Leicestershire County Care Limited

Curtis Weston House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected the service on 25 September 2018. The inspection was unannounced.

Curtis Weston House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Curtis Weston House is registered to accommodate 44 people in one adapted building. On the day of our inspection 34 people were using the service.

We previously inspected the service on 7 December 2015. We rated the service as `Good' overall, but rated the key question 'Safe' as requiring improvement because risk assessments were not always reviewed and updated and aspects of medicines management were not consistently good. We found at this inspection that improvements to 'Safe' had been made and that all other key questions remained Good.

The service had a registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were supported by staff who knew how to recognise abuse and how to respond to concerns. Risks in relation to people's daily life were assessed and planned for to protect them from harm and they lived in a clean, hygienic service.

People were supported by enough staff to ensure they received care and support when they needed it. Medicines were managed safely and people received their medicines as prescribed.

The service had safe procedures to respond to outbreaks of infection which protected people, staff and visitors.

People were supported by staff who had the knowledge and skills to provide safe and appropriate care and support. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People lived in a service which met their needs in relation to the premises and adaptions were made where needed. The provider had implemented a refurbishment plan for the premises at the time of our inspection.

People had access to information in a format which met their needs.

People were supported to maintain their nutrition and staff were monitoring and responding to people's

health conditions.

People lived in a service where staff listened to them and got to know them. People's support needs were recognised and responded to by a staff team who cared about the individual they were supporting. People were supported to enjoy a social life.

There was an open and transparent culture. People were involved in giving their views on how the service was run and there were systems in place to monitor and improve the quality of the service provided. People had access to a complaints procedure.

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 were kept safe and the risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents.

People received their medicines as prescribed and medicines were managed safely.

There were enough staff to provide care and support to people when they needed it.

Is the service effective?

Good

The service was effective.

People were supported by staff who received appropriate training and supervision.

People made decisions in relation to their care and support and where they needed support to make decisions they were protected under the Mental Capacity Act 2005.

People were supported to maintain their nutrition and their health needs. They were supported to access health services when they needed them.

Is the service caring?

Good

The service was caring.

People lived in a service where staff listened to them and cared for them in a way they preferred. People's emotional needs were recognised and responded to by a staff team who cared about the individual they were supporting.

Staff respected people's rights to privacy and treated them with dignity.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care and support. They were supported to have a social life and to follow their interests.

People received support that was tailored to their individual needs.

People had access to a complaints procedure.

Is the service well-led?

Good

The service was well led.

People were involved in giving their views on how the service was run.

The management team were approachable and there were systems in place to monitor and improve the quality of the service.

Curtis Weston House

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.

We inspected the service on 25 September 2018. The inspection was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from commissioners who fund the care for some people who use the service. We also contacted Healthwatch Leicestershire who are the local consumer champion for people using adult social care services. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with four people who used the service and relatives of two other people. We spoke with the registered manager, an area manager and three members of support staff. We looked at the care records of three people using the service, staff training records, rotas and a range of records relating to the running of the service including audits carried out by the registered manager and registered provider.

Good

Is the service safe?

Our findings

When we inspected the service on 7 December 2015 we rated Safe as Requiring Improvement. This was because people's risks assessments were not always reviewed and medicines storage temperatures were not consistently recorded. At this inspection we found that improvements had been made. Risk assessments were reviewed when required and medicines storage had been made safe.

People were protected from abuse and avoidable harm. People told us they felt safe. A person told us, "Yes, I am much safer here than I used to be in my flat." Another person told us they felt safe and reassured at night. They said, "The staff come in every night when I'm in bed."

People were supported by staff who recognised the signs of potential abuse and how to protect people from harm. Staff had received training in protecting people from the risk of abuse and staff we spoke with had a good knowledge of how to recognise the signs that a person may be at risk of harm and to escalate concerns to the registered manager. Staff told us that they were confident that if they raised concerns they would be taken seriously. Staff knew they could raise concerns with external organisations such as the local authority, the police and the Care Quality Commission. A staff member told us, "I'd know how to report abuse and I'm confident anything I reported would be taken seriously."

People could be assured that safe recruitment practices were followed. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of identity and appropriate references had been obtained prior to employment and were retained by the provider. This meant that the necessary steps had been taken to ensure people were protected from staff that may not be fit and safe to support them.

