Goatacre Manor Care Limited

Goatacre Manor Care Centre

Inspection report

Goatacre Lane
Goatacre
Calne
Wiltshire
SN11 9HY

Tel: 01249760464
Website: www.goatacre.com

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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

Goatacre Manor Care Centre is a nursing and residential care home for up to 48 older people. At the time of the inspection, there were 31 people living at the service.

At our last inspection we rated the service as good overall, however the service required improvement in Safe. At this inspection we found the service continued to require improvement in Safe. The service requires improvement in safe because of issues with the documentation for the administration of medicines. In all other domains the service remained good and therefore is rated good overall.

This inspection report is written in a shorter format where the domain remains good.

Two recommendations have been made in safe. The recommendations are regarding the information recorded in protocols for medicines administered on an 'as and when required' (PRN) basis. Also, for the consistency in recordings of administration for prescribed topical medicines, such as creams and lotions.

One recommendation has been made in effective. The recommendation is regarding the recoding of best interest decisions.

One recommendation has been made in responsive. The recommendation is regarding the quality of information recorded in behavioural support plans.

People and their relatives spoke positively about the staff and management. Relatives praised the staff for the support they received while their loved ones received end of life care at the service.

Staff had a good understanding of the Mental Capacity Act (MCA) and applied the principles of the act to the care they provided. However, the assessments for the MCA lacked detail and did not include details of a best interest decision.

There was a friendly and relaxed atmosphere and people were comfortable in the environment. People and staff spoke with one another as though they were good friends.

The registered manager was passionate about continuing to improve the service and had long term development plans for this. This included building a cinema room.

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 was not always safe.

Documentation for the administration of medicines was inconsistent in the quality of information recorded.

Topical medicines were not applied in accordance with the prescription instructions.

Staff received safeguarding training and understood how this related to their role.

There were sufficient trained staff available.

Is the service effective?

Good

The service remained effective.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Good

The service was well led.

The audit systems in place did not always identify shortfalls in the service.

People, relatives and staff spoke positively about the management team.

There was a structured training programme in place.

Feedback was sought from people using the service.

Goatacre Manor Care Centre

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. The inspection took place on the 7 and 8 February 2018 and was unannounced. The inspection team consisted of two inspectors and one 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.

Prior to the inspection we requested a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was returned and completed in full. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are how the service tells us about important issues and events which have happened at the service.

During the inspection we spoke with eight people who use the service and four relatives. We also spoke with fourteen members of staff, including the registered manager, the deputy managers, nurses, senior care assistants, care assistants, the activities coordinator, kitchen staff, and a member of the maintenance team. After the inspection we requested feedback from twelve health and social care professionals, but unfortunately no feedback was received.

We reviewed the care plans and records for eight people and pathway tracked using the care plans and observations for three people using the service. Observations were made in the communal areas, including observing the lunchtime service and medicine administration. We also looked at the recruitment and training records for five members of staff.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection we identified that medicines requiring crushing were not being administered following best practice guidance. At this inspection, we found that practice and recordings regarding crushed medicines included pharmacist involvement.

Protocols for medicines administered on an 'as required' (PRN) basis, did not consistently include enough information. Some protocols lacked information regarding why and when a person may require their PRN medicine. For example, two protocols we reviewed were regarding PRN medicines for treatment of anxiety. The protocols had not been completed to explain the potential 'triggers for administration', 'types and location of pain' and 'behaviours and indicators for administration'. Although the nursing staff knew the people in the service well, the inconsistent protocols meant it was unclear for some people, what steps staff should take when trying to alleviate their anxiety before resorting to the use of medicines.

We recommend that the service reviews best practice guidance regarding the completion of PRN protocols.

Recordings for topical medicines such as creams and lotions were inconsistent and were not always signed to evidence when prescribed creams had been applied. One of the deputy managers explained that they were aware that this was an issue and had recently implemented a new system of signing for creams and lotions in people's bedrooms. The recording charts did not consistently provide enough information for staff when explaining when and why creams and lotions should be applied. For example, one person had been prescribed a barrier cream to prevent skin soreness. The guidance for staff was to "apply to sore areas as needed." The chart had not been signed to confirm that the barrier cream had been applied for the week prior to the inspection, despite manufacturer guidance to administer twice per day. This meant that the creams were at risk of not being used in the same way by each member of staff. Also there were risks that people were not receiving their creams as prescribed.

We recommend that the service reviews best practice guidance regarding the completion of prescribed medicines administration records.

