Care Quality Commission

Squeaks House Residential Care Home

Squeaks House Residential Care Home

Inspection report

Steeple Road
Southminster
Essex
CM0 7BD
Tel: 01621 772 385

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Ratings

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

Overall summary

The inspection took place on 12 January 2016 and was unannounced.

Squeaks House provides personal care and accommodation for up to 29 older people, primarily those living with dementia. The service does not provide nursing care. At the time of our inspection there were twenty people using the service.

A registered manager was in post at the service. 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.

Staff were not supported to have the competence, skills and experience to provide safe care and support when assisting people to move and transfer safely.

Summary of findings

The manager had carried out detailed audits and developed detailed improvement plans highlighting risks within the service; however these had not been implemented effectively by the provider. There was a visible and committed manager who listened to people and staff and involved them in the service.

The service had appropriate systems in place to keep people safe. Staff knew how to recognise when people might be at risk of harm and what actions to take. There were sufficient numbers of staff available to meet people's care needs. There were systems in place to manage medicines and people were supported to take their prescribed medicines safely. The provider had a robust recruitment process in place to protect people from the risk of avoidable harm.

Staff supported people to have sufficient food and drink and staff spent time finding out what people's preferences were. People were supported to maintain good physical health and access health services.

Deprivation of Liberty safeguards (DoLS) had been appropriately applied for. These safeguards protected the rights of adults who used the services and who do not have capacity to make their own decisions. Applications had been made appropriately for people who may require them. Appropriate assessment and authorisation by professionals had been completed, for any best interest decision taken regarding any restriction on their freedom and liberty. This ensured that the decision was taken in accordance with the Mental Capacity Act (MCA) 2005, DoLS and associated Codes of Practice.

Staff listened to people and treated them with compassion. Communication between staff and people using the service was respectful. Staff knew people well and could describe their personal preferences and preferred routines. People's needs had been assessed and personalised care plans were in place to inform staff how to support people in the way they preferred. People were supported to pursue individual interests and hobbies and had access to a range of activities.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

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 safe

The service had appropriate systems in place to keep people safe.

There were enough staff to keep people safe and meet their needs.

People received their medicines safely and as prescribed.

Good

Is the service effective?
The service was not consistently effective.

Staff were not supported to have the necessary skills to support people to move and transfer safely.

People were supported to eat and drink in line with their preferences however staff were not effectively deployed during meal times.

People were supported to maintain good physical health and have access to health professionals.

Where a person lacked capacity there were correct processes in place so decisions could be made in the person's best interests.

Requires improvement

Is the service caring?
The service was caring.

People felt staff knew them well and treated them with kindness.

Staff listened to people's views and communicated with them with respect.

Good

Is the service responsive?
The service was responsive.

Staff knew people's needs and preferences and provided personalised care.

People were supported to maintain social relationships with people who were important to them.

There were processes in place to deal with people's concerns or complaints and to use the information to improve the service.

Good

Is the service well-led?
The service was not consistently well led.

The provider had not effectively addressed the risks to people's health, safety and welfare.

There was a visible and committed manager who listened to people and staff and involved them in the service.

Requires improvement

Squeaks House Residential 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.

The inspection took place on 12 January 2016 and was unannounced. The inspection team consisted of three inspectors.

We reviewed all the information we had available about the service including notifications sent to us by the provider. This is information about important events which the provider is required to send us by law. We also looked at concerns we had received. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. All of this information helped us to plan what areas to focus our attention on for the inspection.

During the inspection we spoke with 15 people who lived at the service and five people's relatives and friends. People who used the service had a range of different needs and ways of communicating their needs. We therefore used informal observations to evaluate people's experiences and help us assess how their needs were being met. We observed how staff interacted with people and with each other. We spoke with the provider, the registered manager and the deputy manager. We also met with six care staff and one kitchen staff. We also spoke with two health and social care professional to find out their views on the service.

We looked at seven people's care records and examined information relating to the management of the service such as recruitment, staff support and training records and quality monitoring audits.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I couldn't walk when I came here but now I can with a frame. I've lost confidence in going home but I feel safe here." Another person told us that they required two members of staff to support them with their mobility and that they felt safe with the level of support provided.

