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Enbridge House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection which took place on 02 August 2016.

Enbridge House Care Home is registered to provide care (without nursing) for up to 17 older people. There were 14 people resident on the day of the visit. The building offers accommodation over two floors in 14 single and two double rooms. The double rooms are generally used as singles, unless shared by a married couple. One room is currently used to provide short term care. This meant that the service had one vacancy on the day of the inspection. The second floor is accessed via a staircase or lift. There is a small flight of stairs on the second floor leading to the lift from two bedrooms. Only people who are fully mobile are allocated these bedrooms. The shared areas within the service are spacious and meet the needs and wishes of people who live in the home.

The service has a registered manager running the service. 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 management team, generally, kept people, visitors to the service and staff safe. However, there were areas of safety that required improvements. These included developing a more comprehensive emergency plan and ensuring people were protected from the risk of burning themselves on hot water tanks and pipes. Most risks were identified and managed to make sure that people and others were kept as safe as possible. Staff were provided with training in the safeguarding of vulnerable adults and health and safety. Staff were able to describe how they kept people safe from all forms of abuse.

There were enough properly trained staff who had the necessary skills to provide people with safe care. The service's recruitment procedure ensured that as far as possible, all staff employed were suitable and safe to work with vulnerable people. People were given their medicines in the right amounts at the right times by staff who had been trained to carry out this task.

The management team and staff protected people's rights to make their own decisions and consent to their care. The staff team understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. People in the home had the capacity to make their own decisions and choices and no one was deprived of their liberty.

Staff were properly trained and supported to enable them to meet people's health and well-being needs. People were supported to make sure they received health and well-being care from appropriate professionals. Staff were trained in necessary areas so they could effectively meet people's diverse and changing needs.

Staff built relationships with people so that they were able to provide caring and compassionate support. Staff encouraged people to make as many decisions and choices as they could to enable them to keep as much control of their daily lives, as was possible. People were treated with kindness, dignity and respect at all times. The service had a strong culture of person centred care which recognised that people were individuals with their own needs and preferences

People benefitted from a well-managed service. The management team was described by staff as supportive and helpful. The registered manager worked directly with people and was very knowledgeable about their individual needs. The service made sure they maintained and improved the quality of care provided. Some improvements were needed with regard to sending the appropriate notifications to Care Quality Commission and additional information was needed in some plans of care.

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 mainly but not always safe.

Some very hot tanks and water pipes could be touched by people. Staff may not be clear about what they needed to do to keep people safe in unusual emergency situations.

People were given their medicines safely.

Staff protected people from any type of abuse.

There were enough staff to make sure people were cared for safely.

Staff were checked to make sure they were safe and suitable before they were allowed to work with people.

Is the service effective?

Good

The service was effective.

People were supported and cared for by staff who had been properly trained to meet their needs.

Staff helped people to take all the necessary action to stay as healthy as possible.

Staff encouraged and supported people to make as many decisions for themselves as they could and made sure they protected their rights.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and dignity. Staff interacted positively and patiently at all times.

People were helped to stay as independent as they were able for as long as possible.

The home had a friendly and homely atmosphere where people

and staff felt at ease.

Is the service responsive?

Good

The service was responsive.

People's needs were responded to quickly by the care staff. They listened to people with regard to their daily choices and acted on their wishes.

People were recognised as individuals and were supported and cared for in the way that they preferred and that suited them best.

People chose not to be involved in organised daily activities.

People knew how to make complaints about the service if they wanted to.

Is the service well-led?

Good

The service, generally, kept good records but some extra information was needed in people's plans of care.

The registered manager and senior staff were highly thought of by staff, people and visitors to the service.

The management and staff teams checked it was giving good care to people. They made changes to improve things, if they needed to.

Enbridge House 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 inspection took place on the 02 August 2016. It was unannounced and carried out by one inspector

Before the inspection we looked at all the information we had collected about the service. This included all information and reports received from health and social care professionals and others. We looked at the notifications the service had sent us. A notification is information about important events which the service is required to tell us about by law.

