Elba Care Limited

Divine Care Centre

Inspection report

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Overall summary

We inspected this service on 13 January 2015 and the inspection was unannounced. We have not given this service a rating. This is because, at the time of our inspection the home had recently opened and there were only eight people using the service.

The home is registered to provide nursing and personal care for up to 36 people. The newly refurbished home is set over two floors in the Wingate area of County Durham. The home is independently run with a registered manager in place.

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.

Care plans we looked at contained information which related to people's needs and the level of support they required. Risk assessments were completed to work in conjunction with the care plans to keep people safe and maintain their independence.

Robust recruitment and selection processes were in place and pre-employment checks had been carried out to ensure people who used the service were cared for safely.

The service had an appropriate medication policy in place and staff were trained in the administration, storing and disposal of medicines. Regular checks were carried out to ensure that medicines were in date and correctly stored and administered.

Staff working in the home received regular supervisions and comprehensive records of discussions were held in personnel files. Additional supervisions were carried out if there was a concern about their ability to carry out a particular task.

People who used the service received care and support that was person centred and individual to their needs. Care plans were reviewed regularly with changes being made when needed.

The registered manager and staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Medicines were regularly reviewed and checks were carried out to ensure that people did not suffer any adverse effects. Changes to care were accurately recorded to take account of people's changing needs.

There was a formal complaints procedure in place and people who used the service were given information on how to raise a complaint if they wished.

Advocacy services were available and information was displayed on a notice board for people to view.

Summary of findings

There was a quality assurance system in place which was used to ensure people received the best care possible.

Everybody who used the service and the staff working in the home said the registered manager was approachable and led by example.

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.

There was enough staff to support people who used the service. Staff we spoke with had a good understanding of how to recognise and report any concerns of abuse.

People received their medicines in line with the provider's medication policies and procedures. All medicines were stored, administered and disposed of safely with regular checks being made to ensure stock was accurate.

Staff were trained in infection control and appropriate personal protective equipment was being used.

Is the service effective?
The service was effective.

People received effective care and support which met their needs. Staff were provided with enough training to ensure they had the skills and knowledge to provide effective care to people.

Health care professionals carried out visits to the service to provide continuous and effective care and treatment. Referrals were made to outside health services where concerns were identified.

Information about advocacy services was displayed in the home and people who used the service were supported to use these services.

Is the service caring?
The service was caring.

People were supported by staff that were caring and respected their privacy and dignity.

Staff supported people who used the service in a caring and friendly manner which promoted their independence.

People, who lived at the home, their family or representatives, were encouraged to be involved in decisions about their care and support needs.

Regular meetings were held with staff and people who used the service to discuss concerns or suggestions.

Is the service responsive?
The service was responsive.

When people were transferred between service information was accurately recorded and passed on.

Professional advice was sought and recommendations followed when changes to care were required.

There was a complaints procedure in place and information on how to make a complaint was provided to people who used the service.

Is the service well-led?
The service was well-led.

The service had clear values and a positive and caring culture which was clearly led by the registered manager.

Summary of findings

There was an open door policy in the home meaning people were able to talk to the registered manager or another member of staff when they wished.

The provider had a quality assurance system in place which was used to ensure people who used the service received the best care.

Divine 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 inspection took place on 13 January 2015 and was unannounced. This meant the staff and the provider did not know we would be coming.

The inspection team consisted of an Adult Social Care Inspector and an Adult Social Care Inspection Manager.

Before the inspection we reviewed information we held about the service and the service provider.

This included reviewing statutory notifications submitted by the service, information from staff, members of the public and other professionals who visited the home. No concerns were raised.

During our inspection we spoke with the families of three people who used the service, two staff and two of the people who lived in the home. We also spoke with one of the healthcare professionals that regularly visited the home. We reviewed records that were part of the provider's quality assurance tool, tracked the cases of four people who used the service and looked at the files for three of the staff employed to work in the home.

For this inspection, the provider was not asked to complete 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. We spoke with the registered manager about planned improvements as part of the inspection.

Is the service safe?

Our findings

People who lived in the home and their relatives told us they felt the home was safe. One of the people who used the service told us, "They [the staff] are brilliant", and the relative of one of the people who used the service said, "[Relative] has been in other homes and used to get upset when we left. [Relative] doesn't cry when we go now".

