Crown Care VI Limited

Sandringham Care Home

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 3 July 2017. The inspection was unannounced and was carried out by two adult social care inspectors and two experts by experience.

We last inspected the service on 8 November 2016 and rated the service as good for the Safe and Well-led domains. This was a focussed inspection in response to information received by CQC. We also carried out a comprehensive inspection in February 2015 and rated the service as good overall. At this inspection we found the service remained good and met all the fundamental standards we inspected against.

Sandringham Care Home is registered to accommodate up to 92 people. It offers personal care and support to people who have dementia, people who have general nursing care needs and older people who require residential care. The home is located in the town centre of Bishop Auckland.

There was a registered manager in post. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run. The registered manager was on leave at the time of our inspection and we met with an acting manager who had been overseeing the service since April 2017.

There were safeguarding procedures in place. Staff were knowledgeable about what action they should take if abuse was suspected. The local authority safeguarding team informed us that were no current safeguarding concerns regarding the service.

The premises were clean. Checks and tests had been carried out to ensure that the premises were safe.

There were safe systems in place to receive, administer and dispose of medicines.

We found that recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people.

Staffing levels were provided to meet the needs of people using the service. Some staff we spoke with stated they felt there could be more staff on duty and people generally told us they were attended to reasonably quickly. Records confirmed that training was available to ensure staff were suitably skilled. Staff were supported through an appraisal and supervision system.

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 saw the service identified where an authorisation may be required and followed the correct procedures to apply and maintain a DoLS.

People's nutritional needs were met and they were supported to access healthcare services when required.

We observed positive interactions between staff and people who lived at the service. Staff promoted people's privacy and dignity. There were systems in place to ensure people were involved in their care and support and treatment.

Care plans were in place which detailed the care and support to be provided for people. These were reviewed regularly or when needed and were held electronically.

There was an activities coordinator employed to help meet the social needs of people. Some people told us that more activities would be appreciated; others said there were sufficient activities at the home. People were supported to access the local community.

There was a complaints procedure in place. Feedback systems were in place to obtain people's views.

The provider was meeting the conditions of their registration. They were submitting notifications in line with legal requirements. They were displaying their previous CQC performance ratings at the service and on their website.

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 remains good.

Is the service effective?

Good

The service remains good.

Is the service caring?

Good

The service was caring.

People told us their privacy and dignity was upheld.

We saw people were treated with respect and benefitted from positive relationships with the staff team.

People were supported to maintain their current relationships and relatives told us they felt supported by the service.

Is the service responsive?

Good

The service remains good.

Is the service well-led?

Good

The service remains good.

Sandringham 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 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 took place on the 3 July 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and two experts by experience. The experts by experience had experience of supporting older people living with dementia.

Prior to our inspection, we checked all the information which we had received about the service including any notifications which the provider had sent us. Statutory notifications are notifications of deaths and other incidents that occur within the service, which when submitted enable the Commission to monitor any issues or areas of concern.

We contacted Durham local authority safeguarding and contracts and commissioning teams prior to our inspection. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. We used their feedback to inform the planning of this inspection.

The registered manager had completed a Provider Information Return (PIR) prior to the inspection. 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

On the day of our inspection, we spoke with 12 people currently using the service and six visitors. We also talked with the acting manager, the deputy manager, two nurses, five care staff, one activity co-ordinator and the chef. We examined seven people's care plans. We also checked records relating to staff and the management of the service.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Sandringham Care Home. People told us, "They wouldn't dare do anything but offer good safe care because I would let them know if it was falling short," and "I feel surprisingly safe."

