Tricuro Ltd

Streets Meadow

Inspection report

Hanham Road
Wimborne
Dorset
BH21 1AS

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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 4 March 2017 and was unannounced.

Streets Meadow provides accommodation and personal care for up to 60 people. There were full at the time of inspection. Two of the beds in the home were booked regularly for people who wanted to have a short stay or respite break. The service is located in Wimborne and is a large detached building with bedrooms on both the ground and first floors. All of the bedrooms have their own en suite bathrooms and there are several fully accessible showers and assisted bathrooms available for people. There is lift access to the first floor of the home. The home is separated into four separate units which each have 15 bedrooms, a lounge, dining room and small kitchen area. People have access to a level garden to the rear of the home and use of a sensory garden, sensory room and sensory bathroom.

There was a registered manager in post. 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.

People felt that staff were caring and told us that they had choices about their care. Staff understood their role in supporting people to make choices. We observed that people were relaxed with staff and there was a friendly atmosphere.

The service was well led and we were told that the registered manager was approachable and took action if changes were needed. Staff were encouraged to raise ideas and suggestions and felt supported in their roles.

People and relatives told us that the service was safe. Staff understood the risks that people faced and their role in managing these risks and we observed staff supporting people safely. Staff understood the signs of possible abuse and how to report any concerns.

People did not have to wait for support because there were enough, safely recruited staff available to respond when people used their call bells. The service had appropriate emergency plans in place and ensured that any accidents or injuries were recorded and used to identify ways to improve the safety of people at the home.

People received their medicines as prescribed from staff who had the necessary training to administer medicines. We observed that people were consulted where they had medicines which were 'as required'.

Staff understood and supported people to make choices about their care. People's legal rights were protected because staff knew about and used appropriate legislation.
Training was available in a range of essential topics and other learning opportunities were available to

further develop staff skills and knowledge. Staff received an induction into the service and senior staff checked competencies in a range of areas. Staff were supported with regular supervision and appraisals with senior staff.

There were systems in place to ensure people had enough to eat and drink. Where people needed particular diets or support to eat and drink safely this was in place and most people felt the food was good. People had choices about what they ate but some felt the quality of food could be improved.

People were supported by staff who knew their likes, dislikes and preferences. Staff knew their roles and responsibilities and told us that they communicated well.

People had individual care records which were person centred and gave details about people's history, what was important to them and identified support they required from staff.

Relatives told us that they felt welcomed at the service and people and relatives said that they would be confident to make a complaint or raise any concerns if they needed to.

Quality assurance measures were used to identify gaps or trends and to take actions to improve service delivery.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People had individual risk assessments and staff understood their role in
managing the risks that people faced.

People were protected from the risks of abuse because staff knew how to recognise and report concerns.

People were supported by staff who had been safely recruited with appropriate pre-employment checks.

People received their medicines safely and as prescribed.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about the people they were supporting and received relevant training for their role.

People who were able to consent to their care had done so and staff provided care in people's best interests if they were not able to consent.

People enjoyed a choice of food and were supported to eat and drink safely.

People had prompt access to healthcare services and communication with health professionals was effective.

Is the service caring?

Good

The service was caring.

People were relaxed in the company of staff and staff knew people well.

People told us that they had choices about their care and staff understood their role in supporting people to make choices.

People were supported to maintain their privacy and dignity.

People were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People had individual care records which were person centred and gave details about people's history, what was important to them and identified support they required from staff.

People were able to access a range of social opportunities and the home linked closely with the local community.

People and relatives knew how to raise any concerns and told us that they would feel confident to do so.

Is the service well-led?

Good

The service was well led.

Staff told us that the registered manager was approachable and that they
were encouraged to discuss any issues or concerns.

Staff felt supported and were confident and clear about their roles and responsibilities within the home.

Quality assurance measures were regular and used to drive high quality care.

Streets Meadow

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 4 March 2017 and was unannounced. The inspection was carried out by two inspectors.

The provider had completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does and improvements they plan to make. In addition we reviewed notifications which the service had sent us. A notification is the form providers use to tell us about important events that affect the care of people using the service. We also contacted the local authority quality improvement team to obtain their views about the service.

During the inspection we spoke with ten people and seven relatives. We also spoke with three healthcare professionals who had knowledge about the service. We spoke with five members of staff and the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked around the service and observed care practices. We looked at the care files of seven people and reviewed records relating to how the service was run. We also looked at three staff files including recruitment and training records. Other records we looked at included Medicine Administration Records (MAR), emergency evacuation plans and quality assurance audits.

