Hampshire County Council

Solent Mead Care Home

Inspection report

Church Lane
Lymington
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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

Solent Mead Care Home is a purpose built care home in a residential area of Lymington. The home is registered to provide care for up to 36 older people, some of whom may be living with dementia.

The inspection was unannounced and was carried out on 2 and 5 August 2016 by one inspector.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to respond to and meet people's needs.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

Staff developed caring and positive relationships with people, were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people in a patient and friendly manner.

The service was responsive to people's needs and staff listened to what people said. Staff were prompt to raise issues about people's health and people were referred to health professionals when needed. People

were confident they could raise concerns or complaints and that these would be dealt with.

People and, when appropriate, their families or other representatives were involved in discussions about their care planning. People were encouraged to provide feedback on the service provided both informally and through an annual questionnaire.

People and their relatives spoke positively about how the service was managed. Staff felt supported by the management to raise any issues or concerns. The quality of the care and treatment people experienced was monitored and action taken to promote people's safety and welfare. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The registered manager had assessed individual risks to people and had taken action to minimise the likelihood of harm in the least restrictive way.

People received their medicines at the right time and in the right way to meet their needs.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's independence, privacy and choices.

People were encouraged to maintain friendships and important

relationships.

Is the service responsive?

Good

The service was responsive.

The service was responsive to people's needs and any concerns they had.

Care plans and activities were personalised and focused on individual needs and preferences.

The registered manager involved people and their representatives in planning care and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The registered manager adopted an open and inclusive style of leadership. Staff understood their roles and responsibilities and there were clear lines of accountability within the service.

People, their families, health professionals and staff had opportunities to feedback their views about the home and quality of the service being provided.

The quality of the care and treatment people experienced was monitored and action taken to promote people's safety and welfare.

Solent Mead Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection was unannounced and was carried out on 2 and 5 August 2016 by one inspector.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with four people using the service and four relatives. We observed care and support being delivered in communal areas of the home to help us understand the experience of people who could not talk with us. We spoke with six members of the care staff, an activities co-ordinator, a member of the domestic staff, an assistant unit manager, the deputy manager and the registered manager.

We looked at a range of documents including six people's care records, risk assessments and medicine charts, staff recruitment, duty and training records. We also looked at information regarding the arrangements for managing complaints and monitoring the quality of the service provided within the home.

The home was last inspected on 9 July 2014 when no issues were identified.

Good

Is the service safe?

Our findings

People and their relatives we spoke with confirmed they felt safe living in the home and that care was delivered in a safe manner.

Staff respected and promoted people's independence, while remaining aware of their safety. For example, staff ensured people had their walking frames at hand so they could use these to move around the building as they wished. A person told us "I like to do things for myself" and that staff had supported them to go into town.

Risks to people had been identified, assessed and actions had been taken to minimise them, such as those of people falling, becoming malnourished or developing pressure sores. This information was recorded in each person's care records and updated regularly with any changes to the level of risk or changes to health. Daily care records showed staff supported people in line with the risk assessments, for example four hourly repositioning to prevent pressure damage to people's skin. There was a system in place for recording incidents and the registered manager reviewed these each month to look for trends and identify potential learning. For example, where a person had a fall more than three times in three months, this raised a flag to review their care plan. In addition incidents were reviewed by the provider's care governance team on a monthly basis.

Staff had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. They knew how to report any suspicion of abuse to the management team and agencies so that people in their care were protected and their rights upheld. Policies were in place in relation to safeguarding and whistleblowing procedures and these were accessible to all staff. Whistleblowing is a policy protecting staff if they need to report concerns to other agencies in the event of the organisation not taking appropriate action. All staff had received safeguarding awareness training and were supported by managers who had received more detailed safeguarding training. Regular refresher courses were arranged for staff to attend. Support was sought where needed from the local authority safeguarding coordinator. The registered manager used senior staff meetings to review and discuss any safeguarding alerts.

