St Dominic's Limited

Raj Nursing 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

This inspection took place on 24 July 2017 and was unannounced. At the last inspection on 11 and 12 March 2015 we found the service was rated 'Good' in all key questions and overall. At this inspection, we found the service remained rated 'Good' overall.

Raj Nursing Home is a care home, which provides accommodation, nursing and personal care for up to twenty eight adults, some of whom have dementia. The home accommodates people from different cultural backgrounds. At the time of the inspection the majority of people living at the service were from an Asian background. There were twenty three people using the service at the time of our visit. The accommodation is laid out over two floors. The first floor can be accessed by a lift. Each person had their own bedroom and could access the communal facilities such as a lounge, dining area and garden.

There was a registered manager in place at the time of the inspection. 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 provider had systems in place to keep people safe. There were policies and procedures guiding staff on how to protect people from harm and abuse. Staff we spoke with knew what to do if they thought somebody was at risk of harm. Risks to people's health and wellbeing were assessed and staff had guidelines telling them how to minimise and managed these risks. People received their medicines as prescribed and staff were appropriately trained to support people with taking of their medicines.

The provider had effective staff recruitment procedures to ensure that staff were safe to work with the people using the service. There were sufficient numbers of staff deployed to support people safely and effectively.

People were supported by staff who received appropriate induction to their role and duties and were sufficiently trained and skilled. Staff received regular support and supervisions from the registered manager to ensure that they provided the care that was safe and responsive to people's needs and preferences.

The CQC monitors the operation of the DoLS (Deprivation of Liberty Safeguards) which applies to care homes and hospitals. The registered manager had submitted applications under DoLS where people might have been deprived of their liberty and they followed up on these applications to check if these had been authorised. Staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and decisions about people's care were made in their best interests.

Staff supported people to maintain good physical and mental health and have a balanced and nutritious diet that reflected people's health needs and personal preferences. Staff had made appropriate referrals to relevant healthcare professionals to ensure changes in people's care and health needs were addressed in a

timely manner.

People told us they liked staff who supported them and they were happy with the care provided. We saw that staff were gentle and kind when caring for people and had taken the time to support people and make them feel they mattered. Staff respected and maintained people's right to dignity and privacy and they managed end of life care with sensitivity and compassion.

Each person using the service had an individual care plan that was personalised and contained specific information on their care needs and preferences. People had access to activities in the home and were supported in maintaining relationships with friends and family members.

People and their relatives were asked about their opinions on how the service was managed and provided. The registered manager responded to any suggestions and complaints appropriately and in a timely manner.

Staff told us they felt supported by the registered manager and they were happy to work at the home.The registered manager had numerous systems in place to audit and monitor the service and was able to effectively maintain required standards of practice and take action if the home was not meeting these standards.

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**

Raj Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 July 2017 and was unannounced. It was carried out by one inspector, a specialist advisor 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.

Before the inspection we gathered information from 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.

During our visit, we spoke with the registered manager, four care staff members, one nurse, the activities coordinator and a member of the catering staff.

We also spoke with four people who used the service, four relatives and one external health professional.

Many people using the service were unable to share their experiences with us due to their complex needs. Therefore, in order to help us understand people's experiences of using the service, we observed how people received care and support from staff. To do this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at records which included nine people's care records, recruitment, training and supervision records for six staff members, activity records for 5 people and other documents relating to the management of the service such as quality audits, health and safety checks and the home maintenance records.

Following the inspection, we contacted four external health professionals and two of whom gave us

feedback about the service.

Good

Is the service safe?

Our findings

As we found at our previous inspection in March 2015, people using the service felt safe with staff that supported them. One person said "Yes. The staff make me feel safe". A relative told us, "Yes. [My relative] looks well and is happy here."

The provider had systems in place to help protect people using the service. These included policies and procedures for safeguarding adults and whistleblowing and these were available for staff to use. The registered manager told us all staff had completed safeguarding adults training within the past 12 months and the training records we looked at confirmed this.

The provider had assessed risks to the health and wellbeing of people who used the service. Where risk assessments had been completed, it was evident that care and control measures were in place to manage any identified risks. Examples of risk assessments we saw were associated with falls, specific nursing needs, pressure ulcer prevention and the environment people lived in.

The provider carried out regular checks relating to the safety of the environment people lived in. These included periodic health and safety and fire checks as well as the maintenance of the equipment used at the home. This meant the service had systems in place to help ensure people lived in a safe environment.

Staff were recruited in a safe way with all of the necessary background checks, including criminal records checks being undertaken as well as verification of staff's previous employment history, identity and qualifications.

The registered manager maintained a dependency level assessment of all the people living in the service and used this information to allocate appropriate numbers of staff on each shift. This meant there were suitable numbers of staff to care for people's needs in a safe and effective way.

