Salisbury Management Services Limited

Salisbury House Residential Home

Inspection report

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Date of inspection visit:
05 July 2018
10 July 2018

Date of publication:
31 July 2018

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

The inspection took place on the 4 July 2018 and was unannounced.

Salisbury House Residential Home is registered to provide personal care for up to 37 older people and at the time of our visit the service was providing support for 36 people some of whom were living with dementia. The accommodation is provided in single and double rooms over three floors. Access to the upper floors is by way of stairs or passenger lift.

At the last inspection on 15th January 2016 the service was rated 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.

Why the service is Good.

People and relatives told us they felt the service was safe. People remained protected from the risk of abuse because staff understood how to identify and report it.

The provider had arrangements in place for the safe ordering, administration, storage and disposal of medicines. People were supported to get their medicine safely when they needed them. People were supported to maintain good health and had access to health care services.

Staff considered peoples capacity using the Mental Capacity Act 2005 (MCA) as guidance. People's capacity to make decisions had been assessed. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People and their relatives felt staff were skilled to meet the needs of people and provide effective care. Staff felt fully supported by management to undertake their roles. Staff were given training updates, supervision and development opportunities.

People were encouraged to express their views and results of customer satisfaction surveys were positive. People and relatives felt listened to and any concerns or issues they raised had been addressed.

Staff supported people to eat and drink and they were given time to eat at their own pace. People's nutritional needs were met and people reported that they had a good choice of food and drink.

The service had a relaxed and homely feel. Everyone we spoke with spoke highly of the caring and respectful

attitude of a consistent staff team which we observed throughout the inspection.

People's individual needs were assessed and care plans were developed to identify what care and support they required. People were consulted about their care to ensure wishes and preferences were met. Staff worked with other healthcare professionals to obtain specialist advice about people's care and treatment.

People, staff and relatives found the management team approachable and professional.

Further information is in the detailed findings below:

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Salisbury House 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 inspection took place on 5 and 10 July 2018 and was unannounced. One inspector completed the inspection.

Before the inspection the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. We looked at the latest Healthwatch 'enter and view' report, reviewed comments about the service on an online care home review web site and received feedback from the local authority who told us they had no concerns about the service. We also reviewed information from the fire authority about the outcome of their last visit to the service and contacted the local Clinical Commissioning Group (CCG) 'Six steps to success' end of life programme.

During the inspection we observed the support that people received in the communal lounge areas of the service. We spoke with ten people who lived at the service, three people's relatives, five care staff, the chef, the activities co-ordinator and the manager, two deputy managers and a visiting healthcare professional. We spent time observing how people were cared for and their interactions with staff and visitors to understand their experience. We also took time to observe how people and staff interacted at lunch time and the administration of medicines.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a

way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including four people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, accident/incident recording and audit documentation. We also 'pathway tracked' the care for some people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

People and relatives told us they felt the service was safe. One person told us, "I feel very safe. I've never been made to feel I couldn't speak out".

People were protected from the risk of abuse because staff understood how to identify and report it. Staff had access to guidance to help them identify abuse and respond in line with the provider's policy and procedures if it occurred. They told us they had received detailed training in keeping people safe from abuse and this was confirmed in the staff training records. Information on safeguarding and the contact details for CQC and the local authority had also been provided to people living at the service and discussed at residents' committee meetings.

Staff were recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff have a criminal record or are barred from working with children or vulnerable people. Other checks included obtaining proof of identity, employment references and employment histories.

People and relatives felt there was enough staff to meet their needs. One person told us, "I would say there are enough staff. They came quickly when I fell in my room and used the call bell". Staff duty rotas showed staffing levels were consistent over time and staff leave was covered by permanent staff. We observed there was enough skilled and experienced staff to ensure people were safe and cared for.

Staff had taken appropriate action following accidents and incidents to ensure people's safety and this was recorded in the accident and incident book. We saw specific details of any follow up action taken to prevent a reoccurrence. Any subsequent action was updated on the person's care plan and then shared at staff handover meetings. The registered manager and health and safety person analysed this information for any trends and to check whether the person would benefit from assistive technology to alert staff if they had a fall.

People received their medicines safely. Medicines were only administered by staff who were trained to do so and whose competencies had been checked. We observed a member of staff administering medicines sensitively and appropriately. We saw that they administered medicines to people in a discreet and respectful way and stayed with them until they had taken them safely. Nobody we spoke with expressed any concerns around their medicines which were stored appropriately and securely and in line with legal requirements.

