

Avery Homes SH Limited







Spencer House Care Home

Inspection report

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Northampton
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Ratings

Overall rating for this service	Good	
Is the service safe?	Requires improvement	
Is the service effective?	Good	
Is the service caring?	Good	
Is the service responsive?	Good	
Is the service well-led?	Good	

Overall summary

This inspection took place on the 11 and 18 May 2015 and was unannounced.

The service is registered to provide nursing and personal care, treatment for disease, disorder or illness and diagnosis and screening for up to 64 older people. The service provides care to people living with dementia, mental Health conditions, old age, physical disability, sensory Impairment and younger adults. At the time of our inspection there were 51 people living there. The premises are purpose built and provide facilities for people with disability.

There was a registered manager in post 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 protected from the risks associated with the recruitment of new staff because the provider had robust recruitment systems in place; which included appropriate checks on the suitability of new staff to work in the home.

Summary of findings

Staff received a thorough induction training to ensure they had the skills to fulfil their roles and responsibilities. There were enough staff available to meet their needs and there was a stable staff team.

Systems were in place to ensure people were protected from abuse; staff had received training and were aware of their responsibilities in raising any concerns about people's welfare. People's care was planned to ensure they received the individual support that they required to maintain their health, safety, independence, mobility and nutrition. People received support that maintained their privacy and dignity. Systems for the management of medicines were in place were safe and effective on the Churchill and Althorpe Units. However medicines were not always effective and safely managed on the Blenheim Unit.

Staff were able to update and maintain their skills through a robust training programme. Consent was sought from people before any personal care or support was provided

and people were supported to have sufficient to eat and drink and maintain a balanced diet. People were supported to maintain good health and had access to health care services.

People were cared for with kindness and compassion and were supported to express their views about their care and support and their privacy and dignity was maintained. People had opportunities to participate in the organised activities that were taking place in the home and were able to be involved in the running of the home.

There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People had confidence in the management of the home and there were robust systems in place to assess the quality of service provided. The management took swift action to address concerns raised about the safety of the medication systems on the Blenheim Unit.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

The systems in place to manage people's medicines were not always safe.

Systems were in place to promote people's safety and they were protected from avoidable harm.

Risk was well managed and did not impact on people's rights or freedom.

There were sufficient staffing levels to ensure that people were safe and that their needs were met.

Requires improvement



Is the service effective?

The service was effective.

People received care from staff that had the knowledge and skills they needed to carry out their roles and responsibilities effectively. Staff sought consent from people before providing any care.

People were supported to eat and drink enough and to maintain a varied and balanced diet.

People were supported to maintain their health, received on-going healthcare support and had access to NHS health care services.

Good



Is the service caring?

The service was caring.

Staff demonstrated good interpersonal skills when interacting with people.

People were involved in decisions about their care and there were sufficient staff to accommodate their wishes.

People's privacy and dignity was maintained.

Good



Is the service responsive?

The service was responsive.

People were supported to maintain their links with family and friends and to follow their interests.

Staff were aware of their roles and responsibilities when responding to concerns and complaints.

Good



Is the service well-led?

The service was well-led.

The management promoted a positive culture that was open and inclusive.

Good



Summary of findings

There were established links with the local community.

There was good visible leadership in the home; the registered manager understood their responsibilities, and was well supported by the provider.

Robust quality assurance processes were in place.

Robust records and data management systems were in place.

Spencer House Care Home

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 11 and 18 May 2015 and was unannounced. The inspection team comprised two inspectors 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.

Before the inspection we looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted

the health and social care commissioners who help place and monitor the care of people living in the home and other authorities who may have information about the quality of the service. This included Northampton County Council Safeguarding Team and Healthwatch Northampton; who help local people get the best out of their local health and social care services.

During our inspection we spoke with 16 people who used the service, 12 staff, including registered nurses and care staff, three managers and five visiting health professionals. We also looked at records and charts relating to seven people and 17 medication records. We also looked at two staff files which included staff recruitment and staff training records.