We looked at the policies and procedures the provider had in place and found there were appropriate policies in place in relation to the potential abuse of people who used the service. We saw clear guidance to staff on what abuse was and how it should be reported. Staff we spoke with were able to identify different types of abuse and were able to tell us how they would report concerns. We looked at the files of three staff who worked in the home. We saw all staff had received training in safeguarding and the protection of vulnerable adults. All these things meant people were protected because staff had been trained to recognise abuse.

We asked the registered manager about the home's policy on restraint. We were told restraint was not used in the home and that staff had been trained to distract people if they displayed behaviour that challenged the service. This meant people were protected from the risk of harm because physical interventions were not used.

We looked at the care plans of four people who used the service. Two of these permanently lived in the home and the other two were admitted into crisis beds for rehabilitation after an accident or illness. We saw care plans contained information associated with potential risks to people who used the service, staff and visitors to the home. Where potential risks were identified we found risk assessments had been carried out and strategies were put in place to minimise the risks associated with identified activities. For example, one of the people who used the service had been identified as being at risk of falls. We found the care plan gave staff information on how they should assist the person to mobilise while keeping them safe.

We spoke with the registered manager about the staffing levels in the home. At the time of our inspection the home had only been open for a short time and there were a number of empty beds. The registered manager told us a dependency tool was used to help work out the number of staff needed. However, this was used in conjunction with the registered manager's knowledge of the people who used the service and the level of assistance they required. In addition we were told the staffing levels were under constant review so they could be adjusted if people's needs changed or if more people started using the service.

We found the provider had a robust recruitment and selection process in place which included the completion of an application form, an interview and the receipt of two references. In addition staff were required to have a Disclosure and Barring Service (DBS) check completed. DBS checks are used to help employers ensure the people they are employing are not prevented from working with vulnerable people. We also saw that appropriate identity checks had been carried out for people working in the home.

We looked at the arrangements the provider had in place for the administration and storage of medicines. We looked at the Medication Administration Records (MARs) for people who used the service. We found the MARs had been initialled by staff when medicines were given to people. We found when new medicines were received in the home they were checked to ensure the correct types and doses of medication was delivered. We saw the provider had a policy in place for the storage and administration of medicines and found clear guidance to staff. We also found the provider had a policy in place for the use of homely remedies and also 'when required' medicines.

As part of our inspection we spent time looking around the service. We saw the home was clean, tidy and fresh with no odours. Prior to the home opening all areas were decorated and refurbished with new equipment purchased throughout. Staff working in the home received training in cleanliness and infection control and we observed staff using protective equipment such as disposable gloves and aprons at appropriate times.

We found the provider had a whistleblowing policy in place which enabled staff to raise concerns without fear of persecution or reprisals from other members of staff. We asked staff if they were aware of the policy and if they felt their concerns would be taken seriously. Staff told us they felt they could speak to both the registered manager and the provider if they were worried and they believed any concerns would be listened to and properly investigated.

Is the service effective?

Our findings

People who worked in the home were provided with training in order to help them carry out their roles effectively. The registered manager told us that when staff were employed in the home they were required to have an induction, and this was verified by the staff we spoke with. We found staff had completed mandatory training such as infection control, food hygiene and fire safety and some staff were working towards National Vocational Qualifications (NVQ) in Health and Social Care. We saw staff files contained certificates for in-house training and also any accredited qualifications and training that had been carried out. Certificates gave details of the training area and the date training was completed. Where training needed to be renewed or refresher training was required we saw some certificates had a date when this was required. We spoke with two members of staff who both confirmed they had received an induction and additional training to help them carry out their roles. This meant staff were appropriately trained and supported to carry out their roles.

We saw staff files contained evidence of supervisions being carried out by the registered manager every two months. Records of supervisions were comprehensive and there was evidence of discussions held between manager and staff member about concerns and areas for improvement. Records showed particular care was paid to how care was provided and it was evident that the registered manager gave clear direction about values and the standard of care that was to be provided.