People were supported by sufficient staff with the right skills and knowledge to meet their assessed needs. Staffing levels were kept under review and additional staff could be used if people's needs changed. The service used ancillary staff to help support people at meal times. People told us that staff were available when they needed care and support. Staff confirmed there were enough staff on duty and were able to respond to people quickly. They were aware that the provider was recruiting for more staff and using regular agency staff as much as possible to cover vacant posts. Staff recognised that this provided continuity of care for people: "They know our voices. That can help people to feel calm". A senior member of care staff told us "The staffing is fine. Occasionally we may need more, for example if someone is unwell. The management team listen and act. They are good here".

The provider had a system in place to assess the suitability and character of staff before they commenced

employment. Records included interview notes and previous employment references. Staff were required to undergo a Disclosure and Barring Service (DBS) check. DBS checks enable employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with adults who may be at risk. The system of checks included agency staff who worked at the service.

There were appropriate plans in case of an emergency occurring. Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Fire policies and procedures had been updated in 2015 and regular fire alarm tests and drills were carried out. Staff attended fire drills at least six monthly and an annual fire evacuation practice in addition to training. Equipment was serviced at regular intervals and an annual legionella test was carried out. A maintenance person undertook minor repairs reported by staff and a record of this was kept.

Systems were in place to help ensure people's medicines were ordered, stored and administered safely. This helped to ensure that people were protected against the risks associated with the unsafe use of medicines. There were detailed individual support plans in relation to people's medicines, including pain relief. For example, one person had pain relief patches that were changed every week. Clear guidelines were in place that helped staff to understand when 'as required' medicines should be given. Medicines were only given by senior staff trained to administer them and who had successfully completed an annual competency assessment.

The management team had a clear audit system to check medicines. This was completed monthly or weekly where controlled medicines were in use. A controlled drugs (CD) cabinet and logbook was in use and the records were completed in line with the relevant procedures. A new system for recording when topical medicines such as creams and lotions were administered had recently been implemented to help ensure that people received the medicines they required for skin protection.

We observed one of the management team giving people their medicines, supporting them in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them. The manager asked a person if they were in any pain and did they need any pain relief. Then gave the person time to think about the question and answer in their own time. They ensured each person had a drink to assist them to take their medicines. Medicine administration records (MAR) were signed after each medicine was successfully dispensed.

The registered manager was aware of their responsibilities in relation to infection control. An annual infection control statement was written and the registered manager was aware of what needed to be reported. There was a cleaning schedule in place for staff to follow and records showing checks took place. We spoke with a member of the domestic staff who told us that keeping the home clean was manageable, particularly since the home had been refurbished and had new carpets. The home environment was clean and we observed that staff were aware of infection control procedures. Protective clothing was available and in use by staff. The training record showed that staff received training in infection prevention and control.

Good

Is the service effective?

Our findings

People confirmed that staff worked effectively as a team and had the knowledge and skills to meet their needs. A relative told us "Staff are very good, they're excellent". A community care professional told us "Solent Mead Care Home staff have always had access to very good training provided by Hampshire County Council". They also commented "The service provided by the staff have, in my opinion, always had the resident's best interest at heart. And they have a good support network from the local surgeries".

The staff training programme showed that staff were provided with knowledge and relevant qualifications to support them in meeting people's needs. A system was in place to track the training that each member of staff attended. Staff confirmed they had the training and on-going updates in subjects including moving and repositioning, infection prevention and control, safeguarding, emergency aid, fire safety, dementia awareness, nutritional risk assessment, recording and reporting, and care planning.

The provider's induction programme for new staff involved eight days of essential training during the first four weeks, complemented by shadowing experienced staff to help ensure that the training could be applied in practice. A recently recruited member of staff told us their induction was thorough and plans were in place for them to commence working on a diploma in health and social care. They said the provider gave them "Very in depth training". An agency care worker who had been covering for a regular member of staff told us they received a good induction to introduce them to the service and people.

Staff told us they had supervision approximately every two months where they "can talk about anything" with their supervisor, including "checking care plans, discussing key working and any training needs". We saw records of staff supervision, which showed that staff were able to raise issues and these were followed up.

They told us the management team were supportive and said "I think we all get along very well".
They told us a full time member of staff would usually be a key worker for three people. They described key working as "Generally looking after their health and wellbeing, things like checking their weight, supporting them with bathing".

