Shaw Healthcare (North Somerset) Limited

Petersfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

We undertook this comprehensive inspection on the 18 and 19 June 2018 it was unannounced.

Petersfield care home provides accommodation for up to 36 people who require personal care. The service is a residential care home for older people. At the time of our inspection there were 27 people living at the home.

Petersfield has 36 rooms set over two floors and has communal lounges and sitting rooms, staff room, training room, laundry room, hairdressing room, offices, a dining area, kitchen and gardens including outdoor seating area.

The service 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.

People were supported to receive their medicines safely and when required although some records relating to medicines were not always accurately completed.

Staff did not have access to suitable handwashing facilities to minimise the risk of cross infection after helping people with personal care.

People felt the use of agency staff at times meant they were supported by staff who were not always familiar with their individual needs. Staff felt at times there was a lack of staff. However we found that enough staff were available to meet people's needs.

People were supported by staff who had suitable checks in place prior to being employed by the service. Staff received supervision and training and the registered manager was planning any outstanding appraisals. However, staff were not always able to demonstrate who to raise safeguarding concerns with or how to support people's individual diverse needs.

People had care and support plans that confirmed how they wished to be supported. People who had dietary requirements had a detailed information in place. People received food and drink to meet their needs, however there were limited options for people who were diabetic.

Not all people had risk assessments that identified their individual risks and how these were being managed.

The staff respected the rights of people who lacked capacity to make certain decisions in line with the Mental Capacity Act 2005.

People had access to a range of healthcare professionals to ensure their health needs were met, these included the GP, dentist, district nurse and the falls team.

People were supported by staff who were kind and caring and who encouraged people to be independent. Staff offered people choices. People received support by health care professionals when required.

People's care plans contained important information relating to their life histories and people felt able to choose the care that was important to them.

People could participate in a variety of activities and were able to spend their time how they wanted within the home and within the community.

The service had quality assurance systems in place that identified shortfalls and there was a clear action plan for areas to improve upon.

People, staff and relatives all had their views sought so that feedback could improve the care provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always Safe.

People were not always supported by staff who had access to effective liquid hand soap and paper towels whilst providing care and support.

People had mixed views on the support they received from staff they were not always familiar with.

People did not always feel safe.

Is the service effective?

Requires Improvement

The service was not always Effective.

People's individual dietary needs were limited and did not always reflect a variety of options to suit their requirements.

People were not always supported by staff who had received effective training.

Staff received supervision and staff had either received an annual appraisal or had one planned.

Is the service caring?

Good

The service remained Caring.

Is the service responsive?

Good

The service remained Responsive.

Is the service well-led?

Good

The service was well-led.

The provider had quality assurance systems in place that identified areas to improve and there was a detailed action plan that confirmed actions required.

Staff felt the manager was accessible and approachable and that the culture at the home was positive.

People, relatives and staff were all asked their views on the quality of the care provided.

Notifications were made as required.

Petersfield

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 was an unannounced inspection that took place on the 18 and 19 June 2018. It was carried out by two inspectors, a specialist professional advisor and an expert by experience on the first day and two inspectors on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We spoke with 11 people living at Petersfield and two healthcare professionals about the quality of the care and support provided. We also spoke with the registered manager, the operational manager, a team leader, three care staff, the activities co-ordinator and the chef.

We looked at six people's care records, and documentation in relation to the management of the home. This included four staff files including supervision, training and recruitment records, quality auditing processes and policies and procedures. We observed care practices and the administration of medicines.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous inspection reports. 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 also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found the water supply in people's rooms was inconsistent and at times hot water in other areas of the home were above the recommended safe temperature. At this inspection we found improvements had been made. Water temperature checks were undertaken in line with recommended guidelines and records confirmed they were safe. People experienced improved washing facilities within their rooms. For example, following the last inspection people's sinks now had lever taps fitted which enabled people to use them easily.

At our last inspection we found people were not fully protected from the risks associated with incomplete and inaccurate records relating to medicines management. At this inspection we found improvements had been made. The service had moved to a new electronic system for recording of medicines. Most records were accurate and up to date however the records for one person who required medicines 'as and when' (PRN) did not always record they had received their medicines and if not why. Following the inspection, the provider confirmed they had taken action to ensure if the person did not take their medicines their (MARs) chart would accurately record medicines offered but declined. This meant there would be an accurate record of the person's medicines administration.

Medicines were managed safely. People received their medicines from staff who had received training. Medicines were stored safely and stock was managed to ensure only the amount needed was available. Medicines that required greater security were managed safely with accurate checking procedures in place.

