Brownlow Enterprises Limited

Aronmore Residential 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

Overall summary

The inspection was carried out on 18 and 20 May 2015 and the first day was unannounced. The last inspection took place on 10 August 2013 and the provider was compliant with the regulations we checked.

Aronmore Residential Care Home is a service which provides accommodation for up to 31 older people who have a range of needs, including dementia. At the time of inspection there were 26 people using the service.

The service is required to have a registered manager in post, and there is a registered manager for this 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.

Summary of findings

People were happy with the service and we received positive feedback from people, relatives and visiting healthcare professionals, who felt the service was well run and people's changing needs were being identified and met.

Staff recruitment procedures were in place and were being followed to ensure suitable staff were being employed at the service.

Staff had received training and demonstrated an understanding of people's individual choices and needs and how to meet them. Staff supported people in a gentle manner, respecting their privacy and dignity.

Staff understood safeguarding and whistleblowing procedures and were clear about the process to follow to report concerns. Complaints procedures were in place and people and relatives said they would feel able to raise any issues so they could be addressed.

Medicines were being well managed at the service and people were receiving their medicines as prescribed.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted.

Care records reflected people's needs and interests and were kept up to date. Communication between the registered manager and staff was effective and staff understood people's changing care and support needs.

Systems were in place for monitoring the service and these were effective so action could be taken promptly to address any issues identified.

Summary of findings

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 was safe. The provider had arrangements in place to safeguard people against the risk of abuse. Staff recruitment procedures were in place and being followed. The service was being appropriately staffed to meet the needs of the people living there. People told us they were happy living at the service. Risk assessments were in place for any identified areas of risk and were kept up to date. Medicines were being well managed at the service and people were receiving their medicines as prescribed.	**Good**
Is the service effective? The service was effective. Staff received training to provide them with the skills and knowledge to care for people effectively, and we observed this in the support they provided to people. Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff acted in people's best interests to ensure their freedom was not unduly restricted. People's individual dietary needs were identified and were being met and people were offered food choices, so their preferences were met. People's healthcare needs were being monitored and they were referred to the GP and other healthcare professionals as required.	**Good**
Is the service caring? The service was caring. We saw staff listened to people, interacted with them well and supported them in a gentle and friendly manner. People were involved with making decisions about their care. Staff understood the individual support and care people required and treated them with dignity and respect.	**Good**
Is the service responsive? The service was responsive. Care plans were in place and were updated to reflect changes in people's needs, so staff could meet these. There was input from religious representatives to meet people's faith needs. Activities took place and overall people enjoyed these. Relatives said they knew how to raise concerns and felt these would be addressed.	**Good**
Is the service well-led? The service was well-led. The service had a registered manager who was approachable and a staff team who worked together well. Good practice guidance and current legislation was reflected in policies and procedures, so staff could keep up to date with best practices.	**Good**

Summary of findings

The provider had systems in place to monitor the quality of the service, so areas for improvements could be identified and addressed. Innovations to meet the changing care needs of people at large were considered in the provider's development plans.	

Care Quality Commission

Aronmore Residential 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.

The inspection was carried out on 18 and 20 May 2015 and the first day was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed the information we held about the service including information received from the local authority and notifications. Notifications are for certain changes, events and incidents affecting their service or the people who use it that providers are required to notify us about.

During the inspection we viewed a variety of records including four people's care records, three staff files, twelve medicines administration record charts, servicing and maintenance records for equipment and the premises, risk assessments, audit reports and policies and procedures. We used the Short Observational Framework for Inspection (SOFI) during the lunchtime on the first day. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interaction between people using the service and staff throughout the inspection.

We spoke with eight people using the service, three relatives, the nominated individual, the registered manager, the deputy manager, three care staff, the chef, and two healthcare professionals, including a practice nurse and a community nurse.

Good

Is the service safe?

Our findings

People confirmed they were happy living at the service. Safeguarding procedures were in place and staff had received safeguarding training and were able to describe the various types of abuse and the action they would take if they had any suspicions of abuse. One staff member identified the risk of people becoming institutionalised through lack of person centred care as potential abuse and highlighted the importance of individualised care. Staff were clear about the procedures for reporting any concerns which required them to inform their line manager and make a written record. Staff understood the whistleblowing policy, a copy of which was in the staff room alongside a poster about abuse awareness, and they knew to report concerns to the local authority and CQC if necessary.