The staff we spoke to were able to demonstrate awareness of the importance of safeguarding vulnerable adults from abuse. They were able recognise the potential signs of abuse and knew who to report concerns to in order to keep people safe. The provider had a whistleblowing policy and staff could explain how this worked. Staff told inspectors the registered manager had an open door policy and they felt supported to report issues of concern without fear of bullying and harassment.

We saw that the manager and staff had completed assessments to measure risk for each person and plans were put in place for them to be managed safely. For example, aprons and gloves were available for staff to use when providing personal care and staff used these appropriately to minimise the risk of infection. The manager was committed to minimising risk and reviewed people's support plans and records regularly to capture levels of risk across the service. As a result, there was an awareness of people who were particularly at risk, for example from urinary tract infections, pressure sores and chest infections. Each member of staff was required to review named people at least once a month and escalate any risks to the manager. For instance, when a person had been assessed as not safe to use their call bell, significant changes had been made so the person was more visible to staff who were supervising them.

People told us they thought there were enough staff at the service to meet peoples' needs and our observations confirmed this. We saw that call bells were answered promptly. One person told us, "Even if they can't help straight away, they have the decency to come and tell you they will get to you as soon as possible – you are not ignored". The registered manager worked out required staffing levels based on a detailed and personalised analysis of people's needs. Staff said there were enough staff on duty which meant they did not feel rushed. Agency staff were supported to keep people safe by being paired with regular staff and provided with a good hand-over from senior members of staff.

The provider had a safe system in place for the recruitment and selection of staff. The recruitment records included a completed application form which detailed past employment history and qualifications, previous employer references, proof of identity and criminal records checks. Staff told us that they had only started working at the service once all the relevant checks had been completed.

Medicines were given to people in a safe and appropriate way. Senior staff received face-to-face medication administration training and initial competency observations were carried out by a pharmacist plus subsequent observational checks by the registered manager. We observed a senior member of care staff carrying out the medicine round and they were competent at administering people's medicine. They followed the medication procedure which was in place and took care to record each medication as it was administered. The member of staff wore a bib which highlighted that they were not to be disturbed whilst they were supporting people with medication, which helped minimise the risk of medication errors. They spoke to and treated people in a dignified manner, explaining what medicine they were having. They asked people if they were happy to be observed having their medication taken, which we felt demonstrated a sensitive and respectful approach. There were appropriate facilities to store medicines which administered from a lockable trolley. The home had an effective system for receiving and disposing medications safely.

Records relating to medicines were completed accurately and stored securely. For residents receiving pain relief patches, care plans included charts to show staff where the patches had been placed in line with good practice. Residents requiring creams had their own creams locked in individual cupboards in their bedrooms. However, we noted that staff did not record when creams had been opened so staff were not aware when these needed to be disposed of. Where people were administered medicines covertly, for example when a medication was disguised in food due to the person's reluctance to take it, the manager had processes in place to ensure this done in the person's best interests.

Requires improvement

Is the service effective?

Our findings

During our inspection we observed that staff struggled to move a person when using a hoist sling. Whilst we observed staff speaking to the person in a kind and reassuring manner, we did not feel that they had the necessary skills to assist people to move safely and with confidence. On two occasions, staff used an old style hydraulic pump hoist with a person who did not appear comfortably placed in the lifting sling. This meant they were lifted for a longer period than necessary and the lifting motion is less smooth, increasing the potential for discomfort and anxiety. We were told that an electronic hoist was available on the first floor but the staff had not brought it down.

We also observed a person who was at risk from sliding out of their chair. We did not feel staff had the skills and knowledge of the options available to support the person to remain comfortable and safe in their chair. After we had raised this as a concern, the manager made a referral to a health professional for assessment to ensure that risks to this person were minimised and for further guidance to be given to staff to enable them to support them safely.

We discussed our concerns with the manager and provider regarding staff skills in the area of moving and handling. We were shown comprehensive risk management plans and care plan interventions for those people at risk of falls. This included photos of manual handling equipment to be used by staff as a point of reference. All staff were trained in manual handling techniques and equipment. In addition, we were shown detailed observations carried out to check staff had the skills to move people safely.

We spoke further with the provider after our visit, to establish the nature and quality of the manual handling training being provided to staff. The provider advised us that they were personally responsible for providing manual handling training to staff and they also provided on-going guidance in the use of hoists within the service. The provider could evidence they had attended a manual handling course, however we were not assured that staff had been supported to develop consistently effective skills to assist people with moving safely.