During our inspection we spoke with the registered manager (who is also a partner provider), the other partner provider, two care staff, a visiting professional, a person's relative and five people who use the service. We received feedback from two local authority professionals, one relative and one staff member after the inspection visit.

We looked at the records, including plans of care and daily notes for six people who live in the service. In addition we looked at a sample of other records related to the running of the service. These included four medicines administration record charts, one recruitment file, staff training records, duty rosters, menus and records used to measure the quality and safety.

Requires Improvement

Is the service safe?

Our findings

People told us or indicated, by nodding or smiling, that they felt safe in the home. Comments included, "staff make me feel safe" and "I feel safe here". One person told us they had never seen, "Anything bad happening".

People were safeguarded from abuse or harm by staff who were trained and knew how to protect people in their care. Safeguarding training was up-dated every three years. Staff were able to describe what actions they would take if they identified any safeguarding concerns. They told us they were confident that the registered manager would take prompt action to protect people. However, they were clear that they would report issues outside of the organisation if the appropriate action was not taken. The service had reported one safeguarding concern (during the last 12 months) to the local authority although this had been dealt with appropriately it had not been notified to the Care Quality Commission (CQC). Local authority representatives from two authorities told us they had no adverse information about the service. The registered manager told us they thought they had to report to CQC only if there was harm to the individual. She undertook to review Regulation 18 of CQC (Registration) Regulations 2009 and ensure the service send safeguarding notifications in the future.

People, staff and visitors were, generally, kept safe whilst in the home. However, on the day of the inspection, hot water tanks and pipes were in an open cupboard which people, staff or visitors had access to. The registered manager explained that doors were to be fitted to the cupboard but she would ensure a temporary safety measure would be taken until then.The registered manager confirmed that temporary safety measures had been taken and permanent doors were to be fitted to the cupboard by the end of September 2016.

The safety of people and staff was improved because the service learned from accidents and incidents. Accident and incident reports recorded the incident and the immediate action taken. Whilst it was evident in procedures and care plans that action had been taken to minimise the risk of recurrence, these actions were not always clearly recorded in accident and incident records. The registered manager told us they would ensure accident and incident records included this information in the future.

The service had an emergency evacuation plan which was included in the emergency fire book. However, it did not cover other emergencies such as loss of heating or other services. The registered manager told us a four wheel drive vehicle was available to transport staff in extreme weather conditions. She undertook to develop a more comprehensive, separate emergency plan.

Staff followed health and safety policies and procedures which had been up-dated in April 2016. Generic, safe working risk assessments were in place. These included moving and handling, window openings and legionella. All baths and showers had thermostatic valves fitted and the water temperature was tested before people were immersed in the bath. Thermometers and temperature records were available in all the bathrooms. People's en-suite showers had been decommissioned because they were rarely used and this created a higher risk of legionella. Maintenance checks to ensure the service was safe were conducted at the

required intervals. These included water temperature checks, the lift and fire equipment. The local fire and rescue service had conducted an inspection of the premises in February 2015 and checked all required improvements were completed in May 2015.

People were kept safe by risk assessments which were incorporated into people's care plans. Any significant risks for the particular individual were identified and a separate risk assessment was developed. These included mobility, nutrition and fluid intake.

People benefitted from living in a clean and hygienic home with no offensive odours. Staff were provided with protective clothing to assist people with personal care and when handling food. They changed their gloves and aprons when entering different areas of the building. An infection control audit was completed every three months. The service was awarded a rating of five (very good) following an environmental food safety inspection in June 2016.

People's medicines were given and stored safely. Systems were in place for the safe receipt, administration and disposal of medicines. People's medicines were stored in a locked medicine cabinet. Medicines were given from original packaging which the service felt gave them more opportunity to check it had been supplied correctly. Staff were trained to follow the medication administration processes and procedures. Their competency to administer medicines was tested before they were allowed to carry out this duty. The medication administration records were accurate and showed that people had received the correct amount of medicine at the right times. No medication administration errors had been reported in the previous 12 months. The care commissioning group's care home support pharmacist had visited the service in July 2015.They had made one recommendation about the medication administration records which the service had complied with.

