Vesta Care Homes Limited

Mount Hermon Dementia Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 27 June 2017and was unannounced.

Mount Hermon Dementia Care Home provides care and accommodation for up to 30 people who were living with dementia and there were 24 people living at the home at the time of our inspection. All were aged over 65 years. The home is situated on the seafront at Lancing, West Sussex.

All bedrooms were single and each had an en suite toilet with a wash basin. There is a passenger lift so people can access the bedrooms on the first floor. Communal living rooms and a dining area were also provided as well as a garden and an activities room.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 16 August 2016 we recommended that the activities for people should be improved. At this inspection we found action had been taken to extend the range of activities for people.

At this inspection we found the provider had not ensured the proper and safe management of medicines. Records of medicines administered to people were not always accurately maintained. We also found some medicines had not been administered and there were no recorded reasons for this.

A range of audits and checks were made on the service including regular visits by the provider's regional management team. Audits of incident s such as falls and accidents were completed and action plans devised to prevent any reoccurrence. Medicines audits were carried out but these had not identified the errors we found and we have made a recommendation about this.

People and their relatives said the staff provided safe care to people and people said they felt safe at the home.

Risks to people were assessed and recorded along with care plans with guidance for staff to follow to mitigate those risks.

Sufficient numbers of staff were provided to meet people's needs. Checks were made on newly appointed staff to ensure they were suitable to work in a care setting.

The premises were found to be clean and well maintained. There was an absence of any unpleasant odours.

Staff were trained and supervised so they had the skills to provide effective care to people.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the MCA and DoLS. People's capacity to consent to their care and treatment was assessed and applications made to the local authority where people's liberty needed to be restricted for their own safety.

People's nutritional needs were assessed and people were supported to eat and drink. There was a choice of meals.

People's health care needs were assessed. The staff had good links and worked well with local health care services.

Staff were kind and compassionate and were observed to treat people well and with dignity. Care was personalised to reflect each person's preferences and lifestyle. People's privacy was promoted. Staff were trained in end of life care and a health care professional reported that this was an area of practice the staff were particularly good at.

The service had introduced a system whereby care records were held on a specifically designed IT system which staff accessed via smart phones provided by their employer. This had numerous advantages such as alerting staff to risks and staff having ready access to information on people.

People's relatives said they were able to raise any concerns which were usually resolved. The provider maintained a record of any complaints and any action they took as a result of complaints, although we identified a lack of full records regarding one complaint. This was later rectified.

Relatives and a health care professional described the management team as approachable and responsive. There was a management team which included team leaders who coordinated care when on shift.

You can see what action we told the provider to take at the back of the full version of the report.

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 always safe.

The provider had not ensured the safe and proper management of medicines.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance provided for staff to mitigate these.

Sufficient numbers of staff were provided to meet people's needs.

The home was found to be clean.

Is the service effective?

Good

The service was effective.

Staff were skilled and well trained and had access to a range of training courses. Staff received supervision of their work.

The staff were trained in the Mental Capacity Act 2005. Where people did not have capacity to consent to their care and treatment their capacity was assessed. Applications to deprive people of their liberty under a Deprivation of Liberty (DoLS) were made when appropriate.

People were supported to have a balanced and nutritious diet and there was a choice of food.

Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. Staff interacted well with people and had a good rapport with people.

People's care was personalised to reflect their choices were acknowledged.

People's privacy was promoted.

Arrangements were made for people to receive end of life care according to their wishes.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences. A range of activities were provided to people.

People knew what to do if they wished to raise a concern. There was a complaints procedure displayed in the home.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were a number of systems for checking and auditing the safety and quality of the service. These included checks on accidents and actions to reduce the likelihood of any reoccurrence. Audits of medicines were not sufficient to identify errors in the recording and administration of medicines. We have made a recommendation about this.

The management team had good communication channels with relatives and sought their views as part of the quality assurance process.

The ethos of the service was person centred.

The ethos of the service was friendly with a staff team who promoted people's rights to a good standard of care. Staff felt supported by the service's management team.

Mount Hermon Dementia Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and took place on 27 June 2017 and was carried out by one inspector. The inspection was brought forward from the planned date due to concerns raised with us. We wrote to the provider about one of these and they looked into the concerns and wrote back to us. We have referred to the complaints in the relevant sections of this report.