Staff managed medicines safely and people received their medicines as prescribed. Staff recorded each medicines administration on respective Medicine Administration Records (MAR) which included information about allergies and any other considerations for taking the medicines. Staff had access to protocols about medicines that were prescribed to be taken when required. We saw that medicines received by the home were stored, disposed of and administered according to the provider's medicines policy. Staff who administered medicines received appropriate training to ensure they were competent to assist people with their medicines. Medicines were well managed and were regularly audited by the manager.

Good

Is the service effective?

Our findings

People using the service thought staff that cared for them had sufficient skills and knowledge to respond to their care needs effectively. Family members we spoke with told us staff cared for their relatives well. They said, "[My relative] certainly improved here. The staff are very nice, very friendly, and very helpful. They talk to us, make us feel very welcome" and "Yes, I'm quite happy. Because [staff's name] is brilliant." One relative though there could be more exercises to keep people physically active.

Each new staff member undertook an induction that consisted of the training the provider considered mandatory. Staff also received yearly refresher training to ensure they continue to have the skills and knowledge needed to support people they cared for. We viewed the training records for six staff and we saw that staff received a variety of training such as first aid, manual handling, safeguarding adults, dementia awareness and the Mental Capacity Act 2005 (MCA). The registered manager provided us with a copy of a training matrix, which showed the training that staff had undertaken. This meant that the register manager had the tool to screen and tract the competency level of staff employed at the home.

Staff told us they felt supported by the registered manager and they had received regular supervision and appraisal of their work. Staff records we viewed confirmed this.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

As we found at our previous inspection, the service was working within the principles of the MCA. Where people required an assessment under DoLS the registered manager had submitted applications to the relevant local authorities and they followed up on these applications to check if the DoLS applications had been authorised.

Staff had a good understanding of the MCA and how to support people using the principles of the Act. One staff member told us, "We cannot deprive people of making decisions on what they need. We need to assess their ability to make their own decisions, and encourage them to make these decisions, for example, what to eat or what to wear." Staff confirmed they had received training on the MCA and records of staff training confirmed this.

Staff supported people to have a balanced diet and sufficient food and drink that were nutritious and reflected people's health needs and personal preferences. The catering staff we spoke with were knowledgeable about the nutritional needs of the people at the home. This included which persons had specific dietary requirements, such as a soft, low fat, or diabetic diet, as well as which people had religious or

cultural considerations with regard to their diet. During the lunch meal, we observed staff asking people which item they wanted from the menu, and offering alternatives if people did not want what was offered. People's dietary needs and preferences were recorded in their care plans. We saw that the care plans for two people had not accurately reflected their dietary needs. However, we saw that both people were receiving appropriate meals according to their needs and support from staff. We spoke about this with the registered manager and they updated the records immediately to match the support that was offered.

People were supported to maintain good physical and mental health and had access to local health services. People told us that a doctor who visited the home twice a week regularly saw them. They also thought staff would support them if their health suddenly deteriorated. We saw evidence that staff at the home supported people with their healthcare needs well. They had made appropriate referrals to relevant healthcare professionals and worked with them to make sure any changes in people's care and health needs were addressed in a timely manner.

Good

Is the service caring?

Our findings

People told us they liked that staff who supported them and they were happy with the care provided. Their comments included, "Very nice, friendly. They laugh and joke" and "I've been here for two years and I love it here. The staff are great and I go out when I need to, and staff come with me. I'm quite happy with that". Relatives told us, "They [staff] are good and co-operative. They're feeding my relative and putting him to sleep."

We observed that staff interactions with people at the home were meaningful, kind and positive. We saw that staff were gentle and supportive when caring for people and they responded to people's needs quickly. For example, one person asked for tea and biscuits and had it served without delay.

Staff knew the people well and responded to their wishes and preferences in a caring way. For example, we observed staff asking people in the lounge what music they wanted to listen to while another staff member took a person to the garden to pick some flowers. One person was playing a musical instrument and staff passing the person made comment about their play and encouraged to play some more tunes. Another person was coming back from the garden. A staff member made sure the person came back slowly and safely.

We observed staff supporting people during lunchtime. The interactions were considerate, caring and respectful. We saw staff offering hand wipes to those people who could not easily be moved to a wash basin to wash their hands prior to the lunch meal. Staff approached every person asking for their choice of meal. We observed that people appeared relaxed and comfortable. Staff who were helping people to eat did not rush them so people could eat at their own pace. When people stopped eating, staff gently encouraged them to finish their meal but were not forceful and respected if people chose not to.

Staff respected and maintained people's right to dignity and privacy. Staff were observed to knock on bedroom doors, and await a response before entering. Personal care was only carried out in private rooms. Staff told us, when providing personal care, they always explained to people what they were going to do so people felt involved and could participate in the process. They also ensured the doors were closed and curtains drawn so people did not feel exposed when receiving personal care.

