Care South

St. Ives Country House Care

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

The inspection took place on the 19 February2018 and was unannounced. The inspection continued on the 20 February 2018 and was announced. This was the services first inspection since registration on 10 February 2017.

The home had a registered manager who had been in post four months 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.

St Ives Country 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. The home is registered to provide care for up to 60 people. The service had been registered for providing nursing care in the care home and personal care to people living in their own homes but had not commenced these activities so were not included in our inspection. At the time of our inspection there were 31 people in the home some of whom were living with a dementia. The home provides accommodation over two floors. Rooms have en suite shower facilities. Communal facilities include specialist bathrooms, lounges, dining rooms, quiet social areas and an accessible garden.

People and their families described the care as safe. Staff understood how to recognise signs of abuse and the actions needed if abuse was suspected. Staff had completed equality and diversity training and respected people's individuality. People had their risks assessed and actions put in place to minimise avoidable harm whilst respecting people's rights to freedom and choice.

Medicines were ordered, stored, administered and recorded safely. Protocols were in place for medicines prescribed for as and when needed but required more detail to meet best practice guidance. Staff understood the actions needed to protect people from avoidable infections.

People were supported by enough staff that had been recruited safely including checks to ensure they were suitable to work with vulnerable adults. Accidents and incidents were reviewed and where necessary actions taken to reduce further risk. Processes were in place to ensure lessons are learnt when things go wrong both in the home and across the wider organisation.

People were supported by staff that had completed an induction and on going training that gave them the skills to carry out their roles effectively. Pre-assessments had been completed with people and their families which provided information about peoples care needs and life histories.

Care and support plans detailed how people liked to be supported and recognised their individuality.

Working relationships with other professionals such as district nurses provided effective outcomes for people. Staff understood their roles in supporting people whilst respecting a person's right to privacy, dignity, independence and life style choices. People and their families were involved in end of life plans which included cultural requirements.

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.

Staff were described by people and their families as caring, kind and patient. Relationships between staff and people were warm and positive and demonstrated that staff were knowledgeable about people, their likes, dislikes and things that were important to them. People's communication needs were understood which meant people could be involved in decisions about their day to day lives. A complaints process was in place which people and their families felt if they used they would be listened to and actions taken.

People had opportunities to join in with group activities and one to one time with staff. Links with the community included trips out to local places of interest, social, health and spiritual groups and local schools. The environment provided opportunities for people to access communal areas, private areas to meet with family and friends and accessible outside space.

The service had visible leadership and staff described morale and teamwork as good. Processes were in place to enable effective communication with people, their families and the staff team including regular meetings. Quality assurance processes captured the effectiveness of service delivery and where improvements were identified actions were successful in improving standards.

Innovative use of technology and equipment supported people's safety and independence.

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 supported by staff that had been trained to recognise abuse and the actions they needed to take if abuse was suspected.

People had their risks assessed and actions put in place to minimise the risk of avoidable harm whilst having their freedoms and choices respected.

People were supported by enough staff that had been recruited safely.

Medicines were ordered, stored, administered and recorded safely.

People were protected from avoidable infections.

Lessons are learnt when things go wrong and used to improve service delivery.

Is the service effective?

Good

The service was effective.

People were involved in assessments prior to admission which reflected their care needs and choices.

Staff received an induction and ongoing training that provided them with the skills to carry out their roles effectively.

People had their eating and drinking needs met.

Working relationships with other organisations supported effective outcomes for people.

People had access to healthcare for both planned and unexpected health needs.

The environment provided both social and private space that enabled people to have freedom and independence.

People had their rights and freedoms upheld within the framework of the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

People received kind, caring and emotionally supportive care.

People were able to express their views and make decisions as staff understood the communication needs.

People had their dignity, privacy and independence respected.

Is the service responsive?

Good

The service was responsive.

Care and support plans reflected a person's individuality, interests and choices.

A complaints process was in place and people and their families felt able to use it, would be listened to and actions taken.

People's end of life plans reflected people's cultural and spiritual needs.

Is the service well-led?

Good

The service was well led.

The culture of the service was open and inclusive with visible leadership.

Staff understood their roles and responsibilities.

Processes and systems were in place to enable engagement with people, their families and staff.

Quality assurance processes were effective in capturing areas of improvement and positively impacting on service delivery.

Partnerships with other agencies supported appropriate reporting and sharing of information.

St. Ives Country House Care

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection began on the 19 February 2018 was unannounced and the inspection team consisted of an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of care service. It continued with one inspector on the 20 February 2018 and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider was asked to complete a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make..