During the inspection we spoke with four people who lived at the home. Following the inspection we spoke to two relatives of people who lived at the home. We also spoke with four care staff, the deputy manager and the provider's group operations manager as well as the nominated individual for the provider.

A number of people at the service were not able to communicate with us very well so we spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for five people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents, medicines records and complaints. Records for seven staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke with a visiting community nurse who gave their permission for their comments to be included in this report.

The service was last inspected on 16 August 2016 and was rated as Requires Improvement. A recommendation regarding activities was made and not all records were found to be accurately maintained.

Requires Improvement

Is the service safe?

Our findings

We looked at the service's procedures for the administration and handling of medicines. A monitored dosage system was used to administer medicines. This consisted of medicines being supplied by the pharmacist in containers for the month ahead. These had clear plastic 'blisters' for each medicine the person needed at specific times. This allowed staff to see easily which medicines needed to be given at the prescribed times. Staff completed a record on a medicines administration record (MAR) each time they administered medicines to people. People's medicines were stored in a lockable cupboard in their bedrooms. We checked a sample of six people's medicines. We noted there were omissions on the MAR records. For example, one person's MAR had no record to show a night time medicine for treating dementia was given on 8, 9, 14 and 15 June 2017. The blister packs showed the medicine was not administered on 9, 14, and 15 June 2017. There was no record of why the medicine was not administered. We also noted there was a lack of record on the MAR to show whether a medicine was administered on the 24 June 2017 for another person. The medicine was still in the blister pack signifying it was not administered. There was no record of why the medicine was not administered. For the four other people whose records and medicine stocks we looked at the MAR and stocks of medicine showed the medicine was administered as prescribed. These errors were discussed with the deputy manager and operations manager who agreed the medicines procedures needed to be more closely monitored and action taken to address any errors. Procedures for the storage and administration of controlled medicines were satisfactory.

The provider had not ensured the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home. For example, one person said, "I feel safe here. The staff are very good. Excellent. Very careful with their work. I'm looked after well." Another person also said they felt safe at the home, adding that staff checked they were safe and responded when they used the call point in their room to summon help. We saw call points were accessible to people in their rooms so they could easily ask for help. A relative said staff were always available to assist and were "always popping into the bedroom to check at all times."

Staff were trained in safeguarding people and in procedures for raising any concerns to organisations such as the local authority safeguarding team. The service had policies and procedures regarding the safeguarding of people. The staff told us they would report any suspected abuse or poor care to their line manager or to outside organisations such as the local authority.

Each person's care records included risk assessments to determine if people were at risk of injuring themselves. These were comprehensive and included the risks of falls, mobility, the risk of pressure areas developing on people's skin from prolonged immobility and risks of malnutrition. There were care plans to give information to staff on how to mitigate the risks to people. These were recorded with enough detail to give staff sufficient guidance although we noted one person's care plan regarding support with mobility said, 'Although I am able to mobilise independently I will need a carer to support me;' but did not say how staff should provide this support. This was raised with the deputy manager and the provider's operations

manager who agreed this aspect of this care plan needed to be in more detail, which would be addressed. A community nurse told us the staff were prompt in making referrals regarding any risks to health and well-being such as when people were identified at risk of developing pressure areas on their skin. The community nurse said the staff followed advice to ensure people got the right care and equipment to reduce the risks of pressure injuries developing. Staff said they considered the service provided safe care to people and that the care records gave them information on supporting people safely. The system of care records was held on an IT system accessed by staff on smart phones supplied by the provider. These highlighted any assessed risks to each person by a moving icon containing information on risks which ran across the bottom of the smart phone screen. This meant staff were alerted to concerns regarding safety risks for people so action could be taken to mitigate them.

Sufficient numbers of staff were provided to meet people's needs. Staff said they considered the service had enough staff to meet people's needs, although one staff member said they would like one more staff member on duty to improve the standard of care. This staff member there were, however, enough staff to meet people's needs. Our observations and judgement was that there were enough staff to provide safe care to people. A community nurse said there were always enough staff available when they visited the service. At the time of the inspection there were 24 people living at the home. Staffing consisted of a team leader and four care staff from 8am to 2pm each day and one team leader and three care staff from 2pm to 8pm. Night time staff consisted of a team leader and three care staff. In addition to this the service employed two activities coordinators for 20 hours a week each, a cook and kitchen assistant plus cleaning, laundry and administrative staff. The deputy manager also worked full time and at the time of the inspection 16 hours of her hours were supernumerary to the staff team so she could work on management tasks. The service's own audits had identified a high use of agency staff and the provider was taking steps to recruit more permanent staff in order to reduce this. One of the agency staff who worked at the service told us they had worked at the home on a number of occasions and therefore knew people's needs well and how the service operated. The provider told us the service used the same agency staff as much as possible so that there was continuity in the provision of care as these staff would be familiar with people's needs.

