Care Quality Commission

Whitehill Homes Limited

Strathmore Nursing Home

Inspection report

51 Seymour Road
Bolton
BL1 8PT
Tel: 01204 309795
Website:

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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

We carried out this unannounced inspection on 1 December. At the previous inspection, in July 2013, the home was found to be meeting all regulatory requirements inspected. Strathmore Nursing Home is registered to provide residential and nursing care for up to 32 people. On the day of the inspection there were 29 people in the home.

There was a registered manager at the home. 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.

We found the home was not completely safe as we witnessed a member of trained staff administering medication in an unsafe manner. This was immediately addressed by the home registered manager. There were a number of potential trip hazards around the home that could have caused injury to people who used the service. We felt this area could be improved.

Summary of findings

We found there were sufficient staff to meet the needs of the people who used the service. Recruitment procedures were robust and staff training was comprehensive and on-going. Safeguarding issues were addressed appropriately and staff were aware of how to record and report these matters.

Staff had an understanding of their roles and administered care in a compassionate and friendly manner. They had undertaken training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and the home ensured they worked within the legal frameworks.

Care files were complete and up to date. They included a range of health and personal information and were person centred. Other agencies were contacted when specialist advice or guidance was required and the home worked well in partnership with these agencies.

There was a range of activities available to people who used the service. People's views and opinions were sought via residents' meetings and questionnaires.

The registered manager was readily available for people to raise any concerns or voice any opinions. Staff felt they were well supported by the management and were listened to and respected. A number of quality assurance audits were carried out at the home, the results analysed and areas where improvements needed to be made were identified and addressed.

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?

Requires Improvement

The service was not completely safe. This was because there were some pieces of equipment left out that people may potentially trip over.

We saw an example of unsafe medication administration on the day of the visit, when tablets were left at the side of a person who used the service, for them to take, but were still there an hour later. No one had checked that the person had taken the medication, and there was potential for another person who used the service to have come along and taken the tablets as this had happened once before.

The home dealt with safeguarding issues efficiently and staff were knowledgeable and confident in these areas.

Staffing levels were sufficient to meet the needs of the people who used the service and recruitment processes were robust.

Is the service effective?

Good

The service was effective. People were given a choice of food and their nutritional requirements were catered for. Health issues were appropriately monitored and other agencies contacted and advice taken and followed as required.

Staff were well trained and training was on going and comprehensive. Staff demonstrated an understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and DoLS authorisations were sought appropriately.

Is the service caring?

Good

The service was caring. Staff were observed to speak with people who used the service in a caring and friendly manner. People who used the service and their relatives felt they were treated well and staff respected people's privacy and dignity.

The staff at the home had achieved the Gold Standard Framework in end of life care. People's wishes and preferences for care at the end of their lives were respected.

Is the service responsive?

Good

The service was responsive. People's suggestions and opinions were taken on board via residents' meetings, questionnaires and general conversation.

Care files reflected people's individual needs and preferences and these were regularly reviewed and kept up to date.

There was a range of activities on offer and people who used the service were encouraged to follow their interests.

Summary of findings

Is the service well-led?

Good

The service was well led. Staff, people who used the service and relatives felt the registered manager was approachable. Staff meetings were held regularly and supervisions and appraisals were undertaken on a regular basis.

Professional visitors to the home had made positive comments about the care given and general running of the home.

A number of regular audits were carried out to help ensure continual improvement in all areas.

Strathmore Nursing 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 1 December 2014 and was unannounced. The inspection team consisted of a lead inspector from the Care Quality Commission 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 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. We also reviewed information we held about the home in the form of notifications received from the service.

Before our inspection we contacted Bolton Local Authority contracts team who commission services from the home. We also contacted health and social care professionals who provide care and support to people living in the home. These included a social worker and the district nursing team registered manager.

We spoke with three people who used the service, seven visitors, one professional visitor and ten members of staff during the visit. We looked at records held by the service, including four care plans and five staff files.

Requires Improvement

Is the service safe?

Our findings

We spoke with three visitors who felt their loved ones were cared for in a safe manner. All said yes. One visitor said, "Yes, there are always two staff to lift her and dress her".

