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The Minstrels Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The Minstrels Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. It provides accommodation for older people and those with mental health conditions or dementia. The home can accommodate up to 33 people. At the time of our inspection there were 26 people living in the home.

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. In this report when we speak about both the company and the registered manager we refer to them as being, 'the registered persons'.

At the last inspection the service was rated, 'Good'. At the present inspection the service remained 'Good'. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Medicines were managed safely. However, we found that protocols for 'as required' medicines were not in place. Where people received their medicines without their knowledge (covertly) the provider had not followed their policy.

Where people were unable to make decisions arrangements had been made to ensure decisions were made in people's best interests. However not all best interests decisions were issue specific as required by national guidance.

Suitable quality checks were being completed and the provider had ensured that there were enough staff on duty. In addition, people told us that they received person-centred care.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse including financial mistreatment. Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. Background checks had been completed before new staff had been appointed.

There were arrangements to prevent and control infections and lessons had been learned when things had gone wrong.

Staff had been supported to deliver care in line with current best practice guidance. People were helped to

eat and drink enough to maintain a balanced diet. People had access to healthcare services so that they received on-going healthcare support.

People were supported to have maximum choice and control of their lives and to maintain their independence. Staff supported them in the least restrictive ways possible. The policies and systems in the service supported this practice.

People were treated with kindness, respect and compassion and they were given emotional support when needed. They had also been supported to express their views and be actively involved in making decisions about their care as far as possible. People had access to lay advocates if necessary. Confidential information was stored securely, however we observed that there were occasions when records were left in public view during the inspection.

Information was provided to people in an accessible manner. People had been supported to access limited activities and community facilities. The registered manager recognised the importance of promoting equality and diversity. People's concerns and complaints were listened and responded to in order to improve the quality of care. Arrangements were in place to support people at the end of their life.

There was a registered manager who promoted a positive culture in the service that was focused upon achieving good outcomes for people. They had also taken steps to enable the service to meet regulatory requirements. Staff had been helped to understand their responsibilities to develop good team work and to speak out if they had any concerns. People, their relatives and members of staff had been involved in the running of the service. The provider had put in place arrangements that were designed to enable the service to learn, innovate and ensure its sustainability. There were arrangements for working in partnership with other agencies to support the development of joined-up care.

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?

Requires Improvement

The service has deteriorated to Requires Improvement

Information to support staff when administering as required, (PRN) medicines, was not available. arrangements were not in place to ensure medicines were effective when given in food.

There were systems, processes and practices to safeguard people

Risk assessments were completed.

Is the service effective?

Good

The service remains Good

Is the service caring?

Good

The service remains Good

Is the service responsive?

Good

The service remains Good

Is the service well-led?

Good

The service has improved to Good

The Minstrels Residential 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 comprehensive inspection.

This inspection took place on 1 May 2018 and was unannounced.

The inspection was carried out by an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance the care of older people and people living with dementia.

Before the inspection we looked at information the registered persons sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also examined other information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

During the inspection we spoke with eight people who lived at the service, three members of care staff, three relatives, three visitors and the registered manager. We also looked at three care records and records that related to how the service was managed including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

The service was rated good at the last inspection and this time it was rated requires improvement.

Information to support staff when administering as required, (PRN) medicines, was not available to staff in five of the nine records we looked at, to ensure people received their medicines when they needed them. Where people received their medicines in food without their knowledge(covertly), to assist them to be able to take their medicines, we observed the appropriate arrangements had not been put in place to ensure the method of administration did not affect the way the medicines worked. The registered manager took action to address this during our inspection.

We observed the medicine round and saw people were given their medicines safely and according to their preferences. Medicine administration records (MARs) were completed according to the provider's policy. Medicine front sheets were in place and included information about allergies, however we observed three of the records we looked at were not fully completed. We also observed MARs did not always reflect people's allergies. There was a risk people would receive medicines which they were allergic to. A medicine audit had been completed in April 2018 but this had not checked these issues. We spoke with the registered manager who told us they would address these issues.

