Crystal Care Services Ltd

Blossom Hill Care 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

Summary of findings

Overall summary

This inspection took place on 30 October and 1 November 2018. The first day of the inspection was unannounced. This meant that the provider and staff did not know we were coming.

This is the first time Blossom Hill Care Home has been inspected.

Blossom Hill Care Home is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Blossom Hill Care Home is registered to provide residential care and support for up to 40 people. At the time of our inspection 24 people were living at the service.

A registered manager was in place. 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.

The service had a warm homely atmosphere. People and relatives we spoke with were complimentary about the care and support provided.

The provider had systems in place to safeguard people from the risk of abuse and discrimination. Safeguarding referrals were fully investigated. The provider recorded, collated and analysed safeguarding concerns and accidents and incidents to identify any patterns or trends for lessons learnt.

A robust recruitment process was in place which included ensuring appropriate checks were undertaken before staff started work. Staff training, supervisions and appraisals were monitored and up to date.

People lived in a safe environment. The premises were decorated to a high standard and were clean and tidy. Health and safety checks were completed regularly. Identified risks were assessed and managed to reduce the risk to people who used the service and others.

Medicines were managed safely. People were supported to access health professionals when required.

Staff supported people to maintain family relationships and links with the local community. We observed staff treating people with dignity and respect. Staff had a sound knowledge of the people they supported. Care plans reflected people's current needs and were regularly reviewed.

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.

The provider had systems to monitor the quality and safety of the service provided.

People and relatives told us they had no complaints about the service and knew how to make a complaint. People were supported to engage in activities and access the local community.

People, relatives and staff were positive about the management of the service. The registered manager was approachable and provided strong leadership and direction for staff. Staff told us they enjoyed working at the service and felt supported by the registered manager and the provider.

The provider had systems to audit various aspects of the running of the service. The registered manager ensured statutory notifications had been completed and sent to the CQC in accordance with legal requirements.

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.

A robust recruitment process was in place. All appropriate checks were conducted prior to an applicant starting work at the service.

People were protected from abuse. Safeguarding concerns were thoroughly investigated.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Training and development was up to date. Staff told us they felt supported.

People were supported to have access to healthcare professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were kind and caring.

Staff treated people with dignity and respect. People were supported to remain as independent as possible.

People were supported to maintain relationships important to them.

Is the service responsive?

Good

The service was responsive.

Care records were personalised and were reviewed regularly.

People were supported to participate in group and individual activities.

The provider had a complaints process and procedure in place.

Is the service well-led?

Good

The service was well-led.

The provider constantly reflected on its performance and utilised information from a range of sources to drive improvement.

People and relatives told us the management team were approachable. Staff were passionate about their roles.

The registered manager ensured statutory notifications had been completed and sent to the CQC in accordance with legal requirements.

Blossom Hill Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 October and 1 November 2018. The first day was unannounced. This meant the provider did not know we would be visiting. The inspection team was made up of an adult social care inspector, an expert by experience and a specialist advisor in nursing care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed other information we held about the service, including any statutory notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG) and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used information the provider sent us in the Provider Information Return. 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.

As part of the inspection we conducted a Short Observation 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.

We undertook general observations of how staff interacted with people as they went about their work. We looked around the service and visited people's bedrooms with their permission. We examined documents relating to recruitment, supervision, training and development records and various records about how the service was managed. We looked at care records for four people who used the service. We spoke with four people who lived at Blossom Hill Care Home, seven relatives, the registered manager, operations manager, one nurse, one team leader, three care staff members, one activities co-ordinator, administrator and two

kitchen staff.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Blossom Hill Care Home. One person told us, "I've been here for six weeks now because I fell at home getting out of bed. I feel very safe because the staff are really good." Another person said, "I've been living here since April and I've always been safe as the staff are very caring."

The service had a homely feel and was spotlessly clean throughout the building. Lounge areas were spacious and clutter free. The provider ensured people lived in a safe environment. Health and safety checks were completed monthly and service certificates for the premises were up to date.

