Mr Anthony Howell

St Bridget's Residential Home

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection.

St Bridget's Residential Home provides accommodation and care for up to ten older people. Ten people were living at the home at the time of the inspection. A registered manager was in post at the time of inspection.

A Registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The provider had made appropriate arrangements to identify and respond to abuse. Staff were aware of the provider's safeguarding policy and how to respond to actual or suspected abuse to keep people safe.

The registered manager was aware of and meeting their responsibilities under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS).

Summary of findings

People's needs were met in a timely manner. There were sufficient staff to enable them to perform their roles safely and effectively. The registered manager monitored staffing levels to ensure that they remained sufficient.

People's needs were assessed and care was planned and delivered to meet them. Risks to people had been assessed, for example of falls and skin damage. Staff were aware of the risks each person faced and how these risks should be managed.

There were a number of distractions during the lunchtime meal which may have had a detrimental effect on the pleasure of the mealtime. However, no one complained or looked uncomfortable.

People were able to see healthcare professionals whenever needed. We looked at people's care records and found evidence that people had accessed healthcare professionals such as the GP and chiropodist.

People were treated with consideration and respect and their privacy was respected. One person told us, "The carers are very good and treat us very well."

The provider had a complaints procedure and people felt able to complain. Staff felt able to raise concerns and were encouraged to do so. The provider had a whistle-blowing policy which provided information for staff as to how they could raise concerns.

The registered manager told us they kept updated as to changes in practice. For example, they told us they subscribed to e-mail bulletins from a variety of organisations including, the Health and Safety Executive and the Care Quality Commission.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were aware of how to identify and report abuse in line with the provider's policy.

The registered manager was aware of their responsibilities in relation to the Deprivation of Liberty Safeguards.

There were sufficient numbers of suitable staff to keep people safe and meet their needs.

Risks to people had been assessed. Staff were aware of the risks each person faced and how these risks should be managed.

Is the service effective?

Good

The service was effective. People were supported to eat and drink enough.

People received care from staff who were trained and supported effectively.

People accessed the services of healthcare professionals when they required.

Is the service caring?

Good

The service was caring. People were treated with consideration and respect by staff.

Staff were aware of people's preferences and offered people choices.

People's privacy was respected and they were able to entertain their visitors without restriction.

Is the service responsive?

Good

The service was responsive. The provider had a complaints procedure and people felt able to complain and were confident that they would be listened to.

People received care which met their needs when they needed it.

Is the service well-led?

Good

The service was well-led. Staff felt able to raise concerns and were encouraged to do so.

Actions were taken following incidents to reduce the risk of re-occurrence.

The provider monitored the quality of the service provided and kept up-to-date as to changes in practice.

People were able to give feedback about the quality of the services which was then used to make improvements.

St Bridget's Residential Home

Detailed findings

Background to this inspection

This inspection was carried out by one inspector and an expert-by-experience who had experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The last inspection of this service was in May 2013 and we had not identified any concerns.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

On the day of the inspection we spoke with seven people who lived at St Bridget's Residential Care Home who were able to share their experiences and views with us. We also spoke with the registered manager, two care staff and the cook. We observed how people were supported and looked at three people's care and support records.

We looked at records relating to the management of the home such as staffing rota, policies, incident and accident records, training records, meeting minutes and audit reports.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

There were sufficient numbers of staff to support people safely. People told us that care was provided at the time they needed it. For example, one person told us that staff were always available to help them out of bed in the morning. Another person said, “If I tell them I’m going out they will get me ready to go.” Staff told us that there were always the required numbers of staff on duty. Staff were not rushed and people’s needs were met in a timely manner.

The registered manager told us that the needs of the people had been taken into account when calculating the numbers of staff required. The registered manager told us they spoke with people and staff to gain their feedback as to whether there were enough staff as well as using their own observation. They told us that agency staff were used to cover unexpected staff absence. We looked at the staffing rota over a four week period and found that the numbers of staff the registered manager had assessed as being required were consistently shown on the rota.

The provider had made appropriate arrangements to identify and respond to abuse. Staff were aware of the types of abuse and the signs that may indicate that someone was being abused. Staff told us they would inform the registered manager immediately if they suspected someone was being abused. The registered manager was aware of the actions to take in the event of actual or suspected abuse. Information leaflets regarding safeguarding people from abuse were available at the entrance to the home. The provider had a policy relating to safeguarding people from the risk of abuse which contained information such as the types of abuse and the local reporting procedures.

The registered manager was aware of their responsibilities in regard to the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS). These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. They can only be used when there is no less restrictive way of supporting a person safely. The registered manager told us that the responsibility for making DoLS applications rested with themselves and another senior member of staff. Of the two care staff we spoke with, one was aware of the DoLS, the other member of staff was not familiar with them. The registered manager had made two DoLS applications following a supreme court decision that clarified the legal meaning of ‘deprivation of liberty'.