People told us that they felt safe living in the service. We saw evidence of people being supported to maintain their feeling of safety. One person said, "I didn't always feel safe at home but I do feel safe here." Another said, "I have always felt safe living here." Relatives also told us they were confident that their family members were safe.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed that care staff had completed training and had received guidance in how to protect people from abuse. We found staff knew how to recognise and report abuse both internally and externally to the service, so that they could take action if they were concerned that a person was at risk. They told us they thought people were treated with kindness and they had not seen anyone being placed at risk of harm.

We found that risks to people's safety had been assessed, monitored and managed so that people were supported to stay safe while their freedom was respected. This included measures that had been taken to help people avoid preventable accidents. For example, risk assessments were in place to manage the risk of falls. Arrangements were in place to protect people in the event of situations such as fire or flood.

Staff were supported to promote positive outcomes for people if they became distressed. For example, guidance was available in people's care plans so that they supported them in the least restrictive way. When we spoke with staff they were able to tell us about these. For example, allowing a person to sleep in their bedroom chair rather than their bed.

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The provider had ensured there was enough staff on duty to provide safe care to people. Staff said they thought there was sufficient staff. People we spoke with told us there had been a lot of changes recently but this had not affected their care. The registered manager told us they had put in place arrangements to ensure there were sufficient staff to support people.

We examined records of the background checks that the registered persons had completed when appointing new members of care staff. We found the registered persons had undertaken the necessary checks. These included checking with the Disclosure and Barring Service to show that the applicants did not have relevant criminal convictions and had not been guilty of professional misconduct. In addition, references had been obtained. These measures had helped to establish the previous good conduct of the applicants and to ensure that they were suitable people to be employed in the service.

People told us they felt the home was clean. Suitable measures were in place to prevent and control infection. Staff had received training and understood how to prevent the spread of infection.

We found that the registered persons had ensured that lessons were learned and improvements made when things had gone wrong. Staff told us they received feedback on incidents and accidents. Records showed that arrangements were in place to analyse accidents and near misses so that they could establish how and why they had occurred. We also noted that actions had then been taken to reduce the likelihood of the same thing happening again.

Good

Is the service effective?

Our findings

We found that arrangements were in place to assess people's needs and choices so that care was provided to achieve effective outcomes. Records showed the registered manager had carefully established what assistance people required before they were admitted. Initial assessments had also considered any additional provision that might need to be made to ensure that people did not experience any discrimination. An example of this was establishing if people had cultural or ethnic beliefs that affected the gender of staff from whom they wished to receive personal care.

People were confident the staff knew what they were doing and had their best interests at heart. Members of staff told us and records confirmed that they had received introductory training before they provided people with care. As part of their initial training, new staff also completed the National Care Certificate which sets out common induction standards for social care staff. In addition, they had also received on-going refresher training to keep their knowledge and skills up to date. When we spoke with staff we found that they knew how to care for people in the right way and where people had specific needs arrangements had been put in place to provide training to staff. For example, training about dementia care. The provider also encouraged staff to study for nationally recognised qualifications in care and management.

Arrangements were in place for staff to receive one to one support and yearly reviews. Staff told us they had received one to one support and had found this useful. This is important to ensure staff have the appropriate skills and support to deliver care appropriately.

People were supported to eat and drink enough to maintain a balanced diet. Drinks and snacks were provided to people throughout the day. We observed lunch. One person said, "It's lovely, I am enjoying my food." We saw people chose where they wanted to have their lunch either in the dining or lounge area, or in their own bedrooms. People also chose what and when they wanted to eat. For example, one person was sleeping at lunch time. The registered manager explained that this was not out of the ordinary and that they would eat later. Later that afternoon we observed the person having a snack and a cup of tea.

Where people had specific dietary requirements we saw these were detailed in care records and staff were aware of these. In addition specialist cutlery and plates were available to support people with their meals. One person was vegetarian and staff told us they were able to provide appropriate choices for them.

People were supported to live healthy lives by receiving on-going healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as specialist nurses, dentists, opticians and dieticians. The registered manager told us that the home had good relations with the local GP practice and that two people were being treated by the District Nurses. We observed the District Nurse visit on the day of the inspection and saw before they left they spoke with the registered manager to update them.

