emotional support. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. A complaints procedure was in place that people and their families were aware of and felt able to use if necessary.

The signage and building layout didn't always provide opportunities for some people living with a dementia to orientate themselves around the property and gardens independently. Plans were in place to landscape the gardens enabling direct access from the building. The registered manager told us they would look at

improved signage around the home. Audits had highlighted areas that required redecoration and a maintenance schedule was in place for works to be carried out.

The registered manager provided visible support to the staff team and worked alongside staff providing leadership. Staff described the management culture as open and supportive which had enabled them to speak honestly about concerns and also share ideas. Quality assurance processes were in place and effective in capturing areas that required improvement. We saw that actions identified had been completed but actions and outcomes had not been recorded. The registered manager told us they would include this in future audits.

Further information is in the detailed findings below.

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 had improved to Good

Systems had been introduced that ensured safe ordering, storing, administration and recording of medicines.

Staffing levels were determined by assessing the dependency needs of people living at the service.

Risk assessments had been completed of environmental risks and actions put in place to minimise avoidable harm.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains good.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service remains good.

Naseby 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.

The inspection began on the 24 May 2018 was unannounced and the inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of care service. It continued on the 25 May 2018 with one inspector and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider had not completed a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection we spoke with nine people who used the service and three relatives. We spoke with the operations director, registered manager, four care workers and the cook. We also spoke with a community district nurse and a community health care assistant to gather feedback on their experience of the service. We reviewed five people's care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

Is the service safe?

Our findings

At our last inspection in January 2016 improvements were required in safe management of medicines, managing environmental risks and staffing levels. At this inspection we found the service had taken actions and improvements had been made and sustained.

People and their families described the care as safe. One person had moved to Naseby Care Home following an illness and explained, "Here I do feel safe and cared for". Staff had completed training and understood what types of abuse people could be at risk from, what signs to look for and the actions they needed to take if they suspected abuse. We spoke with a visiting health worker who told us, "I've no concerns about (patient's) safety. The carers respond as soon as I ring the bell". Notices were displayed in the home that provided safeguarding contact details.

People were protected from discrimination as staff had completed training in equality and diversity. We observed interactions between staff and people that respected people's individuality.

Risks to people had been assessed and staff understand the actions needed to reduce the risk of avoidable harm. When people were at risk of skin damage, actions had included the correct use of pressure relieving aids such as air mattresses and pressure cushions. Risks were reviewed at least monthly and staff were kept informed of any changes with care and support plans immediately updated. Risks had been managed whilst respecting people's freedoms and choices. One person had risks associated with self-administering their medicines and had refused to take their medicines. The registered manager explained "I sat with (name) and asked what can we do to make it easier for us and you to keep you safe and healthy and they came up with the solution".

Records showed us that equipment had been regularly serviced. Staff had completed fire training and fire drills and people had individual personal evacuation plans in place.

People were supported by enough staff to keep them safe and staffing levels were regularly reviewed against people's assessed care and support needs. Naseby had a small staff team who were trained to carry out more than one role enabling them to provide cover for any staff absence. Records showed us that staff had been recruited safely and had included verifying references and completing disclosure and barring employment checks.

People had their medicines ordered, stored, administered and recorded safely. When people had as required medicines, protocols were in place to ensure safe decisions before being administered. A care worker explained one person has a medicine for anxiety., "We try at first to settle them without the medicine; encourage breathing exercises which can work". When people self-administered medicines risk assessments had been completed and regularly reviewed. Staff were able to tell us the actions they would take if a medicine error occurred.

People were protected from avoidable risks from infection as staff had completed infection control and food

hygiene training. We observed staff wearing gloves and aprons appropriately and hand sanitizers and moisturisers available at points throughout the building. A cleaning schedule was in place ensuring all areas of the home received the appropriate level of cleaning.

Records showed us that when things went wrong actions were taken to make improvements. One person had fallen from their chair which had led to their sitting position being reviewed and staff being shown how to reposition in a safer way.

Good

Is the service effective?

Our findings

People, their families and health and social care professionals contributed to assessments prior to a person moving into Naseby care home. This information had been used to form their care and support plan. The plans contained information about people's assessed needs and reflected their choices about how they wished to live their lives. Staff understood the actions they needed to take to meet people's assessed needs and choices. Care plans had been developed in line with current legislative standards and included equipment needed to support a person such as pressure relieving equipment.