Risks were identified so action could be taken to minimise them. We saw risks such as nutrition deficiency, pressure sores, hydration and risk of falls were assessed and monitored monthly for each person and people's specific risks considered. Staff were able to describe the kinds of risks associated with the care of different people living at home and the steps required to minimise these risks. Instructions for staff were clear for interacting with a person who exhibited behavioural issues at times and staff were able to describe to us the best way to approach the person. For people at risk of developing pressure sores, turning charts were in place and these were complete and up to date. The service had a dedicated bedrail assessment document and this had been completed when bedrails were needed to keep people safe. Where it had been identified people were at risk of falling out of bed but bedrails were not suitable, staff understood why a safety mat was in use beside the bed to minimise the risk of harm to the person, without restricting their movement. The fire risk assessment for the service was comprehensive and had been reviewed in March 2015, to keep it up to date. Information had been recorded about people's individual needs in respect of evacuation of the building should this be necessary, so appropriate help and support could be provided.

We viewed a sample of equipment servicing and maintenance records. Equipment including the lift, hoist, call bell system, gas appliances, and the fire alarm and emergency lighting systems had been checked and maintained at the required intervals, to ensure these were safe. Where repairs had been identified, for example, a smoke detector not working, action had been taken quickly to address this. Weekly checks including fire alarm points and call bells were carried out. We saw call bells were accessible to people and staff responded to them promptly. Accidents and incidents were recorded and the provider had a system in place whereby the forms were shared with head office so they could be reviewed to look at frequency and to identify any trends. The registered manager told us the early morning staffing levels had been reviewed as a result of falls and incidents being analysed. A workplace environmental risk report covering each area of risk within the service had been carried out to identify any risks so they could be addressed. This meant safety and risks were being assessed and monitored so action could be taken to address any issues identified.

Recruitment processes were robust and were being followed. Staff confirmed employment checks had been carried out before they started working at the service. Staff records showed employment checks had been completed so that only suitable staff were employed at the service. A photograph of the member of staff was on the file and checks including proof of identity, right to work in the UK and references were obtained, including from previous employers. Disclosure and Barring Service checks had been carried out. Application forms and health questionnaires had been completed and gaps in employment histories explained.

We saw there were enough staff on duty to meet the needs of the people living at the service. The staff rota was up to date and the registered manager said staff adhered to the rota and absences were rare. We saw staff worked well as a team and were available to provide the care and support people needed.

The provider had systems in place for managing medicines and people received their medicines as prescribed. The service used a bespoke blister 'pod' system and medicines were supplied in seven day packs, each of which was numbered and had a photograph of the person included on it. Information sheets were available for each person and included a picture and description of each medicine and the time it was to be administered. It also listed if medicines were supplied in separate boxes so all the person's medicines were identified for staff. Receipts of medicines had been checked by two staff who signed to evidence this. We carried out a stock check of four blister

Is the service safe?

packs, three boxed medicines and two controlled drug medicines and the records and stocks were correct. Medicine administration record charts (MARs) and controlled drug administration entries were complete and up to date. Boxed and liquid medicines had been dated when opened and boxed medicines were being audited each week. This was to ensure stocks were maintained and expiry dates could be adhered to.

Protocols were in place for the use of 'as required' and pain control medicines, providing staff with the information they needed to identify when these medicines could be administered. The temperatures of the medicines trolley and the medicines fridge were checked each day and recorded to ensure medicines were being stored at safe temperature levels. Medicines were audited each week so any issues could be identified and addressed. Policies and procedures for the management of medicines were in place, including a comprehensive document specific to the bespoke system in use, so staff had clear information to refer to. Staff involved with the administration of medicines had received training in medicines management. This was confirmed by staff we spoke with and in the training records we viewed. Medicines were being securely stored and we saw people received their medicines as prescribed.

Good

Is the service effective?