We observed there were enough staff on duty to meet people's needs. For example, we saw seven staff assisted people during lunchtime.

We looked at the staff recruitment procedures. Appropriate checks were carried out to ensure staff were safe to work with people. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting.

We received a complaint that portable electrical appliances were not tested but found this was not the case. Checks were made by suitably qualified persons of equipment such as the passenger lift, hoists, fire safety equipment and alarms, electrical wiring, gas heating and electrical appliances. The risk of Legionnaire's disease was checked by a suitably qualified contractor. Fire safety equipment was checked and serviced. Records showed the fire alarms were tested each week. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises in an emergency. We received information that the fire exit routes were obstructed but could find no evidence of this.

Prior to the inspection we received information that the home was not clean and that it had a strong odour of urine. At the inspection we found the service was clean and hygienic. There were no malodours and no one complained of this being a problem. In fact, a relative commented, "The home is clean with no smells. The cleaners work to keep it pretty spotless."

Good

Is the service effective?

Our findings

People and their relatives said the care staff were skilled in supporting people. For example, one person said, "The staff are pretty good," and a relative said, "The staff know mother/father's needs well and are good at supporting him." Another relative said they considered staff had a good skill level, but also commented there was sometimes a lack of consistency as some staff were more attentive than others. This relative did not expand on this further or suggest this was something which needed to change. The relative also said this was an observation which had not had any negative impact.

A community nurse also said staff had a good knowledge of people's needs and looked after people well.

Staff said they received a range of training which they considered was of a good standard. Training consisted of either face to face or on line training courses. These included training considered mandatory to their role such as moving and handling, safeguarding, fire safety, infection control and nutrition and well-being. Recently appointed staff had received an induction to prepare them for their role which involved enrolling for and completing the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. Staff said they received an induction which involved a period of 'shadowing' experienced staff and that the induction prepared them for their role.

The deputy manager said they had completed a 'Train the Trainer' course provided by the local authority, which qualified them to train staff to a certain standard. This included training and assessing the competency of staff to handle and administer medicines.

Records were maintained of staff training and showed that, in addition to the mandatory training, staff also attended training in providing care for people living with dementia, continence care, challenging behaviour, care planning, end of life care, skin tissues needs, swallowing needs and wound care. Seventeen of the 33 staff were trained to National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care at levels 2 or 3. The registered manager had completed NVQ level 5 as well as the Registered Manager's Award (RMA). These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

We received information that staff were not supervised but our findings confirmed that staff were supervised. Staff said they felt supported and had regular supervision with their line manager where they said they could discuss people's needs as well as any concerns or training needs they had. Records of supervision were maintained, which showed staff received regular supervision with a line manager. The deputy manager said training for team leaders in supervising staff was to be provided. Appraisals of the registered manager and deputy manager had been completed but not the care staff. We were informed by the registered manager that this will be completed in the near future and that there was a plan to achieve this.

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).

The service had policies and procedures regarding the MCA. Staff were trained in the MCA and DoLS. Staff had a good awareness of the principles of the MCA and of the need to get people's consent. We observed that staff communicated well with people and explained to them how they were being supported and asked them if they agreed. Where appropriate, applications were made for people's liberty to be restricted for their own safety. At the time of the inspection 23 people were subject to a DoLS authorisation. Care records included details of mental capacity assessments and if people were subject to a DoLS authorisation.

People were supported to have a varied and nutritious diet. People and their relatives said they liked the food and there was a choice available. For example, a relative said, "The chef is good. The food looks good. It's beautifully presented. Good portions."

The chef described how people were asked in advance what they would like to eat and that this was recorded so meals could be planned accordingly. There was a choice of at least two meals. The day's menu was displayed in the dining room. Food was freshly prepared and there were stocks of fresh fruit and vegetables. For those at risk of losing weight the chef used high calorie foods to fortify meals such as cream and purchased specific high calorie potted foods.

