Community Integrated Care

St Patricks Care 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

St. Patricks is a purpose built establishment in a residential area in Widnes. It provides care and support for up to 40 people diagnosed with dementia. The home provides care over two separate units depending on their level of need; Ashley unit and Maguire unit. Each unit has its own lounge, dining room and utility kitchen. All bedrooms are single with en-suite toilet facilities. The home is operated by Community Integrated Care. At the time of our inspection, there were 36 people living in the home.

At the last inspection on the 5 March 2015, the service was rated Good. At this inspection we found the service remained Good.

The registered provider had taken action in accordance with recommendations we made at the last inspection regarding the development of the environment to make it more dementia friendly. An outdoor theme was created through the use of imitation 'bus stops' and benches alongside brick effect wallpaper. This provided a means of facilitating relief for people who have dementia and may want to leave the home. A mock shop and café with prices displayed in pounds and shillings provided a village feel. A new sensory room had been installed in the home to provide a relaxed environment where people could retreat to when they became agitated or wanted some quiet time.

There were a variety of activities in place provided by two activities co-ordinators employed by the service to promote social stimulation. This included baking, arts and crafts and bingo. People also had access to the on-site bar which was equipped with optics, bar stools and a dartboard. The registered provider worked with community partners such as the Widnes Vikings to enable people to access a dementia café at the grounds.

There was a registered manager in post at the service. The registered manager had worked at the home in a variety of different roles over 20 years, including as a staff nurse, before becoming registered manager in 2016. 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.

Our observations and review of staff rotas showed sufficient numbers of staff were deployed to meet people's needs. Some staff and relatives thought that staff could be stretched at specific times throughout the day. We brought this to the attention of the registered manager during our inspection.

Staff were recruited safely and pre-employment checks were carried out before they started work at the organisation to ensure they were suitable to work with vulnerable people. Staff had received training in 'safeguarding' and understood the different types of abuse and the local reporting procedures.

Medicines were managed safely and effectively. Medication was administered by registered nurses and staff

who had received the relevant training. Medication Administration Records were completed accurately and PRN guidance was in place for people who were prescribed 'as required' medication. People told us they were happy with how their medication was managed and received this when they needed it.

Risk assessments were detailed and contained sufficient information to guide staff on how to minimise the risk of harm for people who lived at the home. Fire procedures in the event of an evacuation were clearly marked out and regular mock fire drills were completed. Checks were completed to ensure the environment was free from hazards.

The training records showed staff had received relevant training to ensure they had the skills to support people effectively. Our discussions with staff showed that they had a good knowledge about the people they supported and understood people's individual needs.

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 service operated within the principles of the Mental Capacity Act 2005 (MCA). Our review of records showed that processes were in place to assess people's capacity and make decisions in their best interests.

People were supported to maintain good health and well-being. The home had a good relationship with a local GP practice through the GP alignment initiative and had regular dialogue with the local community mental health team. Referrals were made promptly to health professionals such as SALT, the dietician and tissue viability nurses. Staff followed guidance that was implemented to achieve best outcomes.

People told us they enjoyed the food served at the home. Staff knew, and catered to, people's individual dietary needs and preferences. Nutritional risk assessments were completed and diet and fluid charts were in place for those who required them.

We observed kind and compassionate interactions between staff and the people they supported. Staff offered tactile reassurance to people in distress. People told us they liked the staff that supported them.

Care plans were personalised and evaluated monthly. We noted that any changes in people's needs were documented and actioned appropriately.

A complaints policy was on display in the home which contained details for the local authority and Local Government Ombudsman. People told us they would not hesitate to raise concerns with the registered manager if they felt they needed to. Complaints were documented and managed in accordance with the registered provider's complaints policy.

Quality assurance systems were effective and measured service provision. Regular audits were completed for different aspects of the service such as medication, care plans and accident and incidents.

Opportunities were provided for people and their relatives to provide feedback on their experience of the care provided and contribute to improving the service delivery. This included quality assurance surveys, a suggestion box and family meetings.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with statutory requirements.

The ratings awarded at the last inspection were displayed at the entrance to the home.