Risks to individuals were assessed and staff had access to information about how to manage the risks. For example, people who were at risk of falls had risk assessments which had guidance for staff about how to support people with their mobility. People at risk of falls in their rooms had sensor mats to alert staff a person was moving in their room and falls mats to minimise the risk of injury in the event of a fall.

People were living in a safe, well maintained environment and there were systems in place to minimise risks. We saw there were systems in place to assess and ensure the safety of the service in areas such as fire and legionella and control measures were in place to reduce these risks. Staff had been trained in health and safety and how to respond if there was a fire in the service. There were personal evacuation plans in place detailing how each person would need to be supported in the event of an emergency.

People received the care and support they needed in a timely way. People told us they felt safe because there were enough staff. A person who had had a fall told us, "I went dizzy and fell in the lounge. I didn't hurt myself and staff were nearby to help." On the day of our visit we observed there were enough staff available to meet the requests and needs of people. A person told us, "It is good having people [staff] around." Staff made regular half-hour observations of communal areas to ensure people were safe and comfortable. We

saw and heard that call alarms were responded to quickly. A person told us, "I use it [alarm] quite a lot, I don't wait long for staff."

Staff were readily available to support people when they needed or requested it. Staffing levels were determined by using a dependency assessment tool which the registered manager used to calculate a safe level of staffing. Two senior members of staff and five care staff were on duty during the day; and a senior and two carers at night. Staff told us they felt there were enough staff to meet people's needs. When we compared the staff rota to information about training staff had, we found that the service was consistently staffed by staff with the right skills and knowledge.

We found the medicines systems were safe and that people were receiving their medicines when they should. People knew what their medicines were for. A person told us, "I'm aware of what I take and why. I have [named pain killer] when needed." When staff supported people with their medicines we heard them tell people what their medicines were for. The service used an IT medicines management system that reduced the risk of medicines errors. Staff had received training in the safe handling and administration of medicines and had their competency assessed prior to being authorised to administer medicines. Arrangements for storing and disposal of medicines no longer required were safe.

The service had acted to reduce the risk of medications errors being made by implementing an entirely new system for medications management. This showed that the service learned from experience and sought ways to make improvements. The system ensured that people had the right medicines at the right times.

The service managed the control and prevention of infection well. A third of the people were affected by an outbreak of an infection the day before our visit. The registered manager had implemented the provider's infection control procedures. People affected by the outbreak continued to receive support, including meals and drinks, in their rooms to reduce the risk of infection spreading to communal areas. We observed all areas of the service looked clean and hygienic. There was equipment in place which would reduce the risk of the spread of infection such as colour coded cleaning equipment and disposable hand towels in toilets and bathrooms. Staff received training to understand their role and responsibilities for maintaining high standards of cleanliness and hygiene in the premises. Staff had access to policies and procedures on infection control that meet current and relevant national guidance and had a good understanding of why systems for managing the risk of the spread of infection had been implemented.

Good

Is the service effective?

Our findings

People's physical, mental health and social needs were assessed and their care and support was planned and delivered in line with legislation, standards and evidence-based guidance. For example, guidance from an organisation that specialised in advising about support for people with dementia was used to develop a stimulating environment for people.

People's rooms were personalised. This supported people to follow their interests and hobbies in their rooms. There was signage in place to support people with a dementia related illness to support them to orientate themselves. Communal areas were decorated with sensory and tactile objects and corridors were 'themed' to make them interesting for people. For example, corridors had 'Hollywood', 'seaside' and 'memory lane' themes which provided people with a sensory experience. A communal lounge was fitted out and decorated to resemble a 'pub' where people played darts and dominoes. People who needed a mobility aid could access the areas of the service they needed to. A person told us, "I don't think I'd find a better place. We even have a covered smoking area." People were consulted about planned refurbishments to the environment to avoid causing distress during the changes.

People were supported by staff who were trained to support them. A relative told us, "The carers definitely have the right skills. The care is really good. [Relative] can present challenging behaviour, but the carers are really good with them." A person told us, "All staff, carers, cleaners and cooks, they all meet my needs." Staff told us that the training and support they received provided them with the confidence and skills to carry out their roles to provide care that met people's needs. A staff member told us, "I'm pleased with training, it has helped me to acquire the skills required to support people."

