Care Quality Commission

Esk Hall Limited

Esk Hall Care Home

Inspection report

Coach Road, Sleights, Whitby,
North Yorkshire, YO22 5EG
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Date of inspection visit: 8 September 2015
Date of publication: 30/11/2015

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?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 8 September 2015 and was unannounced. At the last inspection on 17 September 2013 we found the service was meeting the regulations we inspected.

Esk Hall Care Home provides residential accommodation and personal care for up to 20 older people. On the day of the inspection there were nine people living in the home. The home is located in the village of Sleights and is surrounded by attractive grounds. The home does not provide nursing care.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission 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.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the home. The home had sufficient numbers of suitable staff to care for people safely and they were safely recruited.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date

Summary of findings

in mandatory areas such as infection control, health and safety, food hygiene and medicine handling and also in specialist areas of health care appropriate for the people being cared for.

Staff had received up to date training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and that they should assume that a person had capacity to make decisions. They understood what needed to happen to protect the best interests of people whose capacity was impaired.

People's needs related to eating and drinking were met. People enjoyed the meals and they were of a good quality. However, people were not asked for their views about the menu and they were not consulted for their views when the menu was changed.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with dignity and respect. Staff had a good knowledge and understanding of people's needs and worked together as a team. Care plans provided information about people's individual needs and preferences.

People told us they were well cared for, however; they said they were sometimes bored, with little to entertain them. The registered manager was developing a plan to address this. We have made a recommendation about this.

People told us their complaints were responded to, however the results of complaint investigations were not always clear. People's satisfaction with the outcome not always recorded so that the registered manager could not be sure they were responding to people's concerns appropriately.

People who lived in the home, staff and visitors had raised concerns that the registered manager was sometimes absent from site due to other commitments, and that the quality of leadership was compromised when this happened. However, the registered manager had responded to these concerns and had put plans in place to address this. The registered manager and deputy had recently ensured that there was a management presence within the home at all times.

Quality assurance systems were in place. Some auditing was informal and meant that it was difficult for the service to use the information gathered to plan future improvements. For a home which was caring for nine people we judged that this did not pose a significant risk to people's wellbeing.

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 had received up to date safeguarding training. Staff could tell us how they would act if they suspected abuse.

People told us that they felt safe. There were sufficient staff, with attention to skill mix and experience, to care for people safely.

Staff carried out effective infection control procedures.

People were protected by staff who were safely recruited.

Staff had been trained in the safe handling of medicines. We observed medicines were handled safely and were audited to ensure safe practice.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to meet people's needs.

People were protected by the way the service implemented the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff knew how to support around their mental capacity.

People had access to healthcare services when they needed them.

People enjoyed their meals, their nutritional needs were met and they had access to food and drink whenever they wished.

Is the service caring?

Good

The service was caring.

All staff we observed had positive relationships with people and were reassuring and kind in their approach. Staff were not rushed and always gave people the time and attention they needed.

People told us that they were treated with respect and regard for their privacy and dignity.

Is the service responsive?

Requires improvement

The service was not consistently responsive to people's needs.

People were supported to maintain relationships with family and friends and to make outings, however, they did not always have sufficient stimulation and interest in their lives.

People's concerns and complaints were listened to and acted upon, however, they were not recorded in sufficient detail to include whether the person who complained was happy with the outcome.

Summary of findings

Daily notes and monthly updates contained information about people's care needs and how these changed. People told us that the providers and the staff knew them and their needs well and responded to these.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place. Leadership was visible throughout the home.

An auditing system was in place, some of which was informal. This meant it was not always possible to use auditing to plan future improvement.

Communication between the registered manager and staff was regular and informative, though the providers did not always demonstrate that they took what staff said into consideration.

The culture was supportive of people who lived at the home and of staff. People were consulted about their views.

Esk Hall 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 8 September 2015 and was unannounced. It was carried out by one adult social care inspector and an expert by experience. 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 the information we held about the service, such as notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

We did not request a (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered information which we would have received in the PIR during the inspection visit.

On the day of the inspection we spoke with eight people who lived at the home, two visitors, the registered manager and deputy, the chef and two care staff. After the inspection we spoke with two health and social care professionals about the service.

We spent time observing the interaction between people who lived at the home and staff.