We looked at the care records of four people who used the service. We found care plans were written in a way that enabled care staff to have a good knowledge of the person they were caring for. We saw care plans contained evidence of people being included in decisions about their care and future wishes. For example one person's care plan specified that they wished to be involved with all decisions relating to their health and wellbeing and that family members could assist when there were concerns about the person's ability to make decisions. We also found evidence that some of the people who used the service had made the decision to refuse resuscitation if they stopped breathing. Where this was the case, people's care plans were noted to show their decision and a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form was completed. The DNACPR form was held in the front of the care plan to ensure it was easily accessible if needed.

People who used the service had personal emergency evacuation plans in place to assist staff in the case of an emergency where the service may need to be evacuated. Detailed plans were kept in care records with all emergency information kept in the emergency bag. This included information whether they were high, medium or low risk, any equipment they needed to help them move around, such as a walking stick or wheelchair and the number of staff who would be required to assist them.

We saw consent for care was obtained from people who used the service and found where people were unable to consent we saw consent was sought from family members or people who knew them well. We also found some people had been able to give verbal consent and this had been recorded to show they were unable to sign but verbal consent had been given. In addition we saw staff spoke with people they cared for and asked for consent to help them before carrying out any care activities. For example we saw one member of staff asking, "Would you like me to help you with that?" This meant people had the continuing right to make decisions about their care.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We spoke with the registered manager about MCA and DoLS. The registered manager was aware of her responsibilities and told us that all staff received training in these areas and were aware of people's rights in respect of both. At the time of our inspection no applications had been submitted.

We looked at the menus for meals served in the service. We found there was a two week menu plan in place which gave people mealtime choices that were healthy and nutritious. We saw some people required special diets due to food allergies, medical conditions and the ability to chew and swallow. For example people with diabetes or coeliac disease. Where this was the case we found care plans reflected this, details were recorded in the kitchen and all recipes used included details of ingredients used to enable

Is the service effective?

meals to be changed to take account of these special needs. We found the procedures in the kitchen complied with Food Information Regulations which came into force in December 2014. These regulations mean information must be available about all allergenic ingrediants. We saw this information was available for all meals that were served and was clearly displayed in the kitchen area.

Pureed meals were provided to people who had difficulty swallowing and sugar free diets were provided for people who had been diagnosed with diabetes. In addition where there were concerns about people's weight we saw advice from dieticians was sought and fortified food and drinks were provided to help maintain a healthy weight.

We observed staff and people who used the service during a meal time in the home. We saw people were given meals they had requested and when they received them their meals were hot and well presented. We found staff interacted with people throughout the mealtime and offered assistance where appropriate. People were enabled to take time and enjoy their meals without being rushed.

We saw a daily handover was completed at the change of shift both in the morning and at night. The handover sheet used was comprehensive and contained information which gave details of any GP visits, any care reviews that had been or were due to be held, medication or prescription queries and also any close observations carried out. This meant people starting their shift were given all the necessary information required to help them care for people using the service.

People who used the service were helped to access other healthcare professionals like opticians, podiatrists and dentists because the provider had arranged to have regular visits to the home. We also found, where there were changes to people's needs or concerns about their health, referrals were made to the appropriate people. We spoke with one of the healthcare professionals that visited the service and were told, "The staff are marvellous. They are always helpful and listen to advice." This meant people's wider healthcare needs were considered.

Is the service caring?

Our findings

People who used the service told us staff treated them well and they were happy with the care they received. One person told us, "The lasses are lovely" another told us, "I wouldn't change it for a million pound."

We spent time observing staff interacting with people who used the service. We saw staff treated people with care and consideration, taking time to listen to people without rushing them and responding appropriately. We witnessed one member of staff spending time with someone who used the service and heard them discussing how years ago people had used an aga to cook. During this time we saw the staff member engaging fully and showing interest in what was being said. We saw staff behaving sensitively toward people who used the service and witnessed one member of staff spending time reassuring one person who became distressed during the day. One of the families we spoke with told us, "They [staff] are very caring", and another told us, "I can't praise them [staff] too highly." One of the staff we spoke with also told us, "The owner really cares about the staff and the residents."

Care plans for people who used the service were written in an individual and person centred way. They gave details about people's likes, dislikes and preferences and gave enough specific information about the person to enable someone who didn't know them well to care for them. For example one care plan gave staff information on behaviour that could be challenging and how staff should deal with this behaviour. Another care plan showed the person preferred a small plate of food and sometimes asked for an apron. This meant people were helped in a way that they wanted.