Medicines were stored safely and there was an up to date medicine's policy in place. Medicines were audited by the service and by the pharmacist. Any identified gaps in medicine administration were quickly followed up to reduce risks of missed medicines.

Medicines were administered with dignity and the nurse ensured that the person understood which medicines they were taking and why. For example, we observed that the nurse would speak with the person in a calm and relaxed manner, explain what the medicine was and seek consent before administering.

People told us they felt safe living in the home. Their comments, "There's always someone to help me, so I would say there is enough staff" and "I definitely feel safe here, I was living at home, but this is now for me. I have a walking frame, but I've never fallen over here, but I did when I was at home." One person said, "If there are any problems I just press the call bell and they come to help very quickly."

Staff understood their responsibilities regarding safeguarding and knew how to keep people safe. Staff received training in safeguarding and this included learning from relatable scenario's. When speaking with staff, they demonstrated an understanding of their responsibilities, they could identify the types of abuse and action they would take. One carer said, "Safeguarding is about protecting the person from anything that may cause them harm."

Risk assessments were in place to protect people from the risks of potential harm or abuse. This included risk assessments for falls, mobility, malnutrition and skin integrity. Where risks had been identified, the care plans contained detailed guidance for staff around how to reduce the risks. For example, when equipment was needed to move people safely, this was documented in moving and handling plans and included information such as hoist and sling instructions.

There were sufficient numbers of skilled staff supporting people. The service had identified the need for additional staff during meal times, with a focus on nutrition and hydration. There were two meal time assistants in addition to the care and nursing team providing support.

One deputy manager reviewed and analysed accidents, incident or near miss reporting forms monthly to identify trends or patterns, and the manager maintained an overview of this. The deputy manager explained that they had recognised a time of the day that one person was experiencing falls and that practical steps had been put in place to provide support in reducing the frequency of falls. For example, assisting the person to use the bathroom prior to the time that they may usually experience a fall, to reduce their need to walk at a faster pace, rushing and tripping.

The service was clean throughout and free from odours. Bedrooms and communal areas were tidy and free from trip hazards. Where maintenance issues were identified, these were recorded and acted upon promptly. An infection prevention control (IPC) audit was completed annually for the whole home. The management team had identified that this was not frequent enough, so had appointed a lead for IPC. The IPC lead explained that they were new to the role, but that they planned to complete the audit more frequently. Actions had been taken following the January IPC audit. For example, training carers to inspect mattress covers while supporting people in their bedrooms and to report any issues.

The service had safe recruitment processes when recruiting new staff. We looked at the recruitment and training files for five members of staff and found that appropriate checks were in place before staff commenced employment at the service. We saw that staff files contained pre-employment checks such as written references and satisfactory Disclosure and Barring Service clearance (DBS), as well as evidence of identity. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Good

Is the service effective?

Our findings

The service continued to be effective. People using the service received care and support from trained, knowledgeable and enthusiastic staff. Nurses received training and development in order to meet their professional registration requirements. One nurse said, "I'm the lead nurse for end of life care. We can access training at the local hospice and I have a link nurse there who I can contact for any advice I need. We share learning from training at staff meetings."

The service was in the process of introducing and appointing 'champions'; these are members of the staff team who complete additional training in areas of the service such as safeguarding, tissue viability, and dementia. There was a planned programme in place for staff supervisions and appraisals during 2018. We looked at staff records and saw that in 2017 staff had received supervisions in line with the providers' policy.

People's physical, mental and social needs were assessed and these formed the basis of their care plans. People and their relatives where possible and appropriate, were involved in creating the care plans. One relative said, "We have all talked through the care plan and they always keep us informed of what's going on."

The service used an electronic clinical system which supports a 'one patient, one record' model of healthcare. Staff were able to use the system for raising queries with the GP for example, referring people for other specialist support and advice, and prescription requests. One deputy manager said, "The system reduces the amount of time we might spend on the phone and we can access it 24 hours a day. It gives us an actual record of any queries we've raised and the response given by the GP. We also have real time access to pathology results, such as blood tests or wound swabs." The system was new and not all staff had been trained in its use yet, but staff spoke positively of its impact on the service.

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 make particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible. We found the service had assessed people's capacity where required. However, the assessments did not contain enough information to explain how the person was assessed and what the best interest decision was and whether there was a less restrictive option. Staff we spoke with understood the principles of the Act and we observed that people were encouraged to make decisions about their care and treatment.

