Mears Care Limited

Nichols Court Extra Care Scheme

Inspection report

Nichols Court
Flaxfields
Linton
Cambridgeshire
CB21 4AF

Tel: 01223897723

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 15 April 2016 and was unannounced.

Nichols Court Extra Care Scheme is a domiciliary and extra care service that is registered to provide personal care to people living in their own homes at Nichols Court. At the time of our inspection there were 32 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had appointed a new manager but they had not yet taken up their position.

Staff's suitability to work with people using the service was assessed before they were offered employment. People's assessed care needs were met in a timely manner by suitably trained and qualified staff.

Staff were trained and knowledgeable about the procedures to ensure people were kept safe from harm. Staff were aware of their role in reporting any incident should it occur to organisation including the local safe guarding authority.

Medicines management and administration was undertaken in a safe way. This was by staff whose competency to do this safely was regularly assessed.

The registered manager was aware of the process to be followed should any person have a need to be lawfully deprived of their liberty. They and staff were knowledgeable about the situations where an assessment of people's mental capacity was required. The service was working within the principles of the Mental Capacity Act 2005.

Staff knew the people they cared for well, their levels of independence and respected their privacy and dignity. Appropriate risk management strategies and records were in place for events and subjects including falls and medicines administration.

People, their relatives or family members were involved in the process of assessing their care needs. People's care was provided where the service was able to safely do this.

People's health care needs were identified by staff and met by a range of health care professionals including a GP occupational therapist or GP.

People were supported with their independence to live in their own home as long as they wanted to. People were supported with their nutritional needs and staff ensured people ate and drank sufficient quantities.

Staff were provided with a formal induction, regular and effective training, supervision and mentoring that was appropriate for staff's roles.

People were provided with information, guidance and support on how to provide compliments, report any concerns as well as any suggestions for improving the care they received. The provider took appropriate action to ensure any complaints were addressed to the complainant's satisfaction.

A range of effective audit and quality assurance procedures were in place. The provider had processes in place to help ensure that the CQC is notified about events that they are required, by law, to do so.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were knowledgeable about implementing safe care and they understood what keeping people safe meant.

People's assessed needs, including medicines administration, were met by a sufficient number of suitably qualified staff.

The provider's recruitment process helped ensure that staff's suitability to work with people using the service was safely determined.

Is the service effective?

Good

The service was effective.

People were supported to make and be involved in the decisions about their care. People were supported by staff who had the right skills and knowledge about each person they cared for.

People were supported to eat and drink sufficient quantities of the foods they preferred.

Staff supported people to access and be seen by the most appropriate health care professionals when required.

Is the service caring?

Good

The service was caring.

People were cared for with dignity, compassion and respect. Staff understood the finer points in people's lives and supported people with those aspects which were meaningful.

Staff knew what people's rights were and supported people with these.

People were supported to see their families and friends and maintain those relationships that were important.

Is the service responsive?

Good

The service was responsive.

Staff met people's assessed needs in an individualised way.

Social stimulation was provided to people to support them with a range of hobbies, interests and pastimes.

Compliments, suggestions and concerns, were used as a way of recognising what worked well and if improvements were required

Is the service well-led?

Good

The service was well-led.

The registered manager undertook their role with an emphasis on transparent support to all staff.

Effective audits and systems to measure the quality of the service were in place and actions identified were acted upon.

The registered manager and staff with management responsibilities knew their role and responsibilities in ensuring a high standard of care.

Nichols Court Extra Care Scheme

Detailed findings

Background to this inspection

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

This inspection took place on 15 April 2016 and was unannounced. The inspection was completed by one inspector 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 looked at this and information we hold about the service. This included the number and type of notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we visited and spoke with 12 people in their homes and we spoke with two relatives. We also spoke with a visiting community health care assistant. We spoke the registered manager, a regional operations' manager, the service manager, two care staff and the scheme's chef.

We looked at four people's care records, managers' and staff meeting minutes. We looked at medicine administration records and records in relation to the management of the service such as checks regarding people's homes environmental safety. We also looked at staff recruitment, supervision and appraisal process records, training records, complaint, quality assurance and audit records.

Good

Is the service safe?

Our findings

People, and their relatives, told us that they were supported with their care needs at the times they had requested. One person said, "I feel safe here as staff are only a few minutes away. I know that if I call them they come quickly." Another person told us, "They [staff] are in the building [Nichols Court] so I know they won't get delayed by traffic or weather. I like that reassurance." All people we spoke with confirmed that they were always informed in advance as to which staff would be providing their care. A member of staff said, "Having consistent staff really helps as it puts people at ease." A relative added, "My [family member] is safe here and knowing staff are on site 24 hours a day means a lot."