We looked around the building and, although there was currently some redecorating being carried out in some rooms there was no evidence of this. All work materials were out of sight. However, two vacuum cleaners were left in corridors unattended and these could be considered hazardous to all moving around the building.

We also saw some planks of wood on the floor in front of the washing machines in the laundry room. The staff member working there explained that there was a trough in front of the machines covered by narrow metal grid/covers which were exceedingly rusted. The staff member was concerned that she would catch her foot in this grid. They said they had informed management but that this had not yet been attended to.

We witnessed the nurse on duty, who was in charge of medication that day, leave tablets at the side of a person, whilst they were eating breakfast in the dining room. They had still not taken the medication an hour later. A medication error had occurred recently concerning a person who used the service taking someone else's medication. This could easily have happened again in the circumstances. We spoke with the registered manager about this and she told us that the person whose medication this was, often asked for the tablets to be left for them to take as they wish. However, she acknowledged that this practice was not acceptable and agreed to raise this with the nurse. We were told they would receive further medication training to ensure this did not happen again.

One person who used the service had managed to leave the home recently, as a door was left open following a delivery to the home. This person had since been placed on a Deprivation of Liberty Safeguards (DoLS) authorisation to help ensure their safety. The home had also responded to this issue by ensuring that deliveries were no longer made through this particular door and that it was kept closed at all times. New signs had been put up to remind people to close the door and visitors to the home had been spoken to about the importance of keeping entrances secure. The person who had left the building was being monitored more closely by staff. We spoke with a visiting professional who was involved with the safeguarding issue. They felt the home had responded promptly and efficiently to the incident.

The registered manager told us about an on-going safeguarding issue relating to a particular person who used the service. The home was contributing to safeguarding meetings and fully participating in safeguarding plans of protection to ensure the person was kept as safe as possible. The home was fully mindful of the fact that the person had capacity to make their own decisions, which may sometimes appear unwise, and this was recorded appropriately. Therefore they had to handle this issue with sensitivity and ensure that the person was encouraged to express and follow their own wishes and opinions.

There were two designated safeguarding leads within the home. There was evidence within the training file that all other staff had completed safeguarding training. We asked four staff members about their knowledge of safeguarding and they all demonstrated an awareness of the issues. All four told us they would not hesitate to report any safeguarding issues and they were clear about the process to follow.

We saw within the four care plans we looked at that risk assessments were reviewed regularly and were up to date. Specific care plans, such as wound care, were included in the records and were up to date. Hospital admission plans were included to help ensure a smooth transition should an admission to hospital be required.

There were sufficient staff on duty on the day of the inspection to attend to the needs of the people who used the service. We looked at the staff rotas which confirmed that there were sufficient numbers of staff on each shift. These included a Registered General Nurse (RGN) on each shift, an assistant practitioner throughout the day, six carers in the mornings, four in the afternoons and two at night, a cook during the day, a kitchen assistant each morning and three domestics each day. The home also had a maintenance person in the mornings and there was help from regular students at the home.

We looked at five staff files and saw evidence of a robust recruitment process, including obtaining Disclosure and Barring Service (DBS) checks, two references and proof of

Requires Improvement

Is the service safe?

identity. We looked at four care plans and saw that appropriate risk assessments relating to areas such as mobility, breathing and falls, were complete and up to date.

We were shown the medication systems which included medication administration sheets (MAR) for each person, with an up to date photograph of that person on them. MAR sheets were signed by staff members when medication was given. Medications given as and when required (PRN) were recorded on the MAR sheets and there were systems in place to ensure these were not given too often.

We saw evidence of a monthly stock check and that any surplus medication was returned each month to avoid overstocking. Fridge temperatures were taken daily to ensure any medication kept this way was stored safely. Cream charts were kept in people's bedrooms and we saw evidence within staff meeting minutes that the importance of signing for creams had been emphasised with staff.

We saw that controlled drugs were stored in a locked cupboard as required, and a controlled drugs register was countersigned by a second person for each administration.