We looked at some areas of the home, including some bedrooms (with people's permission where this was possible) and communal areas. We also spent time looking at records, which included the care records for four people. We looked at the recruitment and supervision records of three members of staff, training records, rotas for the past two months, four care plans with associated documentation, quality assurance information and policies and procedures.

Good

Is the service safe?

Our findings

People told us that they felt safe and that the staff and management often anticipated any concerns they may have. One person told us, "Yes, I do feel safe living in here. I feel safe with the staff that support me." Another person told us, "Staff make me feel safe. They make sure I am safe when I am moving from my chair in the lounge to get up and go for my meal in the dining room." Another person told us, "The whole place is quite well lit. I feel quite safe walking around." Everyone we spoke with told us that if they ever felt unsure about their safety, staff would reassure them and deal with their concern.

Safeguarding training for staff was up to date with a clear timescale in place for when updates were required. When we spoke with staff about this they were able to describe different types of abuse and the correct action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt the team would recognise unsafe practice and report it to the registered manager. This gave us evidence that staff had the knowledge to protect people appropriately.

Care plans identified a person's level of risk across a range of areas. People told us that each area of risk had been discussed and agreed with them and we saw records which confirmed this. For example, we saw risk assessments for falls and moving and handling. Risk assessments were proportionate and included information for staff on how to reduce identified risks while avoiding undue restriction. The home did not care for anyone who required any moving and handling equipment at the time of inspection, however, people needs in this area were kept under review.

Staff told us that their approach to risk was responsive to people's changing needs and mental capacity. One member of staff told us that the home was getting better at, "Not wrapping people in cotton wool" and supporting them to go out and challenge themselves, particularly in relation to their mobility. People confirmed that staff would not restrict their freedom and supported them to take a stroll or to go out with relatives and friends.

We saw that the home regularly reviewed environmental risks and the deputy manager told us that they carried out regular safety checks. We noticed that the environment supported safe movement around the building and that there were no obstructions.

Staff application forms recorded the applicant's employment history, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been obtained prior to commencing work at the home and that employment references had also been received. A DBS check helps to ensure that people who are known to be unsuitable to work with vulnerable people are not employed.

We had received two anonymous concerns about the level of staffing at Esk Hall in the three months prior to the inspection. Staff and the registered manager told us that this was because the registered manager had not always been very visible, sometimes leaving people in the care of senior staff for periods of time when off site. Although this had meant there were sufficient staff, they told us they did not feel sufficiently supported when the manager was not present. The registered manager had reviewed the staffing levels and had employed a deputy who now ensured they were at the home each day the registered manager was not on site. Staff told us this arrangement suited them well and that they now felt well supported in their role.

People told us that they felt there were sufficient staff on duty to assist them. One person told us, "I feel safe because I know staff are always nearby." Staff told us that inexperienced staff were on rota with skilled and experienced staff who could support them. We found that during the day there was at least one senior on duty with one care worker plus the deputy manager or the registered manager. The registered manager was not always on site because they were also registered for another home in nearby Whitby. The home also employed ancillary staff such as a cook, gardener and maintenance person. At night there was one waking senior member of staff on duty with one sleeping member of staff. This was to care for nine people and staff told us this felt safe for them. We observed that there were enough staff to attend to people's needs and to be relaxed with them during our inspection visit. The registered manager told us that staffing levels would be responsive to occupancy and people needs. They hoped that the home would increase occupancy and then staffing would increase.

The home had a policy on whistle blowing and staff told us they would feel confident to use this whenever they needed to.

We looked at the way in which medicines were managed. The home had a policy on the safe handling of medicines.

Good

Is the service safe?

Staff told us they were aware of this and we saw that they had up to date training so that they could handle medicines safely. The home used a Monitored Dosage System (MDS) with medicines supplied by a local chemist. A MDS is where medicines are pre-packaged for each person. For those people who wished to manage their own medicines, their capacity to do so and the associated risks had been assessed. We saw that medicines, including controlled drugs were recorded on receipt, administration and disposal. Staff wore a 'do not disturb' apron when they were dispensing medicines which minimised the risk of them becoming distracted and making errors. We observed a medicine round. Medicines were administered correctly. Recording for a chosen sample across one full day was accurate with correct coding used. Medicines which required refrigeration were stored appropriately and we saw that medicines were dated on opening when required. However the home did not keep a running total of medicines in packets and boxes which meant that there was a risk the service would not be able to monitor whether medicines stored in this way had been administered correctly for people's safety.