The registered manager had contacted one of the organisation's Practice Development Nurse (PDN) to facilitate training for staff in relation to Diabetes and Parkinson's disease. A new three day training course for assistant unit managers (AUMs) was being rolled out.

Staff had received training in the Mental Capacity Act 2005 (MCA). 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.

While assessments of people's mental capacity had not all been completed to demonstrate how and when

decisions may need to be made on behalf of someone, the registered manager had an improvement plan in place to complete these by 31 October 2016. Some people had signed to indicate their involvement and/or consent to their care plans. Staff showed an understanding of the principles of the MCA in relation to people they were supporting. Before providing care, they sought consent from people and gave them time to respond. Staff were aware that some people had capacity to make decisions, while others may require more support in relation to bigger decisions that may need to be made. A community care professional told us "Residents are always given choice, regardless of their mental capacity".

One person's care records showed their social worker and GP had been involved in a best interests decision about the person staying at the home. An independent mental capacity advocate (IMCA) had visited one person.

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 application procedures for this in care homes 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.

The registered manager had submitted DoLS applications and, where authorisation had been received the service acted in accordance with any conditions attached to depriving a person of their liberty. For example, one person was able to access the community as part of their care plan. Four people had independent advocates to help ensure that decisions were made in their best interests. Following the inspection the registered manager submitted the relevant DoLs outcome notifications to us as these had not been submitted previously.

People's support plans included nutritional assessments and details of their dietary requirements and support needs. A risk assessment tool was used to help identify anyone who might be at risk of malnutrition and specific care plans were in place to minimise the risk. Food and fluid charts were used to monitor people's intakes during periods of potential risk. During the day we observed staff making sure people had drinks and supporting them to drink if needed. During periods of hot weather staff gave people iced lollies to encourage hydration.

People were complimentary about the meals: "Very good food" and "Food is excellent, very straight forward". Another person gave the thumbs up sign when we asked them about the food.

At lunch time meals were served from a heated food trolley. Some people ate in the main dining area, others in a smaller area and two people chose to eat in their own rooms. There were two options for the main meal and staff knew what people had asked for. Staff demonstrated knowledge of which people were on soft, fortified, or other special diets and records also contained this information. Staff knew people's names and addressed them in a polite, friendly and caring manner, supporting and encouraging people to eat.

One person indicated that they did not want their meal. A member of staff asked if they wanted something different. The person moved away from the dining table and sat in another chair. The member of staff came back to the person after a short while and offered the person a pudding, telling them what it was. The person patted the staff member's arm and smiled. The member of staff gave the person a small tray to put their bowl on and the person ate enthusiastically. The member of staff told us this was usual for the person, who would often eat better at supper time, and that what was important was encouraging the person to eat.

A person had a pressure relieving bed and mattress and a repositioning chart in place. A member of staff told us how the equipment and record was used for monitoring and that staff regularly checked the person's weight and encouraged them to move. A community nurse also made checks and monitored the bed was set correctly.

Records showed staff contacted community health and social care professionals in relation to concerns about people's health. Staff had noticed when a person had been prescribed a drug they were allergic to. Staff checked with the person's GP and the pharmacy and an alternative drug was prescribed. When another person had been unsettled and in pain and staff were unable to administer a medicine because there had not been a long enough interval between doses, staff had contacted a community nurse who came out and administered an injection to help the person.

Staff also asked for advice from an occupational therapist in relation to patterns of falls a person had. A falls protocol had been agreed with another person's GP in relation to decreasing mobility. People had access to a range of services including chiropody, dentists and opticians.

Good

Is the service caring?

Our findings

A person said the service was "Quite impressive" and told us staff "Treat people as they should be treated". Relatives confirmed people were well cared for. Their comments included: "Mum is content and staff are pleasant and polite"; "She is being looked after terrifically well"; and "It's a happy place". A community care professional told us "I have always received very good feedback from both the resident's and family members". The service had received a greetings card from the family of a person who had moved to another home, saying 'Thank you for taking great care of (the person). We won't forget you'.