We discussed staffing levels with the acting manager and looked at staff rotas. Staff members' feedback about staffing was mixed. They told us, "We work hard to keep residents safe but the lack of staff now is a concern," and another said, "We are ok, I think the levels are fine, we can still chat with people." Staffing levels varied across the three floors of the home and depending on the needs of the people who used the service. The acting manager told us agency nurses were used at the home, however, any care staff absences were covered by their existing permanent staff. People told us, "The lack of staff at night may be an issue if two residents need help at the same time - it's a maybe," and "No worries about abuse or poor care here." We observed there were sufficient staff on duty and deployed to keep people safe and meet their needs.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed staff to ensure staff were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

Accidents and incidents were appropriately recorded and analysed on a monthly basis to identify any trends. Risk assessments were in place for people who used the service. These described potential risks and the safeguards in place to reduce the risk. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

Hot water temperature checks had been carried out for all rooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014). Equipment was in place to meet people's needs including hoists, shower chairs and wheelchairs. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER).

Electrical testing, gas servicing and portable appliance testing (PAT) records were all up to date. Risks to people's safety in the event of a fire had been identified and managed. For example, fire alarm and fire equipment service checks were up to date, fire drills took place regularly and people who used the service had Personal Emergency Evacuation Plans (PEEPs) in place. This meant that checks were carried out to ensure that people who used the service were in a safe environment.

The provider's safeguarding vulnerable adults policy described what abuse is, definitions of adults at risk, the responsibilities of staff and action to take. Analysis of safeguarding concerns was carried out on a monthly basis to ensure correct procedures had been followed and to identify any issues. Statutory

notifications had been submitted to CQC when required and staff had been trained in how to protect vulnerable people. One staff member told us, "I just want to care and protect people."

We found appropriate arrangements were in place for the safe administration and storage of medicines. The provider had a detailed medication policy in place and medicines audits were carried out by the deputy manager, which were then reviewed by the regional manager. An action plan was put in place for any identified issues.

Medicines were stored in a treatment room. Room and refrigerator temperatures were recorded to ensure medicines were stored within safe limits and therefore remained safe for use. Each person had an individual medication administration record [MAR] that included a photograph of the person, GP contact details, details of any allergies, and information on how the person preferred to take their medicines.

We observed a medicines round and saw medicines were provided to people in individual cups. People were given time to take their medicines and the member of staff stayed with the person until the medicine was taken.

Good

Is the service effective?

Our findings

People told us that staff effectively met people's needs. They said staff were knowledgeable and knew what they were doing. People and relatives we spoke with told us, "I know that [name] is being well cared for all the time and to me that means the world," and, "The good quality of my care means everything to my family and me."

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 saw that appropriate assessments were undertaken to assess people's capacity and saw records of best interests' decisions which involved people's family and staff at the home when the person lacked capacity to make certain decisions. The acting manager and staff we spoke with had all been trained in the Mental Capacity Act and appropriate DoLS authorisations and requests for authorisations had been undertaken.

Staff mandatory training was up to date. Mandatory training is training that the provider deems necessary to support people safely and included moving and handling, health and safety, food hygiene, first aid, safeguarding, mental capacity, dementia, medication, fire safety, infection control, and end of life care. New staff completed a comprehensive induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Staff informed us that they felt supported by the acting manager and nursing team. One staff member said, "I feel supported by the current manager and she is open and honest." Some other staff we spoke with felt the manager was not always accessible and that some staff and people on the top floor felt "Left out and not important." We discussed this with the acting manager and regional director. They told us they would assure themselves that everyone at the home felt supported by the manager's presence. Regular supervision sessions were carried out and staff had an annual appraisal. Supervision and appraisals are used to review staff performance and identify any training or support requirements.

People were supported to receive a healthy and nutritious diet. Information relating to any specific dietary needs was included in people's care plans and we spoke with the chef who was knowledgeable about people's nutritional support and likes and dislikes, and had been trained in providing good nutrition for older people. People told us, "We get choices so that's good but I would like some different food sometimes, so I ask and I usually get what I have requested." Other comments included, "Food is very good," "Food is nice and we are given a choice of what we want to eat," and "We get snacks and drinks between meals which can be teacakes, biscuits and homemade cakes."