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 Good.	**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 Good.	**Good**

St Patricks 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 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 comprehensive inspection took place on 15 March 2018 and was unannounced.

Before our inspection we reviewed the information we held about St Patricks care home. We contacted the Local Authority quality monitoring and safeguarding teams to ascertain if there were any areas of concern that we should be aware of. We were not made aware of any concerns about the care and support people received. We reviewed the latest Health Watch report which was completed following a visit in September 2017. Health Watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. We also considered information we held about the service, such as notification of events about accidents and incidents which the service is required to send to CQC. We used all of this information to plan how the inspection should be conducted.

The inspection was undertaken by two adult social care inspectors, a registered mental health 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, in this case, the care of someone living with dementia.

During our inspection we spoke with the registered manager, the deputy manager, a general nurse, an assistant practitioner, five carers, a student nurse, the cook and the activity coordinator. We spoke to three people living in the home and six relatives. We case tracked three people who used the service and also looked at care records for a fourth person who used the service. We reviewed three staff personnel files, medication administration records, staff training and development records as well as information about the management and governance of the service. We observed the lunchtime service and care at various points throughout the day.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. Comments included, "I feel safe because my legs just give way and here everyone is about to help me" and "Yes I feel safe because I am not steady on my feet and the girls help me into my wheelchair." People's relatives also felt reassured that their relative was in a safe environment. Comments included, "My relative wanders around but I know they watch him and keep him from any harm" and "My relative was constantly falling out of bed but they are all well-equipped here and they have been fine since coming in here."

The majority of feedback we received suggested that there were sufficient staff on duty to support people safely and the staff rotas evidenced this. However, some relatives and staff working at the service thought staff could be stretched at times. People's relatives told us, "Seems to be plenty of staff about and they all seem to know what they are doing", "The staff work really hard but they could always do with more staff" and "They need more staff at the meal times. If someone requests the toilet, they have to wait a long time and this can cause them discomfort." We discussed this with the registered manager who told us they had no staff vacancies at present but had experienced difficulties with staff sickness. In these circumstances, agency staff were used but these were not always reliable. The registered manager and deputy manager assisted on the floor when there were staff shortages and continued to review shift patterns including the 'twilight' shift to ensure a more consistent staff team. The service had recently employed five new care assistants who were currently undergoing the induction process.

Staff recruitment remained safe because the appropriate pre-employment checks were completed and recruitment files contained all relevant information. Staff had received training in safeguarding and understood the local reporting procedures. Following an increase in the number of referrals to safeguard people's welfare due to challenging behaviour, the registered manager had taken action to strengthen their pre-admission assessments procedures with specific attention to psychiatric need and behavioural issues in order to ensure they could cater effectively for people.

Medications were stored securely and safely managed at the service. Controlled drugs were checked by two staff on a daily basis in accordance with best practice procedures. People told us they received their medication when they required it.

Risk assessments were completed in respect of falls, nutrition, pressure care and moving and handling. Guidance was provided to staff in order to mitigate the risk. Incident and accidents were well documented and analysed for any emerging patterns or trends. People at risk of recurrent falls were identified and referrals were made to appropriate services to minimise the chance of reoccurrence.

Checks were completed on the environment and equipment to ensure these did not pose a risk to people's safety. Staff had received training in infection control and used Personal Protective Equipment when providing care.

Good

Is the service effective?

Our findings

At our last inspection on 5 March 2015, we made a recommendation around the development of the environment to better meet the needs of those with dementia. On this inspection, we noted that action had been taken to promote a more dementia friendly environment. The home was clean, bright and airy and included colour differentiation on areas such as handrails to support people's orientation and reduce the risk of falls. The corridors were decorated with brick effect wallpaper which had hanging baskets of flowers and windows to give the impression of being outdoors. The registered provider had made efforts to create a village feel with bus stops and local bus timetable, benches, a 'shop' and 'an imitation bar'. A mock café was set up with an old gramophone on display and 'prices' displayed on a menu board in pounds and shillings.

People felt that staff had the necessary skills and knowledge to support them effectively. One person told us, "I am hoisted all the time the staff are always good and don't hurt me." People's relatives told us, "From what I observe the staff are well trained to deal with all the people in the building" and "My relative's needs are complex but they do a marvellous job with him."

