Applegarth Healthcare Limited

Applegarth Nursing 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

Applegarth Nursing Home is a care home with nursing, registered to provide accommodation for up to 53 people with a variety of needs. There were 53 people using the service at the time of our inspection. The home is divided into three areas, one providing care for frail elderly people, some of whom are living with dementia, and the other two areas providing care for younger people with complex needs.

The inspection took place on 19 July 2017 and was unannounced.

We previously inspected Applegarth Nursing Home in August 2015, at which time the service was rated good. In May 2017 the provider of the service changed. At this inspection we found the service remained good.

The service had a registered manager in place.

People who used the service felt safe and secure at the home. Relatives and external professionals raised no concerns. Staff had received refresher training in safeguarding and demonstrated a good understanding of how to keep people safe.

There were sufficient numbers of staff on duty in order to keep people safe. Call bells were conveniently placed and utilised by people when they needed extra help.

All areas of the building were clean and generally well maintained. The registered manager had a refurbishment plan in place to ensure standards in the environment were maintained.

Effective pre-employment checks of staff were in place, including Disclosure and Barring Service checks, NMC checks, references and identity checks.

The ordering, storage, administration and disposal of medicines were safe and in line with national guidance. Where minor errors or areas not meeting good practice were identified, the registered manager responded positively to feedback.

Risk assessments were person-centred. Staff had access to clear guidance about how to manage the risks people faced, as well as respecting their desire for independence.

People had access to a range of primary and secondary healthcare, such as GPs, specialist nurses and speech and language therapists to get necessary treatment.

Staff were trained in mandatory topics as well as areas specific to meeting people's needs, for example dementia awareness, acquired brain injury and Non-Abusive Psychological and Physical Intervention.

Staff received regular supervision and appraisal processes and confirmed these were meaningful

conversations. Staff told us they were well supported.

We found lunchtimes to be calm, with people given ample choices and supported to eat where they required it. Staff used recognised tools to help identify when people might be at risk of malnutrition and we saw people's preferences and specialised diets were well catered for.

Staff had a good understanding of the Mental Capacity Act 2005. 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.

People's emotional wellbeing was respected and supported by staff, who interacted compassionately and patiently with people at all times. Feedback from all people we spoke with was positive in this regard.

The atmosphere at the home was calm and inclusive, with people supported to retain their independence and remain a part of the wider community.

Person-centred care plans were in place and there were regular reviews of care plans, involving people, their relatives and external professionals.

There was a range of in-house and external social activities provided, with people having the option to go on trips and outings as well as spending one-to-one time with one of the two activities co-ordinators.

Staff, people who used the service, relatives and external professionals we spoke had confidence in the registered manager. Staff confirmed they took a hands-on approach to the service and we saw they knew people's needs well. The provider had recently implement a new management structure and we found this to be working well, with clear lines of accountability and quality assurance processes in place.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remained good.	**Good**
Is the service effective? The service remained good.	**Good**
Is the service caring? The service remained good.	**Good**
Is the service responsive? The service remained good.	**Good**
Is the service well-led? The service remained good.	**Good**

Applegarth Nursing 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 was 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.

We visited the service on 19 July 2017 and the inspection was unannounced. This meant the provider and staff did not know about our inspection visit. The inspection team consisted of two Adult Social Care Inspectors and a specialist advisor. A specialist advisor is someone who has professional experience of this type of care service.

We spoke with ten people who used the service and three relatives. We spoke with 14 members of staff: the registered manager, the facilities manager, the staff development manager, the deputy manager, two nurses, five care staff, the activities co-ordinator, one domestic assistant and one administrator. We also spoke with two visiting healthcare professionals.

During the inspection visit we looked at seven people's care plans, risk assessments, staff training and recruitment records, a selection of the home's policies and procedures, meeting minutes and maintenance records. We reviewed the service's quality assurance and monitoring systems.

We spent time observing people's support in the living rooms and dining areas of the home. We inspected the communal areas, kitchen, bathrooms, toilets and laundry.
Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We spoke with professionals in local authority commissioning and safeguarding teams.

Good

Is the service safe?

Our findings

People who used the service we spoke with and their relatives told us they were safe and well cared for. No one we spoke with raised concerns regarding safety during our inspection. One person who used the service said, "I feel very safe here, very safe indeed," whilst another said, "I definitely feel safe here – if I was worried about anything I would speak up." One relative told us, "I am in regularly and am not worried about anything." There was a consensus of opinion that people were kept safe and protected from harm.

We found staffing levels to be appropriate, with a member of staff on duty at all times in communal areas. One relative told us, "There always seem to be plenty of staff." There were central nurse call alarms in communal areas and we saw people had ready access to these in their rooms. One person said, "The girls come very promptly if you press the buzzer."