Staff working in the home had received training in dignity and respect. We saw people who used the service were treated with dignity and respect. Staff were seen speaking politely to people and treating them in a dignified and respectful manner. Care plans showed people were asked what they preferred to be called and this was recorded on the care record. We saw staff used people's preferred name when they were speaking with them and addressed them in an appropriate manner. We saw where people required help this was done discreetly and where care was being given, we saw staff closed doors to rooms. Before entering people's rooms staff knocked on doors and discreetly checked to ensure it was safe for them to go in. These things meant people's dignity was kept.

We saw notice boards had been put on the walls of the home and information was displayed that people who used the service, their family and friends would find useful. This included information about advocacy services, contact details for the local authority and Care Quality Commission and also the local Citizens Advice Bureau. In addition to this there was information about hairdressing services and also visits from local churches. We saw one of the people who used the service had an advocate acting on their behalf and found the details were recorded in the person's care plan.

People who visited the home told us they felt welcomed there and they were able to visit at any time. We were also told they were invited to have meals while visiting their friends or relatives. We saw one person who visited sitting in the dining area while their relative was having lunch. We were told "I have had lunch with [relative]. They always make me feel welcome."

Care plans contained information about people's future plans. We saw, some people had made arrangements for the event of their death. This information had been carefully documented to include whether they wanted to remain in the home or be moved to hospital, if they had a preferred funeral director and if there was a funeral plan in place and also whether they wished to be buried or cremated. Some people had also recorded preferences relating to where they wanted to be interred and music.

Some of the people in the home had Lasting Power of Attorney (LPoA) in place. This is a legal document which the person in question had used to appoint another person to act on their behalf for things like finances or health and wellbeing. We saw evidence of these had been put into people's care records, ensuring staff were aware of this decision. This meant the provider was able to adhere to the wishes of people using the service throughout their entire time in the home.

Is the service responsive?

Our findings

People living in Divine Care Centre received care that was appropriate and responsive to their needs.

We were told by the registered manager that the service worked with the local authority to admit people to the home at short notice where they were deemed as being in crisis. This was usually when people normally lived in their own homes but were recovering from an illness or an accident and were temporarily unable to manage at home. We saw people's needs were assessed quickly but accurately and any special equipment that was required was provided to ensure they were able to provide the correct level of care and support. Care plans for these urgent admissions were completed with the same level of detail of those that were for permanent residents of the home. In addition we saw there was a good working relationship between the provider and other healthcare professionals who helped with their recovery. We spoke with one of the healthcare professionals who visited the service. They told us the staff working there were helpful and always listened to advice and recommendations.

We saw care plans were written with the co-operation of people who used the service, their family or someone else who knew them well. Care plans included personal care, medication, challenging behaviour and mobility. We found care plans gave enough information for care staff to have a good understanding of people's abilities and the level of assistance they required. For example one care plan showed how the person was able to communicate and make decisions about meals but was not able to make decisions about more complex matters and may need help. This meant staff were aware of when they needed to offer more assistance.

Risk assessments had been written and linked to people's care plans. The risk assessments were used to identify areas where people's safety may be compromised and what steps were taken to minimise risks while helping people to maintain their independence. For example we saw one person was at risk of pressure sores due to compromised tissue viability. This meant the person's skin was thinner than it should be and this could cause pain and breaks in the skin. In order to reduce the risk a detailed risk assessment had been written which noted how often the person should change position, any special equipment which was to be used and also any medications or creams that were to be used to help protect the person's skin.

On looking at people's care records we found they were usually reviewed monthly or as people's needs changed, however we also saw evidence of care plans being reviewed every week to ensure the person involved was being appropriately cared for. In addition we found the associated risk assessments had been reviewed in line with the care plans. This meant as people's needs changed they were still being protected from risks and encouraged to maintain their independence.

We found health assessments had been completed by other services and saw where people were transferred to or from other services details of the care provided were kept in the care file. For example if people were discharged from hospital a copy of the discharge record was retained in case there were any queries or concerns. We found people had been referred to other professionals like dieticians, speech and language therapists and occupational health. Where people needed to see others we saw they were supported to attend appointments and any recommendations received were appropriately followed.