We observed the lunch and noted people had a variety of different meals. The meal looked appetising and people enjoyed it. Staff supported people to eat where this was needed.

Nutritional needs were assessed using a Malnutrition Universal Screening Tool (MUST). Where needed people had a care plan for eating and drinking, which included details of the support needed, any high calorie snacks and fortification of foods to increase calorific value as well as any preferences. Drinks were available to people in their rooms and staff brought drinks and snacks to people at regular intervals. People's weight was monitored and from the sample of people whose records we looked at we saw their weight was stable or had increased. Referrals had been made to health care professionals where assessments indicated people were at risk of losing weight or had problems with swallowing food.

We received information that one person did not receive appropriate care regarding the management of pressure areas on their skin. We saw records that indicated that the person had received appropriate care to manage pressure areas, including that creams were applied as prescribed cream to alleviate this. People's health care needs were assessed and details recorded about specific needs, such as the assessment and management of health care needs such as chronic obstructive pulmonary disease (COPD) and Parkinson's disease. A community nurse told us the staff made appropriate referrals when people had health care needs and required an assessment and/or treatment. The provider confirmed advice was sought from agencies such as the GP, community nurse and community psychiatric nurses and speech and language therapists.

Good

Is the service caring?

Our findings

People and their relatives described the staff as kind and caring. For example, a relative said of the way staff cared for someone at the home, "They treat her perfectly. They are kind. They are always talking to the clients." Another relative said the staff were, "kind and considerate." People made comments about the kindness of staff and of being treated with respect.

A community nurse said, "All the staff are good with the patients. They are caring and take time to explain anything to them." The community nurse said staff were skilled at dealing with people who were experiencing distress such as anxiety and took action to calm and reassure people. This was also confirmed by our observations on the day of the inspection when staff were seen to respond to a person who was distressed by talking to them calmly and in a warm and loving manner.

We observed a number of staff supporting people during lunch. Staff interacted well with people and spoke to people politely and with respect. Staff engaged well with people, asking them how they wanted to be helped and made good eye contact when they spoke with them. There was meaningful dialogue, banter and jokes between staff and people indicating that people and staff knew each other well and enjoyed each other's company. A relative commented that the home had a good atmosphere and that staff were friendly.

Staff demonstrated they had values of compassion and of treating people well. For example, one staff member said, "People are looked after well. The staff have the love. It is a caring place. We treat people as we would treat our mum or dad." Another staff member said the staff had "the best interests of residents who are happy and content." Staff also described how they dealt with people's distress or behaviour using calming techniques and it was evident staff valued people.

Care plans were individualised which showed people's preferences and choices were acknowledged. This is person centred care. For example, people's care plans included details of their choices and preferences regarding their daily lives. These included the times people liked to get up and go to bed, their food preferences and where they liked to spend their time when inside the home. Care plans were also written in a style which reflected what the person had said about their care preferences. Other areas of care plans also showed people's preferences and choices were recorded as well as those areas of personal care people could do themselves, which helped promote their independence. People confirmed they were able to choose how they spent their time.

People's privacy was promoted. Staff were observed to knock on people's bedroom doors and wait for a response before entering. Relatives confirmed people's privacy was promoted. We observed staff treated people with dignity by speaking to them and listening to what they said.

Where appropriate there were care plans regarding any end of life care for people and these included people's preferences. A community nurse said of the end of life care provided to someone in the following way, "They were brilliant with her." Training was provided for staff in end of life care and the registered manager informed us she would be attending a nine month course in end of life care, which would enhance

her and the staff team's knowledge of this area of care.

Good

Is the service responsive?

Our findings

People and their relatives said the staff met people's care needs. For example, a relative said they were pleased with the standard of care provided and those people who were able to speak to us said they were looked after well. People and their relatives also confirmed there was a range of activities for people to attend which they said were of a good quality.