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 were supported to make decisions on a day to day basis. We observed people decided how and where they spent their time and made decisions about their care and support. We observed in communal areas spending time the way they wanted, for example watching television or walking around the home.

People were supported by staff who had a good knowledge and understanding of the MCA. Both staff and managers we spoke with had a good level of knowledge about their duties under the MCA and how to support people with decision making. People's support plans contained clear information about whether people had the capacity to make their own decisions. We saw that assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. Staff we spoke with understood that people's capacity could change from day to day. They presumed people had capacity but would report to the registered manager if they felt a person lacked capacity so that best interests decision could be made which ensured that the principles of the MCA were

followed.

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.

The registered manager had made applications for DoLS where appropriate. For example, one person had been assessed as requiring support from staff if they went out into the community and they were not free to leave the home alone. There was an up to date DoLS authorisation in place for this person. There were eight people with DoLS authorisations. The registered manager had a system for ensuring that DoLS authorisations were submitted for review before they expired to ensure that people were not being deprived of their liberty unlawfully.

People were supported to eat and drink enough. Comments from people included, "The food is lovely" and "We have a choice every day" and "We can have seconds." People's food preferences and dietary requirements were met. A cook we spoke with knew about people's preferences and requirements because information about these was available in the kitchen. A person told us, "My food plan is in the kitchen." People who required their meals to be served in pureed form to protect them from risk of choking had their meals served to look appetising. The cook used special moulds to shape the food so that each item on the plate was recognisable for what it was rather than all items being pureed into a single mass. People had a choice of eating their meals in a dining room or their own room and at times that suited them. A relative told us, "The food is brilliant. [Relative] has what they want and has choices. If they want breakfast at dinner time they can. If they want something different they can have it."

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People's nutritional needs were assessed regularly and there was information in support plans detailing people's nutritional needs. We saw staff had noted when people's weight had changed and if there were risks that this would affect the people's health. Where risks were identified information was shared with the person's GP so that they could make a referral to dieticians of other health services.

The service worked and communicated with other agencies and staff to facilitate a co-ordinated approach to people's care needs. We saw that people had input from a variety of professionals to monitor and contribute to their on-going support. People were supported with their day to day healthcare. A person told us, "I see a doctor when I want. District nurses visit me." People told us that chiropodists visited them and that the service had arranged annual visits from an optician. People were supported to attend regular appointments to get their health checked. Where people were unable to attend appointments and we saw arrangements had been made for home visits to be made.

Good

Is the service caring?

Our findings

People told us that staff were caring. A person told us, "The staff are very kind." Another person told us that staff supported them in ways that was important to them, they told us, "The staff help me to look nice." A relative told us, "It's in their hearts to be a carer."

The provider promoted values of `kindness, dignity, compassion and respect'. Staff were supported to put these values into practice through training. Fourteen staff were `dignity champions' who supported others to put the providers values into practice. We observed staff interactions with people were characterised by those values. We saw staff ensuring that people were comfortable. Staff offered people blankets for their laps when they sat in communal areas, providing reassurance through conversation and holding people's hands when people showed signs of anxiety. People looked relaxed and comfortable with staff. A relative told us, "The staff are better at cheering [relative] up than we are."

Our observations and discussions with staff showed that staff clearly knew about people's needs and preferences and that they had time to listen to people. We saw in people's care plans that their preferences for how they were supported were recorded, along with their likes, dislikes and what was important to them. As a result of how staff demonstrated a caring nature, the local authority had awarded the service a 'Dignity in Care Certificate' valid until February 2019.

People's suggestions were acted upon. A person had asked for fresh fruit to be included in lunch time menus in addition to being available throughout the day. Fresh fruit was added as a desert to meal times. People preferred different ways for their meals to be served onto plates and the registered manager had arranged for every person's preference to be accommodated.

People's rooms were personalised to their tastes and were distinctive. A person had pets, a goldfish and two budgies, in their room. This meant that people could follow their hobbies and interests in the privacy of their rooms if they chose not to use communal areas.

We spoke to the registered manager about the use of advocacy services for people. An advocate is a trained professional who supports, enables and empowers people to speak up. The registered manager told us no one in the home was using this service but we saw that information about advocacy services was on display on information notice boards where people could see it.

