Mrs K Peerbux

College View

Inspection Report

71 Bargate
Grimsby. DN34 5BD
Tel: 01472 879337

Date of inspection visit: 09/04/2014
Date of publication: 02/07/2014

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Summary of findings

Overall summary

College View is a care home for older people in Grimsby with good access to local transport and amenities. The home is registered to accommodate 12 people and at the time of our inspection the maximum number of people were living at the home. During our visit we spoke with seven people who used the service and four relatives.

We saw good leadership at all levels. At the time of our visit the service had a registered manager in place who was also the provider. The registered manager was supported by an operational manager who had previously been a senior care worker. The registered manager actively promoted an open, honest and inclusive atmosphere.

The home provides care and support to older people, two of whom had a formal diagnosis of dementia. The home is located in a residential area with parking to the front of the property. Accommodation is on two floors and there is a passenger lift.

Mental capacity statements and best interest assessments were in place where required, for people who were unable to make decisions for themselves.

Each person's care plan had a personal profile which described their personal preferences in relation to religion, food, drink, and daily routines. We saw this had been reviewed monthly. This allowed staff to pick up on changes in people's behaviours which may indicate anxiety, pain or distress.

The care plans we reviewed showed people's individual health care needs were addressed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We saw mental capacity statements and best interest assessments were in place where required, for people who were unable to make decisions for themselves.

The members of staff we spoke with were aware of their individual responsibilities to report any incidents or concerns and understood their employer's whistle blowing procedures.

Each person had their needs assessed on admission to the home. Each assessment contained information from the person and their families about their needs, choices and health problems.

We saw each person had a personal profile which described their personal preferences in relation to religion, food, drink, and daily routines. We saw this had been reviewed monthly.

The care plans we reviewed showed people's individual health care needs were addressed. Each person was registered with a GP and had an allocated member of staff who coordinated their care.

We noted the home was kept clean and tidy. The building was decorated well and was free from odour. We observed members of staff wearing appropriate personal protective equipment (PPE) such as disposable gloves and aprons. Members of staff we spoke with demonstrated their knowledge of infection control procedures.

Are services effective?

People living in the home and their relatives told us they had a care plan which they had been involved in creating.

We observed members of staff gave people choices about what they wanted to do, where they wanted to sit, and what they wanted to eat. We observed people who were still in bed being asked if they wanted to get up or stay in bed.

Records showed there was a stable team of staff, this helped to build relationships and promote continuity of care.

Records showed people were supported to have a healthy diet. We observed the lunch time meal and saw that people were given a choice of what to eat and drink. The meals were well presented and we observed staff assisting people to eat. We saw people's weights had been monitored regularly. Records were kept of how much people ate and drank each day.

Summary of findings

Are services caring?

We observed members of staff providing care with compassion and respect. We saw staff sat with people talking about things that were important to them. They spent time watching their body language and facial expressions to understand how they were feeling. One member of staff told us, “We are encouraged to sit with people who can’t communicate so that we pick up on their facial expressions to pick up if they are in pain or worried about something.”

Care plans contained up-to-date information on how to care for the person and how to meet their individual preferences. We saw people were encouraged to be as independent as possible. People told us they felt able to ask to go out for a walk or to ask to undertake particular daily activities.

People were able to express their views and these were listened to. We saw records from the regular residents’ and relatives’ meetings which showed the manager had acted on people’s views, particularly around menu planning.

We reviewed the home’s equality and diversity policy which included information for staff about different faiths and cultures and the potential implications for care and dietary requirements.

Are services responsive to people’s needs?

People’s capacity to make decisions for themselves was considered under the Mental Capacity Act (2005). When people did not have capacity, decisions had been taken in the person’s best interest and this had been recorded.

We saw people were encouraged to maintain relationships with friends and relatives. The manager told us friends and relatives were free to visit at any time of the day. We saw a number of relatives visit who were all complimentary about the care people received in the home.

The manager told us the staff carried out most of the activities work. At the time of our visit an external activity provider held a movement and singing session. People told us they enjoyed this.

People living in the home were aware of how to make a complaint. Information was provided in the foyer of the home and also in the ‘service user guide’.

Are services well-led?

We saw good leadership at all levels. The registered manager actively promoted a positive culture that was person centred, open, honest and inclusive. Members of staff told us they felt empowered to act professionally and make day-to-day decisions.