People were satisfied with the way they received their medicines. One person told us, "I have my tablets at meal times, they bring them to the dining room and watch me take them". Another person told us, "They give me my tablets and make sure they stay until they are washed down. Another person told us, "My medication is kept in a locked drawer, when I need more I just ask and it is restocked."

During this inspection we found people were not always supported by staff who had access to effective infection control measures when they were assisting people with personal care. For example, staff had no access to liquid hand soap and paper towels in people's rooms to minimise the risk of cross infection. Staff were able to confirm how they ensured people's laundry was handled safely and washed within the recommended guidelines. Staff had access to personal protective (PPE) clothing at various points throughout the home. During the inspection we observed staff using PPE when supporting people.

People felt there were enough staff however had mixed views on the provider's use of agency staff. One person told us, "All staff are good at knowing what to do, I am happy with that." However other people felt agency staff were not familiar with their needs. One person told us that agency staff were unable to make their bed in a way that enabled them and their legs to be comfortable. They required specialist equipment. They told us, "Agency staff do not know how to make my bed correctly. Regular staff are all lovely and do all they can to make me comfortable". Another person told us, "Agency staff some don't even know how to make a bed properly".

The registered manager explained the current staffing levels within the home. They confirmed these were above the recommended staff required as the home was not fully occupied. During the inspection people were supported by adequate staffing numbers however staff confirmed there had been occasions when staffing numbers had been low. One member of staff told us, "Saturday was a bit short. Bells were going all morning". The member of staff went on to explain that there was only two care staff on in the morning with no senior. Another member of staff told us, "We have agency on most shifts, we have staff come and go". The registered manager and the operations manager confirmed there had been problems with the new procurement of agency staff which had meant staff had not been booked when required.

People living in the service had mixed views on whether they were safe. Some people told us, "There is always someone to call on, which is reassuring". Another person told us, "I am settled here, it is not quite like home but I am definitely safe. Another person told us, "I am safe, I don't think about it, I take it for granted". Two people however didn't feel safe. They told us, "I am not safe, the person [Name] in the next room comes in day and night." Another person told us, "There is a resident who opens my door and walks in day and night, but goes away when I say 'wrong room'."

Not all people had a risk assessment or guidelines in place to support staff with their individual care needs. For example, one person required a risk assessment relating to the risk of them smoking and their finances. Another person required a risk assessment in relation to their behaviour towards staff. We fed this back to the registered manager for them to action. Care plans contained other risk assessments and important information relating to people. The registered manager, operations manager and care staff all knew people well and what their individual support needs and risks were.

Staff had received safeguarding adults training however we found their knowledge of who they would report abuse to was variable. For example, staff were not always confident in who they would report abuse to other than their manager. One member of staff said, "I would speak with [manager's name] and [other manager's name], CQC and the police". We asked them who else they might raise a concern with and they said, "The social worker and family". Another member of staff confirmed they would raise concerns with the management of the home however were also unclear who else they would externally raise concerns to. Both staff were unable to demonstrate who they would raise concerns externally too. The local safeguarding team are responsible for managing safeguarding vulnerable adults from abuse. We fed this back to the registered manager and operations manager.

Environmental risks to people were well managed. Visitors to the building signed a visitor's book. This meant there was a clear record of who was visiting the building in case of an emergency. There were completed safety checks such as portable applicant testing (PAT), electrical safety certificates and records confirming equipment such as hoists and lifts had been serviced. People had personal evacuation plans in place (PEEPs). PEEPs confirmed the support and assistance the person required in an emergency situation. The record confirmed what support the person required with their individual needs such any support from staff or equipment. The provider had up to date certificates relating to portable appliance testing (PAT). Other equipment such as hoists, wheelchairs and the home's lift had safety checks and if required certificates in place.

There was a system in place to monitor any adverse events in the home. Incidents and accidents were recorded and logged. The registered manager kept an overview of all incident and accidents so that any trends could be analysed. The registered manager undertook a review of the incidents and accidents by reviewing the overall number of incidents per person. The registered manager was fully aware of what incidents had occurred including actions taken.

Recruitment practices were in place to check that suitable staff were employed. Staff files contained an application form, references and terms and conditions of employment. Records showed that a range of checks had been carried out on staff to determine their suitability to work with vulnerable people. This included a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing a check on the person's suitability to work with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found food that was not modified as required and people who had diabetes received meals that were not in line with their individual requirements. At this inspection we found some improvements were still required. For example, people with diabetes had limited meal choice due to their individual dietary requirements. There were limited diabetic suitable puddings options available to people. Six people living at the home had diabetes. The chef confirmed the puddings on the menu were not always suitable for people with diabetes. For example on the second day of the inspection the pudding choice was a cheese cake. However the chef acknowledged this was not suitable for people with diabetes due to the sugar content. The chef told us people who were diabetic could have fruit, yogurts, and jellies for pudding however the menu they followed didn't cater specifically for people with diabetes. The chef told us later in the day that they had ordered diabetic ice cream as an additional option for people and that they were also considering ordering sorbet.

