Shaftesbury Care GRP Limited

De Baliol

Inspection report

Woodham Road
Newbiggin By The Sea
Northumberland
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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

De Baliol is located in the coastal town of Newbiggin by the Sea and provides care for up to 59 people who have nursing care needs. There were 36 people using the service at the time of the inspection.

The inspection took place on 20 April 2017 and was unannounced. This meant the staff and the provider did not know we would be visiting. At our last inspection of this service in January 2016 the provider was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe care and treatment. We found that the provider was not fully complaint with fire safety regulations at that time.

At this inspection, we found that the provider had acted to make the necessary fire safety improvements. Regular fire safety training and drills were carried out.

Risks to people had been assessed, and steps taken to mitigate these. Staff had received training in the safeguarding of vulnerable adults and knew what to do in the event of concerns. Specialist equipment was provided for the comfort and safety of people where necessary.

Suitable procedures were in place for the management of medicines, and staff received regular training and checks of their competency to administer these.

Infection control procedures had been updated following an inspection by the local authority last year which highlighted issues to be addressed. We found that appropriate action had been taken and the home was clean and well maintained. Staff were aware of infection control procedures.

The service was working within the principles of the Mental Capacity Act 2005 (MCA) and applications had been made to the local authority in line with legal requirements. People were supported to make decisions about their care and treatment.

Staff received regular training, supervision and appraisals and placements were provided to student nurses. Nursing staff received support to maintain their professional registration.

People's nutritional needs were met, and they had access to a range of health professionals.

Staff were caring, courteous and friendly during our inspection. We saw numerous examples of caring interactions and there were several references to the close knit community and the connection which therefore existed between people, relatives and staff.

Care plans were in place which recorded people's individual needs and preferences, and work was taking place to standardise these as they varied in detail. People and their relatives were involved in care planning and reviews of their care.

People had access to a range of activities, including group and individual sessions. A minibus had been secured for the sole use of the home to increase the number of trips.

A complaints procedure was in place and was displayed in the home. There had been no recent complaints received by the service.

A new manager was in post, who was in the process of registering with CQC. They had previous experience of managing a care home, and were also a registered nurse. A deputy manager was in post and the manager and deputy told us they felt well supported by the provider and regional manager.

There were systems in place to audit the quality and safety of the service, and to gather the views of people, relatives and staff. Procedures were in place to show how these would be acted upon.

Staff told us they enjoyed working in the home and morale appeared good. The provider was praised by staff for their responsiveness to requests for new equipment or refurbishment to improve the quality of the facilities and service offered to people.

Further information is in the detailed findings below.

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 is now Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

De Baliol

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 20 April 2017 and was unannounced. The inspection was carried out by one inspector.

Prior to the inspection we consulted with the local authority safeguarding and commissioning teams, and reviewed all of the information we held about the service, including statutory notifications. Statutory notifications are notifications of deaths and other incidents that occur within the service, which the provider is legally obliged to notify us of.

We spoke with five people, two relatives, the manager and regional manager, two care staff, two nurses, a student nurse, two domestics, a cook and a member of maintenance staff.

We checked two staff recruitment files, two care plans and a variety of records related to the quality and safety of the service.

We did not request a provider information return (PIR) due to the scheduling of the inspection. A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make.

Good

Is the service safe?

Our findings

People told us they felt safe. One person told us, "To tell you the truth, it's excellent. I feel very safe here."

At the last inspection, we found that the service was not fully compliant with fire safety regulations. We received feedback from the fire safety officer who confirmed that this work had been completed. An external independent fire safety review had recently been completed, with minor suggestions for improvement which were being carried out by maintenance staff. Fire drills were carried out twice monthly during the day, and once monthly on night duty.

Risk assessments related to the premises, equipment, and individual care needs were carried out. A number of routine checks were in place to ensure the safety of the premises, including water temperatures, window restrictors and electrical safety. Where risks to people had been identified, care plans were in place and in some circumstances, specialist equipment had been provided to ensure their safety and comfort.

There were safe procedures in place for the ordering, storage, administration and receipt of medicines. We checked medicine administration records (MARs) and found no gaps. We checked the quantity of a controlled drug (CD) and found the correct amount. CD's are drugs which are liable to misuse and are subject to more stringent controls. Staff competency to administer medicines had been assessed, and medicine refresher training was provided. Night staff responsible for countersigning medicines administered had also been trained and had their competency checked despite not having full responsibility for administering medicines. This was good practice.

Safeguarding procedures were in place, and staff had received training in the safeguarding of vulnerable adults. The local authority told us there were no on-going organisational safeguarding matters regarding the service. Recruitment procedures remained safe, and helped to protect people from abuse. Application forms were completed and disclosure and barring checks undertaken to ensure that applicants were suitable to work with vulnerable people. References were obtained and staff received a period of induction and training once appointed.

There were suitable numbers of staff on duty. People and relatives we spoke with told us they thought there were sufficient staff deployed. One relative said at times they could be busy, but thought that people's needs were met. We observed staff responding to people in a timely manner and were calm and unhurried when supporting people.