Good

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person told us they had lived at the home for several years and said: "You couldn't live in a better place", another explained "One thing I do feel safe". Other people also told us that they felt safe and relatives explained that they had peace of mind because their loved one was living at the home. One relative said "I know (name) are safe, it has changed my life, (name) being in here." Another told us that staff "keep a good eye on people". We observed staff supporting people safely, for example, one staff member was supporting a person with their meal. They checked that the temperature of the food was safe and told the person that it was a little hot and waited for it to cool down before they supported them to eat it.

Staff understood about the possible signs of abuse and how to report any concerns. For example: One told us about how they would identify possible abuse. One explained that it was important to be observant all of the time and be aware of any possible signs of concern. Another explained what they would do if a person disclosed abuse and that it was important to listen and report immediately. Staff were aware of the policies around protecting people from abuse and whistleblowing and told us that they would be confident to report if needed.

People had individual risk assessments which explained what risks they faced and what support staff should provide to manage the risks. For example, one person was at risk of bruising because of a medicines they were taking. They had a risk assessment which identified this and gave staff clear details about how to support with minimal pressure to manage this risk. Where the person had bruising, this had been identified, recorded by staff and discussed with involved health professionals. Another person had sore areas of skin and health professionals had given staff guidance to elevate the person's legs when they were sat in their chair to manage this risk. We saw that the persons legs were elevated in the way described.

Accidents and incidents were reported promptly and included detail about what had happened, what actions were taken immediately and any actions to prevent reoccurrence. Where there were any injuries, body maps had been completed. These were audited monthly by the registered manager who identified if there were any trends or patterns and took actions to manage these where needed. This meant people were at a reduced risk of reoccurring incidents and accidents.

People did not have to wait for support because there were enough staff to support them. We observed that call bells were answered promptly and when an emergency call bell was activated, staff responded immediately. People told us that they did not have to wait and the registered manager explained how they used staff within the home to ensure that people had enough support to meet their needs. They explained that there was a minimum staffing level and that if staff were sick or unable to work for any reason, senior care and community service officers would be called to come in to prevent the staffing from dropping below this level.

Recruitment at the service was safe. Staff files included references from previous employers, applications forms and interview records. Checks with the Disclosure and Barring Service (DBS) were in place before staff

started in their role. The service had some evening vacancies which the registered manager was offering to existing staff before considering external recruitment. The home used volunteers on a weekly basis and one previous volunteer had progressed to a permanent role within the home. Another volunteer had taken up an apprenticeship and the registered manager explained how they were working with a local college to support the person.
The service maintained a safe environment for people because regular checks of the building and fire evacuation procedures were in place. Each person had a person emergency evacuation plan (PEEP) which included details of what support they would need to evacuate the premises safely. Emergency contact numbers for services were recorded and there were regular checks of the fire alarms, fire doors and fire safety equipment.

People received their medicines and creams as prescribed. We saw that people were supported by staff who had received appropriate training and that they followed safe procedures when giving people their medicines. Some people had medicines prescribed 'as required'. We observed a staff member asking people whether they wanted their medicine before administering this and recording this correctly in the MAR. We saw that MAR included important information about how people wanted to take their medicines. For example, one person wanted their medicine put into their hand. We saw that they received this in the way described. Some medicines required additional checks and we saw that these were in place and that medicines were stored securely.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw that people had MCA assessments in place and that these were decision specific and provided evidence about how the decision had been made. Where people required decisions to be made in their best interests, these were documented and included who had been involved in the decision. Staff understood their role in seeking consent from people. For example, one person had an MCA and best interests decision around refusal of support from staff. It outlined the least restrictive option which had been agreed in the person's best interests and we observed staff supporting the person in the way described. The home had made DoLS applications for several people and where authorisations had expired, these had been identified and further applications made.

Staff had the correct knowledge and skills to support people. Health professionals told us that staff were knowledgeable about people and understood how to support them effectively. A relative told us that they "couldn't fault the staff, they are so good". They went on to explain that staff knew their loved one well and had picked up that they were low in mood which was now being followed up with their GP. A person told us that staff "have been trained and they make you feel comfortable".

