Messrs A & M & K Desai - Desai Care Homes

Culverhayes 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

We undertook an inspection of Culverhayes Nursing Home on 11 and 12 April 2018. Culverhayes Nursing Home provides accommodation for up to 65 people requiring nursing care. The service offers care to people with mental health needs and to those living with dementia. People live in one of three dedicated areas of the service according to their particular needs, Hayes, Culver and Lymore Wings. At the time of our inspection 64 people were living at the service and another person was due to move in.

At our last inspection in October 2015 we rated the service Good. At this inspection we found the evidence did not continue to support the rating of Good. .

People felt safe living at the service and staff were able to tell us what action they would take to keep people safe and protect them. The management of medicines was carried out safely. However the registered persons' attention was drawn to improvements that could be made regarding the storage of drinks thickener and the accessibility of guidance relating to 'as required medicines''

The environment was suitable for people living with dementia. People were accommodated in small groups and there was signage and use of colour to help people find their way around. The home was clean, well maintained and equipped. A range of activities were provided and people were supported to get involved in activities outside the service.

People received effective care because their needs were assessed. Staff were trained in core topics to meet people's specific needs such as safe handling and different aspects of dementia care.

People's rights were upheld as required by the Mental Capacity Act 2005. They were supported to make choices and if they lacked capacity to make some decisions these were made in their best interests.

The service provided food and drink that met people's need and referrals were made if people had swallowing difficulties or lost weight. Some people would benefit from pictorial menus or visual cues to support them making meal choices.

Staff were kind and caring and knew people well. They treated people with dignity and respect and provided care in a relaxed and compassionate manner.

People received responsive care as plans relating to their specific health needs contained sufficient detail. Some end of life care plans could be improved with more information about people's wishes at that time of their life.

The registered manager led a positive team who felt valued. Visiting healthcare professionals confirmed that the staff worked with them to ensure people received the care they needed.

People and their relatives could be confident that their views would be sought and listened to about the service. We found a number of improvements had been made in response to this feedback.

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 remains safe.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Well Led	**Good**

Care Quality Commission

Culverhayes 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 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 a scheduled comprehensive inspection and was unannounced. The inspection took place on 11 and 12 April 2018. It was carried out by one inspector, a specialist professional advisor, who was a nurse 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.

Before the inspection the provider completed a Provider Information Return (PIR). This 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 looked at the information in the PIR and other information we held about the service, including notifications. Notifications provide information about specific incidents and are required to be submitted to the Commission.

During the inspection we spoke with 14 people who lived in the home, 17 visitors and 17 staff in various roles. We also spoke with four external health professionals. Not everyone was able to tell us about their experiences so we used the Short Observational Framework for Inspection (SOFI) to help us make our judgements. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The registered manager and area compliance manager were present throughout the inspection .

During the day we viewed the premises, observed care practices in the communal areas of the service and lunch being served. We looked at records relating to individual care and the running of the service. These included five care records, medicine administration records, staff training and supervision, seven staff recruitment files and quality and safety monitoring checks.

Good

Is the service safe?

Our findings

The service continued to provide safe care.

People received their medicines when they needed them and in the correct way. The provider's policy stated, "The nurse or/and care coordinator must not assume that it is safe to crush or cut tablets or to disguise medication in any way. This must be carried out only under the direction of the GP and pharmacist." There were covert medication agreement forms in place in line with the provider's policy; however, the listed medicines written on three of the forms did not always correlate with the medicines the person was prescribed because the forms had not been updated. The GP had signed all forms to indicate their agreement and we saw evidence that the pharmacist was in the process of reviewing these with the service and the GP. Following the inspection the service sent us the report of the pharmacist audit which had arranged to be carried out soon after the inspection.
Some people were prescribed medicines on an 'as required' (PRN) basis. Although there were no protocols available to guide staff within the Medication Administration Records, there were PRN care plans in place, for example for people who could become anxious at times. Having protocols available alongside the MARs enables staff to see when and why people might require additional medicines as well as providing information about other actions staff might take before resorting to the use of them.
Thickener which had been prescribed for people on a named patient basis was not stored safely and in line with NHS England guidance. Containers were left unattended in communal areas and were left on tables in people's bedrooms. We observed staff on two occasions add thickener to people's drinks from a communal tub rather than from tubs that had been dispensed for the individual's use. Staff confirmed the thickener was used this way. We showed this to the area compliance manager and this was immediately rectified.