The service was clean and hygienic and staff had access to personal protective equipment (PPE) such as gloves and aprons. There was a cleaning schedule in place which included a schedule for deep cleaning all areas of the service. In February 2018 the kitchen had been awarded a five stars Food Hygiene Standard by the Environmental Health.

Robust risk assessments were in place which identified risks and the measures required to minimise harm whilst empowering people to undertake activities. Risks associated with the safety of the environment and equipment were identified and managed appropriately. There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to evacuate the building in the event of a fire had been considered and where required, each person had an individual personal emergency evacuation plan.

Good

Is the service effective?

Our findings

People and their relatives felt staff were skilled to meet the needs of people and provide effective care. One relative told us, "I've no concerns about the care or the staff".

We saw the staff undertook an assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The pre-assessments were used to develop a more detailed care plan for each person which specified the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided.

People received consistent support from specialised healthcare professionals when required, such as GP's, dentists, dieticians, tissue viability nurses, the local falls prevention team, district nurses and mental health professionals. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. The service also had staff who had undertaken specialist training and took the lead for specific areas of care including hydration, dignity, dementia, end of life care and activities. These staff took responsibility for ensuring people's needs in these areas were being met and supported other staff who could come to them for help and advice.

When new staff commenced employment, they underwent an induction and shadowed more experienced staff until they felt confident to carry out tasks unsupervised. The training plan and training files we examined demonstrated that all staff attended essential training and regular updates. Training included moving and handling, food hygiene, infection control and health and safety. The provider stated on their PIR that they continued to look for ways to develop staff and to provide them with opportunities to update their knowledge and obtain nationally recognised qualifications. Staff confirmed this and told us they were supported to obtain qualifications and that they received regular supervision. Staff also told us they felt very well supported by the management team and received a planned annual appraisal of their performance.

We observed lunch and saw that it was an enjoyable and sociable occasion. A variety of nutritious food and drink was provided which people enjoyed and people told us they could have a drink or snack at any time. The chef had a list of people's specialist dietary requirements and people's personal preferences which were catered for. We saw people who were at risk of malnutrition or dehydration were encouraged to eat and drink sufficient amounts and records had been maintained.

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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was still working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions. Staff had knowledge and understanding of the Mental Capacity Act (MCA) and had received

training in this area.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Applications had been sent to the local authority and notifications to the Care Quality Commission when required. We found the manager understood when an application should be made and the process of submitting one. Care plans clearly reflected people who were under a DoLS with information and guidance for staff to follow.

The premises met people's needs for example grab rails were in place, bathrooms were adapted and corridors clutter free. Assistive technology was available to use when assessed as needed for example sensors to alert staff if people who were at risk of falls got out of bed or left their rooms.

Good

Is the service caring?

Our findings

People and relatives felt staff were consistently kind and caring. One person told us, "The staff are all kind. Very caring. I've no problem with any of them".

The service had a relaxed and homely feel. Everyone we spoke with spoke highly of the caring and respectful attitude of a consistent staff team which they knew well. Throughout the inspection, people were observed freely moving around the service and spending time in the many communal areas or in their rooms. People's rooms were personalised with their belongings and memorabilia. One person told us they had been able to bring some of their own furniture which had helped them to settle in and feel at home.

People were encouraged to be independent. They told us and we saw that staff were there if they needed assistance, but that they were encouraged and able to continue to do things for themselves. Records and our own observations supported this. One person told us and we saw they laid the tables at lunch time each day and another told us that after lunch they liked to clear the plates from their table. We saw that thermos tea pots and coffees pots; milk jugs and sugar were provided at each table after lunch for people to prepare their own hot drinks. Staff explained one person had helped at a recent summer fair by manning a stall on their own and another person had helped staff serve people at another stall.

Peoples' differences were respected and staff adapted their approach to meet peoples' needs and preferences. People could maintain their identity; they wore clothes of their choice and could choose how they spent their time. Diversity was respected about peoples' religion and both care plans and activity records, for people staying at the service, showed that people could maintain their religion if they wanted to. Holy communion was held every week and visitors to the service read bible stories to these people who wished to attend. The manager told us these readings had proved to be very popular with people including those who did not actively follow a faith.

People told us they were involved in decisions that affected their lives. Observations and records confirmed that people could express their needs and preferences. Staff recognised that people might need additional support to be involved in their care, they had involved peoples' relatives when appropriate and information was available if people required the assistance of an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Peoples' privacy was respected and consistently maintained. Information held about people was kept confidential, records were stored in locked cupboards and offices. People confirmed that they felt that staff respected their privacy and dignity and our observations were that staff assisted people in a sensitive and discreet way. Staff were observed knocking on peoples' doors before entering, to maintain peoples' privacy and dignity and people could spend time alone and enjoy their personal space.