Environmental risks were identified and risk assessments were introduced to support staff in mitigating the risks. Risks were assessed to ensure people were safe and where possible, actions were identified for staff to take to mitigate these occurring. For example, from the records we viewed we saw risks such as: moving and handling, mobility, falls, use of bed rails, nutrition and hydration and choking.

A business continuity plan was in place to ensure people would receive continuity of care in the event of an emergency. People had an individual personal emergency evacuation plan (PEEP) which outlined the support required in the event of an emergency.

We noted that fire drills had not been completed in line with the provider's policy. The policy stated,"A fire evacuation drill is carried out, at least twice a year during the day and four times a year (simulated) during the night, details of which will be recorded in the logbook." Only three fire drills had taken place since December 2017. The need for a fire drill was referred to in the health and safety group meeting minutes dated 4 September 2018.

We discussed with the registered manager the frequency of drills and how the service was going to achieve the required number as directed. They told us that they had discussed timings with the deputy manager but did not have a record of this. Actions were put in place to complete the required number of fire drills.

All staff we spoke with had completed fire safety training via the provider's eLearning system. However, when asked if they had received training on the available evacuation equipment all advised that they had not received instruction of how to use the evacuation equipment.

We alerted the registered manager and operations manager to our findings who took immediate action. All staff viewed an instructional video online and were involved in hands on practise with the evacuation equipment. Staff were enthusiastic to be involved and discussed people's potential reaction to the equipment and how best to approach the situation.

Staff we spoke with had a good understanding of safeguarding and were aware of the provider's whistleblowing scheme. Safeguarding concerns were fully investigated and referred to the appropriate agencies. The registered manager had a keen interest in safeguarding and had completed additional training with the local safeguarding authority.

Accidents and incidents were recorded and reviewed. The provider analysed the information gathered from safeguarding concerns, accidents and incidents and complaints and any lessons learnt were cascaded to all its services. The service utilised the information to drive improvement and any identified lessons learnt formed part of reflective practise which involved all staff.

People and relatives told us sufficient staff were deployed to ensure people's needs were met. One person said, "There's always staff there when I need them, I've had no problems at all." Staffing levels were determined by people's needs by using a dependency tool. These were reviewed monthly and when new people came to live at the service or people's needs had changed

Medicines were managed safely. Systems were in place to ensure that medicines had been ordered, received, stored, administered and disposed of appropriately. Medicines were securely stored in a locked treatment room and were transported to people in a locked trolley when they were needed.

The medicines administration records (MARs) contained recent photographs of people to reduce the risk of medicines being given to the wrong person, and all the records we checked clearly stated if the person had any allergies. This reduces the chance of someone receiving a medicine they are allergic to. Medicines were given from the container they were supplied in and we observed staff explain to people what medicine they were taking and why. People were given the support and time they needed when taking their medicines. People were offered a drink of water and staff checked that all medicines were taken. People's medicine support needs were recorded in their care records.

Some people were prescribed PRN (as required medicines). Some PRN protocols were in place to assist staff by providing clear guidance on when PRN medicines should be administered and provide clear evidence of how often people require additional medicines, such as pain relief medicines. A pain assessment tool and the Abbey pain assessment tool were used for people who could not effectively communicate.

Audits were regularly conducted and where issues were identified there was an action plan in place to address the matters. Staff had completed appropriate training to enable them to safely administer people's medicines.

Pre-employment checks were conducted prior to staff commencing work at the service. These included obtaining a full employment history, reviewing identification documents, references from previous employers and a Disclosure and Barring Service (DBS) check. DBS checks help employers make safer recruitment decisions and help to prevent unsuitable people from working with vulnerable adults.

The service ensured all nurses NMC registrations were valid and monitored. All nurses must be registered with the Nursing and Midwifery Council (NMC). The NMC is the regulator for all nurses and midwives in the UK.

Staff had received training in infection control and an infection control champion had recently been appointed. Audits were regularly completed and we observed staff wearing protective equipment such as gloves and aprons where appropriate.

Good

Is the service effective?

Our findings

People and relatives we spoke with felt staff had the appropriate skills and knowledge to provide care and support. One person told us, "Yes, I do think they are trained really well because I get looked after really well and I love it here." Another person told us, "I've got no complaints at all, I've no idea what training they get but I get looked after very, very well." A relative told us, "My [relative] is more than happy with the staff here and they all appear to be well trained."