We observed part of a medicines round. The nurse administering the medicines knew people well, informed them they had their medicines and ensured people had swallowed them before signing the medicine administration record (MAR). They did not rush people and asked if they needed any additional medicines such as pain relief. One nurse said, "I know my residents. I do regular walk arounds so even if someone can't say they're in pain, I can tell from their facial expression."

Topical medicines recording charts were in place. There were body maps and clear instructions for staff on when and where to apply creams and lotions. The charts we looked at had been accurately completed..

People and their relatives felt the service provided safe care and support. People told us; "I feel safe-ish here - I look after myself - you can't moan about it here" and "Yes I feel safe. " A relative stated; "He is safe here without a doubt." Staff were knowledgeable about safeguarding adults and received initial training, which was then refreshed each year by the registered manager. The provider's safeguarding policy was in several languages so that staff whose first language was not English could access this more easily.

The provider had systems and processes in place to ensure that there were adequate numbers of skilled and

experienced staff. These included a thorough recruitment process with all the necessary checks so that suitable staff were employed.

There were suitable numbers of experienced staff on duty, including nurses 24 hours a day. Visitors and staff confirmed there was always sufficient staff and stated there was a "High staff to resident ratio" and "Enough staff? I should definitely say so. She was sick the other day and two staff were there immediately. We've never had cause to use the call bells." The provider had a dependency tool that assessed how many care staff were needed to meet people's needs and bank staff were employed to cover any shortfalls. In addition support staff and activity staff were also employed. During the inspection communal areas always had a staff member present to support people and staff assisted people quickly and efficiently.

Risks to people were assessed, managed and reviewed to minimise the risk of harm. Where people's behaviour could cause a risk to themselves or others clear guidance was in place for staff to follow. The possible reasons and triggers for the behaviour had been considered and there was a monthly review. Care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. These had all been regularly reviewed. When risks were identified, the plans guided staff on how to reduce the harm to people and how to keep them safe. Moving and handling plans detailed any equipment needed to move people safely, such as hoists and slings. We observed staff using equipment when transferring people. The equipment was used correctly; staff informed people what was happening and reassured them throughout the procedure. Where accidents or incidents had occurred these were recorded and reviewed by the registered manager to check if further action was needed.

All areas of the home were clean, well maintained, spacious and uncluttered. Safe practice guidance was in place for both the environment and staff hygiene practices. Staff used suitable hand washing procedures and protective equipment, such as gloves and aprons, to reduce the risk of spreading infection. One visitor told us; "They always wear gloves and wash their hands. Staff always have gloves in their pockets."

Environmental risks were well managed and included regular checks of fire safety systems, hoists and gas and electrical appliances. Fire drills for staff were held every three months for night staff and six months for day staff. A number of staff had received additional training to act as fire wardens.

Good

Is the service effective?

Our findings

People continued to receive effective care.

People and visitors told us that staff were well trained, capable and competent to look after them. One visiting professional stated; "Culverhayes is able to deal with the more challenging behaviours that most homes can't. Due to their high staffing ratios they are able to give good 1:1 support and thus reduce the need for medication."
Staff had access to a range of core training including moving and handling, first aid, venepuncture and medication training. In addition training was provided that was specific to the needs of people living in the service. This included meaningful activity and person centred care and different aspects of dementia care. One person had been identified as needing specific support around their behaviour and staff were being trained to provide this safely.

Staff said they were suitably trained in order to carry out their roles. Nurses said they had access to training and development in order to meet their professional registration requirements. They said, "I get lots of training. I'm doing end of life training at the local hospice" and "We get lots. My last training day was venepuncture and I've done catheterisation recently too." All staff said they had regular supervisions and felt supported in their roles. They also said they had annual appraisals. Staff said, "The manager is so supportive, you can go to him with any problem and he really listens" and "I feel very supported by the manager."

People were supported to eat and drink enough and specialist diets were provided when advised by the Speech and Language Therapist. Some people were receiving a soft diet; however not all had been referred for specialist advice, such as a speech and language therapist in relation to these people's swallowing abilities. The registered manager confirmed that the GP did not always consider this necessary. Feedback from people about the quality of the food was variable however we observed that most people were offered choices and staff took time to give people opportunities to eat their meal where they needed help. However people on Hayes wing remained in their armchairs and had meals served on their side tables. People were asked verbally to make a choice. The registered manager advised that pictorial menus were being developed to help people living with dementia make choices. People's preferences in relation to the food and drink they liked had been documented.