Summary of findings

We saw the annual schedule of audits. Recent audits included those for: care plans; moving and handling; tissue viability; and nutrition. We were shown the monthly audit of accidents which listed people's falls. We saw actions plans had been created as a result of this audit, which protected people from further harm and to analyse any trends.

The manager showed us minutes from staff meetings that showed learning from mistakes and incidents took place such as group learning from a medication error.

We looked at the complaints file and saw only one complaint had been received in 2014. We reviewed how this had been handled and saw the complaint had been acknowledged, investigated and responded to appropriately.

We saw people's dependency was assessed regularly and the manager explained how this was a determining factor for staffing levels during the day and at night. The manager told us staff were encouraged and supported to undertake nationally recognised qualifications in care. Records showed 14 members of staff had gained a level two or above.

Summary of findings

What people who use the service and those that matter to them say

We spoke with seven of the twelve people who lived at College View. In addition we spoke with four relatives who visited the home at the time of our visit.

We asked one person if they felt safe at College View; the replied, "I have never felt unsafe here; the staff look after me like one of their own."

Other comments about the home included:

"The food is lovely and always fresh", "I am very settled and happy here" and "It has a lovely homely atmosphere."

When we asked relatives about the care, comments included:

"I am very happy with the care, they would not be in here if I had any doubts", "They are very contented", "I now have peace of mind", "I have got my life back" and "It's run as if it was the residents' own home."

A relative summed up the care by saying, "You would have to really nit-pick to find anything to complain about, I am happy that mum is at College View."

College View

Detailed findings

Background to this inspection

We visited this service on 9 April 2014. We used a number of different methods to help us understand the experiences of people who lived in the home. These included talking with people and observing the care and support being delivered. We also looked at documents and records that related to people's support and care and the management of the service.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

The inspection team consisted of a lead inspector and an expert by experience. The expert by experience gathered information from people who used the service by speaking with them and with the care staff. Both the lead inspector and the expert by experience observed the environment and the support provided. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

At the time of our inspection the maximum of 12 people were living at the home. During our visit we spoke with seven people who used the service and four relatives. Prior to the inspection we spoke with a representative from the local clinical commissioning group who provided positive feedback about the service.

Are services safe?

Our findings

The service had a clear policy and procedures in place that provided staff with guidance to follow if an incident of abuse was reported or suspected. In discussion with members of staff, they demonstrated a good understanding of their responsibilities in terms of safeguarding people from abuse and clearly wanted to ensure the safety and wellbeing of people who used the service.

We reviewed the home's policy on the safeguarding of vulnerable adults. We saw staff had received appropriate training and safeguarding issues were discussed at people's supervisions as well as in more general terms at staff meetings. We reviewed the safeguarding log and saw appropriate referrals had been made and recommendation following investigations had been acted on.

Records showed that training in the area of safeguarding was provided to all staff including all support staff. Members of staff told us this training provided them with the necessary guidance in order to be able to report any instances of abuse.

The members of staff we spoke with were aware of their individual responsibilities to report any incidents or concerns and had understood their employer's whistle blowing procedures. Members of staff said they were confident managers would deal with any such concerns effectively and support them as whistle blowers.We looked at the care records and saw mental capacity and best interest assessments were in place where required, for people who were unable to make decisions for themselves. The registered manager told us that although they were familiar with the process, no DoLS applications had been made for over a year.

We saw the manager completed a monthly audit of accidents or incidents including any falls people may have had. We reviewed the minutes from staff meetings and notes from individual staff supervisions. We saw any accident of incident had been talked though openly with members of staff in order to promote continual improvement and learning. One example was the learning from a medication administration error which had been discussed with a member of staff at an individual level as well as being used as a group learning activity.

The care plans gave guidance to staff about how to manage behaviours which may challenge the service although the manager told us any such behaviour was rare. In addition, information was provided on techniques staff should employ to manage any distress or agitation the person may experience such as distraction techniques.

The care plans we reviewed showed people's individual health care needs were addressed. Each person was registered with a GP and had an allocated member of staff who coordinated their care. Each care plan we viewed had been signed by the person it concerned which confirmed their involvement in their care.