All mandatory training was up to date. The registered manager monitored training and records showed staff members had completed training in areas such as moving and handling, health and safety, infection control, safeguarding and equality and diversity. One staff member told us, "I had an induction first and have done all my training."

Staff received supervisions every eight weeks and an annual appraisal. Staff members we spoke with told us they felt supported. One staff member told us, "I have the opportunity to discuss work and if I want other training." Another staff member said, "I have had a number of supervisions. I never had them at my last place."

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

The registered manager had created a system to monitor DoLS applications. Applications were made in a timely manner and monitored whilst waiting for an outcome by the local authority. MCA assessments were completed prior to applications and best interest decisions were present in people's care records. Best interest decision assessments had been completed in relation to specific decisions. For example, the use of lap belts. However, we noted some had been completed by one staff member and did not involve any consultation or involvement with relatives or health professionals. We discussed our findings with the registered manager who advised they would address the matter.

Throughout our inspection we observed staff obtaining consent from people before supporting them. We noted staff explained what was happening and sought permission from people before supporting them.

Staff we spoke with were able to describe the best way to support people in making day to day decisions. One staff member told us, "I always show [Person] the meals available as they can forget."

People's needs were assessed before they moved into the home to make sure the staff were able to care for the person and had the equipment to ensure the people's safety and comfort. The assessment gathered all appropriate information to ensure all the equality act characteristics were not discriminated against. Where a support need was identified a care plan was developed setting out how it could be met.

The premises were decorated to a high standard throughout. Communal rooms were large with large windows which allowed in natural light. Corridors were wide and toilet, bathroom and shower rooms were spacious to accommodate people's wheelchairs. The gardens were well maintained with raised flower beds, a summer house and seating area.

We noted no dementia friendly signage was available to support people living with dementia to orientate independently around the home. People's bedroom doors resembled front doors and were different colours. Bedrooms were identified with the person's name and the room number. No other supporting imagery or objects were present to support people living with dementia to recognise their own room. The registered manager told us that staff were working with people and their relatives in creating memory boxes to support people.

People were supported to access healthcare professionals including GPs, dietitian, physiotherapist and podiatrist. Routine appointments were recorded and when required staff supported people during the appointments. One person told us, "If I need to see a doctor the home will arrange it for me and the doctor comes into the home, so does the chiropodist and the dentist."

People told us they enjoyed the meals on offer. Comments included, "I've enjoyed everything I've eaten and there's plenty of choice at mealtimes," and "It's great; I've got no faults living here, I'm happy that the food is good."

Meal times were relaxed with music playing in the background. Tables were dressed with tablecloths, cutlery, and condiments. Staff had extensive knowledge of people's preference, how people liked to be supported and any guidance from the speech and language team (SALT). People were promoted to be as independent as possible. Staff were sensitive to the needs of people and gave encouragement and offered assistance when required.

Refreshments were offered throughout the day including hot and cold drinks, cakes and biscuits, fresh fruit and yoghurts. Juices were also available in lounge areas. Staff we spoke with recognised the importance of hydration. One staff member told us, "I'm terrible with fluids. I always offer people, especially people in their rooms. I pop in and ask, I couldn't do without a drink."

Menus were displayed on the wall in a weekly format in small print. The registered manager told us they were creating a pictorial menu to support people living with dementia. We observed staff offer people plated meals to choose from at mealtimes. If people declined their first choice staff offered the alternative option. One person told us, "They made my favourite for me which wasn't on the menu because I've been poorly, the food is really good and I love my mince pie,"

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. One person told us, "The staff are lovely. They look after me so well, so caring. And very kind." One relative said, "They are caring towards my [family member] and treat her with respect." Another relative said, "The staff are very pleasant, and in my opinion, seem to be caring towards everyone."

Throughout our inspection we observed many positive interactions between staff and people living at the service. People were clearly comfortable and happy in the company of staff members. Staff were attentive to people's needs and knew people well. On one occasion one person reached out for a cuddle and the staff member embraced them. The person was visibly comforted by the staff member's action.