Staff knowledge regarding safeguarding principles was good and we saw this was a mandatory training course, renewed yearly. Staff knew about the provider's whistleblowing policy and were confident in reporting concerns if they had any. Whistleblowing means to raise concerns externally about the service. Safeguarding information was readily available in communal areas and in brochures in people's bedrooms. One incident had occurred since the last inspection, which staff and the registered manager had responded appropriately to in order to keep people safe, including implementing the disciplinary policy.

We saw people had risk assessments in place to ensure staff were aware of the risks they faced, and how to minimise those risks, for example in relation to the risk of falls or pressure sore damage. Instructions to staff were detailed and, when we spoke with them, they demonstrated a clear understanding of how to help keep people safe. Staff demonstrated a good understanding of the need to balance their duty of care with respecting people's rights to take some risks.

Medicines were ordered, stored, administered and disposed of safely. Medicines records we reviewed were accurate whilst medicines were stored safely in line with good practice. Where liquid medicines had been opened these dates were annotated on the bottle to ensure they were not used for too long. Temperatures of storage rooms and fridges were regularly recorded to ensure they were within safe limits. Medicines were kept in locked trolleys in locked treatments rooms. Where medicines were kept in fridges these were not lockable – it is good practice to store medicines in a locked fridge. The registered manager agreed to address this.

We sampled a range of Medicine Administration Records and saw the registered manager had reverted from an electronic to paper-based system, as they had found the former time-consuming. We found records to be well maintained and error-free. We checked controlled drugs and found these were regularly checked by staff and stored in line with good practice. Controlled drugs are medicines liable to misuse.

When we asked staff about what they would do if they encountered discrepancies with medicines stock, they answered clearly and we observed medicines rounds to be completed in a professional, dignified fashion. We noted one medicines round took longer than expected due to a number of people requiring

administration via a percutaneous endoscopic gastronomy (PEG) tube. A PEG is passed into a person's stomach through the abdominal wall as a means of providing food and medicines when oral intake is not possible. We saw the registered manager had identified this prior to inspection and showed us plans regarding how they would improve this medicines round.

We found there were specific plans in place for when people were prescribed 'when required' medicines. We highlighted that these would benefit from containing more specific guidelines, as per guidance issued by the National Institute for Health and Care Excellence (NICE).

The home was clean and there were no malodours. We saw alcohol rub and personal protective equipment (such as aprons and gloves) readily accessible, with reminders to staff and visitors about hand hygiene. This meant helped to ensure people were protected from the risk of acquired infections.

Fire safety measures were extremely clear, including a detailed building plan that identified where risks existed. Personalised emergency evacuation plans (PEEPs) were in place to help ensure people could be safely evacuated from the building in the event of an emergency. The facilities manager had reviewed all fire safety preparedness systems prior to our inspection.

Maintenance of the premises was completed by a team of three staff who operated a 24 hour emergency call-out system. We found the premises to generally be in a good state of repair and, when we spoke with a member of the team, they told us they were well supported by the provider. This meant people were prevented from undue risk through poor maintenance and upkeep of systems.

We reviewed six staff recruitment files. In all of them pre-employment checks including enhanced Disclosure and Barring Service checks, identity checks, Nursing and Midwifery Council registration checks and references had been made. The registered manager had signed to indicate they had reviewed the references sought, and that they were suitable. This meant that the service had in place a consistent approach to vetting prospective members of staff. This reduced the risk of an unsuitable person being employed to work with vulnerable people.

Good

Is the service effective?

Our findings

Staff demonstrated a comprehensive knowledge of people's healthcare needs and supported them well. One person who used the service told us, "Most of the time you don't have to ask the staff as they know what you need. If you do ask they help you straight away."

We found evidence demonstrating people were supported to access primary and secondary healthcare promptly, and that they experienced good health outcomes as a result. One person who used the service told us, for example, "I can see the doctor when I want – you only have to ask."

Staff were attentive to people's needs. People who used the service and their relatives reflected positively on this when we spoke with them, and referenced people experiencing good health outcomes. One relative told us, for example, "[Person] has resided here for just over a year and in that time her condition, her general wellbeing and health has improved." One person who used the service told us, "I came here with a pressure sore and they were very good and got rid of it quickly. They nip it in the bud now and stop it from happening – so this is a good home."

Staff received a range of mandatory and additional training to help meet people's needs. Training the provider considered mandatory included fire safety, moving and handling, food safety, safeguarding, medication, diabetes awareness and infection control. Staff had also received training specific to the needs of some people who used the service, for instance dementia awareness, Non-Abusive Psychological and Physical Intervention and acquired brain injury training. Staff new to care were required to complete the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care. We saw the registered manager maintained a training matrix to ensure staff received refresher training when it was due.