Staff received an induction and on-going training and support which enabled them to carry out their roles effectively. A care worker spoke of their induction, "It gave me what I needed when I first started". Induction included for some staff the Care Certificate. The Care Certificate sets out common induction standards for social care staff. It has been introduced to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. Staff told us they had opportunities for professional development and we saw this had included level two and three diplomas in health and social care.

People had their eating and drinking needs met and spoke positively about the food. We observed the cook spending time talking to people about their meal choices and options available to them. Nutritional assessments had been completed for people and shared with the kitchen. They provided details of peoples likes and dislikes and any special dietary requirements. The cook told us, "If somebody loses weight I get told. (Name) needs feeding up and I've got them on a fry up; bacon, egg and toast". A visiting community nurse told us "(Name) has diabetes and the cook accommodates their dietary needs". We saw that people had access to drinks when in their rooms as well as in communal areas. Modified crockery had been provided such as plate guards to enable people to eat independently. When people needed the assistance of staff with eating and drinking this was carried out at the person's own pace.

The service worked with other organisations to ensure people had effective care. An example had been liaising with Parkinson's specialists to support staff training and understanding. A grab sheet had been completed for each person and used to provide emergency information when people moved between services such as a hospital admission. The form hadn't included details of all the risks people lived with such as pressure care or dietary requirements. We discussed this with the registered manager. They told us they had been working with the local NHS and were in the process of implementing the 'Red Bag Scheme'. The scheme involves using a red bag containing information about the person that stays with them and ensures an effective transition between services.

People had access to healthcare both for planned and emergency situations. We spoke with a visiting community health worker who was able to give examples of how people's healthcare needs were responded to appropriately by staff at Naseby Care Home.

The signage and building layout didn't always provide opportunities for some people living with a dementia to orientate themselves around the property and gardens independently. Bedroom doors had either very

small name plates or nothing other than a number. Outdoor space was not connected to the building and therefore only accessible with a member of staff. We spoke with the registered manager who told us landscaping works were planned to enlarge the garden enabling it to be joined to the building and provide people with independent access. They also told us they would review signage around the home in line with any best practice guidance. Areas of the home had been identified as requiring redecoration and a maintenance plan was in place for this work to be completed. A communal lounge and dining room provided areas for people to meet up and socialise. People had been involved in decoration. One example was that they suggested a photo gallery of events and activities at Naseby and this was on display on the dining room wall. People's private spaces had been personalised with photos and pieces of favourite personal belongings.

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 that the service was working within the principles of the act. Mental capacity assessments had been completed for people and DoLs applications had been submitted to the local authority. When people had been assessed as not having capacity decisions had been made in the persons best interest and in line with the MCA framework. We observed staff seeking consent from people and offering choices before providing any care. The registered manager told us, "Staff understand to offer a choice of everything always. Somebody may have porridge every morning but never assume". Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf. This meant people were having their rights upheld.

Good

Is the service caring?

Our findings

People and their families spoke positively about the caring nature of the staff team. One person told us, "The carers are really good; they can't do enough for me and they are kind and caring too". We observed staff demonstrating kindness and patience when helping people. One person was anxious about being transferred using a hoist. Staff showed empathy and provided reassurance and emotional support whilst professionally carrying out the task.

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People had their individual communication needs assessed prior to admission and then regularly reviewed. Staff demonstrated a good understanding of people's communication skills. We observed staff using short simple sentences to aid a persons understanding, enabling them to be involved in decisions about their care.

Throughout the inspection we observed staff giving people time and listening to what they had to say. Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. Examples observed included talking with people at eye level and using hand gestures and facial expressions. The registered manager explained how pictures had been used with people to help them make decisions which had included an end of life care plan. Large print reading books had been sourced and meeting minutes were produced in large print for people with poor sight.

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that interested them. A care worker explained, "We get to know them (people), their likes and dislikes and that helps me do a better job". Staff relationships with people were positive and acknowledged people's skills and life experiences. A care worker told us "(Name) helps me with my language and we have music in common".

People who needed an independent representative to speak on their behalf had access to an advocacy service.