Staff had a sound knowledge of people's individual need and were able to describe to us, in detail, people's specific support requirements. Staff had training in a variety of topics such as dementia, management of actual or potential violence and moving and handling. The registered manager had a colour coded training matrix on display which enabled them to retain quick oversight of any outstanding training due.

Records showed that people were supported to attend medical appointments and received professional advice when they were unwell. The home had good links with the local GP practice as part of the GP alignment initiative and staff told us they found this very effective at achieving best outcomes for people. Staff sought professional input without delay and treatment plans from services such as SALT were reflected in people's care plans.

Food was supplied by an external company who delivered pre-prepared nutritionally balanced meals to the home. People told us they enjoyed the food available. Comments included, "There always a choice of meals, the carer asks what we want at lunch time. If I don't like what's on offer they will make something else" and "The food is very nice and there's always a choice." Nutritional risk assessments, care plans and food and fluid charts were in place for those who required them.

The registered provider worked within the legal framework of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were completed in respect of key individual decisions in accordance with the principles of the Act. Day to day decision making profiles were in place to guide staff on the types of decision the person could make for themselves or what decisions they required support with. We saw evidence of best interest decision meetings being held when people's needs changed, for example, when a new PRN (as required) medication was prescribed.

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). At the time of our inspection, there were 17 people subject to DoLS authorisations and the registered manager maintained oversight of authorisations which remained 'pending' with the supervisory body.

Good

Is the service caring?

Our findings

People liked the staff that supported them. Comments included, "The staff are lovely, real good girls", "The staff are very good; they help me wash and dress and always do this kindly. They help me have a bath when I want one." and "They are very kind to me." People's relatives also told us staff were caring and considerate to their family member. Comments included, "All the staff are very kind to my relative even though he can be very awkward with them" and "Staff are very kind to my relative and always very patient." People's relatives told us their relatives all looked clean and tidy.

We observed warm and compassionate interactions between staff and people throughout our inspection. Staff offered physical contact to people and communicated in a gentle and patient manner with people who were distressed. We saw that staff explained to people what they were doing before providing care. For example, whilst hoisting someone, one carer chatted to the person whilst the other explained to the person what was happening at each stage during the lift. Communication charts were in place for those people who were unable to communicate verbally. For example, guidance was provided to staff as to how to interpret one person's gestures which included, 'When I reach out for my bottle I am thirsty' and 'I become agitated when hungry.'

People were supported to be involved in making decisions about their care where possible. Care plans contained signed consent documents or this was obtained through a best interest process if the person did not have capacity to make decisions. People we spoke with told us their families dealt with their care plans and they were happy with this arrangement. People's relatives confirmed they were consulted with regards to the creation of their relative's care plan and any reviews. One relative told us, "In the 2 years my relative has been here I have had at least 2 reviews of their care plans, one when their mobility decreased and one when her swallow became a problem." All relatives told us that staff were responsive and they were kept informed at all times if their relative had required a Doctor or had had a fall etc. One said, "They notify you straight away by telephone if anything happens even though they know I visit every afternoon."

We spoke to six people's relatives during our inspection who told us they were always warmly welcomed at the service and that a visitor room was available for this purpose. One visitor told us, "We have been told we can go into the kitchen and make a drink anytime."

Good

Is the service responsive?

Our findings

People had access to activities within the home to promote social stimulation. Two activities co-ordinators were employed by the service for a total of 55 hours a week. The activities co-ordinator we spoke with had a good knowledge of people's needs and understood the need for increased support at specific times of the day to manage the sun downing effects for some people living with dementia. On the day of our inspection, the activity co-ordinator was giving manicures and hand massages and alongside a student, was taking three people into the town to have a look around the shops. The service supported people to access the local community and some people visited a dementia café set up at the local Widnes Vikings club. People chose whether they participated in the activities available. Comments included, "There are activities but I don't take part because I don't want to" and "I take part in some of the activities. I like the singers, the one yesterday was very good."