The registered manager or deputy regularly checked all medicines including those which were not in the MDS. Any anomalies in recording were addressed with staff in one to one sessions and in meetings. We saw examples of medicine audits. The registered manager and staff explained how the results of audits were used to support staff to improve the safety of their practice.

People told us they were regularly involved in the review of their medicines. Records of care planning reviews confirmed this. This made sure that medicines were suitable and safe for current needs. Staff were knowledgeable about individual needs around medicines and any associated risks.

We saw records of training in infection control which were all up to date. Clear timescales were recorded for when this needed to be updated. Staff told us that they had received training in infection control. We visited the laundry room and saw that clothes were handled in a way which prevented the spread of infection. We asked two members of staff about infection control and they understood what good infection control practice was. They referred to the use of aprons, gloves and the importance of hand washing when giving personal care to people. We saw that the home was very clean and fresh throughout and that sanitising wash was available at sinks which was stored in disposable pouches. This method of storage is recommended as best practice to protect people from the risk of cross infection.

Good

Is the service effective?

Our findings

People told us that staff were skilled in caring for them. One person told us, "I am delighted with the care and help I get. It could not be better. All my needs are met." Another person told us, "The staff are first class; they do know how to look after me and I feel very well looked after. If I need help they call my own doctor in and he comes quite quickly too." People said that staff explained things clearly and that there was never any difficulty in understanding one another. We saw that staff communicated with people clearly at a pace and in a manner which supported them to respond.

We looked at staff induction and training records. Staff told us that they had received induction before they began their mandatory training. During this time they developed a good understanding of each individual's care needs and the philosophy of the home. Staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people's individual needs and how risks were managed.

In addition to mandatory training, which staff had all received, they received specially sourced training in areas of care that were specific to the needs of people at the home. For example, a number of staff had received training in person centred care, which is training to ensure that staff have the skills to place people at the heart of the care they offer. Staff also had training in dementia care. Other training included diabetes, dysphagia(which was to support them give good quality care to people with swallowing difficulties) and training to equip staff to understand the challenges people may face on admission to care.

Staff told us that they received regular supervision and appraisals and we saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and gave them support to give the care people needed.

The home had links with specialists, for example in diabetic care, nutrition, sight and hearing, pressure care, continence care and the speech and language therapy team (SALT). This helped them to offer appropriate and individualised care. We saw that referrals for specialist advice had been made promptly in discussion with each person. People told us that the service was quick to refer them to specialist support. One person told us, "If I needed to see a doctor it would not be any problem. The staff would call my GP and also let my family know. They are very good at keeping people informed." A member of staff told us, "If any of our residents need to see a doctor or a nurse it has never been a problem. We get a good service. We have a good relationship with the Community Nurses and the G.Ps."

The registered manager told us she had strong links with local GPs and district nurses. We spoke with a health care professional after the inspection who had regular contact with the home. They told us that the staff were, "Very good on the whole. They make sure we are kept informed and they have a good relationship with the district nurses."

The deputy manager told us they used feedback from GPs and other professionals to help them give the best care they could and staff confirmed that they actively sought external professional's advice. Records confirmed what they told us. For example we saw professional advice about nutrition had been incorporated into a care plan. We also saw advice from a speech and language therapist and physiotherapist which had been written into care plans.

People told us they enjoyed their meals. However they had not been consulted over the menu choices. One person said, "The food is very good. It is well cooked, a good variation, certainly enough of it and it is enjoyable. I look forward to my meals." Another person told us, "I do enjoy my meals. The cook is very good indeed, she knows what we like. The ham is lovely and we get nice salads. There are plenty of drinks. You can ask for a drink at any time."

We observed a meal time and saw that the tables were attractively set and that the atmosphere was relaxed and friendly. There were three staff available to assist people and any help was offered discretely and with regard for people's dignity. The quality of the food was high and it was presented in an appetising way. We also observed a time when people were being offered refreshments, with a choice of hot and cold drinks and snacks. Staff knew people's preferences for drinks and offered alternatives if people refused certain snacks.