We observed caring interactions from staff throughout the inspection. For example a member of staff wiping a person's mouth and making them comfortable; then putting out coloured pens and drawings for a person on the seat where they usually sat. Another member of staff showed concern for a person and asked them if they would like a cup of tea. We observed staff assisting a person to move from a chair, which they did in a gentle and reassuring way. A senior member of staff, who demonstrated a calm and patient approach with people, told us they enjoyed their role as "Everyone's different and you get to know them".

The service supported people to express their views and be involved in making decisions about their care and support. Each person had a member of staff assigned to them as a key worker. Key working is a system where a member of care staff takes special responsibility for supporting and enabling a person. The aim of this system is to maximise the involvement and help to build relationships between people using the service, their families and staff. People were also involved in the running of the service through regular resident's meetings that were recorded and shared.

The minutes of a residents meeting showed that people were asked about the service they received and actions were taken in response to what they said. During a discussion about the food, one person wanted thinner bread used for their sandwiches and another person wanted the curry to be hotter. This information was relayed to the kitchen staff and thinner bread and fresh chillies were purchased. The meetings were also used to provide people with information and updates about the service, such as staff recruitment and the refurbishment of the home. During a spell of hot weather a further 10 electric fans had been purchased and people were informed to just ask if they wanted one in their room.

Care plans contained sections called 'all about me and my life' and 'who and what is important to me'. One person's care plan stated that it was important to them to have their dolls with them and we saw that staff made sure they did. Care plans also included people's likes and dislikes. For example, one person liked lots of salt and pepper on their food and did not like quizzes. People's family and friends were involved in recording this information, where appropriate.

Relatives were encouraged to support their relative with personal care where they wished to be involved in this. Visitors were welcome and were supported to stay for lunch and share activities with people. People were supported to keep in contact with friends and families using computer based social networking as well as having telephones in their rooms. Regular social events were also held to involve families in the service.

The relationships between staff and people receiving support demonstrated dignity and respect. The care staff were kind and courteous and we observed they knocked on doors before entering people's rooms. People received personal care in the privacy of their bedrooms. Staff gave examples of respecting people's privacy and dignity, for example keeping a person covered as much as possible while assisting them to wash.

Care plans and associated records were written in a way that promoted dignity and respect. For example, people's preferred names were recorded and used by staff. Where people were able to go to the toilet independently this was supported. One person's care plan stated they did not like to wear a continence pad, though their plan showed an assessed need. Staff therefore encouraged the person to wear a pad but respected their choice if they did not wish to. Care plans supported people's abilities to do things independently, such as eating, mobilising and personal care. Staff cared for people in ways that respected their independence, such as at mealtimes if people wanted to move to eat somewhere else. A person told us "Staff like to do things for me" but respected their independence regarding personal care. They said "Solent Mead is a very good place to live, if you need it".

People's care plans included advance decisions, such as one person's wish to remain at the care home if possible rather than be hospitalised in the event of their health declining. Where end of life care was needed, staff sought advice from a local hospice and specialist nurses. People's wishes at this time were discussed and documented in their care plans. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate.

Good

Is the service responsive?

Our findings

People told us they felt the staff were responsive to their needs and any concerns they had. A community care professional told us "The staff have always worked to resolve any issues in a timely manner". We observed staff were responsive to the call bell and a person told us "Staff will come if needed". A relative told us staff had responded swiftly when their family member had a fall. Another relative confirmed they and their family member had been involved in the pre-admission assessment, along with staff from the service and community professionals.

A personalised approach to responding to people's needs was evident in the service. Before people moved into the home they and their families or representatives participated in an assessment of their needs to ensure the service was suitable for them. Involving people in the assessment and subsequent reviews helped to make sure that care was planned around people's individual care preferences. Following this initial assessment, personalised care plans were developed that provided guidance about how each person would like to receive their care and support, including their preferred routines of care and how they communicated their needs.

Records showed care plans were reviewed regularly including, for example, monthly reviews of risk assessments for preventing falls. Where necessary, external health and social care professionals were referred to as part of the response to people's changing needs. People and/or their relatives/representatives were involved in reviews according to each person's wishes or best interests decision. Information about people's preferred daily routines included when they liked to get up and whether they preferred to eat breakfast in their own room or with others. One person's communication care plan included details of certain gestures the person understood and used instead of verbal communication. Through talking with people and the staff and through observation, it was evident that staff were aware of people's care needs and acted accordingly. All staff contributed to keeping peoples' care and support plans up to date and accurate.