The service ensured that people were looked after by staff who had been recruited safely. The service had recruited one new member of staff in the previous 12 months. The file showed that checks to confirm that prospective employees did not have a criminal conviction that prevented them from working with vulnerable adults, were made. References were taken up and validated by e-mail or telephone, as necessary and candidates identity was checked. Application forms were completed and included a full past employment history. An explanation for a 'gap' in employment history was not noted on the application form or in interview documentation. However, the registered manager was aware of the reason and confirmed that the omission had been rectified immediately after the inspection.

People were supported by staffing levels which were adequate to meet their needs, safely. There were a minimum of two staff on duty during the day and two waking staff at night. Day staff were supported by the registered manager and ancillary staff. The registered manager assessed the needs of people, on a daily basis and provided additional staff as required. For example if people were ill or required extra support. The registered manager worked alongside staff to boost staff numbers at short notice, if necessary. Staff told us there were enough staff to meet people's needs safely. They confirmed that they could request help from the management team, which was always available.

Good

Is the service effective?

Our findings

People were cared for by staff who were trained to meet their diverse and changing needs. Staff told us they received good training opportunities. One staff member told us they were encouraged to register for a recognised qualification in health and social care as soon as possible. Of the 13 staff, eight held a health and social care qualification and the other five were registering for a course. Training was provided by a training company and staff completed distance learning for most core training such as food hygiene, health and safety and fire safety. Specialised, additional training as provided as necessary. For example all staff had received training in palliative care.

Staff received one to one supervision approximately six times a year and as and when they needed it. They completed an appraisal once a year. Staff told us they felt well supported by the registered manager and their colleagues. The service used the care certificate framework (which is a set of 15 standards that new health and social care workers need to complete during their induction period) as their induction tool.

People were assisted to stay as healthy as possible. People's healthcare needs were clearly described in their care plans. They were able to access health care services and received ongoing support from external professionals. For example, referrals to the speech and language therapy team and various consultants (via the GP) were recorded on people's notes. The service did not have specific healthcare records, however all the necessary information was recorded on daily notes. Whilst the information was recorded in detail it was not easily accessible, in the event of an emergency or a need to find the information quickly. The registered manager undertook to review the recording of healthcare appointments, outcomes and follow ups.

The registered manager and staff team told us the service had a good rapport with district nurses and the local GP surgery. One person told us they always saw the doctor, if necessary, and a family member told us their relative's health needs were met in a timely way.

People's well-being needs were identified and met. People were provided with and supported to eat adequate amounts of nutritious food of their choice and to drink enough fluids to keep them healthy. People's care plans included nutritional and eating and drinking assessments, as necessary. Food and fluid charts were kept for those people who needed them. The few fluid and nutrition charts that were kept were up-to-date. However, they did not always include target food or fluid intakes, or what to do if they were not met. Because of the small size of the service the registered manager and senior staff knew, in detail, the needs of people. However, the registered manager undertook to review the food and fluid charts used.

People helped to choose menus and were given alternative food if they did not want what was offered. People told us, "I'm not fussy but I think the food is very good here." Another said they liked the food and could always choose something else if they wanted to. People who needed support were encouraged or physically helped to eat their food to ensure they ate an adequate amount. People were offered drinks and snacks throughout the day on the day of the visit. A large number of people chose to eat lunch in their chairs in the sitting area, rather than eat in the dining room. The room was very quiet and staff were not present as they were helping others in the dining room. The registered manager told us this was as preferred by people.

Three people confirmed this as they said they didn't like to be, "…bothered" whilst they were eating. However, the registered manager agreed to discuss this with people and give further consideration to the dining experience.

People were encouraged to make as many decisions and choices as they could. People could consent to their care or asked the service to discuss issues with their family members. At the time of the inspection people in the home did not lack capacity. Staff described how they helped people to make everyday decisions, if they were reluctant to do so.

People's rights were upheld by staff who understood consent, mental capacity and Deprivation of Liberty Safeguards (DoLS). Staff had received Mental Capacity Act 2005 (MCA) training. Care staff described what action they would take if they noted anyone who appeared to have a deteriorating ability to make decisions. The 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. 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 and hospitals are called the DoLS. The service had not made any DoLS applications because nobody who uses the service was deprived of their liberty.