We saw that staff knew the people they cared for well and ensured they spoke with people in a sensitive and friendly way. Staff and management had a full understanding of the ways to ensure people were protected from harm. Staff described to us what the signs of harm could be such as a person not being their usual selves and who they could report any concerns to. This included to the local safeguarding authority or the Care Quality Commission. One person told us, "[I] most definitely feel safe here, "Staff respond quickly if you need them." The ways which people were supported to access information about being safe included a service user guide with contact details for the relevant authorities. This showed us that there were processes in place to reduce and help prevent any risk of people experiencing harm.

People were supported with their safety by various measures such as risk assessments for people's safe moving and handling. Other subjects included people at risk of falls or when people accessed the community. A process was in place to help ensure risks were regularly reviewed. This was to provide people's care in the safest way practicable. One person told us, "I need a walking frame and the staff make sure I use this as well as keeping it within my reach." Our observations within the scheme showed us that staff assisted people to access mobility aids and equipment. One member of care staff said, "Our health and safety training enables us to assess the risk each person took as well as removing any risks which could put people in harm's way." Other risk assessments included those that were in place to help ensure that people's homes were a safe place for staff to work in.

The registered manager explained to us that they had recently recruited a service manager to help with the day to day running of the scheme. This was because the registered manager was also responsible for two other extra care schemes. People and their relatives confirmed to us, that there were sufficient staff in place to meet people's assessed care needs. Our observations confirmed that people's needs were met by staff who were appropriately qualified. All people we spoke with told us that staff always stayed for the right amount of time that had been agreed as well as not being late. One person said, "If the staff are a bit late the office always lets me know why. It can be that another person needs a bit more help." A relative told us, "Knowing that there are staff on site means a lot to me and that [family member] is safe."

Staff told us that they had recently had to work extra shifts. This had been to cover recent staff departures. We saw that recruitment was in progress and some new staff had already commenced their employment. Other plans were in in place if staff rang in sick. Care and management staff told us that permanent staff covered extra shifts as well as cover for when staff were on annual leave. Two visiting relatives told us, "We

have no concerns about [family member's] safety here at all."

Accidents and incidents such as when people had experienced a fall or serious injury were recorded. Care staff discussed the measures required to help prevent the potential for any recurrence. For example, referrals to the local falls team or provision of additional equipment such as a walking frame. This included liaison with the person's GP for alternative medication options as well as visits by an occupational health therapist. One person told us, "Oh yes, they [staff] always make sure I have my walking frame and that I use it."

We saw that staff recruitment had been undertaken in a safe way. Checks had been completed to ensure staff's suitability to work at the scheme. For example, a satisfactory Disclosure and Barring Service [DBS] check, [this check discloses whether prospective staff have a relevant criminal record] and proof of previous employment. The provider also confirmed in their PIR that "we also have a robust recruitment and retention program for all staff that ensures essential recruitment checks are completed prior to employment and that throughout employment the required standards are met by all staff".

The provider in their PIR told us and we saw that staff had been issued with cards that fitted on to their identity badge. These cards gave a level of support and guidance to care workers on the basic do's and don'ts of medicines administration. We saw and found from records viewed that people were supported to take their medicines in a safe way. One person told us, "I get four visits a day for eye drops; staff are very good [with administering medicines]." This included those people whose medicines had to be taken in a particular way such as 'before food' and 'with water'. Each person's medicines administration records (MAR) contained the level of support, dosage and timings specified by the prescriber. Records and staff confirmed that they had been trained and assessed as being competent in the safe administration of medicines. Staff were able to tell us about the requirements to support people with their medicines. Medicines were recorded accurately and were stored and secured appropriately in people's homes. Another person said, "They [staff] get my medicines out for me, make sure I take them and then they sign my sheet [MAR]."

Good

Is the service effective?

Our findings

People were supported by care staff who had the necessary skills and knew the people they cared for well. The registered manager explained the various programmes in place to support staff in their role. For example, following staff's five day induction they were supported with shadow shifts [working with a more experienced member of staff] until they were confident to their job independently. Staff were supported in their role and they could ask for any additional support if they needed this. New staff were enrolled in the Care Certificate [a nationally recognised training standard for social care] and one staff had commenced this. One staff member told us, "One thing Mears Care is good at is training. I have just completed my level two qualification in care. I was really well supported with my induction." One person said, "They [staff] know me and my relative well to the point where I think they can read my mind."