Staff spoke positively about the training opportunities they had access to, and how this helped them care for people. One staff member told us, "I really enjoyed the speech and language therapist coming in to do a session. It helped a lot, especially with understanding communication needs with people who have had a stroke."

We found staff had clearly defined roles, whilst whiteboards made it clear who was on duty. External professionals were generally positive about staff knowledge and experience. One we spoke with said, "There's sometimes not enough nursing capacity." The registered manager told us they were keen to develop an 'Associate Practitioner' role to support nurses with some aspects of their work, with the intention of freeing up more nursing capacity.

Supervision and appraisal processes were well embedded with nurses completing these for the majority of staff. A supervision is a discussion between a member of staff and their manager to identify strengths and areas to improve. We saw supervision meetings were themed in line with the provider's policies and national guidelines and staff told us these meetings were in depth and helpful.

We observed people were given choices at mealtimes and were supported attentively by sufficient staff. Interactions were discreet where people needed additional support to eat. Throughout the inspection we observed people being offered drinks and snacks.

People's nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST). MUST is a five-step screening tool to identify adults who are malnourished or at risk of malnutrition. Nutritional care plans had been developed in line with people's identified needs. These included instructions on diet, swallowing difficulties, risk of choking, the required texture of food and support needed with eating and drinking. Care plans were personalised and covered areas such as the number of spoons of sugar a person took in their drinks and the foods they liked and disliked.

We reviewed people's care records where they were identified as at high risk of malnutrition or dehydration and found records were completed regularly and accurately.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw appropriate DoLS applications had been made to the local authority and staff were aware of their responsibilities under the MCA.

Where people had a 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) decision in place, we saw they, their relatives and clinicians had been involved in the decision. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest.

The premises were suitable and appropriate for the needs of people who used the service, with ample bathing and toileting facilities. We found the front communal area of the building to be in need of redecoration, with some scuff marks to walls and damage to furniture, although we noted a plan of refurbishment was underway, including replacing this furniture. The registered manager was able to show us how these plans would be completed over time.

Good

Is the service caring?

Our findings

We received a range of positive feedback from people who used the service, relatives and external professionals we spoke with. One person told us, "They look after us really well," whilst others said, "It's grand here – you couldn't be better looked after," and, "I've got everything I want – the girls are so good." A relative we spoke with told us, "The staff are wonderful and [person] is really enjoying life."

All people we spoke with confirmed staff were patient and sensitive to their needs. Staff told us that sometimes they would appreciate spending more time with people to chat as opposed to merely completing tasks. We did however observe a range of dignified and compassionate interactions throughout the inspection. For instance, care staff asked if people would like to have a blanket over their legs, or a cardigan, as some people were more sensitive to the cold than others. Conversations instigated by staff with people who used the service were open and gave people the opportunity to choose, for example whether they would like their door left open or assistance moving to another part of the home. We observed inclusive conversations instigated by staff, for example asking people what they remembered about a particular topic and encouraging them to reminisce.

People's diversity was well supported. People were well groomed in clean, coordinated clothes, wearing slippers where that was their preference. Women had jewellery, sometimes make up and handbags. Men were shaved and smartly dressed, often with watches on and with wallets to hand or in pockets. People's individuality was maintained and respected through measures such as ensuring they dressed according to their own personal style, or referring to them by their chosen name.

We found the atmosphere successfully struck a balance between homely and clinical, with people's room's individually styled to reflect their preferences. For example one person's room had a football theme, whilst another person had religious pictures and symbols in their room. Religious leaders came to the home on a regular basis, meaning that people's right to religious beliefs was respected.

People's dignity was protected throughout our inspection, with staff asking for people's consent at all times, and helping them to remain independent. This was an area senior staff had focussed on in terms of ensuring staff understood how to assist people and also allow them to complete their own tasks. One senior staff member told us, "It's sometimes too easy for staff to want to take over and do things for people (in a nice way), thinking they are being kind." They gave examples of people being helped to retain their independence, such as collecting the newspaper or doing their own shopping.

People's individualities were respected and celebrated. We saw staff had arranged a birthday treat for one person – an afternoon tea at a nearby hotel. Two other members of staff came in to the service while not on duty to sing for people who used the service. This helped demonstrate the genuinely caring culture at the home.

Good

Is the service responsive?

Our findings

One relative told us, "They are doing a marvellous job in encouraging them to take part in outings and events going on at Applegarth. There's always something taking place."