Also during our inspection we used the 'Short Observational Framework Inspection (SOFI)'; SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

Medicine systems were not robust on all of the units; we reviewed the medicine systems on all three floors and found that systems on the Churchill and Althorpe Units were in good order. However the systems were not robust on the Blenheim Unit where nursing care was provided. For example one person told us they relied on staff to support them to take their medicines and about a recent occasion when staff had come into their room and left a pot of medicines on the table without advising or assisting them. This was seen by one of the care staff who was then able to assist them to take their medicines.

Medicine administration records (MAR) were not always accurate; for example one MAR chart specified that one of the prescribed medicines should only be given if the persons pulse was at a specified rate. Although the pulse rate was recorded as having been done there was no record that it was taken immediately prior to administration. Records showed the medicine was given at 7am and the pulse was recorded at times between 10am and 3 pm.

Staff had not always signed the MAR chart to confirm that people had received their medicines as prescribed and it was not always clear what dose had been given when a variable dose had been given. We also found examples where medicine administration had been recorded correctly but the remaining medicines did not correspond with the amount dispensed and the amount that had been taken. In addition one of the MAR charts had been signed to show that two medicines had been taken; however we found there were too many tablets remaining. This suggested that the staff had signed the MAR chart but failed to ensure the medication was taken. There was a lack of correlation between the amounts administered and the medicine records.

However we established that people were admitted to the Blenheim Unit from the local hospital with their medicines and the pre-existing medicine administration records; staff told us that medicines and the MAR charts were not always checked when they were received onto the unit meaning that any pre-existing omissions or errors were not identified at the time of their admission. We discussed our concerns with the manager who implemented a system to ensure that the medicines and records were checked on

admission to establish their accuracy and to ensure a sample of MAR charts in use were audited on a daily basis. The manager also arranged a meeting to discuss concerns with hospital managers to improve the transfer process.

This was a breach of regulation 12 (2) (f) (g) Safe care and treatment. Health and social care Act 2008 (regulated activities) regulations 2014 (Part 3).

All of the people we spoke with told us they felt safe living at the home. One person said “I feel safe and comfortable [here]” and another person said “It’s a superb place.”

Staff were aware of their roles and responsibilities in protecting people from harm and they had received training in safeguarding and were able to talk confidently about the various forms of abuse and tell us what action they would take if they had any concerns. One member of staff said, “I would not hesitate to raise any concerns, it is my job.” Staff were also aware of the provider’s ‘whistleblowing’ procedures and were able to raise any concerns directly through the provider’s dedicated telephone help line. A care worker said, “I would report any concerns to a senior or the manager and go higher up in the company if I needed to. The whistle blowing policy means I can do this without fear of losing my job.” Records showed that safeguarding allegations allocated to the provider for local investigation were fully investigated by senior staff and in consultation with the Northamptonshire County Council Safeguarding Team.

People’s human rights were protected and they were involved in making decisions about their care; for example people were consulted about the use of bedrails to reduce the risk of falls from the bed. People’s individual plans of care contained risk assessments to reduce and manage the risks to people’s safety; for example people had movement and handling risk assessments which provided staff with detailed instructions about how people were to be supported. People also had risk assessments in place to reduce and manage the risks of other complications such as falls and pressure damage to the skin.

People were provided with appropriate pressure relieving equipment and staff supported people with poor mobility to change their position regularly to reduce the risk of damage to the skin. Staff told us that they had sufficient and appropriate movement and handling equipment to safely assist people who were not able to mobilise independently; for example they used appropriate hoists

Is the service safe?

and slings in the correct sizes. Equipment was maintained in good working order and a sample of accident records showed that there were no accidents or injuries relating to the environment or equipment.

The provider had robust recruitment systems in place to protect people from the risks associated with the appointment of new staff. Staff files were in good order and demonstrated that the required checks and references had been obtained before they were allowed to start working in the home.