All staff had received training in subjects such as the Mental Capacity Act 2005 (MCA), infection prevention and control, dementia care and fire safety. The service manager's training matrix showed that all staff training was up-to-date or planned. One member of staff said, "I have just completed my MCA training which has been really helpful for me in understanding what mental capacity is and what a lack of this could mean for people."

Staff also attended training provided by other of the provider's staff including those staff with a particular skill or qualification such as nursing care. This had given staff a better understanding of any potential changes in people's health and when to call a GP. Other training, which the community nurse had provided, included the use of moving and handling equipment. This enabled staff to move a person more safely if they had experienced a fall.

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 must be made through the Court of Protection for people living in the community. We checked whether the service was working within the principles of the MCA.

We found that the registered manager and all staff had an understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). The MCA protects people who might not be able to make informed decisions on their own about their care or treatment. Where it has been assessed that a person lacks the mental capacity to make a decision, a person making a decision on their behalf must do this in their best interests and in the least restrictive manner. A member of staff told us that the MCA was, "Letting people choose, make unsafe decisions or providing care in their best interests and only restricting people if this was required." We saw and found that staff understood people's needs well. This was by ensuring that the care provided was only with the person's agreement and in line with the MCA code of practice. This showed us that staff knew what protection the MCA offered people and also to staff.

People had access to refreshments throughout the day as well as a communal kitchen area for hot drinks and snacks. We saw that people were supported to ensure they ate and drank sufficient quantities. This included the foods people liked, how and where they liked to eat them and any particular dietary needs. One person said, "I am having my lunch in the [scheme's] dining room. I prefer this as it saves me cooking." We observed staff ask what people would like to eat as well as if they wanted ice-cream for pudding. Another person told us, "I get three calls a day and staff help prepare [my] food."

Care staff told us, and we found, that they supported people to access health care professionals including a GP, dietician and community nurses. A visiting health care worker told us, "The staff are very good at having all the records we need to support the person in the best way." They also added, "One good thing is that we see the same staff and they know the people well and exactly what each person is being seen for." A relative said, "They [care staff] are very quick to call a doctor and they [staff] always let us know how [family member] is." This showed us that people's healthcare needs were responded to. The service manager explained that when required they had arranged the support of a dietician, GP, speech and language therapist. This had been to support people to remain living at home as long as it was safe for them to do so.

Good

Is the service caring?

Our findings

Staff cared for people in a kind and compassionate way. People's privacy and dignity was respected. Staff ensured they only entered people's homes with the person's permission. One person said, "They [staff] treat me with respect." Another person added, "They [care staff] really do care for me. I couldn't ask for a nicer way to live. Everything I needs is here and they help me when I need it." A third person, commented, "They [staff] look after me very well, I must say." One relative said, "My [family member] needs support with two baths a week and the carers [staff] are all lovely."

People confirmed that staff always rang the doorbell or entered the person's home in the way the person had requested. One care plan stated, "Please ring my door bell and announce your [care staff] name and I will let you in." We observed that staff took heed of this guidance and respected people's wishes. We saw that staff took the opportunity to engage in conversation with the person they were supporting. For example, whilst escorting people to their midday meal in the dining room. We heard how staff asked people, in a sensitive manner, about their well-being after having seen their GP last week. The person confirmed that they were "now much better thank you". Staff were attentive to people's requests for assistance, referring to people by their preferred name and talking politely and respectfully with people. One staff asked a person, "Did you enjoy the strawberries and cream?" The person responded whilst smiling that "they had".

Staff described to us what people were independent with as well as how to provide their care. We saw that the language used in people's care records was respectful of subjects such as religion, any preference for gender of care staff and what the finer points of people's care were. For example, the days the person liked to attend a hair dressing appointment. One care staff said, "I like my job because I love talking with people and learning about them." Our observations and people we spoke with confirmed that this was the case.

Staff responded to people needs, as well as those people who had sensory impairments such as those for sight or hearing. This was in recognition of what the person wanted. For example, by staff speaking slowly, clearly and with respect to people. One person said, "The staff are very caring and respectful to us at all times they do listen to us and they are lovely." Another person told us, "I can talk with staff knowing it's confidential." It was obvious by staff interactions that they really enjoyed being with people and that this was reciprocated. The staff spoke of people's achievements, aspirations and what the person had planned for the coming week.

Staff gave us examples of how they engaged with each person and explained how they promoted respectful and compassionate care. Care staff described and people confirmed various methods they used to help support people with their privacy and dignity. This included methods such as closing a door, letting people do as much of their personal care as possible and giving people the time to do it. One relative told us, "If I visit when staff are helping [family member] they always ask if I can wait which I don't mind." One person said, "It can't be easy for them [staff] I don't have any qualms about being washed anymore as I am used to it now. I can't do without them."