People were positive about the food and we observed the lunchtime meal in two areas where people were well supported and offered choices in a calm and sociable atmosphere. We observed the lunchtime on the floor for people living with dementia and observed that people had to wait for their meal and became agitated and disinterested and also that there were no menus in an accessible format. One person told us, "Sometimes I am not sure what we are getting I know I might forget but would be good to see." We discussed this with the acting manager who told us that on that day there was some confusion between care staff and kitchen staff about the arrival of the lunchtime trolley [which was discussed in a meeting we attended]. They also told us the service was working on a photographic menu which was to be implemented. We asked the manager to carry out some observations of mealtimes on this unit to ensure themselves it would run more smoothly in future and they agreed with this.

People told us and records confirmed that staff supported them to access healthcare services. We read that people saw their GP, consultants, dentists, dietitian, opticians, podiatrists and speech and language therapist when needed. This demonstrated that the expertise of appropriate professional colleagues was available to ensure that the individual needs of people were being met to maintain their health.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us that staff were caring. Comments included, "The care here is really excellent I enjoy every day," "I am very happy and could not fault staff", and "It is like a second home."

We saw positive interactions between staff and people throughout our inspection. We witnessed staff supporting people in a positive, gentle and caring manner. One person told us, Staff know me well and when my family and friends pop in they always have a chat."

People's independence was promoted. People were encouraged to carry out housekeeping skills and to make choices in relation to activities. One person told us, "I am encouraged to remain mobile and I like the fact that I can have a wander and there are some quiet corners where I can do the crossword." People told us they decided on menus and activities.

Staff were respectful in their approach. They treated people with dignity and courtesy. Staff spoke with people in a professional and friendly manner, calling people by their preferred names. We observed staff supported people when required and asked permission to sit and talk with people as well as knocking on people's doors and waiting for permission before entering. One person said, "Staff always get consent before doing anything." People told us that staff promoted their privacy and dignity. One person told us, "I was not sure how I would feel about help with personal care - I am a little old fashioned that way but the staff, both male and female have been amazing."

We found the care planning process centred on individuals and their views and preferences. One person told us, "I am always being asked what I would choose about everything which is lovely." Care plans contained information about people's life histories which had been developed with people and their relatives. This meant that information was available to give staff an insight into people's needs, preferences, likes, dislikes and interests, to enable them to better respond to the person's needs and enhance their enjoyment of life. Information about choice was written in an easy read way using pictures. For example under interests, one person said they liked folding napkins and fiddling with a crochet blanket and these were shown as images with simple language.

People and relatives were involved in the care planning process which helped maintain the quality and continuity of care. Meetings and reviews were carried out to involve people and their relatives in all aspects of people's care. Relatives we spoke with told us they were given regular updates about their relative and said they could visit and ring at any time and that visiting times were clearly explained to them. This showed the service supported people to maintain key relationships.

At the time of our inspection no one accessed the services of an advocate, but we saw more informal means of advocacy through regular contact with families. Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. The management team were aware of how to contact advocates if they were required to support people.

We saw care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' decisions and we saw that the correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form. End of life care plans were in place for people. We saw where a person had clearly detailed their wishes and requests. This meant that information was available to inform staff of the person's wishes at this important time, to ensure that their final wishes could be met and staff were supported with the process.

Good

Is the service responsive?

Our findings

There were robust systems to ensure the staff team shared information about people's welfare. A staff handover procedure was in place as well as a daily heads of department meeting so that issues and appointments were carried forward between shifts. Information about people's health, moods, behaviour, appetite and the activities they had been engaged in were shared. This procedure meant that staff were kept up-to-date with people's changing needs.

We saw care plans were held electronically and staff recorded any changes in people's condition, professional visits and social activities on a twice daily basis. Staff members also told us that healthcare professionals could input directly onto the system so their guidelines could be exactly followed.

We looked at eight care plans belonging to people who used the service. We found care planning and provision to be person-centred. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. People had contributed to 'life history' documents in care files, which gave staff a good level of information regarding what and who was important to them. People's individual interests, preferences, as well as their anxieties were taken account of. We saw each care plan contained a detailed pre-assessment of people's needs and care plans that were linked to the relevant potential risks.