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with seven people who used the service and four relatives. We spoke with the chief executive, registered individual, registered manager, operations manager, deputy manager, and eight staff. We reviewed eight peoples care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

Is the service safe?

Our findings

People and their families described the care as safe. One person told us "I feel safe, because they look after you, you have regular meals and doctors visit". A relative said "Yes she is safe, she is happy". Staff had completed training and understood what types of abuse people could be at risk from, what signs to look for and the actions they needed to take if they suspected abuse. A senior care worker told us "Information on external agencies we can contact and their telephone numbers are on the nurse's station". People were protected from discrimination as staff had completed training in equality and diversity. We observed interactions between staff and people that respected people's individuality.

People had been protected from avoidable harm as assessments had been completed that identified risks people experienced and were reviewed at least monthly. When a risk had been identified actions had been put in place to minimise the risk whilst respecting the person's freedoms and choices. Staff were aware of people's risk and able to tell us how risks were managed. One person had a risk of choking. A senior care worker explained "(Name) had a SALT (Speech and language therapist) assessment and they can eat a normal diet again but (name) isn't able to eat in their bedroom alone". Some people had a risk of falls. Actions to reduce risk included the use of seat and bed alarm alert pads. We observed staff ensuring a person's seat alarm alert pad moved with them when they changed seats. Another person stood from a chair and their alarm beeped. A care worker responded quickly and went across to the person to check they were safe and offer help. The home were trialling an overhead sensor in one person's room. When the sensor alarm was activated it also put a light on to help the person see better. One person needed a walking stick to aid their mobility. We observed housekeeping staff and care workers frequently finding the walking stick around the home and returning it to the person. People at risk of skin damage had specialist mattresses and cushions in place to reduce the risk of avoidable harm. The provider told us an external clinical lead provided additional advice and support when reviewing skin damage risk. This included upgrading equipment and advising treatment options.

Accidents and incidents had been recorded and provided details of what had happened and the actions staff had taken at the time. Records had been reviewed within 24 hours by a senior manager who detailed any further actions needed to minimise risk of reoccurrence. These had included referrals to a community mental health team, physiotherapist and changes to care and support plans. Shift handovers ensured all staff each day were aware of accidents and incidents and any consequent change to managing risks to people.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

Records showed us that equipment including hoists, lifts and the boiler system were regularly serviced and maintained. Fire equipment had been regularly checked and staff had completed recent fire drills.

People were supported by enough staff to meet their needs. Throughout our inspection we observed staff available to help people in a timely way and having time to talk and spend time with people. One person

told us "If you ring the call bell they (staff) come quickly". Staffing levels were reviewed monthly and matched to the needs of people living at the home. Staff had been recruited safely. Relevant checks were undertaken before people started work. These included employment references and checks were made with the Disclosure and Barring Service to ensure that staff were safe to work with vulnerable adults.

People had their medicines ordered, stored, administered and recorded safely. Medicine was administered by staff who had undertaken medicine training. Staff used an electronic handset that prompted them to provide the right medication to the right resident at the right time and had a number of inbuilt safeguards to minimise errors. Staff understood the actions they needed to take if a medicine error occurred. We found three tablets on a bedroom floor. They were part of a persons prescribed morning medicines which had been administered by staff. We made staff aware and they completed a medicine incident form, carried out health observations, reviewed the care plan to ensure consistency of support and contacted the persons GP to advise. Some people had been prescribed controlled drugs which are medicines that require additional storage and administration safeguards than other medicines. We checked records and these had been managed in line with requirements. Protocols were in place for medicines prescribed for when required (PRN) but in some cases provided limited information to support decisions on when to administer the medicine ensuring people received the medicine appropriately and safely. We discussed this with the registered manager who told us they would review PRN protocols to ensure they met best practice guidance standards.

Some people had been prescribed topical creams that were administered by care workers when supporting people with personal care. They had undertaken training in the safe administration of topical creams as part of their induction. Records contained a body map detailing where each cream needed to be applied and records had been completed confirming their application.

People when assessed to do so safely self-administered their medicines. Risk assessments had been completed with the person and were reviewed quarterly. The assessment included their understanding of symptoms and how to administer the medicine.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and they told us gloves and aprons were always available. All areas of the home were clean and odour free.

Processes were in place to ensure that lessons were learnt when things went wrong in both the home and across the organisation. We read minutes of a focused meeting with medicine trained staff following an audit identifying medicine errors. The meeting included revisiting the homes medicine policy, stock checks and staff accountability. An incident had occurred in another home within the organisation. Learning had led to moving and handling care plans being reviewed and additional information added detailing sling make, size and loop setting.