Each person had a set of risk assessments which identified hazards that people may face and provided guidance to staff to manage any risk of harm. Care plans and risk assessments were reviewed monthly to ensure they were current and relevant to the needs of the person. We saw reviews were meaningful and informative. The service used a traffic light system to identify people who were at most risk of harm, for example falls or skin tissue damage. People at high risk of developing pressure sores, from staying in bed for long periods for example, had specific care plans indicated by the use of a red sticker on their file.

We noted the home was kept clean and tidy. The building was decorated well and was free from odour. One person's relative commented, "When I come in to the home there is always a fresh clean smell." The manager showed us the home's infection control policy and we noted there was a member of staff who acted as the lead for infection control. We saw audits were carried out on infection control and the home had completed a recognised NHS audit tool (Essential Steps) in 2013. One person commented, "It's very clean. I used to be a cleaner and I'm quite particular about it but I've never seen anything here that worries me."

We observed members of staff wearing appropriate personal protective equipment (PPE) such as disposable gloves and aprons. Members of staff we spoke with demonstrated their knowledge of infection control procedures. We noted each bathroom and hand basin was equipped with disposable hand towels and cleansing gels and soaps. Alcohol hand gel dispensers were located throughout the home. Records showed members of staff had been trained in infection control annually.

Are services effective?

(for example, treatment is effective)

Our findings

People living in the home and their relatives told us they had a care plan which they had been involved in creating. People told us they were invited to regular review meetings which they found meaningful and helpful. One relative explained they had been involved in the care planning and that they had completed a 'This is Me' booklet about their relative so the staff could get good background knowledge of the person.

We saw people's bedrooms were comfortable and personalised. People we spoke with told us they liked their rooms. We saw people had brought in their own furniture to make their room more like it had been in their own home. However, we found some areas where improvements could be made. For example, people did not have pictures and photographs on the doors to help them identify their own rooms. Bathrooms and toilets did not have pictorial signs to help people find their way around the home and there were no handrails in the corridors.

The care plans we reviewed showed people's individual health care needs were addressed. Each person was registered with a GP and had an allocated member of staff who coordinated their care. Each care plan we viewed had been signed by the person it concerned or their representative to confirm their involvement in their care.

We reviewed four care plans. We saw each person had a personal profile which described their personal preferences in relation to religion, food, drink, and daily routines. We saw this had been reviewed monthly. Comments from members of staff included, "People here have a lot of choice. We try to make sure they can be as independent as possible" and "People's choices are respected; they choose when to get up, when to go to bed, what to eat and drink, and what to do."

We observed members of staff gave people choices about what they wanted to do, where they wanted to sit, and what they wanted to eat. We observed people who were still in bed being asked if they wanted to get up or stay in bed. We also saw people being asked if they would like to read the newspapers, watch television or have a chat to members of staff. One member of staff told us, "Everything is very personal here; we have time to talk to all the residents and really understand their needs. People are very settled here."

We saw each person had a night care assessment which had been completed with the person or someone who matters to them. Included within this assessment was what people preferred to wear in bed, whether they liked a light on and what time they normally liked to go to bed. We noted one person's assessment indicated they liked to get up around 11.30am. When we spoke with this person they told us this was their own choice.

One person's care record included a 'do not attempt cardiopulmonary resuscitation' (DNACPR) form in place. We saw records of the discussion between the person, their relatives, the manager and the GP which showed the person had made an informed decision about their treatment. We saw people's care files included advanced care plans which contained information about their wishes about the end of their life. This showed the service had taken steps to respect people's dignity.

We looked at the staff records and found most of the staff had been working at the home for some time. The manager told us this helped build relationships and promote continuity of care. The three members of staff we spoke with demonstrated a good understanding of people's care and support needs and clearly knew people well.

We reviewed the staff training records and found there was a system in place to identify the courses staff had completed and to highlight those for which new training or updates were required.

Members of staff were supported through a programme of staff training, supervision and appraisal. These ensured staff were supported to deliver care safely to people. Core training for all staff included the administration of medicines, moving and handling, fire safety, infection control and food hygiene.

Records showed people were supported to have a healthy diet. Risk assessments and other guidance was in place that gave staff information on how to meet people's individual needs. We saw one person's care plans included information from the speech and language therapist on the required texture of their meals to aid swallowing.

We observed the lunch time meal and saw people were given a choice of what to eat and drink. The meals were well presented and we observed staff assisting people to eat. This was done without rushing and at the person's own pace. We saw some people asked for alternative meals and these were provided. One person told us, "The food is

Are services effective?