Arrangements were in place to support people and their relatives to be as involved as possible in the

person's care. Examples we saw included staff's day to day conversations as well as more formal reviews. Staff took opportunities to give people the explanations they needed such as why staff provided personal care. A relative said, "The communication [about care] is very good here." One person said, "I see the [service] manager around and if I need any information [about their care] I just ask. Another person told us, "I feel very comfortable with them [staff]. My family do all my [care planning] as this is what I want."

We saw and people told us that as far as possible they were supported in a way which meant the risk of social isolation was minimised. For example, with visits from relatives, friends, community volunteer and religious groups. The service, and registered, manager also encouraged people to get out into the community with a local mini bus and also going for a walk, shopping or to a day centre.

The service user guide book people were provided with when they started to use the service contained information on advocacy. The registered manager confirmed the advocacy arrangements people had in place such as lasting power of attorney for people's health and wellbeing. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes. Other advocacy was provided by well-known national organisations.

Good

Is the service responsive?

Our findings

People's care needs were assessed using a combination of methods. As well as a local authority assessment the registered, and service, manager confirmed that the service was able to meet each person's needs in a person centred way. This was to identify what was important to people such as their preferences, values and beliefs. For example, we saw that one person had a pet cat and to support the person with this staff had put in place a ramp by which their pet was able to access their first floor flat. The provider's PIR stated, "Where relevant this assessment process will include a discussion around how issues of mental capacity, end of life care and positive risk taking will be supported and implemented". We found that the provider accurately assessed people's needs.

Each member of staff was knowledgeable about the individual needs of each person. People's care plans prompted staff as to how best meet each person's expectations in maintaining their independence to live in their own home at the scheme. Staff told us that they found the care plans easy to follow and that these could be referred to at any time. This also helped staff identify people's interests and hobbies and how these could be maintained. For example, going out shopping, exercise classes, watching a film or going out to a local day centre.

Care plans also included the guidance and information staff needed to support people such as to see a priest regularly. One person said, "It means a lot to me to see the priest every week as it's my faith." Other ways used by staff to improve communication was by the provision in the scheme of a library with large font print. Each situation was centred upon the person and what benefited the person the most.

We found that staff had built a good working relationship with each person they cared for and what really made a difference to the person's life. Reviews of people's care had helped ensure that any issues identified such as a change in a person's bed or other equipment was acted upon by the relevant staff. The provider's PIR confirmed to us that, "a key part of these reviews was to gather feedback from [people] on how they felt the service was progressing and any suggestions regarding changes and improvements that could be made". Staff were also asked for their views using a 'say what you see' survey. This allowed all staff to comment on what worked well and where changes were needed such as more staff as more people chose to use the service. Information gathered by the registered manager had resulted in the appointment of a service manager. This was to better manage people's expectations and the staff required to do this.

One person told us, "They [staff] know me so ever so well. I have been here since last year." I don't need to tell the staff [what to do] unless they are very new." Another person explained to us, "If I need anything I just have to ask." A relative told us that "the service was well organised here and [service manager] would sort things out if we ever had to complain". A third person added, I am very independent but they [staff] are there if I need them I love living here and have made friends, I go down [to the lounge] and play scrabble a lot and we all enjoy each other's company." This showed us that the provider and its staff considered the aspects of people's care that were important to them.

Staff supported people with their pastimes including doing a jigsaw, knitting, reading a newspaper or talking

and reminiscing about people's favourite memories. One person said, "Overall I am very happy and quite satisfied, I am sure staff would respond to me if I needed it." This meant that people were supported as far as practicable to maintain and improve their levels of independence.

The service had up-to-date complaints policies and procedures in the form of a service user guide. This included details on how to contact other organisations such as the Local Government Ombudsman. People told us that staff gave them opportunities to raise concerns about their care and that action was taken where required. For people who preferred an alternative format such as in larger font then this was provided. The record of complaints we viewed demonstrated that people's concerns and complaints were investigated and responded to. Reviews of complaints were undertaken to help identify any potential trends. We saw that complaints had been acknowledged and responded to. This had been, as far as practicable, to the complainant's satisfaction. In addition, where the landlord of the scheme was responsible for taking action a process was in place to address these concerns and feedback to people.

Good

Is the service well-led?

Our findings

Ways in which people were involved in improving and developing the service was through a three monthly quality assurance survey. We saw that the majority of responses, which the registered manager had analysed, were that people were either satisfied or very satisfied with their care needs. In addition, the provider's PIR stated, 'feedback is sought in a number of different ways including postal surveys, home spot checks, quality checks by telephone and one on one consultation with people. All of these processes were designed to identify any good practice in place and any areas where improvement was required'.