People's legal rights relating to consent and decision making were upheld as required by the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework for making particular decisions on behalf of people who may lack the capacity to do so for themselves. Best Interest care plans demonstrated that where people lacked capacity to make a particular decision this had been assessed and decisions made by relevant people in their best interests. For example one person was receiving their medicines covertly (disguised in food or drink) as they would not take the medicine. The decision was made after consultation with the person's GP and a close relative who agreed it was in the person's best interest to take this medicine. The care plan clearly recorded the reasons for the decision and this was reviewed monthly.

Where people could make choices we observed staff offering these and checking with people before providing aspects of their care. One staff was assisting someone with lunch and asked; "May I wash your hands and mouth- can I help you?"

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 registered manager had a system to monitor who had DoLS authorisations and when they expired.

The service ensured that people were supported to receive the care they needed. People were assessed prior to moving to the home and these assessments formed the basis of their care plans. People had access to ongoing healthcare. Records showed that people were reviewed by the GP, the community psychiatric nurse, tissue viability nurse and the diabetes nurse for example. All the visiting healthcare professionals we communicated with spoke highly of the standards of care and co-operative working.

The environment was suited to people living with dementia who may need help to find their way around. This included communal areas that were well lit and pleasantly decorated to give a feeling of calm and comfort. Walls were colour coded in different areas to help with navigation and contrasting wooden handrails in all corridors. Bedroom doors were all numbered and there was an option to include a photograph of the person. Signs around the home were clear and both pictorial and worded were positioned at eye level.

Good

Is the service caring?

Our findings

The service remained Caring.

People were treated with dignity and respect. All personal care took place behind closed doors and we saw that staff knocked on bedroom doors before entering. Staff said, "We give people privacy, close doors, keep people covered, make sure they're wearing clean clothes" and "We close the curtains, tell people what we're doing, and ask them first." We observed positive interactions between staff and people. People were relaxed around staff and we saw them looking at books together, walking and playing games.

Staff spoke highly of the care and support they provided for people. Comments included, "It's not institutionalised here, people get choices and are involved", and "The care here is good in every aspect. We really care for these people. We don't see this as a job, its one big happy family, including the relatives of people; they share aspects of their lives with us and vice versa" and "I like it here because I've really got to know the residents." One relative told us; "The staff are brilliant- kind and caring and very respectful."

People's preferences about the gender of the care staff assisting them was respected. Staffing levels showed a good gender balance so people were usually able to choose the gender of their care worker. One person said; "I prefer lady carers- it's awful to lose your dignity. I usually get them but not always." A relative told us; "He prefers the male care workers for personal care and this happens." Staff we spoke with confirmed these preferences were acknowledged for people.

All staff interacted with people in a friendly, caring and compassionate manner. They were appropriately tactile with people, holding their hands, putting their arms round their shoulders, and when people were walking they often held their hands to guide and support them gently.

Staff knew people well and were able to tell us a lot of background information about them. We observed that staff always took time to explain what they were going to do, why they were doing it and what the outcome was likely to be.

Special care had been given by staff to what people were wearing and their clothes reflected their personalities. One lady had a lovely silk scarf folded like a bandeau and tied in a bow round her head. She was complimented by everyone and this gave her great pleasure. Ladies were wearing jewellery and several men were wearing jaunty hats.

People and their relatives were involved in decisions about their care and kept informed of any changes. One visiting health professional told us that there was a good level of staff understanding and they involve people and their families. There is a, "Triangle of care – can't fault it." The registered manager told us that after the first four weeks in the service people and their families take part in a review of the care. Plans were then regularly reviewed. People and their families were invited to care reviews and these were documented.

Good

Is the service responsive?

Our findings

People continued to receive a responsive service.

People received personalised care and care plans were person centred. They contained details of people's lives before moving to the service and included details of their choices and preferences. For example, night time plans detailed the times people preferred to go to bed, their preferred routine and whether they liked a light on or not. Personal hygiene plans included the clothes people preferred to wear, how often the men liked to shave and people's preferences for male or female care staff.

Advanced care plans were in place but would benefit from having more information on people's choices and preferences for their care at the end of their lives. Having this information in place enables care staff to ensure people are supported to have a comfortable and dignified death and that any special requests are met. In some of the plans we looked at people's choice about where they wanted to be cared if their health deteriorated had been completed; but this was not seen consistently. One health professional told us that the end of life care for one person was, "Absolutely right. "We asked staff about the people they were caring for, they were able to describe in detail the support they provided. All staff said that always working on the same unit with the same staff had enabled them to really get to know and understand the people living there. One staff member said, "We all read the care plans and follow the care plans" and another said "We learn about people from talking to them and their families."