People were supported to be independent. This included supporting people to be more independently mobile. A relative told us about a person who had previously required hoisting to be able to leave their bed or chair, but who had been supported to stand with the use of a stand-aid. They told us, "[Relative] is more independent now." We saw people walking independently from their rooms to different communal areas. People's care plans included assessments of their independence, what they could do for themselves, and what they would need support with.

People were supported to have their privacy and were treated with dignity. We observed people were

treated as individuals and staff were respectful of people's preferred needs. Staff referred to people by their preferred name and spoke respectfully to people. They explained to people how they were supporting them, for example when a person was transferred by hoist, to reassure people and help them feel comfortable. A relative told us, "The staff are so lovely, they create a family feeling." People were supported to take their medicines in the privacy of their rooms if that was what they preferred. A person told us, "I have eye drops given in my room."

Relatives and friends could visit the service without any unnecessary restriction. On the day of our visit a sign politely asked people to consider whether they should visit because of the outbreak of infection at the service. The visitor's signing-in book showed that relatives visited at all times during the day and evening.

We found that people's personal information was respected, for example it was managed and stored securely in one of two offices.

The provider was aware of the protected characteristics under the Equality Act; their policies and guidelines reflected this. The culture of the organisation was open to providing care that met people's needs without the fear of discrimination about their age, sex, culture or religion. For example, we saw that some signage was written in English and a language a person spoke.

Good

Is the service responsive?

Our findings

People and their relatives were involved in planning and making choices about their care and support. We saw in people's care plans that staff had recorded people's preferences and how they would like to spend their day. A person told us, "I go out shopping, buy bags of sweets to share out" and another person said, "I go out when I want." We saw people use a variety of communal rooms, often going from one room to another to spend time. Care plans included information about people's family and employment history. Staff used the information to build their knowledge about people and as a basis of recreational conversation with them.

People were supported by staff who were given information about their support needs. Information was in care plans and also in the form of summaries on small cards that staff carried with them. This meant that staff had information 'at their fingertips' about people's preferences. They also had information they would need immediate access to in the event of emergency services calling at the service. For example, information to share with paramedics about medications, health and whether a person had a 'do not resuscitate order in place.

Care plans included information staff needed to meet the needs of the individual. Staff told us they referred to the summaries every day and that they read the care plans periodically and always when they were notified of changes after a care plan had been reviewed. A person who had pressure ulcers when they first came to the service received support that improved their condition and quality of life. They told us the pressure ulcer had healed because of the support they received which included support with repositioning them at two hourly intervals during the day and four hourly at night. This was in keeping with what was recorded in the person's care plan. This showed that people received personalised care and support that met their needs.

The registered manager completed a full review of each person's care and support every month and care plans were adjusted to meet people's changing support needs. For example, a person's care plan had been reviewed after staff identified why a person at times presented behaviour that challenged staff and which caused the person to isolate themselves from others. Over a four-month period the person was supported to be more confident and to resume interests they enjoyed before they came to Curtis Weston House. The person now went out alone to a variety of venues in the local community where they resumed friendships with people they had known. Another person spent a lot of time on the floor, which other people and visitors found disturbing. Staff identified that the person was reliving a past profession they had. They supplied the person with plumbing equipment they could assemble and dismantle and arranged for the person to have an area where they could do this.

People were supported to follow their interests and take part in social activities. People told us they were supported to go shopping, a local bingo hall and to attend services at a local church. Seven people volunteered to represent Curtis Weston House in a sports event organised by Leicestershire & Rutland Sport, Everyone Active and Leicestershire & Rutland Community Foundation. People trained for 11 weeks to learn how to play five different sports and all won medals. Other people participated as spectators. People's

success and participation was celebrated in a display at the service. The service had an activities coordinator who had developed a programme of weekly activities that people could look forward to and which reflected their interests. For example, activities included baking and knitting. A person told us, "I like it all, bingo and dominoes" and another said, "I love the baking."

The service had looked at ways to make sure people had access to the information they needed in a way they could understand it to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given.

The provider had taken steps to identify accessible information needs during the assessment of people's care and this was clearly detailed in people's care plans.