People had their dignity and privacy respected. Staff were able to tell us ways they protected people's dignity when providing personal care. Family were able to visit at any time and people's private time with family and friends respected. We observed staff knocking on doors before entering people's rooms and addressing people in a respectful manner. People's clothes and personal space were clean and reflected a person's individuality.

Information about people and staff was stored securely to ensure their right to confidentiality.

Good

Is the service responsive?

Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. Care staff were able to demonstrate a good knowledge of the actions needed to meet people's care needs and choices. A relative told us, "The home keeps me informed if there are any issues with my (relative). My (relatives) condition has changed over the time she has been here but the home has coped and responded to the new situation, I am very pleased to say". Staff were kept up to date with any changes to people's care needs. A care worker told us, "We have handovers every day which means if somebody has a change we would know about it".

Staff had a good knowledge and were respectful of people's individual lifestyle choices. Care plans described people's religious, spiritual and cultural needs and these were understood and respected by the staff team. Links had been made with local churches that were able to provide religious support when needed.

People had opportunities to join in group activities, spend one to one time with staff and access the local community. A care worker told us, "With activities we try and engage with a person what they liked doing before and we do it with them. One man likes gardening and he waters all our plants". We met another person who liked taking a staff member's dog for a short walk and observed another person helping staff clear the dining tables. We observed people joining in with word games, reminiscence and pampering sessions. An album of photographs was available in the foyer for families and friends to browse through. One relative shared positive feedback with us. They told us, "My (relative) has changed radically in the short time they have been here; I think it must be the social side working for them".

Links had been made with a local school who had students completing a course about dementia. The registered manager told us, "They've had lots of ideas such as painting and drawing. They've also organised things at the school to involve residents such as a Christmas party". A local church choir visited monthly for a sing song and cakes. Photos were around the home of people enjoying visits from a range of animals such as birds of prey and llamas.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government and social care ombudsman. One person told us, "I don't have any complaints. I know I can talk to the carers and something will get done; they can't do too much for me".

People had an opportunity to develop care and support plans detailing their end of life wishes which included any religious requirements and decisions on whether they would or would not want resuscitation to be attempted. One person had no family and staff had been involved in organising their funeral. They staff spoke with love and pride about how they had ensured the funeral service really reflected the person. Details had included their favourite colour, songs and their love of christmas time.

Good

Is the service well-led?

Our findings

People, their families and staff spoke positively about the management of the home. A care worker told us, "You can talk about everything (with registered manager) and it's confidential. They will always try and help". Another told us "They (registered manager) always tries to fix things; she cares about us and everyone".

The registered manager provided visible leadership and regularly worked alongside the staff team. A care worker told us, "(Registered manager) often helps with people and helps with the cooking; they are a lovely manager". The registered manager explained, "Working on the floor enables me to check things like infection control and moving and handling practices". They had also taken opportunities for professional development and were in the process of completing a level five diploma in management and leadership in health and social care.

Although staff told us they felt supported and appreciated in their roles, they did not have an area in the home where they could take time out for a break. One care worker explained why they felt it was important to have a staff room. They said, "Today is a good day but another day may not be and sometimes you need somewhere for those bad days". We spoke with the registered manager who told us they would discuss with the provider options available in the building.

Staff had their religious and cultural diversity respected. This had included providing flexibility with working hours to support religious practices.

Staff achievements were celebrated. A carer of the month scheme had been introduced. One award had been given to a care worker for their role in supporting a person join in with activities and another for the patience they showed when supporting people with their meals.

The registered manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. Engagement with people, their families and staff was achieved through a range of methods. These included both group and individual meetings, social gatherings and a quarterly newsletters. We saw one newsletter contained professional and fun items about members of the staff team, planned maintenance and information about nutrition and hydration.

Quality assurances processes were in place and effective in monitoring service standards. Audits included medicines, infection control and staff files. One audit had highlighted areas of the home that required redecoration and we were told the plans for the work to be completed. We discussed with the registered manager including action plans with their audits so that progress could be monitored more effectively.

The staff team worked with other organisations and professionals to ensure people received good care. These included the Alzheimer and Parkinson's charitable societies. Information had been shared appropriately with other agencies such as the safeguarding teams and social care commissioners.