Despite our observations, people said they felt staff had the skills and experience to care for them. One person said “The staff here are very proficient”. Staff told us they had received an induction and felt they had the skills and experience to support people effectively. There was a training timetable in place, outlining the training planned for staff. The manager told us that staff were required to do mandatory training such as safeguarding, fire safety, infection control and dementia. In addition, other training, appropriate to the staff members role such as food hygiene, diabetes and medication was also provided. One member of staff told us they had received specialist training to support people with stoma care and incontinence and that they were being supported to take NVQ level 3 to support their learning and development. Staff said they felt supported by the registered manager and had regular supervision. Whilst we had concerns about the quality and adequacy of the manual handling training, staff were positive about other training received and demonstrated they had developed effective skills in other areas of their practice. For example, when we discussed with staff and family members the end of life care and support given to people it was evident that staff had sensitive and effective skills in this area.

We observed mealtimes and saw that the atmosphere in the dining room was calm and unhurried with the TV turned down. People were given a choice of where they would like to sit. There was a good use of space, with two separate lounge areas with dining tables and chairs. Residents were also able to eat in their bedrooms if they did not want to, or were unable to join others. Some people chose to sit at small individual tables. Although there was sufficient staff on duty, we felt staff could have been more efficiently deployed at meal times. We saw that there was only one member of staff in each dining room, with seven people in one room and five in another. Each dining room had one person who required full assistance. As a result, the single member of staff could only provide intermittent support to the other people in the dining room and we observed that one person became frustrated and gave up eating their meal. We discussed this with the manager who agreed staff had not been effectively deployed and assured us this was not a usual occurrence and that it would be addressed in the future.

People told us they liked the food on offer. There was always a choice and if a person didn’t like something staff would make them an alternative. We observed that one person requested to have a sandwich as an alternative to the hot meal and this was provided. Staff ensured at the

Requires improvement

Is the service effective?

beginning of each shift that a choice of freshly prepared cold drinks were available in each lounge area. We observed staff offering these to people throughout the day to support them to remain well hydrated.

The approach to meal provision was very personalised. The registered manager had introduced the "Food First" initiative. This involved the cook receiving a monthly report on residents at risk of malnutrition, with guidance on how to improve their nutritional intake. Kitchen staff had embraced the initiative and we saw collaborative working between them and care staff. For example, the cook told us, "If [person] doesn't want to eat we offer them Weetabix at lunch as we know they have to keep eating." We met with the cook and they showed us detailed forms outlining each person's like and dislikes. A person told us, "I like to eat my main meal in the evening so they switch things around for me." A member of staff visited all the people in the morning to inform them of the different meal options on offer and support people to make an informed choice. Where people struggled to verbally communicate staff used picture cards to help them to choose. People were actively involved in choosing the menu at the monthly residents meeting. We observed the cook engaging with people and seeking feedback. Every time a person made a comment about the food, staff completed a meal comments sheet and the cook made changes where possible.

We reviewed nutritional and MUST assessments (Malnutrition Universal Screening Tool), which identify when individuals are at risk of malnutrition. Weight was recorded each month in line with the provider's policy and staff monitored diet and fluid intake. Where people were at risk of malnutrition staff worker with specialist such as Speech and Language to meet their needs.

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. The staff we spoke to informed us they had not received training in the Mental Capacity Act (MCA) 2005 and DoLS legislation and guidance. We saw that this training had been booked to take place in the following month. Although they lacked knowledge about legal issues around capacity, staff were able to demonstrate how they applied the principles of the act in their daily practice. For example, they were able to tell us how they supported people living with dementia to make everyday choices such as what to wear and what they would like to eat. In addition, we observed that staff sought peoples' consent before providing care. The registered manager had completed comprehensive and personalised capacity assessments; however there was not a clear process for ensuring these assessments were reviewed regularly.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People who could not make decisions for themselves were protected. The manager had made Deprivation of Liberty Safeguard (DoLS) applications for people living at the home, for example one application related to a person being restricted from leaving the building unattended. They were waiting for the outcome of the applications from the local authority.

People were supported by staff to have access to healthcare professionals to meet their physical needs. We saw that people had involvement from a wide range of health professionals such as speech therapists and district nurses. Staff completed a GP information folder, so that any concerns were reported quickly and safely to the GP who did a surgery every two weeks at the service, or as necessary. One person told us that the manager had supported them with hospital appointments and had asked their consultant's advice on how best to support the person to help them maintain health and independence.