Our findings

One person told us “The carers are nice people. They are doing their best. It's homely here.” A member of staff said, “I like the job. I like helping people and you get a lot of job satisfaction.” Staff told us about the training they had received. They spoke about mental health training, fire safety, health and safety, infection control, safeguarding, first aid and dementia care training. One member of staff said they had been supported to achieve a qualification in health and social care and we saw the training record identified the training people had undertaken and when updates were due, so these could be planned. Staff who had more recently undergone induction training said that they had been required to read people's care plans as part of their induction and to familiarise themselves with people's risk assessments, so they understood people’s needs. Staff induction training was being reviewed to introduce the Care Certificate which replaced the previous recognised induction programme. The provider explained they were working with their preferred training company to provide this induction training for new staff.

Staff received supervision every two months, during which a work related topic was covered, with a short questionnaire being completed to demonstrate their understanding. These included many areas of health and safety, care needs, behaviours and first aid. During our inspection staff demonstrated a good understanding of people’s individual needs and how to meet them. This meant staff were receiving training and supervision to provide them with the knowledge and skills to care for people effectively. We saw staff communicated well with each other and one healthcare professional confirmed this and said if they asked staff to get something they needed when providing treatment, for example, a dressing, the staff always knew who had the keys so they could provide what had been requested promptly.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). This is where the provider must ensure that people’s freedom was not unduly restricted. Where restrictions have been put in place for a person’s safety or if it has been deemed in their best interests, then there must be evidence that the person, their representatives and professionals involved in their lives have all agreed on the least restrictive way to support the person. Some staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Whilst some staff understood people’s right to make choices for themselves and also, where necessary, for staff to act in someone’s best interest, others had a limited understanding of MCA and DoLS requirements. Policies and procedures were in place and clearly explained the processes to be followed. We observed staff supporting people within the service and we did not identify any areas of concern with regards to people’s rights being respected and staff acting in their best interests. Where people had been identified as being safe to go out of the service unaccompanied this was respected and we saw one person coming and going as they so wished. People's capacity to make decisions for themselves had been assessed and we discussed with the senior staff ensuring the assessments considered people’s communication as well as cognitive needs, as this was not always clear. The service had sensor mats in place for some people who had been identified as being at risk of falls, but who were not always aware of this. Although these were for safety purposes, they could be deemed as restricting a person’s movement. We discussed this with the registered manager who said she would contact the DoLS coordinator at the local authority to identify if a DoLS application should be made for any of the people using the service.

People confirmed they liked the food and we saw that there were enough staff to support people who needed assistance at mealtimes, and staff offered help in a gentle manner. Staff supporting people to eat did so carefully and sat beside them when providing help. People were weighed each month and the records were clear and included the action taken to address any changes in weight, for example, someone was seen by their GP and had been prescribed meal supplements. There was a comprehensive file of information about monitoring people’s nutritional status and publications relevant to people’s nutritional needs so staff could refer to these when assessing people. Staff were aware of specific nutritional needs for religious or cultural reasons and we saw people were provided with appropriate meals to meet these. Where people had been identified as being at nutritional risk, food and fluid charts were in place and we saw these had been completed and kept up to date, so people’s intake was being monitored. Drinks and snacks were available throughout the day and night and staff provided these for people when they wanted them.

Good

Is the service effective?

People received the medical input they needed to meet their needs. The healthcare professionals confirmed people were referred appropriately for medical input. One explained that they had worked with the service and the palliative care team to improve staff knowledge and confidence so if they so wished people could stay at the service and receive end of life care. The service had a file for hospital appointment letters and we saw staff had ensured people attended appointments and any follow up arrangements required had been made. People's care records contained a healthcare professional visits log, and we saw where people had been referred to health care professionals when they needed to be and they received input from healthcare professionals including their GP, paramedics, the podiatrist and community nurses. Any instructions received from healthcare professionals were recorded for staff to follow. At the time of inspection one person became unwell and the staff were calm, reassuring and arranged medical assistance in a timely way.

Good

Is the service caring?

Our findings

People told us they were happy at the service. Comments included, “They are great. Nothing is too much trouble. I did get an information sheet about the house and they came to see me before I moved here. It's really nice. Staff always check if we are right and even the chef asks if we need anything.” “It's very nice, they look after you.” “At home I had to stay in bed because there was no one to help me get up. Here you get more attention and there are people to talk to.” And, “I like it here. It's a very comfortable house.” A relative told us, “Staff are always welcoming. [Relative] seems okay here. She likes the food and I'm not concerned about her welfare at all.”