Most people were happy with the quality of the meals. People told us, "Plenty of choice, if you don't like it you can have something else". Another person told us, "No complaints, you can ask for what you want, it's good". Another person told us, "Plenty of food, plenty of variety, it's good food". Other positive comments on the food included, "First class, I get plenty to eat and drink". Another person told us, "Food is lovely, I enjoy every scrap". The home had a comments book left in the dining room so that people could share their experience and views about the food. Some comments included people wanting improved options for people with diabetes. This included their being more poached fish, fresh fruit and vegetables and less flavoured squashes with sugar in. The chef told us they reviewed the comments book and listened to feedback. They said they were due to meet with one person and discuss their individual dietary requirements.

We recommend that the service seeks suitable guidance on how to meet people's individual dietary requirements in relation to their diabetes.

People experienced their meals in a relaxed environment. Tables were laid with table cloths, placemats, and condiments. The home had a system that rotated which table was served first. This was so tables which were further away from the kitchen were not always the last to be served. People seemed happy with this arrangement. The menu in the dining room confirmed the meal options planned for that day.

People had access to fresh fruit and during the inspection people asked staff for fruit of their choice. People and visitors could help themselves to a water cooler within the corridor. Tea and coffee were served mid-morning and afternoon however we observed people asking for hot drinks in between these times. A variety of flavoured water was available within the dining area where people could help themselves. The chef confirmed the squash was sugar free. People also had jugs of water available in their rooms.

People had referrals made to health care professionals when required. For example, falls specialists, chiropodist, district nurses and the GP. Other referrals to health care professionals such as dietitians, speech and language therapists and occupational therapists were undertaken when required. People told us,

"There is no problem seeing a GP when you want. It will be arranged for you". Another person told us, "I had a cough, they got the doctor and I was given antibiotics".

People received care and support from staff who had received training however staff were not always able to demonstrate a clear understanding of training attended. For example, staff were unable to clearly demonstrate a clear understanding of equality and diversity. Equality and diversity recognises people's diverse needs such as people's age, disability, gender reassignment, race, sex, sexual orientation. People are protected against discrimination in relation to their equality and diversity. Most staff were only able to identify the protected characteristic of someone having a certain religion. For example, one member of staff told us, "Religion such as Church of England and what people wear and what they eat". We asked them why what someone wears and what they eat was important to them. They confirmed it was due to their religion. We asked what specifically. They were able to tell us, "Jehovah's witnesses don't celebrate Christmas. A Muslim doesn't eat pork or drink alcohol". However they were unable to confirm any of the other protected characteristics. A newer member of staff was able to demonstrate a better understanding of Equality and diversity. They told us, "The Equality Act, treat the same, not to discriminate against religion, mental capacity, colour, sexual (orientation), disability and gender".

Staff had received training in health and safety, infection control, moving and handling, safeguarding adults, food hygiene, mental capacity and deprivation of liberty safeguards and the control of substances hazardous to health (COSHH). The training matrix highlighted staff who were due a refresher training. The registered manager was chasing staff to attend training due. The provider's action plan also highlighted staff who required an update to their training.

Staff had access to additional training such as end of life care, person centered care, report writing, diabetes and dementia. Staff who were responsible for administering medicines had received training and checks of their competency to ensure they could support people safely with their medicines.

New staff received an induction and staff were supported to undertake The Care Certificate. The Care Certificate is an industry recognised set of standards which sets out the knowledge and skills required to fulfil a role in care.

Staff felt they were well supported and had access to regular supervisions and an annual appraisal. Supervision is a meeting with a senior member of staff to discuss issues about a staff members work performance and development. Supervision records confirmed staff discussed topics such as changes to people's support, staff conduct and performance and any training required. The registered manager was aware some staff required an annual appraisal. This was recorded on the supervision and appraisal matrix. Six staff required an annual appraisal. All other staff had either had received their appraisal or were not due one due to being in their first year. Staff felt able to raise concerns with the manager in between their supervision sessions.

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.

Where people lacked mental capacity to consent to aspects of their care, the provider had followed the principles of the MCA. For example, people had mental capacity assessments in place where required and best interest decisions. Care plans also confirmed if people lacked capacity to make decisions about taking

medicines, consent to care and managing their finances.