Staff spoke positively about the training they received at the service. Staff received training in a number of topics which the service considered essential, these included moving and assisting, safeguarding and dementia. Other distance learning options were available and included end of life care and diabetes. A staff member told us "I have the training I need". Another said that the training was "very good". We saw that several staff were undertaking health and social care through the Qualifications and Credit Framework (QCF) which is the new national credit transfer system which has replaced the NVQ. Other staff were booked to start this qualification shortly and we saw that other planned training included nutrition, spirituality and dignity.

New staff completed an induction at the home which included completing competencies which were observed and signed off by senior staff. This covered a range of areas including communication and infection control. New staff were also supported to undertake the care certificate. The Care Certificate is a

national induction for people working in health and social care who did not already have relevant training. We saw that staff had certificates to confirm that they had successfully completed the requirements for the national induction.

Staff received regular supervision and told us that they had opportunities to discuss practice and any learning and development needs. There was a supervision structure in place for staff and a schedule so staff knew when they would have protected time with their supervisor. Supervisions were recorded and included discussions about areas of practice and staff progression. This meant that staff had regular opportunities for support and to discuss and improve practice.

People had choices about what they had to eat and drink at the home and where they required a different diet to eat safely this was catered for. The cook explained that they knew what foods people liked to eat and if they did not want any of the choices available, they would make an alternative for them. We observed that one person did not want their meal when it was served and that they were offered a choice of alternatives which was then requested and provided without delay. We saw that the cook knew which people required a softer diet to eat safely and where people were identified as at risk of losing weight, their meals were fortified. Some people used different plates or cups which enabled them to continue to eat independently and we observed that a person had finger foods which they were able to manage without support from staff. Some people told us that the quality of the food was good, but some people and relatives told us that the quality was not always very good. Comments included pastry which was too hard to chew, chicken and mushroom pie without any mushrooms and choices of food which the person would not historically have eaten. Another person told us "all the food here is lovely" and another commented that they had liked their lunch that day.

People had efficient access to healthcare services. The home was visited each day by a district nurse and there were strong working relationships with the local GP surgeries. Health professionals told us that staff knew people well and had up to date knowledge about people when they visited. Staff recorded if they had concerns about people who needed to be seen by a health professional and they told us that this worked well. Health professionals told us that the home made appropriate referrals and sought guidance promptly if they were concerned about people and this meant that people received preventative health input before any conditions worsened.

People were supported to be orientated in the home by environmental clues. There were signs on toilets so that people could identify these easily and people's rooms had memory boxes outside which people filled with items of their choice. This helped people to identify which was their room if they were disorientated. Displays on the walls included celebrations and topics of interest of discussion. For example, there were large displays about Valentine's day and marriage and one area included pictures about the royal family in which people had expressed an interest. Another wall included information about people's school days and included pictures of some staff during their school life as well as people living at the home. These displays provided opportunity for discussions with people about areas in which they had an interest.

Good

Is the service caring?

Our findings

Staff spoke with genuine warmth and affection about people. We observed that people were relaxed in the company of staff and that there was appropriate banter and use of humour. One person told us "the staff are wonderful, they are so patient". Another person took a staff member's hand and told us that they were "their favourite". Relatives spoke about feeling included in the home and that the warmth from staff was extended to them whenever they visited. One relative said "everyone genuinely cares" and told us that the home was "amazing". Another said that people were "very well cared for". A staff member explained that they felt it was "a privilege to look after other people's loved ones". A health professional said that "staff are lovely with people, very patient……its almost like their families and they are included in everything".

People were actively supported to make decisions about their care and staff understood their role in supporting people to make choices and communicating in ways which were appropriate for people. For example, we observed staff communicating with a person and offering them choices . They used short, clear questions and gave the person time to communicate their choice before asking a further question. The person was able to make their own decisions when asked in this way. We observed staff offering people choices throughout the inspection and a person told us that they had choices about all aspects of their day and said "I decide whether I want to stay in bed in the mornings". The registered manager explained that they re-enforced that "our residents do not live in our workplace, we work in their home".

People, relatives and health professionals told us that staff knew what their preferences were and how they liked to be supported. A staff member explained that a person was sat in a particular seat in the dining area because they liked the view out of the window. We saw that people were seated together at mealtimes with others with whom they were friends and this meant that people chatted and socialised over their meals. Another staff member knew what programmes a person lived to watch on the television and another explained how a person needed comfort and reassurance because they sometimes felt upset.

People were treated with dignity and respect by staff and we saw that care plans included guidance about people's privacy to ensure that this was maintained. For example, one person could become upset about staff supporting them and their care plan explained how to offer support and explained that it was important to the person to be in control of their decisions and to be respected by staff. Staff understood how to engage with the person in a way which was respectful and the importance of enabling the person to remain in control of their situation. Where intimate care was given, staff ensured that doors were closed and were respectful of people's privacy.