We recommend that the service reviews how they record best interest decisions; including evidencing how the best interest decision is the least restrictive option for that person.

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). 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 service had made DoLS applications to the local authority and these were waiting approval.

People were supported to have enough to eat and drink. Care plans contained details of people's food and drink preferences and the chef had copies of these in the kitchen. The chef demonstrated a good knowledge of people's preferences and any specialist diets that were required. People were assessed for the risk of malnutrition and when concerns were noted, this was highlighted on the handover sheet. This meant staff could see easily those people at risk.

Good

Is the service caring?

Our findings

The service continued to be caring. The atmosphere was calm and friendly. People were relaxed around staff as they happily conversed together. The staff and registered manager stopped to chat with people in the communal areas. People were smiling and laughing while in the company of others within the home and while in the company of the staff.

People were positive in their views about the staff team. Comments included, "Oh the staff are lovely" and "I've never had any concerns, they're really friendly here." One person said, "They are marvellous here, the staff do everything for us that we need."

Relatives praised the staff team. Comments from relatives included, "I think the staff are really caring people. My dad was really poorly when he was at home and the GP really only gave him a small chance of living much longer than two weeks. I went to look at nursing homes and when we came here we were shown around and we chose this one. He's really perked up. Before, when he was at home, he was cared for in bed, but when he came here, within two days he was up, dressed, and sitting in the lounge, we could not believe the turnaround, I cannot praise the staff enough."

Staff spoke positively about their roles. Comments included, "I like to think we look after people really well here. I can go home knowing I've done a good job." And, "The care here is really good, the care staff know people really well" One staff member said, "This is such a rewarding job, getting to know the residents as individuals. I've never been so happy in a job." All of the staff we spoke with said they would be happy for their relative to live at the service.

Staff had a good knowledge of the people they supported. We asked one person if they had ordered their breakfast, the person explained, "I've no need, they know what I like and when I like it." The person said, "They always think of us before they think of themselves. The staff are so lovely, they make me feel special and I feel involved."

Staff shared well-received banter with people who appreciated the light-hearted humour. All staff, in every role, stopped to chat with people and spoke as though they were good friends.

People received kind and caring one to one support when required, during meal times. We observed the nutrition and hydration support assistants chatting to people and supporting them at a relaxed and appropriate pace to enjoy their meals.

Memorial services were conducted within the home when people who had lived at the service had passed away. The memorial services were for all to attend, including relatives and friends. These included readings from the activities coordinator which were praised by relatives. Written feedback included, "Thank you for your tributes, they were just beautiful. Such a lot of thought went into each, a real snapshot of the real personalities." And feedback from one professional included, "As I said in the prayers, you always go that extra mile to ensure the wellbeing of the residents, and their relatives."

The activities coordinator had ensured aspects of the service were accommodating of different religions. In anticipation of supporting people with specific religious requirements, the faith room had prayer mats with a compass on; and the kitchen staff had received guidance on the preparation of halal meals.

Good

Is the service responsive?

Our findings

The service continued to be responsive to people's needs. However, guidance in behavioural support plans was not always detailed and at times conflicted with the recordings in the monthly reviews. For example, in one person's plan it was documented "can be anxious and frustrated due to dementia" and "showing signs of agitation at times", but the signs were not described. The guidance for staff included "talking quietly and calmly." However, in all of the care plan reviews since September 2017 it had been documented "When she gets agitated, try to give Lorazepam, especially in the evening." This meant it was not clear exactly how staff should support the person, as the plan indicated that staff should always administer medicines rather than try alternative methods .

We recommend that the service reviews behavioural support plans to ensure they provide detailed guidance around when to administer medicines and what support should be provided before the medicine is offered.

Care plans were person centred and included details about people's choices and preferences in relation to how they wanted to receive their care. For example, in the plans for personal care, details were included around if the person would prefer to be supported by a male or female carer; their preferences for toiletries and what clothing they usually preferred to wear.

People's life histories were documented and there were framed picture documents in people's bedrooms that listed the things that were important to them. The registered manager explained that this supported the staff to remember the things of personal importance for each person.

Wound care plans were detailed and evidenced if there were any improvements or deteriorations. There were photographs in place which meant staff could easily monitor any developments with the wounds. Specialist healthcare professional input was sought and the advice received was documented and recorded when followed.

Communication plans were clear and informative. These included details about how staff should communicate with people, and whether they had any sensory impairment such as poor eyesight or poor hearing. For example, in one person's plan it was documented "care staff to ensure they are in close proximity whilst talking and looking at [person's name]. Lip reads."