An infection control policy was in place and staff had received training in the prevention and spread of infection. The local authority had picked up some concerns related to infection control at their last monitoring visit in 2016, including some odours and furnishings and flooring that were difficult to clean. At this inspection we found no odours, and flooring had been replaced in a number of areas. The home was clean and well maintained. Chairs were being replaced at a rate of seven per month, with special fabric that was easier to clean. We spoke with two domestic staff. They were aware of the procedures to follow to prevent the spread of infection, and an infection control 'champion' was in post who attended infection

control meetings at the local hospital.

Good

Is the service effective?

Our findings

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked the provider and registered manager were continuing to work within the principles of the MCA and that any conditions on authorisations to deprive a person of their liberty were being met. We found the service was operating within the principles of the MCA and the manager had completed DoLS applications in line with legal requirements.

Capacity assessments were carried out, and the individual's ability to make simple or complex decisions was recorded in people's care records. This meant that people were supported to make decisions where possible, and staff were aware of the types of decision people might need support in making.

Staff told us and records confirmed that they received regular training. Training was provided in a range of topics considered mandatory by the provider including; health and safety awareness, moving and handling, medicines, and infection prevention and control. The manager told us they found that staff preferred face to face training so arranged this wherever possible. E- learning (computer based training) was carried out, and the manager told us they used this as a baseline for a training foundation, which they then added to with specific training around a care need or based upon what staff felt they required. A nurse told us, "I have received far more training here than I did when I worked for the NHS." We saw that training had been provided by the community matron in a range of topics including skin care and diabetes. Placements were provided for student nurses and we spoke to a student on the last day of their placement. They told us, "I have really enjoyed it here. I had never considered working in a nursing home before, it has been really interesting and I have learned a lot. I didn't expect to enjoy it so much." Staff received regular supervision and annual appraisals. These provide staff with support and assess learning and development needs.

People were supported with eating and drinking. Nutritional assessments were carried out, and specialist advice was sought in the event of concerns. People were weighed weekly or monthly, depending upon their level of risk of malnutrition, and these were monitored by the manager. We joined people at lunch time. We found that tables were fully set with tablecloths and condiments. People were supported sensitively. A staff member saw that a person was struggling to eat their meal and asked, "Do you want to try a teaspoon?" This meant the person was offered support to continue to try to eat their meal by themselves which they did. Dignity aprons were provided which matched tablecloths and were therefore discreet. We spoke with the cook who was aware of special diets and told us that people were able to choose an alternative if they didn't like what was on the menu and they would make something different for them. Music was playing which was unobtrusive and appropriate, including over the mealtime where it enhanced the atmosphere without distracting.

People had access to a range of health professionals, including optician, dietician and chiropody. A GP visited once a week to carry out non urgent reviews, which was time effective for staff who could prepare for these in advance. They were called in between visits for urgent issues only. Monthly observations of people's temperature pulse and blood pressure were taken and recorded to monitor overall health. These were carried out more frequently when required. Do Not Attempt Cardiopulmonary Resuscitation (DNAR) orders were in place where required, and these were filed in a prominent location and kept under review.

Good

Is the service caring?

Our findings

People told us they felt well cared for, one person said, "They are all lovely staff here. I can't complain." A relative told us, "I like the close knit feel of the home, it feels part of the community." We observed courteous and caring interactions between staff and people. Staff took time as they went about their duties to stop to speak to people and acknowledge visitors. Staff were also professional and courteous with one another, asking each other politely for help and then saying thank you.

Privacy and dignity training was provided, and we observed that privacy was maintained. We observed staff knocking on doors before entering rooms, and offering help with personal care discreetly. Signs were available to put on people's doors warning that personal care was in progress so that they would not be disturbed. The administrator for the home delivered private mail to people in their rooms, and supported them to open it if necessary, including noting any important appointments. This helped people to maintain their privacy and independence where possible. Records held about people were stored confidentially in locked cupboards.

People were involved in decisions throughout the day about where they would like to sit or what they wanted to do. Staff spoke with people while they provided care, and explained what they were doing especially during moving and handling. We observed that staff approached people from the front before moving their chair for example, to avoid startling people. One person was asleep in their chair and was gently woken for lunch, but given sufficient time to wake up before being helped to move.

There was no one receiving end of life care at the time of the inspection, but care plans were in place which recorded people's end of life wishes where appropriate and staff had received training. No one was receiving any form of advocacy service during the inspection but the manager was aware of how to arrange this if necessary. An advocate provides people with independent support to make and express their opinions.

A number of compliment cards were available to read which praised staff for their care and kindness. Staff had also involved relatives in setting up a book of remembrance for people that had lived in the home, which included a personal short paragraph about them. It was moving to read and deputy manager told us they had set it up because they wanted to remember people no longer in the home.

Good

Is the service responsive?