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 law 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. Staff were supporting people to make decisions for themselves whenever possible. Records showed that when people lacked mental capacity the registered manager had put in place a decision in people's best interests. However these were not consistently decision specific as required by national guidance. We spoke with the registered manager about this who told us they would address this.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found where people were subject to DoLS the appropriate arrangements had been put in place. At the time of our inspection there were nine people subject to a DoLS.

We saw that refurbishment had taken place since our last inspection and issues we had previously identified had been addressed. Colours and picture signage had been used around the home in order to assist people to orientate themselves around the building.

Good

Is the service caring?

Our findings

People and their relatives were positive about the care they received. A person told us, "I do not think that if you are going to live in a home you could be in a better one." "I am quite content." A relative told us, "The staff are all very friendly and very hardworking."

People were treated with kindness and were given emotional support when needed. For example, staff used quiet tones when speaking to people and made eye contact. We observed staff approached people in a kind manner, and greeted people with a smile. When staff changed shift they came into the lounge and greeted people and had a quick word with all the people present.

People told us staff were considerate. Where people required specific support to prevent them from becoming distressed this was detailed in their care records and guidance was in place to support staff. One person was upset and wanted to go home and we observed staff reassured them and offered them to stay for lunch first in an attempt to divert the person's distress. We observed another person required a change of clothing after lunch. When staff approached them to offer support they initially refused. We observed staff removed themselves for a short period and then tried again which resulted in the person agreeing to support.

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. For example, a care record explained how staff should support a person with their mail and any documents, stating that staff should read these aloud to the person. Another person had made a decision not to take their laxative medicine but to use natural remedies instead. We saw staff had discussed this both with them and the dietician in order to support them in their decision.

We observed staff supporting people to move and saw this was done safely and at people's own pace. Staff explained what they were doing and how people could assist them when moving. Records detailed how people should receive their support when being assisted to move.

Most people had family, friends or representatives who could support them to express their preferences. We noted that the provider had access to local lay advocacy resources. Lay advocates are people who are independent of the service and who can support people to make decisions and communicate their wishes.

People's privacy, dignity and independence were respected and promoted. People told us staff were usually respectful when giving personal care and they had never felt undignified or embarrassed. We observed people were encouraged to remain as independent as possible. For example, people were provided with specialist cutlery so they could continue to eat independently. People were called by their preferred name and records also referred to people by this. One person said, "
The home had four double rooms however the registered manager told us they no longer used these as double rooms unless people expressed a wish to do so. For example they had previously provided accommodation for a married couple in these facilities. Staff told us about and recognised the importance

of not intruding into people's private space and maintaining their privacy. For example, knocking on doors and asking people if they required support before providing it.

We found that suitable arrangements were in place to ensure that private information was kept confidential. However we observed two people's care records were left in communal areas where information could be seen by visiting relatives or members of the public. We spoke with the registered manager about this who said they would address this issue. Computer records were password protected so that they could only be accessed by authorised members of staff.

Good

Is the service responsive?

Our findings

People said that nurses and care staff provided them with all of the assistance they needed. We found that people received personalised care that was responsive to their needs. Assessments had been completed before people came to live at the service. Records showed that staff had consulted with each person about the care they wanted to receive and had recorded the results in an individual care plan. This helped staff to understand people's needs and wishes. Care plans were regularly reviewed to make sure that they accurately reflected people's changing needs and wishes. Where people's needs had changed this was detailed in care records. For example, a person had experienced a fracture and their care plan had been reviewed to reflect this.

Information was included in the care record to inform staff about what was important to people. For example, information about people's work history and life experiences. We observed staff speaking to people about their past life experiences and families.

Care plans and other documents were written in a user-friendly way according to the Accessible Information Standard so that information was presented to people in an accessible manner. For example where a person used an alternative name we saw the care record was written using that.

Arrangements were in place to provide activities on a daily basis. The registered manager told us a member of staff came on duty at 12 noon and after assisting with lunchtime was responsible for leading on activities. We observed this occurred however there was no activities programme or timetable available. This meant people were not always aware of what activities were available. One person we spoke with chose to remain in their room most of the day. They told us, "I didn't know there were any activities." Three family members and three visitors also raised concerns about the lack of activities. They told us that they thought there were insufficient activities and they did not have any trips out.