We spoke with the activities coordinator who worked at the home full time Monday to Friday and had attended dementia awareness and other relevant training. They had organised an 'ad lib' activity including music and chatting over tea and biscuits for a small group of people, who had been unable to attend a day centre that morning due to a staffing issue there. A 'virtual fish tank' was on display on a large television screen, which helped to create a relaxed atmosphere in the room. A relative commented "The small units are beneficial, user friendly". The home was split into small areas, which helped to create a more homely atmosphere.

The activities programme was on display and a copy was given to each person. Yellow boxes in the communal areas contained a number of activities that care staff could help to facilitate. In addition to group activities, one to one activities and social interaction was provided. One person's past working life had involved mathematics and the activities coordinator told us how the person still enjoyed activities of this nature. A relative told us the activities coordinator was "Very good and there are good activities". They said their family member "Likes to not take part sometimes" and staff respected this. Another relative said

"There's always something going on" with regard to activities for people. A community care professional told us people "Have spoken of their enjoyment of the activities provided".

The registered manager told us that faith leaders and religious ministers were invited in to the home to hold regular services. A relative confirmed their family member was able to take part in communion in line with their religion.

People told us they would feel comfortable raising any concerns or complaints. The registered manager told us they had received no complaints about the service in the last 12 months. There was a system and procedure in place to record and respond to any concerns or complaints about the service. Staff understood people's needs well and demonstrated how they would be able to tell if a person was not happy about something, which meant that people would be supported to express any concerns.

Good

Is the service well-led?

Our findings

People told us they felt the service was well-led. One person said the home was "Very well run" and another person's relative said the service maintained "High standards" of care.

The service worked in partnership with community professionals to help ensure people received the care they needed. For example, a social worker and a specialist community service were involved in assessing a person's changing needs. A community care professional told us "The staff of Solent Mead have always been good at communicating with the care management team".

The registered manager was promoting an open and inclusive culture within the service. The registered manager carried out walkabouts to check what was happening on the floor and had an open door policy for people living in the home, staff and relatives.

Records of team meetings confirmed that staff were asked for their input in developing and improving the service. A member of staff said the management team "Kept everyone happy. I enjoy working here. It's a friendly home". Staff we spoke with understood their roles and responsibilities and there were clear lines of accountability. Staff told us there was always an assistant unit manager (AUM) on duty. There were processes in place to enable the registered manager to account for the actions, behaviours and performance of staff, and the registered manager told us how she had implemented the procedures when necessary. Staff were supported by regular supervision and each member of staff had a performance plan and goals, which were set at the beginning of the year in relation to both corporate and personal objectives.

The service used feedback to drive improvements and deliver consistent and high quality care. A satisfaction survey was carried out that included questionnaires sent to people who used the service and their relatives. We saw that the results of a recent survey were overall positive, with all of the 15 people who responded saying they were satisfied with the overall care provided.

Regular audits of the quality and safety of the service took place and were recorded. For example, there were audits of care plans, medicines, infection prevention and control and equipment. In addition to these, a service manager for the organisation carried out regular checks that were also recorded. The registered manger maintained a record of actions taken in relation to audits, incidents, and feedback from people using the service or others acting on their behalf. A copy of the report was sent to the service manager and provider. The service had systems in place to report, investigate and learn from incidents and accidents. Records showed that investigations were undertaken following incidents and that appropriate actions were taken in response. For example, in the event of a pattern of falls being identified, the provider's internal local governance team would contact the home to check what action was being taken to reduce the risks of similar accidents happening again.

Following the provider's audits, actions taken to improve the service included more detailed recording of the management of topical creams and ointments. Another action point had been for the service to conduct a quality assurance survey and this had also been completed. The registered manager had a service

development plan. As part of a new project the service was looking at introducing new roles such as senior carers, a Dementia Advanced Practitioner, and recruiting more domestic staff who could take over the tasks of bed making and other tasks, which would free care staff up to assist people with activities and to give more one to one support.