People told us they were treated with respect and dignity. One person said, "Oh yes, it's embarrassing for me what I can't do and they are very good at taking care of me, and I feel my dignity is respected all of the time." One relative told us, "The staff don't embarrass my [family member] when taking her clothing off as her privacy is provided all the time as far as I can see." Staff we spoke with were able to describe how they maintained people's dignity when supporting with personal care. One staff member told us, "I always explain and ask if it's okay I can help. Keep the person covered and give them a hand when they want me to."

When staff were not going about their duties they were sat chatting to people. We observed staff spoke with people in a respectful way. They were patient with people and did not rush them to respond.

Staff had extensive knowledge of people, their likes and dislikes and preferences on how to be supported. One staff member recalled how one person's relative had advised that their family member was previously always very active and out and about. When possible, staff supported the person on walks around the local area. A staff member told us how the person did not engage in the service yet whilst on a walk the person began telling the staff member stories about the local area and recognised it was an area they once lived in.

A number of the staff lived locally to the service and had knowledge of people's past and the local community. This enabled them to engage in meaningful conversations and reminiscence with people, creating a strong bond.

People were supported to be as independent as possible. We observed at mealtimes staff were readily available to support and offered assistance but never took over. One person told us, "They are there to help but I do try to do as much as possible, I can put the fork in my hand but the carers always ask if I'm ok to do it." One relative told us, "The carers always encourage them to be as independent as possible when I'm visiting."

People had access to information about local advocacy services. An advocate is someone who represents and acts on a person's behalf and helps them make decisions.

People were supported to maintain relationships. The registered manager told us how one person was supported to use Skype to communicate with their family who lived out of the area. Relatives were made welcome at the service. The service had made an adjacent building available for overnight stays to accommodate relatives and friends visiting from outside the local area.

Confidential information was held securely and was only accessible by staff members who required the information to perform their role.

Good

Is the service responsive?

Our findings

People received personalised care which was responsive to their needs. Care plans we looked at contained some personalised information and outlined people's support needs and re-enforced the need to involve people in decisions about their care and to promote their independence.
Care files included a range of specific care plans designed to support the person and covered such areas as: maintaining a safe environment, communication, mental health, eating and drinking, mobilisation, expressing sexuality, sleeping and end of life care.

Care plans differed in content, with some containing more detail than others. One person had a visual impairment, their communication care plan gave specific information for staff to follow. It stated, "Staff when approaching person must speak slowly and clearly explaining who they are and what they are going to do, give person enough time to digest this and continue to tell them what's happening at all times." However, for one person who suffered from a low mood and anxiety guidance was limited to 'give reassurances'. No further information was available to support staff on how to engage with the person in a manner to ease their anxieties.

The registered manager told us they had sought guidance from the challenging behaviours team to support people. People, staff and healthcare professionals had taken part in formulation sessions. Formulation involves developing an explanatory story which makes sense of an individual's behaviour based on the information gathered at assessment.

People living in the home were at varying risk of pressure ulceration. Assessments had been carried out to identify which people were at risk of developing pressure ulcers and preventative pressure relieving measures were in place for those people who required them. People had detailed care plans to inform staff of the intervention they required to ensure healthy skin. We noted that the pressure relieving mattress settings were recorded daily on the mattress records.

People's mobility needs were identified and specific plans were adopted to support people with their mobility needs and transfers. There was a clear plan for staff to follow in the event of anyone falling.

Care plans had been evaluated monthly and were reflective of people's changing needs, preferences and new guidance received from external health care professionals.

Staff we spoke with had a good understanding of people's support needs and preferences. One staff member told us, "I read the care plans but I talk to the person and their family to really get to know them."

We checked if the provider was adhering to the Accessible Information Standard (AIS). The Standard was introduced in July 2016 and states that all organisations that provide NHS or adult social care must make sure people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. People's care records included information about people's communication needs and how best to support them. The service offered large print for

people with a visual impairment and the registered manager advised photographs were being taken to produce a pictorial menu to support people living with dementia.