Staff interacted with people in a positive and friendly way and we observed staff asking people before they did anything. We saw staff supporting people in a gentle and caring way, listening to them and treating them with respect. At lunchtime, one person arrived in the dining room after the meal had started. Staff made sure they had their meal and gave them time to eat at their own pace. Support given by staff at mealtimes was provided in a calm and unhurried way, allowing people time to eat their meal. People were offered a choice of meals and were consulted about the size of meal portion they wanted. We saw people received what they had requested, so their choices were being met. At lunchtime, staff showed people the puddings available, so they could make a choice at the time of the meal.

People were given information about the service and had been assessed prior to coming to live there. Three people told us that they had been given information about the service before they went to live there. One person said they had visited the service before deciding to live there. Another person showed us the information pack about the service which was available in the sitting area. This provided comprehensive information about the service, what people could expect and the terms and conditions for living there. The provider explained the company had a referrals manager who was responsible for carrying out all the pre-admission assessments and overseeing admissions and the settling in period, to promote a smooth integration into the service.

In the care records we saw people had been asked their preferences, for example, what time they liked to get up and go to bed and if they wanted their bedroom door open or closed. When we asked about choices one person said, “It's a good place to come to, very acceptable. They run a good ship. I get to go out. We can say what we want and they try to please people. There's not much wrong with the place. It's fine.” Staff told us although people were able to get up when they chose, most people who were able to get up were up and dressed quite early, and they seemed happy with this. One person told us they preferred to get up at four o’clock every morning and go to bed at seven in the evening, and they were able to do so. The staff we spoke to were also able to describe people's individual needs and preferences, for example whether a person preferred their lights on at night or not and what time they liked to get up. We asked about advocacy services and the service had contacts with Age UK, who were assisting with arranging an independent advocate for someone using the service. The staff understood people’s right to access advocacy services if they so wished.

Good

Is the service responsive?

Our findings

People told us they were happy at the service. Comments included, “I've been here since last year it’s all right really. I was glad to get out of hospital.” “It's not too bad here - no trouble with anyone.” And “It’s a nice place.” We received a variety of comments regarding the activity provision in the service. These included, “It's pretty good place there's not enough to do for me.” “There is not enough to do but otherwise it's ok. I read and they have some books.” “I can't fault the care. My [relative] has been here two years. She is always clean and their hair is always tidy and dressed well. There is enough to keep her occupied…… There is usually a lively atmosphere here and she is comfortable.”

There was an activity board in the main dining room listing the activities for each day. These included board games, handball games, a prayer session and keep fit exercises and people told us musicians and singers came in regularly. The registered manager explained they had previously encouraged people to attend events outside the service, however they found when the day came people often did not wish to go. As a result of this they now had entertainers coming to the service each week, which people preferred. People we asked generally said they enjoyed the entertainments. People could go out for walks and shopping trips were also arranged for people.

There were photographs displayed showing activities people had been involved with including arts and crafts, church services and music shows held at the home. Other posters were on display about music therapy, manicures, hairdressing and drawing and painting. Staff encouraged people to join in with activities but also respected if they preferred not to do so. During the afternoon a quiz took place in the dining room and people were interested and animated. After the quiz people stayed at the tables and were talking together about their hobbies and interests and there was a good atmosphere. We saw people had been provided with that day's copy of a free newspaper and were enjoying reading these. Staff were present throughout the day in the communal areas and people were not left alone. We noted staff were aware of people’s individual needs and were attentive to these. For example, in one instance staff broke off conversation with us to support a person who was identified to be at risk of falls, who had gone into the garden. The service had a well maintained accessible garden and we saw people walking around or sitting out there, and they confirmed they enjoyed being able to go out into the garden when they wished to.

A monthly Catholic service took place and a representative visited each week to bring communion to Catholics who wished to receive this. A representative from the Church of England also visited the service twice a month. We also asked about people of other faiths and the registered manager said families were good at taking their relatives to places of worship. The registered manager confirmed they could contact representatives for other religious input if necessary. A relative confirmed they felt the religious needs of their family member were being met.