District nurses visited daily to administer insulin. Staff knew how to contact the district nurses if they needed advice for skin care management. A chiropodist visited regularly to carry out foot care. Staff told us that family members often took people for eye checks and dentist appointments, but they could also facilitate this.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. One person told us "It's like the Princess and the Pea getting me comfortable in bed but they are really patient with me, taking the time to make sure I'm comfy, moving me around until I'm just right."

On one occasion, we observed staff announce to a person in a public area that it was time for them to go upstairs to see the incontinence nurse. We felt that this demonstrated a lack of respect for person's dignity and privacy and the need to maintain their confidentiality. Overwhelmingly, however, people told us that they were treated with respect and that their privacy was upheld and our other observations confirmed this was the case. A person said "The girls are very good, especially that one over there. When I spoke to her about a problem I had, she was very good and very discreet." We observed staff asking permission before providing support and knocking on peoples doors to ensure their privacy. We were told that following feedback from people, staff were provided with t-shirts rather than a more traditional uniform, which some felt was more institutional.

Staff treated people with kindness and compassion. We saw staff checking that people were warm enough and placing blankets over people who were asleep. We observed an occasion where a person had spilled a drink down himself. Staff noticed immediately and reassurance was offered and the person was taken discreetly to their room to change their clothes so they were clean and dry.

We saw that staff spoke to people with warmth and took the time to chat, sharing moments of laughter. A person told us, "They're all good girls, always have time to have a laugh and a joke – that's important." Staff asked people how they were feeling and engaged in conversations with them that demonstrated they knew peoples life histories. For example, when we asked one person what they did before coming to the service, the person was unable to remember and asked a member of staff for help. This staff member was able to answer immediately detailing all the places they used to work.

People told us they felt listened to and that their views were acted upon. People told us they had the freedom to choose when and how much support they received. A person told us "There's no bossiness here, we are left to get on with our lives the way we want to." One health professional told us they visited regularly and said, "The staff here are lovely and very helpful. There are never raised voices, staff are very patient, it's a really good service."

Good

Is the service responsive?

Our findings

People told us that they were well supported by staff. One person said, "They are really lovely here, nothing is too much trouble." A health professional told us, "The people who live here seem very happy and very well cared for."

Staff had a good understanding of how to meet individual needs safety on an on-going basis. People's individual needs had been captured and personal preferences were detailed in care plans in sufficient detail for staff to meet people's needs. For example, staff had assessed people's continence needs in a dignified manner, identifying when people needed only minimal support or where greater support was needed.

Staff shared information about people's needs with their colleagues on a daily basis. A member of care staff completed a 'walk round' with one of the members of staff taking over the next shift to check people were safe and comfortable. When there had been changes to resident's needs, clear and concise information was recorded and handed over to colleagues. Staff were required to complete monthly reviews to capture any changes. The registered manager then ensured care plans reflected these changes.

Staff actively sought, listened to and acted on peoples' views and decisions. We saw that an assessment had recommended that bed rails be fitted to minimise the risk of a person falling out of bed. Staff had discussed this with the person who chose not to have a bed rail. Their views were respected, and a specialist sensor mat, bed and alarm were in place so that bed rails were not needed. Preferences and risk assessments were updated to reflect the person's wishes.

Staff supported people to be engaged in meaningful occupation. One person had brightly painted nails and told us they had chosen the colour and appreciated the experience of being pampered. We observed staff playing board games with people in the lounge. Those who were not able to get up and join in watched and commented on the progress of the game.

A photo album was on display in the main lobby which showed people engaged in various activities and outings within the community such as visiting garden centres and going out for meals. The people in the photos were smiling and looked as though they were enjoying the experience. There was a planner on the wall in the lobby listing the weekly activities within the service to let people know about what activities were available. Staff reminded people to look at the planner and advised people that a bus would be available to take people out every other week to access the community. This received positive feedback from people who told us they enjoyed getting out and about. The manager told us that the member of staff responsible for activities had recently left but that the provider had agreed to them being replaced.

Bedrooms were personalised. Staff had put photos on bedroom doors to help orientate people. One person told us they preferred to stay in their bedroom and watch television, and "Look at the view of the fields." Staff facilitated this and continued to offer support via a call bell and regular checks. Family and friends were encouraged to visit and staff supported people to keep in touch with important people in their lives. A member of staff told us that when a person was poorly staff had rung a family member regularly to let them know how their relative was.