Social plans were in place. These detailed what people liked to do and activities they liked to participate in as well as other things that were important to them. For example, one person who was being nursed in bed enjoyed reading and it was documented that staff had brought in books and magazines for them. One member of staff said "I plant flowers outside people's rooms. I ask them what they like so that they can see them when they bloom." Staff described how another person enjoyed listening to classical music.

There was mixed feedback regarding the activities on offer at the service and the activities schedule lacked information in advertising what was planned for the week. The activities programme and feedback from people did not reflect that people's interests were always being incorporated into the activities on offer at

the service. One person said, "I go and listen to the singers and that's it really". Another person said, "I don't like the activities here." The activities coordinator said, "Some like to make cards, but it's very hard because of their dementia" and, "We try to target activities. We look at the history of the resident and we have made bird feeders and now I'm trying to do a memory box and get the relatives involved, but it's very hard."

Advanced plans were in place and where able and willing to do so, people and their relatives had discussed their choices about their end of life care. This included whether the person wanted to be admitted to hospital during acute illness. The service had close links with the local hospice and staff spoke passionately about the end of life care they provided. One staff member said "Families can stay overnight if they want to. We support the families as well as the person who is dying. For example, we had one relative who had a dog with them here. The staff walked the dog so that the person could sit with their dying relative" and "I always find out about people's religious wishes if they have any. I arranged for a catholic priest to come in for one person recently." The service had produced a step by step support plan to support relatives after their family member had passed.

Good

Is the service well-led?

Our findings

The service continued to be well-led. However, recommendations have been made in safe, effective and responsive. Shortfalls were identified in safe regarding the quality of medicine administration documentation. In effective there was a lack of Best Interest Decisions. Also in responsive, due to the lack of detail contained in the behavioural support guidance.

There was a registered manager and two deputy managers at the service. In addition to the management team, the registered manager also worked with a private social care consultant one day per month. The care plan and MCA documentation was sourced via a consultancy service who provided guidance around completing the paperwork. The management team and the consultancy services had not identified or taken action regarding these shortfalls. This meant the service did not consistently comply with best practice.

There were a range of policies in place. These were kept up to date and reviewed regularly. Audits were completed monthly for different areas of the service. For example, medicine audits were completed monthly. The audits that had been completed regarding these aspects of the service had not identified the issues that were found to be present during the inspection. The registered manager and deputy managers were aware of some of the issues raised, such as the quality of recordings for topical medicines (creams and lotions), yet effective action had not been taken to resolve this.

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. The registered manager understood their responsibilities with regards to notifying CQC of incidents.

One person said, "I've met the manager and yes, they're doing a good job." Another person said, "I met the manager on the first day and they showed me all over the building. They always look in when passing and as far as I'm concerned, they're doing a good job."

Staff spoke highly of the registered manager and the deputy managers. Their comments included, "The manager is very good. He's responsive, he listens and he's not dismissive of you. I feel very valued here" and, "All of the management is very good. We can talk freely to them; they're very supportive." Another said, "The support here, from the whole team is brilliant. You can talk to the manager, anybody and they listen to you. Our opinion is valued." The registered manager was a visible presence throughout the building. Staff said "He often walks round the building. He doesn't just care about the residents; he cares about the staff too." The registered manager said the team are "caring, friendly and welcoming" and "Integrity is essential and I've got that with my team."

Staff were recruited based on their values and how they engaged with people. The registered manager explained that they operated a values based recruitment process and offered a competitive salary to attract the right people. The registered manager said that once staff were appointed, the service invested in them.

They said "staff should feel valued. We offer a formalised training process and invest in the staff to ensure we retain them." The service supported student nurses with their placements and linked with the local colleges to introduce an apprenticeship programme. The registered manager explained that they have been able to learn from the student nurses. For example, introducing pocket medicine booklets, with details and guidance to refresh staffs' understanding at a glance about different medicines.

Through attending different learning exchange sessions with health and social care professionals, the registered manager maintained an up to date knowledge of care standards and initiatives. The registered manager told us that they had recently completed their NVQ level 5 in leadership.

Feedback was sought from people who live at the service and their relatives and meetings took place. There were examples of how people's feedback was used to develop aspects of the service, such as introducing a range of greetings cards that people could write and send to family and friends. The registered manager had incorporated the needs of people when planning refurbishments and the dining room had recently been redecorated with a focus on becoming more "dementia friendly."