Good

Is the service effective?

Our findings

Assessments had been completed before a person moved into the service and this information had been used as a basis for their care and support plan. People, their families and professionals were encouraged to participate in the assessment. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. Care plans had been developed in line with current legislation, standards and good practice guidance.

Staff had completed an induction and received on-going training that provided them with the skills to carry out their roles effectively. A care worker explained that their induction included a week of learning such as first aid, how to move and position people safely, infection control and then shadowing staff for a few days. Inductions included completing 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. A care worker explained how dementia training had helped them with their role. "If somebody is upset it taught me how you could redirect their mind onto something else; I've found it really works. One resident who can get quite worked up, if we sit together and talk about something else they will forget all about it". Staff told us they received regular supervision, felt supported and had opportunities for professional development such as national diplomas in health and social care.

People had their eating and drinking needs met. Care staff and the catering team had up to date information about people's dietary requirements including likes, dislikes and allergies. The chef told us "Any drops in weight we're made aware of and we know people's default dish; their favourite dish". They went on to explain how people were involved in menu planning. "I have a committee upstairs. I have a cuppa with them and we discuss likes and dislikes. The menu gets tweaked as we go along".

People were offered a choice of well balanced meals. To help people make their choice they were shown plated meals of the options available and then a desert trolley with a range of desserts including fresh fruit. One person told us "Yes I choose what I want to eat and if you don't fancy that they say we will make you something else". Menus and condiments were on dining tables. We observed people enjoying a meal with family and friends. The meal experience was calm, relaxed and unhurried. We observed people being offered a choice of drinks throughout the day.

Working relationships with other organisations supported effective care outcomes for people. Examples included district nurse support with catheter care and a physiotherapist assessing a person and setting an exercise plan that staff carried out. Records and feedback from healthcare professionals reflected that staff responded appropriately to both on going healthcare needs and health emergencies.

The environment provided opportunities for people to access communal areas, private areas to meet with family and friends and accessible outside space. Around the home were small themed areas for people to sit and enjoy. One area had a kitchen feel with cookbooks and utensils, another had a garden theme with gardening tools. People, their families and staff described the environment positively. A care worker told us "It's a lovely home and the environment helps. It's a bright, light home. The outdoor space gives people a

little bit of freedom without us being with them". An enclosed central courtyard garden was accessed and visible from all areas of the ground floor. Terraced areas on the first floor provided accessible outside space for 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 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 found that the service was working within the principles of the MCA. Mental capacity assessments had been completed for people and DoLs applications had been submitted to the local authority. Where people were not able to make decisions this had been clearly assessed and best interest decisions made on their behalf reflected the principles of the MCA. Staff were knowledgeable about people's communication skills and this meant they were able to support people to make choices. A care worker told us "(Name) has limited communication and you have to prompt with suggestions; giving her choices; you have to slow everything down and give (name) time". We read a best interest decision that stated '(Name) consents with their smile'. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf. This meant people had their rights upheld and needs and choices met.

Good

Is the service caring?

Our findings

People and their families described the staff as caring, kind and patient. One person said "They (staff) always make sure I'm happy". A relative told us "They make a fuss of (relative) and make them feel special". We observed a person feeling sad and crying. A staff member went and gently put their arm around their waist and walked alongside the person offering comfort and reassurance which the person responded to positively.

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's communication needs were clearly assessed and detailed in their care plans. This captured the persons preferred methods of communication and how best to communicate with them.

People had their communication needs understood which enabled involvement in making decisions and choices. A relative explained "(Name) is finding it more difficult to speak and sometimes you have to guess. The staff seem to understand how to communicate with him". Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example talking with people at eye level and using hand gestures and facial expressions. A senior care worker explained "The care staff are quick at picking up what people want who can't tell them; it reduces people's frustration. It means they don't get upset that we don't understand them". One person had poor hearing and staff had used a pen and pad to communicate with them. Another person had poor sight and we saw large print messages which had been put on appropriately coloured paper to help with their communication needs.

Staff had a good understanding of people's interests, likes and dislikes. Information gathered had been used to create memory boxes for people. They included photographs of special events, pictures and memorabilia of a favourite sport or hobby. We observed staff talking to people about things that were important to them such as their family and memories of their younger years.

People were involved in decisions about their day to day care. One person told us "I choose what time to get up and go to bed and the girls (staff) do what I ask them to". Another said "They ask me if I want to have a drink or personal care". Throughout the inspection we observed staff involving people in decisions, explaining their actions to people, giving people time and listening to what they had to say. People who needed an independent representative to speak on their behalf had access to an advocacy service.