Risks of harm to people were assessed and plans were in place to reduce these risks. People’s care records included a variety of risk assessments such as in relation to falls and skin damage from pressure and continence. One person was assessed as being at a high risk of skin breakdown and there was a plan for them to use a pressure-relieving mattress. A pressure-relieving air- mattress was on the person’s bed and records confirmed that the air-mattress was checked twice a day to ensure it was functioning safely. Staff were aware of the risks of harm to people; for example, staff told us that one person was at risk of falling and required a mobility aid.

People who spent time in their bedrooms had access to a call bell. One person told us, “I don’t really use the call bell. They put it near me when I go to bed.” People’s mobility aids were placed within their reach.

Good

Is the service effective?

Our findings

People who ate in a communal area were assisted, where necessary, to sit at the table and their meals arrived soon after. People were provided with napkins and salt and pepper to enable them to season food to their own personal preference. People ate at their own pace and were not rushed. Staff checked people had finished their meal before removing their plates. However, during the mealtime the television remained on and a carpet was vacuumed in close proximity to the dining area. In addition staff administered people's medicines while they were having their meal. This may have had a detrimental effect on the pleasure of the mealtime, although no one complained or looked uncomfortable.

The cook told us that people usually had their main meal at lunchtime. They told us there was one option for the meal, but if people did not like that option then an alternative would be provided. There was a list of people's food dislikes displayed in the kitchen. The cook was aware of people's food dislikes, for example, one person did not like mashed potato. This person told us, "They know what I like. They know I don't like mash so I get roast or chips."

Dehydration risks had been assessed and a target daily intake of drink had been calculated for each person. Fluid charts were filled in to monitor whether people were achieving their target. People had been meeting or exceeding their daily assessed target. A plan was in place to offer people extra drinks and jellies if they had not achieved the target fluid intake over a 24 hour period. If people's fluid intake did not increase then staff were guided to seek medical advice.

People told us they were not explicitly offered a choice of food. One person said, "I get a choice of cereals but not a cooked breakfast." Another person said, "The food is generally good but it would be nice to have a choice." A further person commented, "I usually have what they give me. They know I don't like tomatoes so they don't give them to me." The registered manager told us that people were informed of the menu for the day in the morning. The cook told us they developed menus based on their experience, speaking with people and staff as well as monitoring the food waste returning to the kitchen. The registered manager told us that no one living at the home required any form of specialist diet

Malnutrition risks were not always effectively assessed. Malnutrition screening assessments were undertaken on a monthly basis, but one person's assessment had not been fully completed. This meant that the risk of malnutrition for that person had not been fully assessed. Two other people's assessments had been fully filled in.

People could access healthcare services. For example, one person's care records showed that their GP had been contacted as they were experiencing a cough which resulted in the prescription of antibiotic medicine. A community nurse had been contacted for another person as they had the early signs of pressure damage to their skin. The community nurse's advice regarding assisting the person to change position regularly was being followed. One person told us, "I meet with the chiropodist and I go out to the hairdressers with my daughter." Another person said, "They arrange for the doctor to come and see me if needed."

Staff received appropriate training to carry out their roles. Staff said they had received effective training and support to carry out their roles. Training records demonstrated that staff had received appropriate training in a variety of relevant topics such as, moving and handling, fire, and food hygiene.

Staff told us that they felt supported to carry out their roles, and that they received regular supervision and appraisal. The registered manager told us staff participated in a minimum of six supervision sessions per year and also had an annual appraisal. Supervision and appraisal records confirmed what the registered manager told us.

Good

Is the service caring?

Our findings

People were treated with consideration and respect by staff. For example, while one person was being supported by staff to walk to their chair staff spoke with them about topics of interest to them and actively listened and responded. Another member of staff assisted a person to achieve a comfortable position while sitting at the dining table. One person told us, “The carers are very good and treat us very well.” Another person said, “Things are pretty well perfect.”

People’s privacy and dignity was respected. For example, people’s bedroom doors were closed when they were being supported with their personal care needs. Staff knocked on people’s doors before entering. People’s care records were kept in a lockable cupboard and no personal information was displayed publically. One person told us, “The staff usually knock before entering my room.”

People could be visited by their friends and relatives without restriction either in their bedrooms or in the lounge. One person told us, “I see my friend downstairs sometimes when I can.” Another person told us, I can have visitors when I want. They make them very welcome.”

People were involved in decisions about their care. For example, people were offered choices about where they would like to sit. One person told us, “I feel they listen to me. I like to have my breakfast in my bedroom and my lunch in the lounge. There is never a problem with this.” Another person said, “I prefer to get up later, and the carers are happy to do this”. A further person commented, “I am a night bird. I like to watch telly until late in the evening and I’m allowed to do this.” Staff were aware of people’s preferences. For example, one member of staff told us that one person particularly enjoyed talking about a specific festival. Another member of staff told us of a person’s preference in relation to the time they liked to get out of bed.