(for example, treatment is effective)

lovely and always fresh." We observed a homely atmosphere during lunch with music playing in the background. Records of residents' meetings showed people living at the home had been involved in the planning of menus. One person said, "We always discuss the menus and the food. We can have what we want basically, they never quibble."

The home had appointed one member of the care staff to act as a 'dignity champion'. Minutes from staff meetings showed dignity had been discussed and staff had been reminded about issues to do with people's privacy whilst they received care such as closing the curtains when somebody is being helped in to bed.

We saw people's weights had been monitored regularly. When people's weight had decreased, appropriate risk assessments had been put in place and people were weighed more frequently. In addition records were kept of how much people ate and drank each day. This ensured people maintained healthy weight. One person's care plan indicated they needed to have a high protein diet to help with skin integrity.

Are services caring?

Our findings

We observed members of staff providing care with compassion and respect. We saw staff sat with people talking about things that were important to them. We observed one care worker listening to one person who had become upset at the thought of sitting in the dining room at lunchtime. The care worker listened to the person's concerns patiently, without interrupting them. Following this the care worker suggested an alternative place for the person to eat which they were happy with.

We saw members of staff took time to understand the needs of people who were not able to communicate as well as others. They spent time watching their body language and facial expressions to understand how they were feeling. One member of staff told us, "We are encouraged to sit with people who can't communicate so that we pick up on their facial expressions to pick up if they are in pain or worried about something." The members of staff we spoke with were all able to explain in detail about people's needs and behaviours including their facial expressions if they were in pain or didn't like their food.

We observed staff using the hoist with some people to ensure they were transferred safely. Staff spoke to each person throughout the procedure reassuring them and explaining what was happening. We saw staff used the hoist in a calm and patient manner. The person's dignity was preserved throughout the transfer by adjusting their clothing and also closing the lounge door whilst the hoist was used.

We reviewed four care plans and saw they were written with the needs of each person in mind. Each plan contained up-to-date information on how to care for the person and how to meet their individual preferences. One member of staff told us, "Our care plans try to make sure that each resident is treated as a person in their own right. We make sure we know all their preferences so we know what they like to do and when as well as how often they would like a bath or shower." Each care plan had an objective which had been reviewed monthly. We noted objectives were written in such a way that independence was always promoted.

People's care plans included records of formal reviews every six months. Each review took place with the person or their relative, the manager and other external professionals such as a social worker. We saw people's views were considered as part of this review process and included discussions about mobility, personal hygiene, continence, sleeping, orientation, and, eating and drinking.

We saw people were encouraged to be as independent as possible. People told us they felt able to ask to go out for a walk or to ask to undertake particular daily activities. During our visit we saw one person asked if they could go out for a walk. A member of staff immediately arranged this and accompanied them outside. One relative told us, "That's not just for your benefit, when people ask for something the staff usually go out of their way to make it happen." One person living at the home said, "I am a very independent person and the staff respect that, they encourage me to do as much as I can for myself."

People's privacy and dignity were maintained and promoted. We saw staff knocked on people's doors before entering rooms. People appeared well dressed and well looked after and told us they chose what to wear each day.

People were able to express their views and these were listened to. We saw records from the regular residents' and relatives' meetings which showed the manager had acted on people's views, particularly around menu planning. People told us they felt able to make comments to the manager and the provider and knew these would be acted on.

The manager told us currently there was no one at the home who had any specific cultural or religious preferences but the home would respond to people's needs if necessary. One member of staff told us, "We are trained in equality and we know about it. At the moment though most of our people don't really have any specific cultural or spiritual needs." We reviewed the home's equality and diversity policy which included information for staff about different faiths and cultures and the potential implications for care and dietary requirements.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People's capacity to make decisions for themselves was considered under the Mental Capacity Act (2005). When people did not have capacity, decisions had been taken in the person's best interest and this had been recorded. Whilst no one had used an advocate, there was information made available in the home and the 'service user guide' about independent advocacy services.

The manager was able to describe the principles behind DoLS and understood their responsibilities to make an application when they considered to be in the person's best interests.

We reviewed four care plans and saw each had been evaluated monthly. This ensured the home responded to any change in people's needs.