People were provided with any necessary equipment to ensure people's comfort and to keep them as mobile as possible. The service used the National Health's equipment loan service to access the necessary equipment such as, special beds, cushions and mattresses. People were only accommodated in rooms which met their mobility requirements. For example some of the floors in the home sloped quite acutely. People who had to traverse these areas to access their bedrooms were those who were taken in wheelchairs. Bathrooms were equipped with bath seats and grab rails, as necessary.

Good

Is the service caring?

Our findings

One person reflected the comments of others when they said, "The girls are wonderful, kindness itself". A visiting professional told us, "Staff are respectful and look after [name] very well, I would have no hesitation for a family member of mine to be admitted."

People were treated with kindness by caring and compassionate staff. Staff interacted with people positively and reacted to them in a patient and kind way. For example they used soft caring voices and spent time assuring people that responding to their needs was not causing them any inconvenience. We heard staff saying on several occasions when responding to a request, "yes of course I can, it's no trouble at all." Staff spoke with people in a warm and friendly way. Some staff did use endearments such as, "dear" or "darling" but it was used appropriately, with physical touch to comfort people. Generally, staff used people's preferred name and spoke with them respectfully.

People were respected they and their families were encouraged to make their views about the home and how it was run, known. The registered manager spoke with people a minimum of once a week but more usually every day when they were on duty. People told us they could talk to the registered manager or other staff at any time and felt they were always, "Listened to." Staff told us they were very respectful of people's choices and wishes. They gave an example of ensuring people were helped with their personal care by staff who they had chosen.

Staff made sure that they maintained people's privacy and dignity. Care plans noted how staff were to help people, whilst ensuring their dignity and privacy. Staff gave examples of how they offered people personal and intimate care privately and in a dignified way. They said they only gave one to one care, wherever possible. If two staff were needed then one of the staff would withdraw at the earliest opportunity and only be involved when it was essential for safety. Other examples included closing doors and curtains, covering people with towels and asking if they needed assistance quietly and discreetly.

Staff had developed strong relationships with people. They were knowledgeable about people's individual needs and personalities and were fully aware of people's needs, likes and dislikes. There were a small number of people who live in the home and staff respected their diversity and individuality. People's religious, cultural and lifestyle choices were included in their plans of care.

People were supported to maintain as much of their independence as they were able to, for as long as possible. Some people were mostly independent whilst others needed more assistance. Staff were sensitive when providing additional assistance and encouraging of people's independence. For example, we saw and heard staff encouraging people to try to do things for themselves with the assurance that they would be there to help if needed.

End of life care plans were developed, when necessary, taking into account people's preferences and choices. There was no-one in the home receiving end of life care, on the day of the inspection visit. However, the registered manager told us they had a very good relationship with the local GP and district nurses who

supported the person and advised care staff, when needed, about end of life care. Do not attempt cardio-pulmonary resuscitation forms (DNACPR) were completed and signed by the GP or consultant, where appropriate. Additionally the service used the 'message in a bottle' system so that emergency services were clear if people did not require resuscitation. The registered manager undertook to discuss with the GP the limited amount of detail they had entered on the DNACPR form. All staff had completed palliative care training.

Good

Is the service responsive?

Our findings

People told us that staff were always around if they needed help. They said that call bells were answered very quickly. Staff responded to people when they identified that they may need attention. They were able to interpret people's communication and respond appropriately to their needs, even when assistance was not verbally requested. People were very confident to ask care staff for help or attention. They said that staff always responded to them if they asked for something or wanted something to be done differently.

Staff responded to people's requests, in a timely way, throughout the day of the inspection visit. A staff member commented, "Each resident from the moment they wake has a choice from what time they wake what they would like for breakfast if they would like to have a bath or wash, what they would like to wear. No one is ever told what to do eat or wear they are offered guidance and support but always a choice."

People's needs were assessed before they moved in to the service. The assessments were developed into individualised care plans which met their specific needs. Care plans were personalised (person centred) and included eating and drinking, mobility and communication. People signed to confirm they were involved and agreed with the care to be provided. The care given to people followed the care described in their care plan.