We recommend that the registered person researches available resources to support consistent practice in advanced care planning.

Plans for people who were unable to verbally communicate were clear and described the best way for staff to engage meaningfully with them. For example, in one care plan staff were guided to address the person by name, make eye contact and to speak slowly and clearly. Some people experienced episodes of aggression and agitation. These plans provided clear guidance for staff on how to support people at these times whilst also ensuring people and staff remained safe.

Plans in relation to people's health needs were detailed including moving and handling, wound care, epilepsy and diabetes. We looked at the care plan for one person with diabetes. The care plan guided staff how to support the person to maintain safe blood sugar levels and informed them of the signs and symptoms of low blood sugar and the action to take if this happened. A seizure plan for one person described what staff should do in the event this happened. Wound plans were clear, and included the dimensions of wounds, the dressing regime and detail of whether the wound was improving or deteriorating. Tissue viability nurse support was sought when required

Care plans on how to meet people's religious needs were minimal and did not always specify any support that people needed. However people's faith needs were being supported in practice through services and visits by relevant religious leaders. One health professional told us the home was; "A much more rounded psycho-social environment." Another told us that there was, "Usually some small activities going on."

People were supported to take part in social activities. One person told us; "I go out with [staff] to Weatherspoon's for lunch every Tuesday. We get a taxi." We spoke with all three members of the Activity Team. They were all employed full time for this role. There was a full monthly schedule of activities available and this was prominently displayed on all areas as were the actual activities for that day. The Activity Team members told us that they were going to be renamed the "Wellbeing Team." They had participated in 'Oomph' training and were now fully implementing this in their day to day work. This training is designed to help staff provide meaningful activities to people. The service also had a scheme called 'Extra Mile' in which they organised trips into the community supported by members of staff and family and friends. So far they had taken people to Bath Rugby, shopping, cinema in Bath, and lunch trips.

People and their relatives told us they felt able to make a complaint should they need to. One visitor said; "She loves the outside - I asked for her to be taken out in the garden as much as possible. This has been resolved to my satisfaction." The service had received two complaints in the past year. Actions had been taken and clearly recorded in line with the provider's policy. All complaints are followed up and the provider's head office informed.

Good

Is the service well-led?

Our findings

The service continued to be well led.

The provider had a range of audits in place to check the safety and quality of the service. Whilst most of these audits were effective the medication audit had not identified the shortfalls relating to covert administration. However the registered manager was aware of these and action was being taken. The medication audit tool recorded if there was a procedure in place for staff to follow when crushing medicines, but did not prompt any confirmation that the procedure was being followed.

There were systems in place to assess and monitor the service provided. These included compliance checks, infection control, care plans and falls. The registered manager checked these audits and action was taken where needed to make improvements.

People's views are sought and acted on to develop the service. The provider sent out surveys annually to relatives and health care professionals. Feedback was also gathered from people living at the service, including meetings held with people twice a year. Improvements have been made in response to this feedback including a hair salon, a 'coffee station' and lines in the car park.

There was 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 and visitors spoke very positively of the registered manager. One relative told us; "He is an excellent manager. Very approachable - he's helpful and considerate." A visiting health professional said; "It is so much better now. Staff are more relaxed with [registered manager] on board. He is a very competent manager."

The staff felt valued and felt that the management team engaged with them in a positive way. They said the culture was, "Positive." Comments included; "My opinion is definitely valued. I wouldn't stay if they didn't listen to me" and "The owner comes in regularly, always makes a point of saying hello to us and asking how our families are." One staff member said; "Our mission is to provide high quality care. I've never worked anywhere else so have nothing to compare it to, but other people tell me it's the best here."

The registered manager supported staff through supervision, a daily walk around the service and calling night staff. The registered manager told us the culture, "Is a mirror of the manager." There was a clear staffing structure. This included nurses, senior care staff and care assistants and housekeeping staff including domestic staff, chef and kitchen staff and the activities team.

All the visiting health professionals we spoke with confirmed that the registered manager and staff worked effectively with their organisation and team. They said they could, "Talk to the owners at any time." We saw

there was regular communication through monthly multi-disciplinary meetings and regular reviews.

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