We saw people were encouraged to maintain relationships with friends and relatives. The manager told us friends and relatives were free to visit at any time of the day. We saw a number of relatives visit who were all complimentary about the care people received in the home. Comments included, "It's run as if it was the residents' own home", "It has a lovely homely atmosphere", "You would really have to nit-pick to find anything to complain about."

One person's relative told us they were regularly kept informed about their relative's well-being. They told us they were now quite happy to go away for a holiday as the home, "Always keeps us up-to-date." They said they felt they could contact the home at any time to talk to staff about their relative.

The home did not employ an activities coordinator. The manager told us the staff carried out most of the activities work. At the time of our visit an external activity provider held a movement and singing session. People told us they enjoyed this. Comments included, "I really enjoyed the movement class this morning; it's not good to sit in front of the TV all day" and "It was good this morning but we only get something like that every now and again and I do get bored sometimes."

We noted there was no notice board displaying the week's activities. The manager told us this was because the staff responded to people's requests rather than planning activities. However, two people told us they felt there was not enough to do most days.

We noted two people chose to spend much of the day in their rooms. We observed members of staff checking on them several times. They spent time chatting to the person to ensure they were not lonely or felt isolated.

People living in the home were aware of how to make a complaint. Information was provided in the foyer of the home and also in the 'service user guide'. One person told us, "I would have no problems in going to see XXX, the manager, if I had any concerns or complaints." We noted there was not an easy read version of this on display using pictures and simple text. This meant that people may not readily understand how to make a complaint if they had difficulty in reading and understanding relatively large amounts of text.

Are services well-led?

Our findings

We saw good leadership at all levels. At the time of our visit the service had a registered manager in place who was also the provider. The registered manager was supported by an operational manager who had previously been a senior carer. The manager actively promoted a positive culture that was person centred, open, honest and inclusive. Members of staff told us they felt empowered to act professionally and make day-to-day decisions. The manager told us they valued the input of the staff and worked hard to maintain a good level of morale.

We saw there was a whistle blowing policy in place; members of staff confirmed they were aware of the policy and would feel able to use it without fear of any adverse redress. The registered manager told us staff were encouraged to question practice and policy openly.

The registered manager showed us the annual schedule of audits. We saw recent audits included those for: care plans; moving and handling; tissue viability; and nutrition. We were shown the monthly audit of accidents which listed people's falls. We saw actions plans had been created as a result of this audit which protected people from further harm and analysed any trends. We saw the manager had signed to indicate when actions, such as updating risk assessments, had taken place. We saw the home had specific risk assessments and monitoring systems in place for people who had been diagnosed with dementia. We saw how people's ability to eat and express their views was monitored continually.

The manager showed us minutes from staff meetings that showed learning from mistakes and incidents took place. We saw a recent medication error had been discussed openly with staff and had been used as a learning opportunity. One member of staff told us, "If something goes wrong then we all learn from it. No one here wants anyone to fall or get hurt so we make sure we look at anything that goes wrong." We also saw infection control issues and tissue viability was discussed.

We saw one audit had identified that two people had lost weight. We saw the staff meeting discussed any difficulties the people may be experiencing; the potion size of their food and potential fortified food regimes.

We reviewed the home's emergency plans. We saw the provider had put in place contingency plans for incidents ranging from electrical failure and flooding through to actions required as a result of a bomb threat.

We looked at the complaints file and saw only one complaint had been received in 2014. We reviewed how this had been handled and saw the complaint had been acknowledged, investigated and responded to appropriately.

The manager showed us a residents' survey from February 2012 as one had not been issued since that time. We saw largely positive comments from people about their care although there had only been five respondents. The manager may wish to undertake another survey this year and ask staff to support people with their completion or seek the assistance of an independent advocate.

We saw people's dependency was assessed regularly and the manager explained how this was a determining factor for staff levels during the day and at night. We were told that staffing levels were adjusted when people's needs changed or when occupancy levels changed. The manager told us the home did not employ any agency staff and shortfalls as a result of sickness or holidays were covered by other members of staff.

The manager told us staff were encouraged and supported to undertake nationally recognised qualifications in care. Records showed 14 members of staff had gained a level two or above. We saw staff had been encouraged to attend specialist training other than courses the provider considered to be mandatory, such as dementia care, mental health awareness, and diabetes care. We observed training was embedded into practice. For example, members of staff demonstrated skills in recognising the needs of people with dementia through their facial expressions.