People living at the home had varying levels of ability to verbally communicate and to understand written documents. The registered manager had ensured that all people had access to information that enabled them to understand their care needs and the health services available to them and this ensured people were not unduly discriminated against. Accessible 'easy-read' documentation was included in people's care plans which meant that people knew about the care and support people should expect from the service. A person told us, "I've seen my care plan" and another said, "I know about my risk assessments." Other `easy-read' information included how people could make complaints, report concerns about their care or access independent advocacy services.

People living at the home had varying levels of ability to express choices. For example, most people were able to choose what meal they wanted by selecting it from a menu. Other people were shown plated meals so that they could make an informed choice using their sensory skills. The service used communication systems using signs, symbols and pictures as a way of communicating with people with communication difficulties.

The registered manager involved people about developments at the service through well attended resident's meetings where people had a say. For example, people had made suggestions about how they wanted communal areas to be decorated which had been acted upon. Raised garden beds and a greenhouse were made available for people with an interest in flowers and growing vegetable. People were involved in deciding how they wanted their rooms decorating. A person told us, "I'm going to get my room decorated to my taste."

Residents meetings were used to remind people about the provider's complaints procedure. Information about the complaints procedure was displayed in communal areas. No complaints had been made since our last inspection.

Care plans included information about how people wanted to be supported when they reached the end of their life and funeral arrangements.

Good

Is the service well-led?

Our findings

The service promoted and supported fairness, transparency and an open culture for staff that was underpinned by the provider's values of 'Integrity, trust, kindness, dignity, compassion and respect.' Staff we spoke with knew what the values were. They told us they themselves felt valued and that this motivated them to do their job well. Comments we saw in compliments from people and relatives included `good carers, we can relate to them', 'nothing is too much trouble', 'very caring' and 'always willing to help'. A person told us, "They are very good to me, I can't fault the place. What more could I want." This showed that staff 'lived' the values.

There was a registered manager in post. The people we spoke with knew who the registered manager was. We saw people stop to have conversations with the registered manager and it was clear that the people enjoyed this. The registered manager operated an 'open door' policy and we saw people and staff go into the registered manager's office. We found the registered manager was clear about their responsibilities. They had notified us of events in the service, such as people having falls, which meant that we were able to monitor the service in between inspections.

The manager had a clear understanding of their role and responsibilities. They had processes in place that ensured the CQC and other agencies, such as the local authority safeguarding team were notified of any issues that could affect the running of the service or people who used the service. They showed interest in developments in social care, especially how care home environments could be improved to enhance the experience of people living with dementia and sensory impairment. Much of the décor we saw in communal areas stemmed from what the registered manager had read about. They were supported to implement their ideas by an area manager. Together they were in the early stages of writing a plan for how the service could be further developed over the next three years.

People told us that the registered manager was friendly and approachable. A person told us, "I can have little chats with the manager. I can talk about any issues." Staff told us that they felt the service was well managed. One told us, "The home is really well run, the manager is friendly." The registered manager gave staff opportunities to raise concerns at one to one supervision meetings and team meetings.

People who used the service and their relatives were given the opportunity to have a say about the quality of the service. The registered manager used residents and relative's meetings to obtain people's views. At the time of our visit the provider had begun a survey to obtain people's feedback about their experience of the service.

The registered provider oversaw the running of the service to ensure that people were happy with the service being delivered. They or a director of the service made unannounced visits to the service. Staff told us that the provider spent time talking with them and checking on how things were. We found that those visits expected high standards. Feedback that was left by the provider or a director was acted upon by the registered manager. For example, in July 2018 a director had identified a number of improvements they wanted to see. These included a display of safeguarding information for people and staff, use of

standardised forms to record information and ensuring that risk assessments for new residents were fully completed when they began to use the service. The director's feedback was shared with staff and all of the improvements were made before the end of August 2018.

The registered manager carried out a series of monthly audits that included audits of care plans, medications, falls and records of people's weights and food charts. A maintenance officer carried out weekly checks to ensure the environment was safe. An area manager visited the service regularly to check that the registered manager had carried out their audits and to discuss the results. People could be confident that the quality of the service was being closely monitored by the registered manager and provider.

Following our previous inspection, we noted the rating for that inspection was on display in the main reception of the home. The provider operated in an open and transparent way ensuring people living at the home, relatives, visitors and healthcare professionals were aware of the home's current CQC rating and where appropriate the areas they needed to improve.