Staffing levels were maintained at an appropriate level. One person said “Oh yes they [the staff] are all very good,

they are very accommodating, they help with anything” and another person said “They do everything they can to help people, I can’t find fault at all”. People who were in their bedrooms had their call bells close by; and they told us they did not have had to wait very long before the staff answered them; nor did we hear call bells ringing for long periods before they were answered. The care staff were supported by additional staff including activity co-ordinators, catering and domestic staff. Staff told us they felt there were enough staff; one member of staff said, “We have busy times of course, but we also have time to spend with the residents.” Another said, “If someone phones in sick the shift is always covered.”

Is the service effective?

Our findings

People were provided with effective care and support from staff that had the required knowledge and skills. New staff received formal induction training that provided them with the skills and knowledge required to meet people's needs. Staff induction was followed by a period of supervision where new staff worked alongside more experienced staff. One member of staff said, "I could ask any of my colleagues if I did not know what to do." We also spoke to a senior member of staff who was also a staff trainer, they said, "I can provide practical training as part of routine care and I can work with any of the staff and support them at any time."

Existing staff had the opportunity to update their knowledge and skills; they told us the provider had a training programme in place that they could access. The staff training programme enabled staff to maintain their skills and receive timely updates relating to current best practice in a range of care related subjects; including the care of people living with dementia, movement and handling, infection control and fire safety. Training records showed a high level of compliance with staff with training.

Staff received regular staff supervision from their line managers to ensure they were supported in their roles and in their development; either in one to one sessions or as a group, every eight weeks. A senior member of staff who was responsible for supervising staff said, "I prioritise supervision, it is important time."

Everyone we spoke with was very positive about the care they received from the staff. One person said "The attitude of the staff is lovely, they are ever so good" and another person said "The carers are very good" and went on to explain that they were very sensitive when providing support with their personal care.

People's views were sought and their consent was obtained before any interventions were made; for example people at risk of falls from their bed had provided consent for the use of bedrails. Consent for the use of photographs and the sharing of information with health professionals was well documented within the individual plans of care. Records showed that when required Mental Capacity Assessments (MCA) had been completed. The registered manager and

staff were knowledgeable about the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS); training records showed that 96% of staff had received this training.

The manager told us that all of the people who lived at the home had capacity to make decisions about their lives and therefore no applications had been made to the local authority for an authorised deprivation of liberty (DoLS). However during our inspection one person became unsettled and distressed and expressed a wish to leave the home. The staff told us they could not safely leave the home without staff support. During the inspection the manager took appropriate action and submitted an application to the local authority for an authorised deprivation of liberty.

Staff showed a good level of understanding of the needs of people living with dementia and exhibited effective communication skills to enable people to make choices in their daily lives; for example where and how to spend their time. People told us they could choose where to eat their meals. One person told us they had their breakfast in their room but joined other people in the dining room for their other meals.

People were complimentary about the food provided. One person said "The food has been really nice" and another person said "The food is very good, the service is excellent." Another person said "They [staff] come round the day before with the menu to ask what we'd like." People living with dementia were supported by staff to exercise their choice of meals because staff showed people the plated alternatives to assist their selection.

We reviewed a sample of the menus; these offered people a varied seasonal selection of food with a variety of options at each service, including a three course meal at lunch time including vegetarian food and special diets. We observed the lunch time service and saw that the food served was of an adequate portion size and that it looked and smelt appetising; the atmosphere in the dining rooms was calm and relaxed; this provided people with a pleasant social experience.

Staff were aware of people's individual needs and preferences; for example people who required support from the staff were assisted with patience and sensitivity. Records showed that when people were identified as being a nutritional risk their food and fluid intake was monitored

Is the service effective?

to ensure adequate intake to reduce the risks of complications such as infection. People were weighed regularly according to their individual needs and their nutritional risk was regularly reviewed. People who had been identified as being at risk had access to additional snacks and food supplements and when required were referred to the dietician.