Our findings

Relatives told us that staff responded to people's needs. One relative said, "They always contact us if there have been any issues and let us know about things such as falls or if they have had to get a GP." They said that staff sought advice for their relation in a timely manner and communicated with them well.

Care plans were in place which outlined any risks to people, and how these would be mitigated. There were also plans in place related to specific physical and psychological needs which were reviewed on a regular basis. Plans were in place to support the transition between the care home and hospital, and vice versa. These detailed any important information or changes in condition or medicines for example. People's choices and personal preferences were recorded.

The format of care plans was in the process of being updated. We found that the level of detail between care plans varied, and some appeared more generic and less personal in style. One care plan we read was related to pain and gave clear information about the source and site of the pain, and how the person expressed it. Another care plan referred to the person experiencing pain at times but was less explicit. We spoke with the manager who was aware of this and we saw audits had been carried out, which highlighted areas for improvement which had led to the review of all plans. A relative told us they had been invited to reviews of care and had seen care plans; they felt involved in the care planning process which had included their relation.

A range of activities were available. One relative told us there had been an issue with insufficient activity, but that this was now resolved. A minibus had been secured for sole use by the service and staff were very pleased about this and looking forward to planning outings. We spoke with the activities coordinator who told us they provided a variety of activities in the home and community. In the home, there was a quiet lounge with a gramophone. This space was used for reminiscence and pamper sessions. A tuck shop had been set up which enabled people to buy a selection of sweets, drinks and toiletries. There were close links with the local community, and the home was well supported at open events and fetes. Gardens were well maintained, and the sea front was within walking distance of the home. People attended activities in the community including those arranged by the church, and Mind Active. Mind Active is a not for profit organisation supporting care home staff to provide activities for people in the home and community.

The activities coordinator also planned activities based on the needs and abilities of people, including those cared for in bed. They told us, "I can wash people's hair in bed, which makes people feel better, and I do hand rubs and fingernails, or play music. I have been thinking about other sensory activities." Entertainers also visited the home. Care staff were also aware of the need for people to feel occupied and stimulated. One staff member said, "It's lovely outside, shall we put our coats on after lunch and go and sit in the garden while it's nice?" Another staff member asked one person, "Where would you like to sit? Why don't you sit here so you can look out of the window?"

A complaints procedure was in place, and information was displayed about how to complain about the service. There had been no recent formal complaints received by the service.

Good

Is the service well-led?

Our findings

A new manager was in post who was in the process of registering with CQC. They were experienced in care home management and were also a registered general nurse. They were supported by a deputy manager. One person told us, "The manager is pleasant; I would go to them if I had any problems." On the day of the inspection, a regional manager was at the service meeting with the manager. They told us they had recently taken up the post and visited the service regularly. The manager and deputy manager told us they felt well supported by the provider and regional manager and staff commented that they had seen improvements in the service, including investment in the building and décor. One staff member told us, "If we need things for the residents it doesn't seem to be too much of a problem. Obviously we can't have everything but if we need something we get it."

Systems were in place to monitor the quality and safety of the service. The views of people, relatives, visiting professionals and staff were gathered through surveys and meetings. The manager told us they had looked at previous surveys, analysed the results and found that it was difficult to see what action had been taken in response to some of the feedback. They had therefore developed their own action plan and were in the process of changing the system to include formal action plans. A nurse manager from another home was visiting the service on the day of the inspection to introduce improved clinical auditing systems. They had been highlighted as good practice at another home and the provider was therefore replicating the system in other services to standardise quality and improve consistency. This showed that learning was shared between services. The manager told us they had plans to develop a clinical nurse manager post to support nurses with training and revalidation. Revalidation is the process nurses must go through to remain on the professional register.

A range of monthly audits and daily checks were carried out. These included checks related to health and safety, infection control, medicines, finances and catering. Checks on the safe use of equipment were carried out including bed rails, and special mattresses used for the prevention of pressure ulcers. The health and wellbeing of people was monitored by the managers including nutrition, falls and catheter care. The manager told us it was important to be visible in the home, and they did daily walk around checks. 'Surprise' visits took place out of hours, where the manager or deputy visited the service late at night or early in the morning. The manager and deputy also had contact with night staff by starting their shift earlier in order to overlap with night staff on a regular basis.

Regular meetings were held, including daily 'flash' meetings with each head of department including care, maintenance, kitchen, activities, housekeeping and administrative staff. These meetings highlighted and discussed any people giving cause for concern and clinical needs, accidents or incidents, GP visits, hospital admissions or discharges, appointments and staffing issues. Action points were recorded including the person responsible. This meant the manager was aware on a daily basis of what was happening in the service.

Statutory notifications had been submitted to CQC in line with legal requirements. Notifications are changes, events or incidents that the provider is legally obliged to tell us about.

Staff told us they were happy working in the service, and morale appeared good. The home appeared tidy and well organised. A nurse told us, "The carers are very good here, there is a really good team spirit. I get on well with my colleagues. We have low sickness levels and low turnover of staff."