Staff were able to demonstrate how they gain consent sought before care and support was provided. For example, one member of staff told us, "I ask if they are okay. If I can help with anything. Offer a selection of clothes, ask if they need anything, and even if they would like their hair brushing."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had made applications when required.

People were supported with any changes to their health needs. One person told us how the home had respected their wishes about having a GP visit rather than being taken to hospital. One member of staff gave an example of how they had supported a person to attend a dentist appointment and a have a soft diet as the person had lost their teeth whilst away from the home. The home had quickly reacted ensuring there was an up to date risk assessment in place until the situation was resolved.

Good

Is the service caring?

Our findings

The service remained Caring.

During the inspection we observed positive interactions between staff and people. Staff were seen to interact with people in a kind and compassionate manner. Staff addressed people by their preferred name, talking to them respectfully and at a volume and tone of voice appropriate to their needs. Terms of endearment were used and people seemed to respond well to this. We heard lots of friendly banter between staff and residents about up and coming sporting events. People were relaxed and spent time with the activity co-ordinator doing puzzles and jigsaws.

People felt staff were kind and caring. They told us, "Staff are friendly, they are caring and kind to me". Another person told us, "They are kind, thoughtful, caring, and cheerful, both day and night staff. They are prepared to listen". Staff took time to explain what they were going to do, why they were doing it and what the outcome was likely to be.

Most people felt treated with dignity and respect. One person felt able to choose carer staff that they wanted. They told us, "They are all such nice girls, I have one man too who is excellent, he treats people nicely and is a great favourite". Staff ensured privacy by closing curtains and shutting doors when personal care was provided. One person however told us, "He uses the ladies toilet and [is incontinent] on the floor".

Some people felt at times they experienced care that didn't respect their privacy. For example, some people felt staff did not always knock before entering their room. One person told us, "Regular staff knock, but agency staff don't, they walk straight in, don't even call out". Another person told us staff, "They are respectful and I can't speak too highly of them". We fed these comments back to the operations manager as part of the feedback from the inspection process they confirmed they would review this as a complaint.

People were supported by staff who were familiar with their individual support needs. Staff talked about the close bonds which they built up with people. For example, staff expressed their sadness when people became ill and passed away. Staff held people's hands and showed a close bond to people they supported.

People were supported to be independent. For example, people could choose how they wanted to spend their time and how much support they received. One person told us, "I please myself when I get up and go to bed, I can manage this on my own". Another person told us, "I choose my own clothes, the staff ask me what I fancy wearing, then hold things up and show me, this or that". One member of staff said how they prompted people's independence. They told us, "People can choose what they want to do". People were observed making their own decisions about their care and how much support they received. This meant people were encouraged to do things for themselves.

People were involved in decisions about their care and relatives were involved if required. Two visiting health professionals felt the service was caring and recognised when information needed to be shared. They told us, "Staff are caring and vigilant, they follow health plans and instructions for the resident to make sure

their needs do not deteriorate".

People had their individual needs respected. For example, one person had an impairment with their sight. The registered manager had put a sign up following the person asking for staff to announce themselves before entering their room. The person told us, "I am blind in one eye and partially blind in the other. I asked the manager to put a notice asking staff to announce themselves before entering my room". This had been undertaken and their care plan confirmed their individual needs relating to their visual impairment.

People's personal information was kept secure in locked filing cabinets. The registered manager told us they made sure people's personal information was not shared with anyone else and adhered to the provider's data protection policies.

Good

Is the service responsive?

Our findings

At this inspection the service remained good.

Care records contained detail about people's needs and were personalised. People's care plans contained important information about them. For example, they contained people's likes and dislikes, if they had siblings, a spouse or any children. Care plans also confirmed if people had a religion or any impairment for example if people required a hearing aid or glasses. Records also showed if people were being supported by an eye hospital.

People felt involved in planning their care although not all were aware that they had a care plan. One person told us, "I had a review of my care plan four months ago by the Team Leader, I am happy with it. All my needs are being met". Another person told us, "I am getting all the care that I need and as I want it, it's extraordinary care". Two other people were unfamiliar with their care plan but both felt happy with their care. They told us, "I am not aware of a care plan, I came direct from hospital, I haven't got any worries or concerns, they are doing everything I want". Another person said, "Don't know about care plans, I speak to the Manager regularly, she knows me well and what I think, all my needs are being met by lovely people".

People had access to a complaints policy however during the inspection complaints were raised with us. People had access to a complaints policy and all felt able to complain should they need to. However some people during the inspection raised concerns with us. Due to some of these concerns being of a specific nature we raised them with the registered manager so they could investigate and take any action required. The registered manager confirmed they would share the outcome of these complaints with us.