The service, and registered, manager maintained contact with third parties such as healthcare professionals, the landlord of the scheme and also family members to resolve any identified issues. For example, with soft food diets and the involvement of community nurses where this need had been identified. One person told us. "They [office staff] called me last week to make sure I was happy with my care and if there was anything else I needed." This showed us that the provider considered ways to identify what worked well for people and where changes were needed.

The registered, and service, manager had as a result of the information they had gathered from surveys, audits and spot checks, put together an action plan. These included reviews of risk assessments where people had, or were planning to, return after a spell in hospital. Staff commented that they now found it easier to dispose of clinical waste in the communal bathrooms as bins specifically for this had been provided. Other examples included the provision of a feedback form for the local authority commissioners about any changes in care provision that may be required. This helped the registered manager evidence why, if required, these changes were needed.

Strong links were maintained with the local community and this included assisting people to attend a day centre, see relatives, friends or members of the religious profession. One person told us, "I see the [service] manager every morning and can approach her at any time if I need help." The registered manager and staff confirmed that people were supported to access the scheme's library, visiting artists, singers and musicians. This showed us that there were measures in place to reduce the risk of people's social isolation. We saw that several people enjoyed sitting at the main foyer area of the scheme and meeting various visitors such as healthcare professionals, relatives and a clothing supplier.

The registered manager told us and we saw that staff were rewarded and recognised for their achievements. For example, having awards for their standards of work and the differences they had made to people's lives. The provider's PIR stated that, "we award a care worker each month for their quality of care and support based on compliments from service user and other staff members and compliance with arriving on time, delivering the correct amount of time to an individual. This recognition was then included into a newsletter which was distributed to people and care staff. One staff told us, "If it wasn't for the [registered] manager I wouldn't be in care. She is very supportive as a manager

Care staff told us about the service provider's values. These included treating each person as a person and making sure people came first and foremost in everything. A weekly memo was also distributed to all staff to

remind them of subjects including the conditions of the extra care contract. One relative said, "It's a well-managed place. I have no complaints about anything here, I am very happy." The registered manager kept a monthly record of compliments which included many thank you letters from people and relatives about the way staff cared for people. One compliment we saw stated, "I would like to thank you [staff] all for the way you looked after [family member] over the years. You went way beyond the call of duty and I will never forget that." Staff told us that the reason for this was because the person had been enabled to spend their final days living at the service.

Staff were supported with supervisions, appraisals and on the job mentoring. Staff team meetings were held regularly, staff were expected to attend and they were encouraged to discuss general themes such as any changes to the service people received, the completion of MAR sheets and disposal of waste. For example, one staff told us, "My supervision is definitely a two way process. I highlighted that a [service] manager would be beneficial and now we have one." The provider had commenced a programme of introducing new staff to complete the Care Certificate as well as existing staff completing aspects of this training to assist with their development.

Observations on staff's performance were undertaken frequently. We saw that these checks were to help ensure that people's care was provided to the required standards. These checks also included staff's adherence to any changes such as those to moving and handling practices. The registered manager used the information from senior care staff and the service manager to assess the day to day culture of staff. They could then liaise with the operations' manager with any advice or guidance needed as well as providing praise on the things staff did well.

Staff were confident and described the circumstances they needed to be aware of if they became aware of any poor standards of care. One care staff said they would "always report any staff whose standard of care fell below what was expected and acceptable". Another member of care staff said, "With all the checks in place the [registered] manager would soon take action if things weren't right." All staff we spoke with commented that they would feel supported in raising concerns and that there would be a fair and appropriate response.

The service had a registered manager. The provider is required, by law, to notify the CQC of certain important events that occur at the service and in people's homes. From records viewed we found that they and the registered manager had notified us about these events where required. This was for incidents where the regulated activity of personal care was provided in people's homes

People, and their relatives, told us what the provider did well with regard to their care needs. One person said, "There is always going to be the odd little thing to improve. I have never had any issues and I can't think of anything they could do better for me." This helped confirm that the provider and its staff considered and acted upon what people told them.

All staff commented very positively about the support that management provided. One member of staff said, "I have the [registered and service] manager's mobile numbers and I can call them at any time. I know they would help especially if I am on 'on-call' duty at night." Another care staff told us, "We have an out of hours contact number which is useful if any issues are difficult to resolve on my own." One person told us, "Everyone [staff] is nice and I am happy, [service manager] and [office manager] are lovely." Another said, "The management are very good here and we see them all the time, I am sure staff would respond if I pressed the buzzer, I am happy with things in general."