The activity co-ordinator told us that smaller groups work best for certain activities such as baking, bingo and dominoes. The home was planning the development of a separate activities room for this purpose. The home had a 'sensory room' which was a relaxing room with a light up star filled sky, fragrance oils, lava lamps, relaxation music, mood cushions and massage chairs. We were told that people sometimes used this room when they were agitated and it helped to calm them down. We saw that interest and activities care plans were in place. One care plan encompassed the social isolation which may be suffered by someone nursed in bed and suggested ways to alleviate this.

Care plans were in place regarding support needs in areas such as continence, mobility, nutrition and social activities. We reviewed people's daily records and saw that care plan guidance was adhered to. For example, one person required two hourly repositioning to promote skin integrity and the daily charts we reviewed showed this was completed. Care plans were reviewed on a monthly basis and any changes in circumstances were clearly documented. For example, one person's deterioration in mental health was recorded and we saw evidence of a subsequent revision of associated care plans such as nutrition and falls following this change.

A complaints policy was displayed in the communal area of the home and within the service user handbook which was circulated to each person living in the home. The policy contained details of the Local Authority as well as the contact details for the Local Government Ombudsman (LGO) if people wished to escalate their complaint. Complaints were reviewed and these were managed appropriately in accordance with the registered provider's policy. We saw that the registered manager took remedial action following a complaint regarding individual staff conduct which included additional training for the staff member.

Staff had received EOL training and care files showed consideration was given to people's wishes at the end of their lives. Some members of staff had been on the six steps programme relating to the provision of quality care for people at the end of their lives. Care records contained information in respect of whether people had completed 'Do Not Attempt Resuscitation' (DNAR) forms.

Good

Is the service well-led?

Our findings

People spoke positively about the home and the service in generally. Comments included, "I am very happy here in the home, it's very pleasant", "To be honest it's lovely and you are well looked after" and "It's nice here, it's like my own home." People's relatives told us, "[The atmosphere is] generally very pleasant and the staff do what they can to make it homely. It's also spotlessly clean"; "I think the atmosphere here is brilliant. I am really happy I moved my relative here", "It's very much a home from home and it always feels relaxed" and "It's nice and friendly and nothing is too much trouble for any of the staff."

The registered manager was visible on the floor throughout the day of our inspection. People we spoke with knew who the manager was. People's relative told us they would not hesitate to approach the registered manager if they had any concerns and felt they would act on comments that required action. The registered manager and deputy manager were both registered nurses and staff felt this level of clinical knowledge contributed to the success of the service. Staff told us, 'It's run by nurses which makes a massive difference" and 'We're a good team, we get on and have registered nurses to fall back on."

We saw a range of quality assurance processes in place at the home which included audits in respect of medication, care plans, DOLs and accidents and incidents. These systems were sufficiently robust and made recommendations for improvement. For example, care plan audits identified any gaps in recording within care records. The deputy manager created an action plan following each audit with their findings, action points and timescales. We reviewed the progress updates and saw that actions were addressed to ensure the health, safety and well-being of those living in the home. The registered manager also completed daily handover checks to keep abreast of any issues in respect of the environment or changes to people's needs. We saw that a monthly clinical governance report was compiled to ensure oversight at registered provider level. This report collected data in respect of incidents at the home such as deaths, pressure sores and falls.

The registered provider supported ongoing progression and development of staff as part of their vision to deliver high quality care and support. We spoke to some staff who were currently undergoing training to become an 'advanced carer'. This role was developed to enable suitably trained care staff to assist with more clinical tasks to strengthen their skills and knowledge base as well as alleviate pressure on nurses within the service.

Opportunities were available for people to comment on their experience of the care delivered through quality assurance questionnaires and a 'suggestion box'. People's relatives told us they had also attended family meetings at the service and found them useful. Comments included, "I attend the relatives meetings and always feel that people are listened to" and "I now get monthly newsletters by e-mail. This was a suggestion that came out of a relatives meeting." Staff meetings were also held regularly to enable staff to discuss any issues. We reviewed the agenda and minutes which showed discussion was held regarding safeguarding, supervisions and care plans and future training.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service in accordance with statutory requirements. This meant that CQC were able to

monitor risks and information regarding the service. The ratings from the last inspection were clearly displayed at the entrance to the home.