People were encouraged to maintain their independence and a relative explained that staff regularly supported their loved one to walk which they felt was important in maintaining independence. The registered manager told us that they tried to focus on people remaining independent as long as possible and explained that they had been discussing one person with their GP and had been reluctant for the person to be prescribed medicines which would affect their mobility as this would also reduce their independence. A health professional told us how a person had been provided with the tools to help with some cleaning in the home. This was something that they had wanted to do and staff had enabled and

encouraged them to maintain this independence as they would have done in their family home. This demonstrated that people were encouraged to do what they could for themselves and that the service advocated for people to retain their independence.

The service had received re-accreditation with the Gold Standards Framework (GSF) which sets out standards for end of life care for people. Information about GSF was included in the information people received when they moved into the home. The senior care and community support officers supported people in considering their wishes for their end of life care and we saw that this was recorded in people's care plans. The home offered a space for families to sleep at the home if they wished and the home held an annual remembrance service with the Salvation Army which enabled relatives, friends, staff and other people from the home to come together and remember people who had passed away. The home had a large wall display of butterflies to represent people who had passed away and there was a quiet seating area and memory books for people to access if they wished. A relative of a person who had lived at the service provided written feedback and told us "I was thoroughly impressed with not only the quality of care that my (name) received but also the care all of the staff showed towards (name). It was nothing short of exceptional…… The staff made what was an incredibly difficult experience bearable, for which my family and I are extremely grateful."

Good

Is the service responsive?

Our findings

People had person centred care plans which considered them as an individual and reflected their preferences about how they wished to be supported. Information was recorded about people's personal histories which meant that staff were able to have conversations with people about subjects which were meaningful to them. For example, one person's record included how they preferred to be addressed, hobbies and interests that they had and information about people who were important to them. We saw staff addressing the person in the way described. Care plans were regularly reviewed and we saw what changes had been made to people's care as a result of these reviews. For example, one person had not been sleeping well. This had been highlighted at the review and a referral made to a health professional to explore options to improve this for the person. Where people wished, their loved ones were involved in reviews and relatives told us that they had been involved where appropriate.

Visitors and relatives told us that they were welcomed at the service and visited whenever they chose. There were several visitors during the inspection and the front door was always answered promptly by staff who welcomed people and ensured that they signed in the visitor's book before entering the service. One relative explained that they "come whenever I like and I'm always welcomed". Other relatives echoed this view and all felt that they were able to visit whenever suited them. We observed that relatives knew staff and interactions were relaxed and familiar. The registered manager placed a high priority on including people's families within the home and the home was viewed by people, staff, relatives and health professionals as integral in the local community.

People were able to access social opportunities in which they had an interest. The home had activity staff who managed a mixture of external and internal activities for people including visits from pat dogs, word and puzzle games and regular visits from two local schools. The home had recently set up a monthly butterfly café to encourage people who had lost someone living at the service to come in and spend time with staff and other people with whom they had formed strong bonds when their loved one was at the home. The registered manager said that the first café had been well attended and enjoyed. They explained that several people at the home had expressed an interest in gardening and a local National Trust place had allocated the home an allotment for the year. People planned to go and choose plants and spend time each month at the allotment if they wished to do so. Several people had already expressed an interest and this was being arranged. Staff also arranged to discretely support a person to meet their spouse on a regular basis for a meal in a local pub. This would have been part of their family life before coming to the home and the registered manager understood that this was important to the person and their spouse. The home also had a sensory room and sensory bathroom. The registered manager explained that some people found these resources calming and staff engaged with some people using these areas on a regular basis. There was also a sensory garden which people could access.

In addition to the community links with local schools, the service had regular services at the home from a local Church which people attended. They took part in community activities in Wimborne including the annual pancake race and used fundraising opportunities to raise funds to support activities outside and inside the home. A donation to the home had been used to create a cinema in one of the lounges and films

were screened regular movies which were attended by people, their families and staff and their children. The occasions were sociable opportunities and well attended. The home also raised funds for charities and received support from a local supermarket chain who provided donations for Christmas and other celebrations at the home.

Relatives told us that the home kept them updated and communicated effectively regarding the care of their loved one. One relative explained that they had been called promptly when their loved one had fallen and told us that they were kept informed by staff about any changes with their loved one. People had consent forms in their care plans which asked when people would want their loved ones to be contacted.