People had access to NHS services; people told us they trusted the care staff to make decisions on their behalf. One person said, "The staff are on the ball they, know if I need to see a doctor and call one." One person told us that the GP comes in on Mondays, Wednesdays and Fridays to see people on his lists.

Visiting clinical staff told us that they had no concerns about the care provided; they said that the staff contacted them appropriately and knew the needs of people who used the service. Other visiting health professionals also told us that people were well looked after and they had no concerns about the care provided. Records showed that people also had access to the health professionals they needed such as dietitians, physiotherapists, podiatrists, speech and language therapists and general practitioners. A visiting optician had also been booked to provide eye tests to people living at the home.

Is the service caring?

Our findings

People were cared for by staffs that were kind and compassionate towards them. All of the people we spoke with praised the staff for their kind and caring ways. We saw staff were proactive in checking on people's welfare as they knocked on people's doors to check if the person was happy or if they needed anything.

Some of the people who were living with dementia were limited in their ability to recall and express their views about the service. We spent time observing the interactions between them and the staff to gain an insight into the care that people received. All of the staff working on the dementia unit were skilled in communicating with people for whom they cared. For example staff approached people from an angle they could be seen; they also approached people with smiling faces, provided good eye to eye contact and open body language. They also addressed people by their preferred name and used touch to engage and reassure people. This provided people with reassurance and a calm and contented atmosphere; people were stimulated and had confidence to initiate contact with staff and other people who used the service.

Staff also had a good understanding of the needs of the people they cared for and we witnessed several acts of kindness towards the people who lived at the home. For example when people became unsettled or distressed staff comforted them and took time to understand the cause of their distress. We also saw staff take swift action to address the cause of their distress whenever possible. One member of staff said, "We don't have to prepare for an inspection; what you see is what you get."

On the Blenheim Unit individual choices about people's care and personal routines were necessarily less flexible because of their scheduled medical and therapeutic interventions. Whenever possible staff supported people to be involved in planning their care and to make their own decisions. People told us how they were able to manage

their own care but could request assistance if they needed it. For example people were able to choose what time to get up, when to have their breakfast and how to spend their day. One person told us, "I love the idea that I can decide for myself when to get up." Another person said "I can get up what time I like" and another explained "We are free to do what we want, our time is our own."

People looked well cared for and were also supported to make decisions about their personal appearance, such as their choice of clothing. One person told us the hairdresser comes every week and that they had booked to have their hair done the next day. A member of staff said, "I take pride in providing personal care and I know the families appreciate seeing their relatives washed and dressed nicely".

People were supported to maintain links with family and friends. Staff told us that there were no restrictions on relatives and friends visiting the service. We saw that visiting times were flexible and visitors were made to feel welcome; visitors were offered a cup of tea and the opportunity to eat with their relative or friend. People were able to receive their visitors in their own rooms or in any of the communal areas. The activity co-ordinators told us they helped people keep in contact with relatives through email, social media and Skype.

There were several quiet areas where people could be alone or receive their visitors in private if they wished. Privacy signs were used on doors when personal care was being provided and a member of staff told us that some people chose to use these when friends and relatives visited. Staff had a clear understanding of the role they played in making sure people's privacy and dignity was respected. Staff told us they would ensure doors were closed when personal care was provided and would take care not to talk about other people or their own interests when providing care. We observed that staff knocked on people's bedroom doors and bathrooms and waited to be invited in before entering.

Is the service responsive?

Our findings

People were well looked after and were empowered to make decisions about their care and individual lifestyle.

All of the people living at Spencer House had an assessment of their needs completed before being admitted to the home. These formed the basis of the individual plans of care which provided instruction to staff about how their care needs were to be met. Individual plans of care included information about people's preferences, including their preferred name and the gender of the staff they wished to support them with their personal care. Individual plans of care were regularly reviewed and updated as people's needs changed.