Care plans were kept up-to-date to meet people's diverse and changing needs. People and their relatives or representatives were involved in planning and reviewing their care if they wanted to be. A relative told us the service worked co-operatively with them and they were very involved in the care being given. Care plans were reviewed formally every six months and whenever people's needs changed. Care plans did not always include people's history or previous interests and hobbies. The management and staff team demonstrated their knowledge of people's past and previous hobbies but this information was not written down. The registered manager told us they were currently reviewing the care planning system used and would review the contents of the care plans to be used, in the future. Staff told us they worked very closely with families and kept them informed of any changes to people's well-being. A family member told us that staff up-date them about their relatives care, at all times.

Changes to people's care recommended by external health care professionals were recorded on specific plans of care. For example recommendations made by a speech and language therapist were recorded on the eating and drinking care plan. The service had good working relationships with other professionals and shared required information (with people's consent) with others to ensure people had the best possible care. The service identified when they could no longer meet people's needs. They worked with the person, families and other professionals to minimise the distress of the transition to an appropriate service.

People told us they had enough to do but did not like organised activities. The service did not have an activities programme and preferred activities were not noted on people's plans of care. The service did provide occasional activities such as visits by young people, weekly visits from members of the local church and hairdressing. Staff told us that people did not like to join in organised activities but they preferred one to one sessions such as nail care. They said that they had time to spend with people to do some one to one

activities. One person told us they preferred to spend time in their room watching the television or listening to their radio. Activities were noted in people's daily notes but not noted separately so it was difficult to see what activities had taken place. The registered manager undertook to review the recording of activities and people's preferences regarding activities and hobbies.

Comments on the way care was being offered were welcomed by the service. There was a robust complaints procedure in place which had been reviewed in 2016. People and their relatives told us they knew how and would be comfortable to complain and would do so if necessary. The service had not recorded any complaints since the last inspection and the registered manager confirmed that they had not received any.

Good

Is the service well-led?

Our findings

One of the provider partners was registered as the manager of the service. She had been registered under current legislation since 2010. People, relatives, staff and other professionals told us the management team were responsive and approachable. The registered manager was very knowledgeable about the needs of people and regularly worked on the care rota. One staff member told us, "You can ask [registered manager's name] at any time for practical help and assistance and/or advice." Another commented, "The management's door is always open and they are always willing to listen and support."

People, staff and others were listened to and their views were taken into account. The registered manager interacted with people on a daily basis. She told us she had an individual conversation with everyone, about their care and level of satisfaction at least once a week. No specific records were kept of these discussions but they were sometimes reported on daily notes. A minimum of two people, their families or advocates and any professionals involved in their care were asked to complete a questionnaire every 12 weeks. Any actions to be taken as a result of these were noted. Actions taken as a result of listening to people and their families included regulating the time meals were served or explaining to people, more carefully, if they were going to be late.

The service held staff meetings on an irregular basis, when required. The registered manager told us they tried to ensure all staff attended a staff meeting at least twice a year. Staff felt they had enough staff meetings and explained because it was a small staff team they were confident they were always well-informed. Staff told us they felt, "Highly valued" and were able to present their ideas which were respected and listened to. One staff member told us, "They always listen to your opinions and suggestions, and if appropriate help implement any changes."

Both provider partners worked in the service, on a regular basis. They monitored and assessed the quality of care people were offered. A variety of audits to check on all aspects of the service were completed regularly. These included three monthly self-audits of all aspects of the service, cleaning and infection control checks and medicine reviews. Actions taken as a result of various audits included environmental improvements and the development of new medicine administration records.

Good quality care was supported by records, relating to people who lived in the service. People's records were mainly accurate and up-to-date but lacked some details. This did not adversely impact on people but the registered manager agreed to review and amend records, as necessary. People's records, overall, gave staff enough information to enable them to meet people's needs safely and in the way they preferred. Records relating to other aspects of the running of the service were well-kept and up-to-date. The Care Quality Commission received some notifications as required. However, it was not clear if we were notified in all circumstances as described in Regulation 18 of CQC (Registration) Regulations 2009. The registered manager agreed to ensure appropriate notifications were made in the future.