Good

Is the service effective?

Our findings

We saw that a number of choices were offered at breakfast time and there was plenty of food on offer. We asked some of the people who used the service if they liked the food. One person said, "Yes", and another commented, "The food is good". One relative said they brought breakfast in each day for their relative, but remarked, "They have good dinners".

Relatives we spoke with told us people who used the service were given plenty drinks between meals and milky drinks were available at bedtime. Fresh fruit or biscuits were offered as snacks between meals. One relative said, "My X has Weetabix at supper time". Another relative said that their loved one was diabetic and was given an appropriate diet, and was putting on weight.

There was a menu board displayed in the dining room, comprising of a white board, with the writing in red. This helped it stand out for people to read more easily. There was a choice of two hot dishes for lunch and tea, with a dessert. All the people who used the service that we spoke with were aware it was there. The cook said they spoke to each person who used the service prior to each meal to ask what they wished to have.

We observed lunch and we saw some people being assisted to eat, but staff did not appear to have a clear system about who required help. There was a new student and a bank nurse on duty on the day of the visit. The mealtime felt slightly disorganised and we spoke with the registered manager about this. She explained that the regular staff were knowledgeable about who required assistance, but agreed that clearer guidance and leadership at mealtimes would assist new staff to identify more easily those who required assistance.

We saw tables were set with cloth table coverings, cutlery and napkins. One member of staff served drinks with the help of the student, each person was given a cup appropriate for their use. Some people who used the service were served a pureed diet, which was served in identifiable portions of meat, vegetables and potato, with gravy.

We asked people who used the service and their relatives if they were supported well with their health care needs.

They said the doctor came into the home quite regularly and in fact he attended on the day of inspection. We were also told that the chiropodist and optician also attended regularly.

We looked at care plans for four people. We saw mental capacity assessments were carried out on admission and updated as and when changes occurred or new decisions needed to be made. We saw evidence recorded within the files of decisions made in people's best interests.

People's ability to consent to interventions was recorded and gained where appropriate and possible. We spoke with four staff members about issues of consent and how they obtained consent from people who used the service who may be unable to express this. They were able to give examples of instances where people may refuse or be resistive to care interventions. They told us about techniques they might use in these circumstances, such as walking away and trying again later.

We saw that, where there was a safeguarding issue relating to a particular person who used the service, the home had clearly recorded the person's ability to make their own decisions, albeit these decisions may appear unwise. This demonstrated an understanding of the principles of the Mental Capacity Act (2005) and a commitment to working to these principles.

We noted that in one of the care files documentation reflected a request for a reassessment by the Clinical Commissioning Group's (CCG) Continuing Health Care professionals of a person whose health needs had improved. The home felt this person no longer needed to be funded by CHC and were demonstrating good practice in ensuring the person's needs were accurately portrayed and the correct funding in place.

Care files that we looked at included monthly observations of pulse, temperature, blood pressure, weight, BMI and nutrition. We saw that any issues, such as rapid weight loss, were identified and actions recorded. We saw evidence of the implementation of a fortified diet for one person, due to weight loss. This person was on pureed food as per advice and discussion with the specialist Speech and Language Therapy (SALT) team.

We saw within the four care files we looked at that visits from professionals, such as GPs, were recorded. The reason for the visit and the outcome were clearly documented within the care files.

Good

Is the service effective?

There was evidence of a Deprivation of Liberty Safeguards (DoLS) authorisation in place for a person who required this. One more application was in progress as per discussion with and advice from Bolton Local Authority DoLS lead. We spoke with the registered manager about DoLS and found she had a good understanding of the issues and was in contact with the Local Authority to ensure the correct procedures were followed in each case.

We looked at the training matrix and saw that staff had undertaken a range of training appropriate to their roles, such as moving and handling, fire safety, hoist awareness, food hygiene, DoLS, MCA, safeguarding, dementia, first aid, safe swallowing, infection control and end of life care. Some staff had completed extra courses such as, syringe driver, enteral feeding and medication administration.