People told us that the carers responded quickly when they used their call bells; one person said "I've had to use my alarm twice at night and the staff came within a couple of minutes". A visiting relative told us the carers always responded very quickly whenever their relative used their call bell.

People had access to aids and adaptations to support their mobility and independence, including walking frames and wheelchairs. People living with dementia had access to a range of memorabilia, music and other artefacts relevant to life in the 1940's and 1950's. People told us they were supported to follow their interests and engage in activities. One person said "The girls that organise the trips are very caring". There was an activities programme in place which was circulated to people so that they could choose to participate if they wished. Activities ranged from craft sessions including a knitting circle to internet access and

social media sessions; outings and 'memory boxes'. There was a small cinema on the ground floor where people could watch a range of films and television programmes on a large screen including sporting programmes and several people had a daily newspaper. Several people commented on the well-tended gardens outside. One person said "The gardens are very nice" and went on to say that people often walk round them on warm sunny days. During our inspection some people chose to go on a trip in the home's mini bus to the local garden centre and cake and coffee.

Everyone we spoke with said that they had had no cause to make a complaint about any aspect of the service but felt confident that they could raise any issues with the manager if they needed to. One person said "I could talk to anyone here and they would listen", another said "I have no issues to raise". Another person told us they had no complaints and said "If something was wrong I would soon deal with it if something was wrong." Staff were aware of their roles and responsibilities in listening to people's views and reporting any concerns to the management. The complaint policy was displayed in the main entrance and was also included in the service user's guide that was provided to people on admission to the home. The complaints policy contained appropriate contact details and information about response times. The complaints file showed that there had been only one complaint since the home opened and this had been responded to appropriately. Comment cards were also available for completion at reception and those that had been completed contained positive feedback about the service and there were many thank you cards that praised the care that people had received.

Is the service well-led?

Our findings

The service was open, fair and transparent. The provider had a dedicated telephone number so that people and staff could raise any concerns directly. The service has a registered manager who had been in post since the home first opened in 2014, this provided people who used the service and the staff with stable management. People told us they thought the service was well run and that they had regular contact with the manager. The manager has an open door policy so that anyone could share their views or raise any concerns with senior staff directly. All of the people we spoke with knew the manager and felt they could talk to him if they had a problem. Staff comments included “The manager is very approachable, you can speak to him about anything.”

The manager holds regular meetings with people who use the service, their relatives and the staff to involve them in the running of the home. An annual satisfaction survey is due to be completed later this year. The provider also seeks feedback about the service through social media and other care related websites. One person said “The home is well organised and everyone has their own roles.”

The manager had established links with the local community; for example the local school for performing arts visited the service to present their performances to the people who lived at the home. Children from the local

primary schools visited the service to participate in festive celebrations such as Easter and Christmas. Links had also been established volunteers from Age UK and clergy from Northampton Cathedral and St Giles Church to enable people to maintain their faith.

The manager notified about events that happened in the service; such as accidents and incidents and any other events that affected the running of the service.

There were robust quality assurance systems in place. The management conducted an extensive range of internal audits designed to cover all aspects of the service and which demonstrated a high level of compliance with the criteria set by the provider; and there were regular safety checks on fire safety systems. Other regular internal audits were conducted such as the analysis of accidents records to identify risk factors and trends; infection control and health and safety systems. The manager responded swiftly to improve medication systems relating to the findings of this inspection.

The provider conducts a minimum of monthly visits to the home to support the manager and standards within the home. During their visits they reviewed the results of monthly audits specific to a range of service related aspects; including any complaints received and their progress towards resolution and changes to care practice as a result.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulation 12 Safe care and treatment. Health and social care Act 2008 (regulated activities) regulations 2014 (Part 3).

The management of medicines was not robust for people cared for on the Blenheim Unit.

Regulation 12 (2) (f) (g)