There were two activities co-ordinators, enabling the service to organise group activities as well as regular individual outings for people who used the service, for example to the local shops. This meant people were supported to remain a part of the wider community and were protected against the risks of social isolation. It also meant people received one-to-one time with an activities co-ordinator on a regular basis. This is particularly beneficial if people prefer not to take part in larger group activities. For example, one person had trouble communicating and was sat on their own. We observed one of the activities co-ordinators sit with them and go through an old book of the area the person used to live in. This prompted conversations between the two and the person evidently enjoyed it, becoming significantly more engaged and animated.

Group activities included interactive music sessions, visiting entertainers, fish and chip nights, craft sessions and animal visits such as petting dogs. We saw other activities in place, such as a gardening club and planned visits to the coast. These were advertised on posters in communal areas.

People's changing healthcare needs were well managed and monitored, with advice being sought where appropriate. We saw there were regular meetings with external healthcare professionals to review people's needs. There were regular visits from doctors, occupational therapists and speech and language therapists and we saw advice from these professionals had been incorporated into care plans. External professionals were complimentary about staff contributions to these meetings, stating, "We meet and discuss what the issue is. Staff tell me what they think, bring clear questions and already have some solutions to discuss. They are a good staff team to work with as they are proactive in managing people's needs."

We found care plans to be sufficiently detailed and person-centred. This means ensuring people's interests, needs and choices are central to all aspects of care. There were specific plans in place for a range of needs, for example nutrition, mobility, personal care and skin integrity, with clear strategies set out for staff. People's preferences were incorporated into these care plans, for example one person did not want to have a male carer for personal care and we saw this was respected. Likewise, plans were written in an individual style and had regard to day-to-day preferences, such as, "I like to get up early, about 7am, and have a cup of tea in my room."

When we spoke with staff they demonstrated a good knowledge of the preferences that made people individual.

Care plans were reviewed on a monthly basis and we saw people who used the service, or people who were able to contribute to decisions in their best interests, were involved.

The service had a complaints policy in place and clear guidelines helping people to make a complaint, and how long they could expect the process to take. We saw the registered manager had acted in line with the

policy on resolving a recent complaint. We spoke with a range of people who used the service and relatives, all of whom said they were confident in raising any concerns they may have. One person told us, "I would see the first nurse and then the manager." The complaints procedure was available in different formats and we found the culture to be one which welcomed feedback as a means of improving the service.

Good

Is the service well-led?

Our findings

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had relevant experience in health and social care. They had been at the service since it registered under a new provider and had previously worked at the service as manager. They demonstrated a working knowledge of all aspects of the service as well as people's needs.

There was a clear management structure in place, with roles well defined and staff accountable at all levels. The registered manager was supported by a deputy manager and managers in clinical competence, quality and estates. This management structure was relatively new but appeared to be working effectively. The registered manager also had the support of two administration officers.

Each area of the home was led by a named nurse, who took responsibility for a range of duties, such as staff supervisions and auditing. The maintenance team had clear responsibilities whilst the recently appointed staff development manager was integral to the continuing improvements to service provision. For example, they had recently taken on some of the quality auditing role and had completed care shifts to ensure they understood the challenges faced by staff and the areas the service may need to improve on in the future. They also had a keen interest in social media and had their own social care blog, where they shared and sought good practice with like-minded professionals.

Staff told us they were well supported and well managed and we found morale to be high. They told us they were confident they could raise any concerns with the management. Numerous staff confirmed the registered manager took a, "Hands on" approach and one told us, "The leadership does inspire me. The care is good and I would be more than happy for my parents to be here." The registered manager took an interest and, where practicable, a lead role in a variety of aspects of the service. For example, when references were sought for prospective new employees, whilst the service had a HR manager in place, the registered manager ensured they were satisfied with each reference prior to the process continuing.

Auditing and quality assurance processes were comprehensive. Nurses completed a range of checks on a monthly basis and provided these to the registered manager for analysis. The service used a 'non-conformity' form to document where an error was identified. This was shared with the registered manager and appropriate actions put in place, such as retraining for a member of staff, or invoking disciplinary procedures if it was a repeated issue. This was documented by way of a 'corrective' action document, which set out what had been done to resolve the problem and acted as a record for future use, should similar issues occur. The registered manager was positive about the new system, stating it had, "Nipped things in the bud." We found it helped demonstrate a culture that was open to learning through mistakes.

We saw the business development plan for the service and found it to be clear and comprehensive, setting out future developments.

During the inspection we asked for a variety of documents to be made available to us. These were well

maintained and easily accessible. Records were clear, up to date and contemporaneous. Policies and procedures were regularly reviewed. Appropriate notifications had been made securely to the Care Quality Commission in a timely fashion.

We found the culture at the home to be inclusive and geared towards the independence of people who used the service. The provider's literature and website stated they provided person-centred care to people and we found this to be the case.