End of life care was managed with sensitivity. For example, in one person's care plan, there was detailed information about the person's wishes in regards to end of life, with input from relatives, the person's doctor and other advocates. Topics covered included the person's religious wishes, resuscitation status, and where care should be provided, for example in the care home or at a local hospital. There was a Do Not Attempt Cardiopulmonary Resuscitation (DNAR) form, completed and signed by the person's doctor, which highlighted any discussions between the person's doctor, the person if they were able to and/or the person's relatives. The end of life care plan included information about any anticipatory medicines that might be needed to promote comfort at the end of life.

Good

Is the service responsive?

Our findings

Care plans contained an initial assessment of people's needs prior to admission, followed by a detailed care plan. All of the care plans we looked at were personalised and contained specific information on each person's individual needs, their preferences, likes and dislikes. These included information on people's mental capacity, special nursing needs, health conditions, mobility as well as communication method and individual hobbies and interests. The registered manager told us that care plans were evaluated monthly and reviewed when people's needs changed. Records we saw confirmed this.

Staff used a handover record at the beginning of each shift, to document any changes to care for each person. The handover record had a detailed summary of care provided for each person, and any specific care intervention required for the following shift. For example, the handover record for one person noted that they had received less fluids than recommended, and so on the next shift, staff were able to encourage the person to drink more. This was confirmed in later daily records. The handover record also included details of any notable events such as birthdays.

People were supported to maintain relationships with people that mattered to them. We saw evidence demonstrating that when it was difficult for the family members to maintain contact with their relatives who lived in the home, the registered manager had worked closely with those family members, the local authority and other relevant professionals to make this contact possible.

There were some positive activities arranged in the home that people could engage in. The activities coordinator was knowledgeable and passionate about the benefits of activities to people at the home, particularly arts and crafts, and had developed some innovative methods to include people with impaired manual dexterity in the activities, including string and stamp drawings. People's activity records reflected their preferences. For example, the activity record noted that a person enjoyed playing instruments, and the person was observed playing the instrument during the inspection. We also observed that there was a limited amount of physical activity offered to people living at the home. An activity folder detailed more physical activities, such as, seated hand ball and skittles, although these were not observed during the inspection, and one person stated that he usually only did the arts and crafts. Individual activity records indicated that arts and crafts or outings to the local shops were the main activities provided to people. We spoke about this issue with the registered manager on the day of our inspection and they agreed to address this matter immediately.

The provider had a complaints policy that was displayed in the communal area of the home and people and their family members knew about it. Records showed that the registered manager had dealt promptly with received complaints. People and family members we spoke with confirmed any complaints were dealt by the provider to their satisfaction.

Good

Is the service well-led?

Our findings

The home had a registered manager in post. People and their family members told us they knew the registered manager and they had a good relationship with them. People's comments included, "Yes, [the registered manager] is all right" and "Yes, [the home] is managed quite well." Relatives told us, "The management are very friendly, very welcoming. We always get a cup of tea and biscuits. [My relative] is looked after well. Always very happy and cheerful" and "I think it's marvellous. It's better when [the registered manager] is here."

As we found at our previous inspection, there was a clear management structure in place and staff were aware of their roles and responsibilities. Staff told us they felt supported by the registered manager and they felt the home was well managed. Their comments included, "The manager is involved in everything we do and knows everything about people living here", "The manager is very good. I feel good here I get to learn new things every day" and "The home is well organised, all documents are in place and the manager has good interpersonal relationships with all the people living here."

Staff told us they had regular handovers and team meetings where they shared information about the health and wellbeing of people who used the service and any matters related to their professional role and duties. The staff meeting minutes of 23 May 2017 included discussion of recruitment, training, and documentation and a demonstration of how to manage new equipment for one of the people using the service.

The registered manager regularly requested feedback from people who used the service and their relatives. A survey was sent out annually, and the registered manager used the responses to direct a "residents and relatives" meeting soon afterwards. The report relating to the survey sent out in October 2016 included suggestions about more information on the named nurse and key worker system. Since then, the registered manager had ensured that each person's named nurse and key worker had been documented on their bedroom door, so relatives would know who they were. Comments taken from the survey report included "I would not change a thing about [person's] care", and "Fantastic care home with lovely, caring and friendly staff".

The registered manager had numerous systems in place to audit and monitor the service provision. These included a variety of audits such as medicines management, staff competency assessment, health and safety checks, staff files and supervision audits. This meant that the registered manager had the tools to effectively screen and maintain required standards of practice and take action if staff were not meeting those standards.

The home received positive feedback from external professionals. One professional told us, "We have not had any concerns or complaints about this service. We received appropriate notifications when required and the registered manager had done it in person as they are very good at informing us about any concerns."