Since the last inspection the provider had introduced a new system of recording assessments and care plans. These were now entered on an IT system and could be accessed on a desk top computer or by a hand held smart phone which each staff member had. Staff said the system worked well and gave them access to all the information they needed about someone. The records showed people's needs were comprehensively assessed and there were corresponding care plans of how those needs were to be met. The care plans and assessments covered mental and physical health needs. The care plans were person centred reflecting how people preferred their care to be provided as well as those areas they could do themselves. For example, one care plan included details about someone's daily lifestyle which reflected their preferences as follows, 'I like my hair to look nice so please encourage me to brush it. If I am unable to do so please do it for me.' People said their choices and preferences were catered for and we observed people were well cared for. For example, people were clean and some of the female residents said they had recently had their hair attended to by a hairdresser.
We saw there were some isolated instances where more detail was needed in the care plans. For example, one care plan referred to staff providing a body wash but it did not say how often this should take place.

Staff entered records on the smart phones of the care they provided. The system had numerous advantages such as alerting staff to risks and information passed between staff during handover meetings.

There was evidence the care plans and assessments were reviewed. The new system of recording people's care had the facility for relatives to access and comment on the care but had not yet been used. The provider's operations manager said they were looking into this.

The previous inspection report recommended the provision of activities for people should be improved. At this inspection we found this had been acted on and there was a range of activities for people. The service employed two activities coordinators over seven days a week. There was an activities programme displayed which showed a range of activities including outings, pet therapy, and crafts. There was also space on the notice board for people to suggest activities they would like. The activities coordinators used an external organisation specialising in providing ideas and equipment for activities for people as well as training for staff in providing activities. There was separate record which showed which people had attended certain activities and these included activities on a one to one basis where people did not join group activities. The provision of activities was varied in order to meet individual's social and recreational needs.

The provider's complaints procedure was displayed in the home. Relatives said they felt able to raise any concerns and said they had a good dialogue with the staff and management to resolve any issues. A record was maintained of any complaints and five complaints had been made since the last inspection. The

provider had looked into and responded to each of the complaints although we noticed for one complaint there was a record of a meeting and an acknowledgement letter to the complainant, but no record of any outcome or any action being taken. This was discussed with the registered manager who agreed these details needed to be added. We also saw there was a record of compliments made about the service by relatives.

Requires Improvement

Is the service well-led?

Our findings

There were a number of audits such as audits of medicines and health and safety. We saw the audit of medicines carried out on 8 May 2017 included observations of staff administering medicines to people. The system of audit had not identified the errors in the recording and administration of medicines to people, indicating this needed to be more thorough and more frequent. We recommend the provider's system of quality assurance checks and audits is extended and improved in order to ensure the safe management of medicines.

Records of accidents in the home were maintained. These included a record to show each accident was also included on a monitoring form with details of when and where the accident happened so any trends could be determined. These were compiled into an end of year report. Any actions needed were recorded such as the provision of equipment to prevent further accidents along with a record of when this was completed.

People's relatives commented that the management of the service was approachable and was concerned not only with the welfare of people but their families also. One relative described the management and staff as understanding and supportive. Another relative said management staff were available when they needed to speak to them.

The provider sought the views of people's relatives by the use of survey questionnaires. The results of the survey responses in 2016 showed relatives were satisfied with the standard of care which was described as 'good' and 'excellent.' There was a negative comment about the menu plans and the registered manager confirmed this was responded to by amending the menus. The provider confirmed people's views were also sought and acted on and that this was an area which was being looked into further as many of the people at the home were unable to understand survey questionnaires.

The staff had good links with health and social care professionals. A community nurse said there was good communication with the service's management saying senior staff were always available and that the management was, "very helpful and responsive."

There was a management structure so staff knew who to go to for advice and support and so decisions could be communicated. The management consisted of the registered manager, a deputy manager and three team leaders who supervised care staff at each shift. Staff said they felt supported and said the staff and management team worked well as a team. For example, one staff member described the management team as "really good," and another described it as flexible with good strategies for organising care. Staff said the ethos of the service prioritised meeting people's needs and was person centred in its approach.

The provider monitored and supported the service and staff in a number of ways. These included a service development manager who assisted with training and the operations manager who visited the home each week. The provider said team leaders had 'team leader days' in order to discuss their role and work. A monthly audit and report was carried out by an external consultant, which the provider said gave valuable information on what needed to be improved and what was working well. There was also an additional three

monthly audit by the provider's development manager as well as a monthly report and action plan by the operations manager. The deputy manager said they worked alongside care staff in order to aid communication with staff and to monitor how care is provided; this was confirmed by our observations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the proper and safe management of medicines. Regulation 12 (1) (2) (g)