The registered manager told us that people were involved in reviews of their care on a monthly basis. There was little recorded evidence of people’s involvement in how their care was reviewed. One person told us that they had been consulted about their care plan on entry to the home. They had been there approximately three years and they were not aware of any subsequent reviews. However, they told us that they were happy with the way they were supported.

People’s care records provided information about their specific preferences. For example, one person’s care records showed their preferred brand of toiletries, we found these toiletries in their bedroom. People’s care records did not contain comprehensive information regarding their personal history which may help staff get to know people.

Good

Is the service responsive?

Our findings

People received care when they needed it. For example, one person was walking independently without any aids. Staff prompted this person to use their walking stick immediately once this was observed. People wore suitable footwear when moving around to reduce the risk of falling due to ill-fitting footwear. People in their rooms had access to call bells which were within reach. People who used mobility aids had these close by to enable them to move around independently.

Staff were knowledgeable about people's needs and the support they required. For example, staff told us about how one person's individual continence needs were managed. Another member of staff told us how they supported a person to maintain their personal hygiene. What staff told us was reflected in people's care records.

Activities were available for people to participate in. Staff played board games with people during the afternoon of the inspection. The registered manager told us that someone came in once a week to provide activities such as exercise and quizzes. Two people received a daily paper of their choice. One person, who spent time in their bedroom, had a television with the subtitles enabled. There were books and DVDs available in the communal areas of the home. A minibus was available and there were regular trips away from the home. One person told us, "We have exercises one day a week. I enjoy the exercises."

The registered manager told us that no complaints had been received in the past 12 months. The provider had a complaints policy and procedure included in the information for people at the entrance to the home. The procedure provided information as to how complaints would be dealt with and what people could do if they were not satisfied with the response. Staff told us they would try and rectify any issue at the time it was raised otherwise they would refer the complaint to the registered manager. One person told us they, "had never had to make a complaint or raise a concern but would be happy to do so. Both staff and management are very approachable".

The registered manager told us they sought feedback from people regarding the service while at the home. They told us that they had been in post for a couple of months and had met with people using the service and their relatives and provided them with contact details to raise any issues they wished. Records showed that the registered manager had met with people and their relatives and no feedback had been received which indicated a need for any changes.

A survey of people and their relative's views of the service was carried out in March 2014. Six people responded to the survey which produced generally positive results. However, one person had indicated that they were unaware of the complaints procedure. There was no plan detailing the actions taken as a result of the survey. The registered manager told us that they thought that the previous manager had explained the complaints procedure to the person concerned. The provider listened to people's views and changed aspects of the service in response.

Good

Is the service well-led?

Our findings

People told us they were aware of the management arrangements for the home. One person said, “The manager has just changed, she is in most days.” The registered manager told us they split their time equally between two of the provider’s care homes. The registered manager was supported by a senior staff team.

Staff told us they felt able to raise concerns. We looked at staff meeting minutes where the registered manager had encouraged staff to raise concerns with them. The provider had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. The policy made it clear that it was not an option to do nothing if staff had concerns. Staff were aware of different organisations they could contact to raise concerns, for example, care staff told us they could approach the local authority or the Care Quality Commission.

The provider had arrangements for reporting incidents and accidents which staff were aware of. The registered manager told us they reviewed every incident to see if there was any action needed to reduce the risk of reoccurrence. We looked at the provider’s analysis of incidents over a four month period which showed no trends in the reported incidents.

The registered manager gave us an example of the action taken following an incident and the changes they had made. They told us about a person who had fallen a number of times during the night when getting out of bed. A sensor mat was introduced to alert staff when this person mobilised so that they could provide assistance. The registered manager told us that this was unsuccessful at reducing the risk as the person stepped over the mat so staff checked the person was safe every 30 minutes during the night.

The registered manager told us that they monitored the quality of the service informally on a daily basis. They told us that they spent time each day speaking to people and staff to gain their feedback along with general observations of the environment. There was not an office in the home and the registered manager worked from a desk in a communal area allowing direct observation of practice.

The provider undertook checks of some aspects of the service. For example, room checks which were carried out monthly. These checks looked at environmental issues such as window security, furniture and door function. The provider carried out three monthly checks of other aspects of health and safety such as fire alarms and nurse call systems.

The provider undertook audits of the management of medicines. An audit in May 2014 had found that the medicine trolley needed to be secured to the wall. The action plan supporting the audit said that this action would be completed by the end of May 2014. However, we saw that this action had not been completed. Staff with responsibility for administering medicines told us the provider was in the process of having the fixtures and fittings installed to enable the trolley to be secured.

An identified member of staff led each shift and they were on-call if required. Staff told us that they felt able to make suggestions and were confident that they would be listened to.

The registered manager told us they kept updated as to changes in practice. For example, they told us they subscribed to e-mail bulletins from a variety of organisations including, the Health and Safety Executive and the Care Quality Commission. They told us they attended ‘learning hubs’ run by the local authority and used these as a method of learning and networking with other registered managers in the local area.