People had their privacy, dignity and independence respected. One person told us "(Staff) leave me alone when I wish to be left alone". Relatives and friends were not restricted in the times they visited people. A relative said "It's nice to come here. (Staff) bring (name) into a private area for us to spend time together which is a lovely gesture". One person described how their independence was respected. ""(Staff) always ask you if you want help or to be independent." A relative told us "(Staff) try to get (name) to walk by holding their arms and encouraging them". People's clothes and personal space were clean and reflected a person's individuality. Confidential information was stored in a locked cupboard or stored on password

protected computers.

Good

Is the service responsive?

Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. Care staff were able to tell us about their role in supporting people with their care needs and choices. A senior care worker told us "Everything is in the handover; we're always kept up to date". Handover records were available for all staff to read and staff told us this was helpful when returning from days off. One care worker said "It's really handy as all the information is on them". Reviews had taken place at least monthly and records showed these at times had included people and their families. We read one care and support plan that did not reflect the catheter care being provided to a person. We spoke with the registered manager who immediately updated the record.

Staff had a good knowledge and were respectful of people's individual lifestyle choices. People had their religious and spiritual needs respected and examples included people attending local church services.

People had opportunities to take part in group activities. We observed some people engaged with a reminiscence activity. Props were being used to initiate memories and conversations. Staff understands of people's communication skills enabled people to be engaged. One person had limited verbal communication skills. We observed the care worker taking an item for them to touch which led to smiles and positive eye contact. We observed people joining in a table tennis game using balloons which created lots of laughter. Other entertainment had included music and entertainers. Photographs displayed people enjoying arts, crafts and cookery sessions. The chef told us "We make cakes and they (people) decorate them".

Some people preferred to spend time in their rooms. The activities assistant told us "Some people like to read or watch TV. I go and chat and check their ok. Some people are happy to sit and watch but not join in". We observed people reading daily newspapers and library books.

Transport was available for weekly trips into the community and included visiting coffee shops, garden centres and local shopping centres. People had retained community links with social and health clubs. Links with local schools had included people attending a Christmas senior citizens party and school children visiting the home to share time with people. Technology was used to help people keep in touch with friends and family and included access to a computer. Staff completed an activity record which captured how people had spent their day.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government ombudsman. Four complaints had been received in the last 12 months and records showed us they had been investigated in a timely manner and led to changes that improved outcomes for people. An example had been staff being provided with guidance on modified diets.

People had an opportunity to develop care and support plans detailing their end of life wishes which

included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted. A staff member explained "When we had a person at end of life we had support from the district nurse and GP".

Good

Is the service well-led?

Our findings

The service had a registered manager. 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, their families and staff described the culture of the home as open and positive with visible leadership and strong teamwork. We observed a relaxed but professional relationship between management and the staff team. A relative explained "I do think it is well managed, very happy home, my relative is happy, staff are happy". The service had introduced 'HEART' values and the registered manager explained "Each letter stands for something and supporting each other and working to our best ability as a team". The values were honesty, excellence, approach, respect and teamwork. A senior care worker told us "It's a great place to work. Morale is really good, residents are lovely. We are so lucky". The director of residential told us the organisation had an annual awards programme which was used to recognise staff practice and achievements and several staff from St Ives had won awards in 2017.

Systems and processes had been introduced to ensure effective communication and involve people, their families and staff in developing the service. This included daily meetings with heads of departments, senior staff meetings, staff, resident and relative meetings. Minutes of meetings included sharing achievements with staff such as a 9.8 score from reviews on carehome.co.uk; a national web page where people write reviews about their experiences of care services. We read in relative and resident meeting minute's changes to the laundry system had been discussed. A trial had taken place and a new system had been introduced. The registered manager explained "It's a much better system and now happening in all of our other homes".

Statutory notifications had been made to CQC. A statutory notification is a legal requirement for the provider to inform CQC of certain situations as part of their oversight of care provision. This meant that CQC had received information to support their monitoring of the service.

Quality assurance systems were in place and effective in capturing areas requiring improvement. Action plans detailed what needed to be done, by whom and gave timescales. We read an action that stated professional visits needed to be reflected in care plans and found this had taken place. Another action had been the sluice needed cleaning and we saw this had been actioned by the housekeeping team.

Service development included innovative use of technology to support people's safety and independence. An example was the building design included each room having the facility for laser room alert sensors. The home had also worked with the local NHS and implemented the 'Red Bag Scheme'. The scheme involved using a red bag containing information about the person that stays with them and ensures an effective transition between services.

To support best practice links with other agencies included Skills for Care and Action on Elder Abuse.