The service used the Malnutrition Universal Screening Tool (MUST) to assess the risks associated with malnutrition.

Good

Is the service effective?

Care plans showed that when people were at risk there were clear instructions on how to manage this to protect people. Those people who needed specialist diets had these in place. Advice from the dietician or diabetic nurse was incorporated as necessary into care plans. Fluid and diet monitoring charts were in place for any person who needed them. Reviews and decisions made about nutritional care were clearly recorded.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that any decisions are made in people's best interests. The registered manager told us that no applications had been made to the local authority for deprivation of liberty safeguards to be put in place as nobody had been assessed to require this.

Care staff were clear on the process for DoLS and mental capacity assessments as well as best interests decision making and the implications of lasting power of attorney powers. The registered manager told us that staff had received MCA and DoLS training and records confirmed this. The registered manager understood the implications of the recent Supreme Court ruling which had clarified the notion of deprivation of liberty for people in a care home setting. This meant that people were protected regarding their mental capacity.

People told us they were regularly asked for their consent to care. We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response. When people declined, staff were respectful and returned to try again later if necessary.

Good

Is the service caring?

Our findings

People told us that all the staff, the registered manager and provider showed them compassion and empathy and that staff gave them time and listened to them. For example, one person told us, “Wonderful girls, every one of them. They will do anything for you. Very kind, very good.” A visitor told us, “I have observed the staff deal with my [relative] and other ladies. I have always found them extremely kind and caring.”

The staff and people we spoke with told us that the home encouraged visitors and we observed that a number of visitors were greeted by staff in a friendly way. Visitors told us that the staff always offered them refreshment and that they were made to feel welcome.

People told us that staff responded quickly when they asked for help and that they did so cheerfully. One person told us, ““Respect, care and dignity is what I think is most important. I feel that is exactly what I get in here from these staff. They are very kind and compassionate.”

A health care professional told us, “This home is lovely. The staff are always thoughtful and I often hear them having a chat with the residents.””

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. Staff gave the impression that they had plenty of time and spoke with people who were sitting so that they were on eye level with them. They reassured people with a touch on the arm or hand where this was appropriate. We observed that staff were talking with people about their lives, who and what mattered to them and significant events. Staff were skilled in communicating with people, anticipating needs and making people aware of what their choices were. They interacted well with people who were observed to be more withdrawn and were also skilled at recognising when people needed time to sit quietly.

People who had difficulty communicating were supported to give their views through staff spending time with them and listening. Nobody required specialist equipment in order to communicate, and those people who had cognitive impairments were given considerate attention.

Some people had Do Not Attempt Resuscitation (DNAR) forms in place, and where we saw these, most were correctly completed and regularly reviewed. We noted that one such form contained an inaccurate address which the deputy manager told us they would address.

Staff told us about the way people were cared for in their final days. They emphasised the need for close liaison with palliative care professionals, attentive monitoring to ensure people did not suffer pain and how important it was to ensure people had company at their beside. They also spoke about the importance of supporting relatives, the people who lived at the home and each other at that difficult time.

Requires improvement

Is the service responsive?

Our findings

People told us that the service was responsive to their needs. One person told us, "Yes, we were both involved in decisions made in the care plan. Staff are very good and co-operate with our wishes very well." Another person told us, "Staff know what help I need. It was agreed in my care plan some time ago. I like to retain as much independence as I can, staff appreciate that."

Where people had the capacity to do so, some gave us a clear account of the care they had agreed to. Others told us they knew about their care plans but did not know what was written in them. Some people had signed care plans and we saw that written plans were regularly reviewed. However it was not always clear from the records that efforts had been made to involve all people in this process.

People's interests were identified within their care plans, though records were brief in this area. One person told us that they regularly went out with relatives and that staff helped them to prepare for this. Books and magazines were available for people to read. We observed that staff had time to chat with people and that the atmosphere was pleasant and friendly.

However, some people said there was not much to do and that they were bored. We observed that people were sitting for long periods of time without any interaction or occupation. The deputy manager told us they had identified that this was an area to develop and spoke with enthusiasm about their ideas. For example organising for people who enjoyed baking to be involved in this activity. They were planning to work with people to identify their interests more fully, and to organise some activities and events to offer meaningful structure to people's day. This had yet to have an impact on people's care.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs.