A range of activities were available including bingo, dominoes, cards and movie afternoons. During our visit we observed people taking part in an arm chair keep fit session and then there was a card game afterwards. This was followed by a sing along session. One person told us, "I go to all the activities and I join in as much as I can. I played the card game this morning, which everyone enjoyed and people bring dogs in from time to time for petting sessions."

For those who chose not to take part in activities staff ensured they popped in to chat with people to protect them from isolation. One relative told us, "[Family member] doesn't get involved as she just likes to sit in her room, but the staff often pop in to speak to my [relative] so she is not isolated." One person expressed a wish to have Sky television put in their room and the service ensured this happened. People were supported to practice their religious beliefs with close links to the neighbouring church.

People had access to a well maintained secure outside area with raised flower beds which people planted in the summer months, a summer house, seating and BBQ area. One staff member told us, "We were all outside in the summer, I went and got ice lollies." Relatives and friends were invited to attend social occasions. During our visit we noted the service was decorated for a forthcoming Halloween party.

End of life care plans were in place for people with terminal and life limiting illnesses. This meant staff had access to information outlining people's wishes at this important time and to ensure their final wishes were respected. Staff had received end of life training and a champion had been appointed. We noted one relative submitted a review of the service, it read, 'Our [family member] was treated with dignity, respect and love. We are certain that they have had the very best care and support from pleasant, friendly yet professional staff.'

The provider had a complaints procedure in place. People and relatives we spoke with told us they had no complaints about the service and knew who to address if they had any issues. One person told us, "I've got nothing to complain about because I'm very lucky to be living here. I know who to complain to, it would be the manager." One relative said, "As far as me and my [family member] are concerned, [family member]'s treated really well but if there was any problems, it would be the management."

Good

Is the service well-led?

Our findings

People and relatives we spoke with told us they felt the service was well-led. One person said, "Yes, I would say it's very well run, it's like clockwork." Another person said, "I would say it's very well managed because the home is nipping clean." One relative told us, "Yes, I believe it is as we've had no problems and everything appears to be fine, staff are great, nothing is a problem."

The service had only been open since December 2017. The registered manager demonstrated a strong leadership. Staff we spoke with were positive about the management of the service. Staff told us they were supported by the provider and the registered manager. Regular staff meetings were held and staff told us they could discuss anything and they were listened to. One staff member said, "We get to have an input." The registered manager had recently set up a champions scheme for staff promoting knowledge and leadership.

Morale was high amongst staff we spoke with. All staff expressed they were happy working at the service. One staff member told us, "We all work well together and make sure people get the care they need. Another staff member told us, "It's like a breath of fresh air. I've never had a manager like it, [the registered manager] works on the floor, listens and is approachable."

The provider had a number of systems in place to assess and monitor the quality of the service. Audits covered areas such as medication, infection prevention and control and catering. The provider conducted operational visits which examined the following areas, accidents, nutrition, safeguarding, complaints, staffing, and business matters. We noted health and safety issues were discussed at a monthly meeting but did not form part of the provider's audits. Following the inspection the operations manager advised that this matter had been addressed and the information had also been cascaded to the provider's other services.

The registered manager and operations manager worked well together and were proactive in utilising information gathered from accidents and incidents, safeguarding and complaints. They were enthusiastic about continuous learning and driving improvement. Reflective meetings were held and involved all staff in discussions. The operations manager told us, "We discuss what has gone well and things that may have not gone so well." We noted a reflective meeting was held after day one of our inspection. The provider ensured that lessons learnt were cascaded to all its services.

The registered manager advised that the service sought feedback from people using the service and their relatives. The provider sent out questionnaires to relatives but only three had been returned. We enquired why only relatives had been consulted for their feedback. The registered manager was unable to outline the rationale behind such action. They advised that they regularly gathered people's feedback day to day and via residents' and relatives' meetings. A suggestion box was also available, as yet no one had used that facility.

The service worked in partnership with a number of agencies, including the local authority, safeguarding teams and multidisciplinary teams, to ensure people received joined up care and support. The registered

manager had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

The service supported people to maintain community links. People were supported to visit local shops, parks and churches. The registered manager told us they had established a good partnership with the local vicar in the adjacent church. They also advised that they were in discussions with a local school with the aim for children to attend the service but this was in the early stages of planning.