People and relatives told us that they would be confident to raise any concerns if they needed to and we saw that complaints were recorded appropriately and responded to. The service had not received any complaints in the year prior to our inspection but the registered manager explained that any concerns raised were treated in the same way as a complaint and used to improve the service.

The service sought annual feedback using a survey which was sent to people, relatives and professionals who had involvement with the home. The last surveys had highlighted that some people were not sure about how to complain and actions had been planned to discuss this at residents meetings to ensure people knew how to raise concerns if they needed to. Survey responses were positive overall and where responses showed that improvement could be made, these were actioned. For example, survey responses indicated that not all staff were aware about how to report abuse, this had subsequently been added to the agenda for staff meetings for six months and was included in supervision meetings. The service also had a suggestion box if people wanted to feedback in another way and we saw that this was accessible in the entrance to the home.

Good

Is the service well-led?

Our findings

People, relatives, professionals and staff spoke positively about the management of the home. They all told us that the registered manager was visible and approachable and that they listened and took actions where needed. The registered manager completed floor walks of the home each day which meant that people had regular opportunities to see and speak with them if they wished. A health professional told us that the registered manager knew people extremely well and had worked with the GP surgeries to ensure that they had a space and some stock available when they visited people which had been helpful.

The home had a clear management structure and the registered manager told us that they had regular support with monthly visits from their line manager. They also had opportunities to discuss and develop the service through management meetings with other registered managers within Tricuro and also partners in care meetings with other local providers. Staff knew their roles and responsibilities within the home and communication between staff was effective with daily handovers and regular team meetings. The registered manager had appointed a wellbeing officer who took a lead role in ensuring that the values and ethics of Tricuro were embedded in staff practice and also supported any disagreements or concerns raised between the staff group. This proactive management approach meant that staff were supported to work effectively together and encouraged to raise and discuss any issues as they arose. Other designated roles included a dignity champion who focussed on ensuring staff understood the wider concept of dignity and considered how they would feel if they were receiving the same support as people in the home. The health and safety officer completed unannounced observations of staff moving and assisting people to ensure that this was done safely and to highlight where any further learning was required.

The home was the designated safe haven for Wimborne. This is a partnership arrangement between the local police and the Alzheimers society. It meant that Streets Meadow was a place where anyone who was living with dementia and other related conditions could temporarily go if they were confused in public and were unable to provide sufficient information to be taken home. The registered manager told us that they had been utilised to support a person through this arrangement and it had meant that the person was able to be kept safe and well until the police were able to make contact with their family. The registered manager had also offered staff the opportunity to become 'I care' ambassadors and two staff were appointed to this role. This is a national initiative to encourage care workers who inspire and motivate people to understand more about working in social care. They were able to attend careers fayres and other local events and encourage new recruitment into health and social care. This demonstrated that the service was developing support for the wider community and engaging and encouraging staff recruitment into care.

Staff told us that there was an open culture at the home and that they were encouraged to bring ideas and suggestions to team meetings and to the registered manager for consideration. The registered manager explained that this was invaluable when developing high quality care as staff often had different views or ideas. For example, staff identified that they would like to be informed if a person was approaching end of life if they were not on shift at the home to give them the opportunity to come and spend time with them. This was now in place and if staff wished to be informed, this was respected. Staff had also fed back that the equipment used to weigh people was not working properly and they were concerned that people's weights

were not being accurately checked. The registered manager told us that they had ordered replacements to ensure that staff had the necessary equipment to effectively monitor people's weights if this was needed.

The registered manager spoke with pride and enthusiasm about the staff team at Streets Meadow. They told us that staff had a "passion for care and are proud to be part of this team". They explained that they had confidence in the staff and knew that they did not compromise on the standards of care they provided. They had also reflected on methods of ensuring that high quality care was received by people and had appointed a 'mystery shopper'. This was the relative of a person in the home and the registered manager had asked for them to observe interactions and practice and update them every few months or before if they had any concerns. This was working well and meant that there was another system in place to drive improvement and high quality care.

Quality assurance measures were regular and used to monitor trends and improve practice. For example, the registered manager explained that accident and injury information was sent to Tricuro who collated it but that they also used the information to audit and identify if there were patterns or trends to the accidents. We saw evidence of this data being used in this way and the registered manager explained how it had been used with one person who they had subsequently referred to the falls team to support with managing this risk. Other audits were completed regularly and the information used to drive high quality care.