Reviews focused on people's wellbeing and any improvements which could be made to people's care. Relevant specialists were consulted for advice at these reviews. Monthly updates were recorded and these contained useful and relevant details to assist staff to plan responsive care.

Staff could tell us about people's care needs and how these had changed. They explained how referrals to health care professionals had been made to ensure care remained appropriate for each person. Records confirmed this. One health care professional told us that the home worked well with them, and consulted with them appropriately.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously, though they all told us they had never made any formal complaints. We saw that the service had a complaint procedure and staff told us this was followed. One person told us, "If I had anything to complain about then I would talk about any problem with the manager. I have not had the need to do so." Another person said, "No I have never complained about anything. I have been very happy since I came here." The service had a complaints procedure and the registered manager told us they followed this to ensure people's complaints were appropriately dealt with.

However, recorded complaints did not include a detailed response with a timeframe, so that it was not clear that concerns and complaints were dealt with in a satisfactory way or that people were happy with the outcome

We recommend that the registered providers consult best practice guidance on promoting wellbeing through meaningful engagement.

Good

Is the service well-led?

Our findings

People we spoke with told us they thought the home was well run, however, they had noticed that the registered manager was not available at all times. For example, one person when asked if they could talk to the manager told us, "Well yes I can, if she is around but she is not here several days a week. The other staff are good. I get the help I need." Another person told us, "The leader is very nice indeed. I am sure if I needed anything more, then she would provide it for me. She only spends some of her time here because she has to help at the other home." Another said, "Yes I can talk to her if I need to. She is very pleasant and helpful, I really like her."

The home was in the process of changing the management structure in response to concerns raised by people who lived at the home, staff and visitors. The home had a registered manager who also had responsibility for another home and was therefore only available for part of the week at Esk Hall. Staff and people who lived at the home had commented that they felt that staff were without leadership for part of the week. We received two concerns to CQC regarding this prior to the inspection and people also told us this on the day we visited. However, in response to concerns, the service had appointed a deputy manager who was on duty during the days the registered manager was committed elsewhere. This arrangement was still in its early stages, however, the deputy manager was visible in the home throughout the day of inspection and we observed them chatting with people and listening to people's comments. We saw that they were approachable and worked with the team addressing any issues promptly with staff and praising good care.

The culture within the service focused upon supporting people's health and ensuring people were treated with dignity and politeness. The registered manager was developing the culture to include more emphasis upon placing each person in the heart of care through consultation.

Staff told us that they discussed each person's care daily and passed on any information between shifts. Staff told us that the lines of communication from the providers to them were clear, however, they did not always feel consulted or encouraged to give their views back to the providers about how to improve care. Staff told us they felt they had valuable ideas which they were not sufficiently encouraged to share. They felt that the registered manager and deputy manager listened but that the providers were less proactive in this area. This meant that staff views were not always sought and acted upon for people's benefit.

Staff told us that they understood the scope and limit of their role and when to refer to another person for advice and support to ensure people received appropriate care.

The registered manager worked well in partnership with health and social care professionals to ensure people had the benefit of specialist advice and support. Daily notes and monthly updates contained information about how advice was to be incorporated into care practice. Health and social care professionals told us that they were consulted and that the registered manager worked well with them.

There were some systems and procedures in place to monitor and assess the quality of the service. For example we saw records of checks such as emergency lighting, fire equipment and lift servicing. Each day a senior member of staff walked around the building to check on infection control practice, general cleanliness and any repairs which needed to be done. They then discussed this with the registered manager who would arrange for maintenance work to be carried out. The registered manager told us that because the premises were not large this method of checking the environment was satisfactory. Staff told us that the registered manager discussed infection control, care planning, and changes in care needs with them regularly. The senior staff told us that they checked medicines each day and fed back any discrepancies and we saw that audits for medicines were in place. As this was a small home with nine people resident, a limited informal auditing system did not pose a significant threat to people's safety or wellbeing. However, because written checks on safety areas such as infection control, safety of the environment and care planning were not available they could not inform plans for ongoing improvements.

The registered manager told us that they consulted with people regularly on a one to one basis and people confirmed that this was the case. For example, people told us about outings they had requested and that the manager had arranged. However, because there was no formal recorded consultation with people, this information was not available to inform plans for ongoing improvements to people's care.