People had access to a range of activities within the home. People told us, "I usually go to activities but I am selective". Another person told us, "I go to activities if I fancy it". Where people wanted to spend time in their room the activities co-ordinator visited them to see if they wanted individual time with them. One person told us, "I don't go to activities; I prefer to stay in my room. The activities co-ordinator comes to see me, we generally just chat, I am always pleased to see [them]". The activities co-ordinator worked six days a week including a day at the weekend. Various activities were available within the home from playing cards, bingo, music, quizzes, singing, exercise classes and trips out. During the inspection we observed people participating in playing cards, exercise classes, quizzes and singing to music. The activities co-ordinator undertook shopping for people once a week. The home also held a weekly church service.

People who were able to go out independently visited the local shops, church and hairdressers. People were supported to maintain relationships with people that were important to them. For example, relatives and friends could visit

No one was receiving end of life support at the time of the inspection. Some people had a Do Not Attempt Resuscitation (DNAR) form in place. This is a form that confirms the person's wishes relating to resuscitation. One health and social care professional had highlighted that the registered manager needed to take action for one person who didn't have wishes sought and recorded on the DNAR form. We raised this with the

registered manager who took immediate action to resolve this shortfall. Staff confirmed they were well supported by the district nursing team should the people's health deteriorate. District nurses could provide equipment should people wish to have end of life care provided at the home. End of life training was also provided to staff.

Good

Is the service well-led?

Our findings

The provider had a system of checks to ensure the home was being managed safely. The registered manager confirmed the regular audits they undertook within the home. The operations manager was also responsible for undertaking regular audits. All audits had an action plan confirming areas to improve on. A senior manager had undertaken a 'Quality Life' audit. This generated an internal action plan that included improvements required to risk assessments, medicines, care plans, improvements to records, the environment and staffing within the home.

The provider had made improvements to the quality assurance systems in place, however we found during the inspection shortfalls relating to safe infection control procedures. This was because staff had no access to liquid hand soap and paper towels within people's rooms where they provided support and care.

The service had a clear staff structure and management arrangements. The service was managed by a registered manager. They were supported by a team of care staff, team leaders, senior carer staff and an office manager. An operations manager was responsible for overseeing the home. All staff were aware of their roles and responsibilities and there was a handover at the beginning of every shift. This meant staff were given the opportunity to be familiar and up to date prior to starting work with any changes to people's care needs.

The registered manager understood the legal obligations relating to submitting notifications to the Care Quality Commission. A notification is information about important events which affect people or the service. The Provider Information Return (PIR) had been completed and returned within the timeframe allocated. This explained what the service was doing well and the areas it planned to improve upon

The registered manager promoted a culture that was open and transparent. People and staff spoke positively and were complimentary about the management of the service. People told us, "The home is well run and suitable to my needs". Another person told us, "The manager is very receptive, she was in to see me and sorted an issue with my laundry". Another person told us, "The manager is very good, she pops in, she is easy to talk to". Some people told us they did not know who the manager was but felt confident they could speak to her if they had any concerns. The Provider Information Return (PIR) confirmed, 'The home promotes an open door policy to staff and Service Users'. Staff felt able to raise concerns with the manager. They told us, "Able to go to the manager". Another member of staff confirmed, "Raise anything with the manager".

We spoke with the registered manager about their vision for the service. They confirmed the service was, "to be a learning and improving service. We want to provide high quality care, you can have all the qualifications under the sun but to work in this role you have to be caring. We want to continue meeting the needs of people and not be complacent". The registered manager spoke passionately about striving to improve all processes and identified accurate and detailed report writing as a key area. The vision of the service was shared with staff at team meetings, hand over and during supervision.

Staff felt happy working in the home and felt supported. Staff told us, "I feel able to go to the [registered] manager". There was a suggestion box were staff were encouraged to give their views for improving the service. The registered manager said staff could nominate a colleague for the Star Award in recognition of outstanding performance. The registered manager told us, "Staff here work very hard and they need to be recognised for their efforts."

Staff attended team meetings. These were an opportunity to discuss changes to people's care needs, problems, incidents and accidents and any other current topic. Staff meetings were an opportunity to discuss a 'policy of the month' and inform staff of available training opportunities.

People, their relatives and staff views were regularly sought through an annual satisfaction survey and regular team meetings. For example, people had been asked about their care experience such as choices in daily life, social activities and their living environment. The registered manager told us there has a provider Newsletter but that the service planned to introduce their own regular newsletter. This was so people had specific information about the service and the local activities.