Good

Is the service responsive?

Our findings

Paperwork confirmed people or their relatives were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews. The care plans were detailed and gave descriptions of people's needs and the support staff should give to meet these. Each section of the care plan was relevant to the person and their needs. Care plans were reviewed regularly and updated as and when required. People and relatives told us they were involved in the initial care plan and on-going involvement with the plans.

The management team and staff alike were passionate about ensuring people had the opportunity to lead fulfilling lives and understood the importance of providing people with the opportunity to participate in activities they found stimulating and enjoyable and how this impacted on their quality of life. People enjoyed the range of activities on offer which were meaningful to them. Minibus trips out to places people enjoyed such as to the theatre, meals out at café's and pubs, visiting the dementia friendly singing café, barge trips and other destinations people had chosen, took place weekly. One person told us, "There's a list in the hallway of all the trips; you can put your name down for the ones you fancy".

A daily activity timetable was in place. One person told us "The activities organiser does something every day, not sure what's on this afternoon. There is a timetable but she comes around and tells us what's on and asks if we want to join in". In the morning we saw people were supporting to go for a walk around the garden and people enjoying a singalong session in the lounge. We saw other people enjoying chatting to one another or sitting reading the paper. In the afternoon we saw a group of people thoroughly enjoying playing bingo outside. This was a very social affair and we heard people laughing and joking with staff and each other. People told us they had recently held a summer fair to which family and the local community were invited and that children's choirs came in to sing to them at Christmas. Other activities provided included, arts and craft, exercises and the reading of bible stories. Entertainers such as singers and musicians also visited the service. We saw that activity logs were kept which detailed who attended the activity and what they thought of it, which enabled staff to provide activities that were meaningful and relevant to people.

People were provided with end of life care that met their needs and preferences. We saw that people had access to palliative care services (end of life) and that advanced decisions made by people and their loved ones in relation to this had been documented. Staff provided dignified end of life care, and liaised with relevant professionals, such as GP's and hospices. The service had signed up to and followed 'The Six Steps to Success Programme' which is a nationally recognised programme aimed to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. As part of this programme the service had a nominated member of staff who acted as their representative. This member of staff had access to current national and local information and had been supported to develop their knowledge and skills and other staff could go to them for help and advice. Feedback from the local 'Six Steps' team was that the service engaged well with them and that they had obtained and maintained their 'Six steps' certificate.

The provider actively sought people's views on the service. People were listened to and complaints were

recorded and responded to appropriately. People told us they were routinely listened to, had completed surveys, and the service responded to their needs and concerns. They were aware of how to make a complaint and all felt they would have no problem raising any issues. The complaints procedure and policy were accessible and displayed around the service. A copy of an easy read guide to safeguarding and complaints had also been provided to people at residents committee meetings and copies given out with the annual resident's survey. An easy reading version of the 'Residents charter' covering areas such as choice, control, privacy, dignity, independence, diversity, fulfilment and purpose and citizens' rights was also made available to people.

The manager told us they held regular fundraising events to raise money for the 'residents fund'. They explained that £7 per person from this fund was used to fund outings and activities. Where the outings cost more than £7 people were asked to pay the difference.

Good

Is the service well-led?

Our findings

The service had a registered manager. 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. At the time of our inspection the registered manager was not available and the service was being run by a manager. The service was a family business at which the manager had worked for many years regularly in day to day charge.

People, visitors and staff all told us that they were happy with the way service was managed and stated that the management team remained approachable and professional. We saw people and their relatives came to speak with the manager throughout the day and that their office door was left open to encourage this.

People looked happy and relaxed throughout our time in the service. Staff said that they thought the culture of the service was one of a homely, relaxed and caring environment. When asked why the service was well-led, one member of staff told us, "The manager is very good and listens to us. We work well as a team".

The manager showed passion for and knowledge of the people who lived at the service. They demonstrated they had a good knowledge of people by describing in detail people's personal backgrounds, preferences and personality traits.

Quality assurance audits were embedded to ensure a good level of quality was maintained. We saw audit activity which included medication, health and safety, and infection control. The results of which were analysed to determine trends and introduce preventative measures. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans accordingly to drive up the quality of the care delivered.

Staff continually looked to improve and the registered manager had liaised regularly with the Local Authority and other professionals involved in people's care to share information and learning around local issues and best practice in care delivery. This learning was cascaded down to staff.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.