Risk assessments were in place, as identified through the assessment and care planning process, which meant that risks had been identified and minimised to keep people safe. These included measures to be taken to reduce the risk of falls whilst encouraging people to walk independently, measures to reduce the risk of pressure ulcers developing, or to ensure people were eating and drinking. Standard supporting tools such as the Waterlow Pressure UIcer Risk Assessment and Malnutrition Universal Screening Tool (MUST) were routinely used in the completion of individual risk assessments.

Care plans were comprehensive and contained up to date, accurate information. Plans contained a recent photograph of people and stated who their keyworker or named nurse was. We found this system to be working well, with the relevant staff showing a good knowledge of people's needs. We saw care plans were reviewed regularly. Relatives we spoke with confirmed they were regularly involved in people's care planning and were updated if there were changes in people's condition.

We found the provider protected people from social isolation. There were two activity co-ordinators employed by the service who provided support. People told us they enjoyed the sessions and some people said they would like more activities, although other people told us they preferred to stay in their own rooms. There was a variety of well supported activities that took place and the service also supported people to access the local community such as facilitating a weekly walk to a local church service. One person said, "I like to sit and chat to other residents and sit in the garden." Another relative mentioned that "We like to play dominoes, we go down together to play dominoes." We observed activities taking place and we saw people attend a purpose built bar, as well as care staff painting people's nails for them.

There was a complaints procedure in place. None of the people or relatives with whom we spoke said they

had any current complaints or concerns. One person told us, "If I needed to complain I would go straight to the top and ring CQC that is why you are there! Not for a paltry issue but if it was for me or someone else in trouble I would not hesitate." We saw there were two complaints on-going and the service had responded to them according to its own complaint policy. There were opportunities for people and staff to raise any concerns through meetings and a suggestion box. Two relatives we spoke with told us there was a period when clothes were not coming back from the laundry or someone else's clothes were put away in their family member's room. The relatives complained about this to the acting manager and they told us this had been resolved quickly.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The registered manager had been on extended leave and the provider had put in an acting manager who had been at the service since April 2017.

We saw that records were kept securely and could be located when needed. This meant only staff from the service had access to them; ensuring people's personal information could only be viewed by those who were authorised to look at records. Care plans which were held electronically were also subject to password protection and data protection measures.

Staff members we spoke with told us they were happy in their role and felt supported by the management team. One staff member said that the management structure was "much improved". People knew who the acting manager was and told us they felt they were honest and open with them. One relative mentioned, "I spoke to the manager because I was concerned about my relative's behaviour and was worried in case they got moved. They were open and honest with me and I was reassured."

Staff were regularly consulted and kept up to date with information about the service and the registered provider. Staff meetings took place regularly and we joined a 'flash meeting' held daily with all heads of department where issues in relation to the running of the home and updates on people were shared and any issues actioned. We saw compromises being reached with kitchen and care staff relating to the timings of meals that meant everyone was involved and had their views heard.

We looked at what the provider did to check the quality of the service, and to seek people's views about it. The provider carried out twice yearly questionnaire surveys and we saw the results were analysed and actioned. We saw in the minutes of a recent residents' meeting held in June 2017 that people were given updates about the service and also that the service would be doing more baking activities and people had said they enjoyed this. This showed the service listened and acted on feedback.

The provider carried out a range of audits within the service to check the quality and safety of the environment. This included health and safety, the kitchen and records relating to people and staff members. We saw that checks implemented by the acting manager such as the daily checking of vital charts relating to food, fluid and positional turns for people meant these were now completed more fully. Other audits had shown actions such as the purchase of new bins for improved infection control measures had been completed.

The service had good links with the local community. People who used the service accessed local shops and leisure facilities. We saw that there were many visitors to the home during the day who told us they felt welcomed by the service.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to

the Commission by law. The provider also displayed its CQC rating at the service and on its website as required.