We looked at five staff files and saw evidence of a robust induction process. This included orientation to the home, introduction to policies, shadowing and training. Staff we spoke with confirmed this. We saw that regular supervision sessions and yearly appraisals took place and staff we spoke with told us they felt this regular support was valuable.

Good

Is the service caring?

Our findings

We spoke with seven relatives. All said they were made welcome, and could visit at any time. They told us they were able to see their relative in private if they wished and that they were offered refreshments.

When asked about preserving dignity most people said staff knocked on their doors before going in. However, one person who used the service said, “They knock and walk straight in”. Their relative said, “I wonder if they are just making sure he isn’t smoking in the room”. They went on to indicate that dignity was respected by saying, “They cover him up, yes, they put him on the commode and leave”.

Another relative said, “Oh yes, he has a bag on his leg, and they always take him to the toilet to empty it, they could do it in the lounge but they don’t”. One relative said, “X is very well looked after, we don’t worry, he’s in good hands”. They told us the care plan had been completed with the involvement of all the family.

Relatives told us their loved ones always looked clean and well cared for. One told us, “Staff are lovely and are generally dedicated. X always looks nicely dressed”. However, one relative said “I take the washing home because things keep going missing”. We asked if people who used the service been given a choice of male or female carer, but were told that there were no male carers.

We asked if they felt that all the staff were kind to the people who used the service. One relative said, “They have the patience of Job”. Another relative said, “Oh yes, I have asked my X”. Another visitor said, “The staff are very professional and friendly and definitely kind to X”.

We asked if people who used the service felt they were listened to. They said they felt staff did generally listen to what they said. We asked if staff listened to friends and family. One relative said, “Definitely”. Another told us, “Yes, except for this issue with the laundry”.

We observed staff interactions which were appropriately caring and reassuring where necessary. Staff spoke to people in a friendly and positive way, using encouragement and gentle persuasion to help people retain some independence. We asked a staff member how they would ascertain the wishes of a person who could no longer verbalise these. They said, “Facial expressions, spitting out food, reactions of all kinds tell us their wishes”.

We saw a recent questionnaire, which had been completed by relatives. There were positive comments about staff, including the comment that they were very interested in the people who used the service and were patient. All who had completed the questionnaire had said that they felt their relative’s privacy and dignity were respected.

We spoke with ten members of staff throughout the course of the day. Staff were able to give good examples of how they respected people’s dignity and privacy, including ensuring they had lockable doors and drawers, knocking on the doors prior to entering and ensuring people were covered appropriately when being assisted with personal care.

The home had achieved the Gold Standard Framework (GSF), which is a staff training programme to care for people according to their wishes at the end of their lives. Many of the people who used the service and their families had been assisted to complete and Advance Care Plan to assist staff to understand their wishes and preferences for their end of life care. We saw that people’s wishes, if they had expressed them, were recorded within their care files.

We spoke with a health professional who visited the home regularly. They told us that staff at the home were extremely committed to providing a high standard of end of life care and did this very well. We spoke with one staff member about the arrangements made regarding end of life plans. They told us that these were usually assessed by chats with the person who used the service. The staff member said “They will either tell you straight off or you can get snippets from chats”.

Good

Is the service responsive?

Our findings

We asked people who used the service and their relatives if they felt that the staff would notice if they were a little out of sorts, or under the weather. One person who used the service said, "I have to tell them". A relative said, "Yes, they noticed that he had fiddled with his catheter and it needed seeing to, so they called the doctor, and informed me". Another relative said, "Yes, the doctor had been called in due to a concern expressed by a family member yesterday". Another person's visitor told us, "They act quickly when X has a (Urinary Tract Infection) UTI". They went on to say that their relative had been placed on a fortified diet as a response to losing weight. The person had now begun to gain weight again.

We asked if staff sit and talk to people about what is important to them. One person who used the service said, "They know (what is important)". Their visitor went on to say, "They show him things in picture books and on the computer". Asked if people were given sufficient information about care and treatment one visitor said, "It's very good".