Some of the people who used the service were prescribed medicines that required them to have regular health checks to ensure there were no adverse effects on their health. We saw these tests had been completed and the results recorded in care records. Where required we saw people's medicines were adjusted by the prescriber, changes were recorded in care records and on MAR charts and adjustments were made to the medicine that was administered in accordance with the amended prescription.

We saw the provider had a formal complaints procedure in place and saw people who used the service had been given information on how to make a complaint. At the time of our inspection there had been no complaints about the service. We spoke with some of the people who used the service and found everyone without exception was happy with the service and said they had no reason to complain. The registered manager told us any complaints that were received would be acted upon immediately.

At the time of our inspection the service did not employ an activities co-ordinator however they had been advertising

Is the service responsive?

and were trying to recruit but had not received any applications for the post. We witnessed staff spending time with people who used the service and saw they were happy to organise activities like board games, quizzes, manicures and reminiscing.

Is the service well-led?

Our findings

Everybody we spoke with told us the home was well run and the staff were helpful and approachable. We were told, "It's like a five star hotel" and "I give them five out of five". One of the staff also told us, "It's like one big, happy family." We were also told, "The manager wants high standards and won't have second best." Another person told us, "[Registered manager] is approachable. She wants top care."

At the time of our inspection the service had a registered manager in place. 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 service adopted very clear values of 'providing choice, seeking opinion and promoting inclusion' and these were evident throughout the service.

The registered manager told us there was an open door policy in the home, meaning people who used the service, their family and friends were able to speak to her about any concerns. One of the families we spoke with told us, "The manager is lovely." One of the staff told us, "The manager is a boss and a friend". We also found the owner of the service visited every week and spent time walking around the home and speaking with people who used the service and any visitors to the home. The registered manager told us she had recently started 'Manager's surgeries'. These were a more formal way for people to speak with the manager privately and enabled the manager to document the meeting in case further action was required. One of the professional healthcare workers who visited the home told us, "I would recommend the home to anyone."

We found the service had a positive feel with a caring but professional feel. We spoke with the registered manager about improvements or changes she wanted to make to the service. We were told that she would like to develop an area on the first floor to make it suitable for people who had been diagnosed with dementia. Although the home had been newly refurbished the registered manager did not feel it was appropriately decorated to help dementia sufferers and would also like to make a self-contained unit for a small number of people which would assist their independence.

We saw regular meetings were held for people who used the service and their visitors as well as the staff. We saw minutes of meetings were recorded and were available for people to read. We also saw surveys had been carried out, asking people who used the service for their views on how the service was run, what was done well or was good about the service and what improvements could be made. All surveys that had been completed contained positive remarks about the staff and the service as a whole.

We found the service had good links with the local community and arrangements had been made for visits from the religious community and the local Women's Institute.

We saw the provider had a policy in place for staff who wanted to raise a complaint. The provider's whistleblowing policy allowed staff to raise concerns about other members of staff working in the home, or their professional practice and were supported throughout the process.

We found the provider had a quality assurance system in place to ensure the care provided and the surroundings of the home were kept to a high standard. We found portable appliance testing, fire safety checks and legionella testing had all been carried out in the home. In addition we saw regular detailed internal audits were carried out for several areas including infection control, catering and medications. We also saw there were day and night 'walk around' which senior care staff were required to complete. These were used to check the environment in the home including people's rooms. Areas reviewed included checking tables were set for meal times, lights were working, people's rooms were at their preferred temperature and the emergency bag is in the correct place with all contents checked. Night-time walk around included where appropriate, checking doors and windows were locked, night records were completed at the actual time care was delivered and all records were up to date, positional changes were implemented as per care plans and documented on chart and ensuring all staff were alert and able to observe people who used the service.

The registered manager told us they used the services of a company called 'Croner'. This company provided a

Is the service well-led?

legislation tracking service which gave updates to legislation related to the care sector. The registered manager and the provider used this information to develop policies and training and also to ensure they were up to date with best practice guidance. Detailed information was provided with forthcoming legislation, legislation that had been brought into force over the previous twelve months and also any government consultations that were current or had been held over the previous twelve months. Updates and changes were sent prior to coming into effect and again as reminders on the day they came into effect. This meant the provider and the service were always up to date with best practice and changes to legislation.