Staff told us as well as group activities they tried to provide one to one sessions during the afternoons as many people were unable or did not wish to join group activities. We observed that during the morning activities did not take place. In the afternoon we observed a game taking place with a soft ball and later some people completing a jigsaw puzzle. We saw evidence there had been visits from entertainers and other groups, including animal therapy and a choir. The registered manager told us they celebrated individual events such as birthdays and Easter and were planning a party for the royal wedding.

People were supported to maintain relationships outside the home, for example a person told us they could have visitors whenever they wished. Relatives told us they were offered drinks and meals when they visited. Some people also attended local community events which they had had links to before coming to live at the home. For example, one person attended a local luncheon club.

We noted that staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs. For example, a communion service was regularly held at the home and a person also attended the local chapel. Furthermore, the

registered manager recognised the importance of appropriately supporting people if they identified as gay, lesbian, and bisexual and transgender.

Arrangements were in place to support people who could not communicate verbally. For example, care records detailed how staff should communicate with people. Another person who was living with a visual impairment was unable to use the electronic call bell and a hand bell had been provided which was kept within easy reach. We observed the person using the bell and staff responding promptly.

There were arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. There had been no formal complaints received since our last inspection. A complaints policy was available to people and people were aware of this. When we spoke with people they told us they would be happy to raise concerns if they had any.

The provider had arrangements in place to support people at the end of their life. The registered manager told us they had an arrangement with a specialist nurse from the NHS who assisted them to put end of life care plans in place with people if they wished to. At the time of our inspection there was no one receiving end of life care.

Good

Is the service well-led?

Our findings

At our previous inspection this domain was 'Requires improvement'. At this inspection we found the provider had addressed the issues previously identified and found the domain to be 'good'.

Records showed that the registered persons had correctly told us about significant events that had occurred in the service, such as accidents and injuries. The registered persons had suitably displayed the quality ratings we gave to the service at our last inspection.

People and their relatives told us that they considered the service to be well run. There was a registered manager in post who promoted a positive culture in the service that was focused upon achieving good outcomes for people. Staff described the home as 'friendly'. One member of staff told us, "I'm so proud of this home." We saw that during the inspection the registered manager was seen around the home and engaged with people. It was clear that the registered manager knew people and they were familiar and comfortable with her. Relatives we spoke with and some of the people who lived at the home we spoke with knew who the registered manager was and felt they could approach them with any problems they had. The registered manager told us they had an open door policy.

Staff told us they were confident that any concerns they raised would be taken seriously so that action could quickly be taken to keep people safe. Staff we spoke with told us they would usually go to the senior carer first, but would feel confident to raise issues with the registered manager if they needed to. The registered manager had developed working relationships with local services such as the local authority and GP services.

In addition, we found that the registered persons had taken a number of steps to ensure that members of staff were clear about their responsibilities and to promote the service's ability to comply with regulatory requirements. Regular staff meetings were held and staff received feedback with regard to issues in the home. A member of staff told us, "Have a good team."

We found that people who lived in the service, their relatives and members of staff had been engaged in the running of the service. The registered persons had invited people who lived in the service and their relatives to complete questionnaires to comment on their experience of using the service. For example, a quality assurance survey had been carried out in December 2017. We saw most comments were positive and where issues had been raised these had been resolved. For example a person had had their bedroom redecorated to their choice. A survey regarding food and drink had also been carried out in January 2018. Following which the cook had discussed new meal options with people.

We found that the registered persons had made a number of arrangements that were designed to enable the service to learn and innovate. This included linking with local organisations such as the local authority to introduce improvements. The registered manager also encouraged staff to develop so that their skills could be used to benefit the home. For example, some staff were taking part in an external falls management course so that they could support staff in this area.

Records showed that the registered persons had regularly checked to make sure that people benefited from having all of the care and facilities they needed. Checks were carried out on issues such as falls, mattresses and health and safety issues. These checks included making sure care was being consistently provided in the right way, and staff had the knowledge and skills they needed. In addition regular checks had taken place to ensure the service met regulation. We saw the results of these checks were reported back to staff at meetings.