We saw minutes of regular residents and relatives meetings, where subjects such as menus, activities and decoration were discussed. People's suggestions were taken on board and we saw that suggestions for colours to use in the dining room and lounge had been acknowledged within a meeting. We saw that Christmas entertainment and activity planning had been a topic at the most recent meeting. One visitor who had attended the last residents' meeting said, "It was good, the residents chose the colours for the redecoration of the lounges".

We saw evidence within staff and residents/relatives' meeting minutes that activities were regularly discussed and reviewed, with people who used the service being encouraged to make suggestions. Menus were also discussed at these meetings and people could put forward suggestions for additions or changes to the regular menus.

Relatives told us they had filled in questionnaires. One person who used the service said they had completed a questionnaire saying, "I've said it's the best place in the world". Some relatives said they had not yet seen the results of the questionnaires they completed.

We asked if people could spend the day as they wished and if they got up or went to bed when they wanted. We were told they could. One person who used the service said, "I tell them when I want to go to bed". A relative said "It was getting 10.30 which was too late so they have changed X's bedtime, but it depends on the staff available at night". We observed people getting up for breakfast in their own time. Some people stayed in bed quite late and were served breakfast in bed or whenever they got up and were ready for it, according to their choice. A staff member told us they would regularly go round and ask people for their choice of meal for the next mealtime. If they were unsure or unable to make a choice she would put a little of everything on a place and watch their faces when they ate to try to ascertain their preferences.

We saw that there were two part time activities coordinators who organised a variety of activities for the people who used the service. There was a list of activities such as music group newspaper games, Zumba and bingo. There were also crafts, word games singing and entertainment. This programme was flexible depending on what people wanted to do on the day. We saw a game of dominoes take place on the day of the visit.

A staff member said that Carol singers from the local Baptist Church were coming into the home, that there was a Christmas party organised and a carol service for staff to which families were invited. We were told a priest came in to the home to give communion on a regular basis.

Within the four care files we looked at we saw that lifestyle identities were described and aspects of daily living were portrayed in easy read pictorial style for those who required this. Activities undertaken by the person were also recorded. We saw that people's particular needs, around areas such as nutritional intake, were recorded within the care files. Guidance and advice from professionals was recorded and followed via observations, charts and documentation.

The students working at the home were involved in completing the above personal history profiles for people who used the service. This was a constructive way of using their time, helping them to get to know people and ensuring people's care files were individual and person centred.

Good

Is the service responsive?

We saw that the complaints procedure was displayed in the entrance to the home. We were told by relatives that the registered manager was very approachable and they would be comfortable to discuss any concerns with her. There had been no recent complaints.

We were shown a compliments book which included some recent messages, such as, “Thanks to all the staff for the care and support you gave my X”, and, “We knew that X was comfortable and treated with respect”.

Good

Is the service well-led?

Our findings

We spoke with four staff members who told us they felt well supported by the management of the home. They said the registered manager was approachable and would deal with concerns raised quickly.

We spoke with a professional visitor to the service on the day of the inspection, who told us they felt the staff cooperated and followed advice well. We spoke to other professionals prior to the visit who felt the staff were caring and supported people well. We were told that they endeavoured to ensure that people's end of life care was carried out according to their wishes and preferences. We saw the home undertook post death audits and analysis to help ensure people's wishes, recorded in their advance care plan, had been respected to the best of their ability. These audits were also to help drive continuous improvement.

A professional visitors' questionnaire had been completed earlier in the year and comments were positive about the standard of care. They included, "Overall, members of our clinical team feel the home is very well run", and, "Strathmore appears to treat residents to a high standard".

We saw that staff meetings were held regularly and included topics such as documentation, activities and staffing. Minutes were pinned on the notice board for staff who had been unable to attend the meeting and they were required to sign that they had read them. Messages to staff were also conveyed via a communication book.

There were a number of audits undertaken in the home and these included room audits, medication, care plans, hand hygiene and registered manager spot checks. These were complete and up to date and included documentation of any issues identified and actions required.

Accidents and incidents were recorded and monitored appropriately. We saw that the home had instigated a new reporting system for incidents, following advice from the Clinical Commissioning Group (CCG). This indicated a willingness to accept advice and strive to improve practice.