Staff actively sought feedback from people. We observed a residents meeting which were held monthly and were an opportunity for people to give feedback to staff and discuss any concerns. A range of topics were discussed including food, activities and entertainment. The meetings made a difference to the people who lived there. For instance, one person told us that they had asked for a specific drink with their meal and this was now provided, other people had requested takeaway nights which had then been organised. People were invited to be involved in the day to day running of the service. For example, staff asked if anyone would like to volunteer to assist with a vegetable patch. Whilst the meeting provided a good opportunity for people to have a say in how it was run, improvements were needed to ensure greater participation and feedback from people with communication difficulties.

The manager captured and logged complaints and compliments. Complaints were investigated and people who had complained received a personalised response. We saw that the manager was pro-active in investigating informal as well as more formal complaints. For example they had examined responses to a person's call bell after a family member had raised concerns and made necessary adjustments in the support they received. Feedback was used to improve the service and people could be assured that their concerns and complaints would be listened to and acted on by the registered manager.

Requires improvement

Is the service well-led?

Our findings

The manager carried out a series of comprehensive and effective checks and audits of the service. They had used information from the audits of the building to develop an improvement plan detailing a schedule of tasks, rated according to risk. However, where the manager was dependent on the provider or a maintenance worker, many of these to tasks had not been completed. We discussed this with the provider and they described many improvements which had been made recently, such as fitting new carpets. The provider could not demonstrate however that they worked effectively to address the priorities and risks raised by the manager.

Some of the tasks which had not been carried out left people at risk. For instance, the manager had identified that a rail was needed on the ramp to assist people and staff to leave the building safely in the event of a fire. This had been raised by the manager to the provider as a risk but had not been resolved. We discussed this with the provider and the registered manager who arranged for the rail to be fitted on the day after our inspection. We did not feel however that the provider had demonstrated an awareness and commitment to address the risks raised by the registered manager relating to people's health, safety and welfare. This is a breach of Regulation 17 (2) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had not consistently addressed issues affecting people's quality of life. We were told that the handyman had retired in July 2015 and only been replaced in December 2015. As a result, the registered manager could not always support people's preferences. For example, there had been a request at the residents' meeting for there to be some "happy pictures" put up throughout the service. This request had not yet been carried out, despite having being raised by the registered manager. The bath hoist in the upstairs bathroom appeared old and stained. We discussed this with the provider who told us the manual handling equipment was regularly checked for faults and we saw audits for this. However, this failed to recognise the impact on people's dignity when being supported with the hoist.

The manager valued the views of people, their families and staff members. They used feedback effectively to highlight where developments were needed in the service. People told us they thought the manager was very helpful and listened to people. A person told us "[Manager] is lovely, they want to help people all of the time." Where possible, we saw the manager had implemented people's requests, for example there was a record in a meeting that a dining table had been put in the front lounge following a request from the residents' meeting. A survey had been sent out to family members and the manager had followed this up by circulating an analysis of the findings in the survey.

Staff said they felt confident to approach the manager if they had concerns about the care of residents. We felt that the manager demonstrated not only a good understanding of people's individual needs, but also the needs of individual staff. The manager undertook observations of staff as they supported people and documented findings and action plans within staff files. They told us they felt this had resulted in staff attitudes and practice. Staff acknowledged that the manager had supported an improvement in staff morale, and enabled improved communication between staff and residents.

The registered manager worked in partnership with other organisations to make sure they are following current practice and providing a high quality service. For example, they had attended a "My Home Life" course, after which they had introduced a system to encourage staff members to identify areas of potential improvement they could make to support the whole team. "My Home Life" is an organisation committed to improving the quality of life in care homes.

The registered manager was working with another independent national charity dedicated to improving health and health care in England. We spoke with a representative of the charity and they confirmed that they were in the process of delivering dementia training to all staff at the home. They were impressed by the level of commitment of the manager to continue to improve care practices and address gaps in knowledge and enhance their awareness of resources and specialist support. They told us that, "[Manager] has been fantastic, they know the people really well, we are really impressed with the service."

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	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider had not demonstrated an awareness and commitment to address the risks to people's health, safety and welfare.**