In the care records we saw people had been assessed prior to coming to the service and where available copies of the assessments carried out by social services were also obtained, so staff had a good picture of each person and their needs. There was comprehensive information in the care plans about each person's needs and preferences based on these assessments. We saw people's needs for support with personal care were well-defined and instructions for staff were set out in the care plan. Two people confirmed they had been involved with their care plans and we saw they had signed to agree to the content. Some care records did not contain much information about people’s interests and we discussed this with staff, who were receptive and said they would address this. Care records were reviewed monthly and alongside this there was a ‘service user of the day’ form, which was comprehensive and covered all of a person’s care and associated needs. This was completed for each person to ensure a full review was carried out so any changes were identified and could be addressed.

Laminated information cards were being introduced and some people had these hanging in their rooms. These contained a helpful and clear summary of the care plan, setting out essential information for care staff when supporting each person in a quick and easy to read style. Important information such as a person's preferred name, their activities and interests, their TV and radio preferences and what they like to eat and drink were included. The summary also included information about how the person communicated and any issues concerning this, the help they needed with their personal care and to mobilize as well as useful statements such as, “My sleep pattern varies.

Good

Is the service responsive?

I can be reluctant when staff approach me to help with personal care. Come back later!" These cards had a picture on one side and were hung with the personal information facing the wall, thereby protecting confidentiality and privacy. This meant staff had quick and easy access to information about how to best approach and help each person.

The service had an 'intershift communication' form that was completed and covered any issues that arose during the shift. This included visits from health and social care professionals, maintenance personnel, social visitors, environmental issues, deliveries, medical and non-medical issues, occupancy and staff handover. This was a good communication tool that all staff could access so they knew what had been going on at the service over the previous shift and further back if they had not been on duty.

The service had a copy of the complaints procedure contained within the service user guide which was available in reception and we were told this was also emailed out to people and relatives. A copy was also put on display during the inspection. People and relatives said they would feel happy to raise concerns if they had any. The service had not received any complaints in the past 12 months and the senior staff were available for people, relatives and other visitors to speak with, so any issues could be addressed promptly. Healthcare professionals confirmed staff were receptive to any points they raised.

Good

Is the service well-led?

Our findings

The registered manager had been in post for several years and people and staff said she was approachable and supportive. In addition to the deputy manager there was a senior carer and they worked as a team to manage each aspect of the service. For example, the senior carer had responsibility for using the IT systems and for keeping people's electronic records and the maintenance of the service up to date. Policies and procedures referenced related legislation and good practice guidance used to inform the relevant document. These were kept under review by the provider and the senior carer explained they were trialling ways of sharing the documents electronically so staff could access them easily and any updates could be incorporated.

There was a business development plan in place for 2015-2016, and this identified the actions the provider was taking to improve the service provision. Since the last inspection five cottages had been built in the grounds, for people who wanted to maintain their independence, whilst having access to any support services they might need. We spoke with people who had moved into these and they expressed their satisfaction with the support they received and the respect for their independence. The rear garden had been landscaped during this project and provided good access for people with varying mobility. This showed the provider had identified the changing needs of people requiring care and expanded the service provision to cater for them.

The provider had systems in place for monitoring the service. These included shared access to emails to ensure these were responded to in a timely way by the appropriate person. All purchases for the service were done via head office who could then review stock usage and identify any trends or issues to be explored. Through the electronic shared calendar the provider was kept informed of meetings for people and staff so they could attend and hear their views. Information about people including incidents, accidents and monthly weight records were shared with the provider. Monthly updates of staff recruitment, staff training and staff rotas were sent to the provider. Weekly and monthly forms were in place requesting information about a variety of aspects of the service and people's conditions, which were completed by the management team and submitted to the provider to assist them with keeping the service under review. The registered manager also provided a daily telephone update to the provider so any issues were highlighted to them promptly. From our observations during the inspection the processes in place for auditing and monitoring the service were informative and maintained good communications between the service and the provider.

Staff meetings took place every 3 months and these covered a wide variety of areas relating to people's needs and well-being. Three monthly meetings for people using the service took place and people were able to express their views and keep up to date with any changes at the service. This demonstrated that people were asked about aspects of the home and action points were recorded. Satisfaction surveys had been carried out and the results had been analysed and incorporated into the annual Quality Assurance Review Report produced in January 2015. All those who completed the forms were satisfied with each aspect of the service it covered and no additional comments had been received, so people who completed the forms were happy with the care they or their family member received. Notifications were being sent to CQC for any notifiable events, so we were being kept informed of the information we required.