Fins Care Limited

St Margarets Care Home

Inspection report

22 Aldermans Drive
Peterborough
Cambridgeshire
PE3 6AR

Tel: 01733567961

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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

St Margarets Care Home is registered to provide accommodation and personal care to 16 people. At the time of our inspection 15 older people some of whom are living with dementia were living in the home. The home is situated over three floors with stairs and a stair lift to access upper floors. Two bedrooms are shared double occupancy rooms, and six bedrooms have an en suite with a basin and a toilet. There are communal bathroom and toilet facilities for people who do not have an en suite within their room. There are a number of communal areas within the home, including two lounges and a dining area and an outside area for people and their visitors to use.

This unannounced inspection took place on 28 October 2016.

At the last inspection on 17 August 2015 there was a breach of a legal requirement found. After the comprehensive inspection the provider wrote to us to say what they would do to meet the legal requirement in relation to improvements required. Improvements were needed to ensure that robust safety checks were undertaken on all new staff members prior to their employment. The provider sent us an action plan telling us how they would make the required improvements.

During this inspection we found that the provider had made the necessary improvement and all legal requirements were now being met.

The home had a registered manager; however, they were not in post. They had recently applied to voluntarily cancel their registration and were no longer working at the home. The owner of the home was in the process of completing their application to become the new registered manager and was overseeing the running of the home on a day-to-day basis. 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's recruitment process was followed and this meant that people using the service received care from suitable staff. However, the manager had not followed their CQC action plan in full to ensure that all areas of improvement actions identified at the last inspection had been completed. We found that gaps in a new staff member's employment history were known but not formally documented.

Although we saw that there was a sufficient number of staff to meet the needs of people living in the home the manager could not provide robust written evidence that the decision making process to determine safe staffing levels, was undertaken in conjunction with people's assessed dependency levels.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found that there were formal systems in place to assess people's capacity for decision making. Applications had been

made to the authorising agencies for people who needed these safeguards. Staff had a basic understanding of the key legal requirements of the MCA and DoLS.

People who lived at the home were supported by staff in a kind and respectful way. People had individualised care and support plans in place which recorded their care and support needs. The information was up-to-date and correct. Individual risks to people were identified by staff. Plans were put into place to minimise these risks to enable people to live as independent and safe a life as possible. These documents prompted staff on any assistance a person may require. However, monitoring records for people deemed to be at risk of weight loss or dehydration were not always documented in detail by staff. This meant that although people's risks were identified and minimised by the manager and staff. There was an increased risk that the monitoring kept did not present a complete record.

Arrangements were in place to ensure that people were supported and protected with the safe management of their prescribed medication. Detailed 'step-by-step' guidance for staff about 'as required' medication was not always kept.

There was an 'open' culture within the home. People, their relatives, and visitors were able to raise any suggestions or concerns that they might have with staff and manager and feel listened too.

People were supported to access a range of external health care professionals and were supported to maintain their health. People's health and nutritional needs were met.

Staff were trained to provide effective care which met people's individual support and care needs. Staff understood their role and responsibilities to report poor care and suspicions of harm. Staff were supported by the manager to develop their skills and knowledge through regular supervisions, observations and training.

The manager sought feedback about the quality of the service provided from people living at the home. They had in place quality monitoring checks to identify areas of improvement required. However, these checks were not always formally recorded with a robust action plan detailing what action needed to be taken; by whom and by when to evidence that the improvement had been completed.

Notifications are information on important events that happen in the home that the provider is required to notify us about by law. The manager was not aware of all of the important events they needed to notify the Care Quality Commission about.

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.

Risks to people's safety and welfare were assessed and minimised effectively. Detailed records to monitor people's risks were not always in place.

People's medication was stored, administered and disposed of safely. Detailed guidance for staff on when to administer 'as required' medication was not always in place.

The recruitment process had been followed to ensure that only suitable staff were employed to work with people.

People were protected from harm because staff had an understanding of what might constitute harm and the procedures they should follow. There were enough staff to provide the necessary support and care for people. However, the dependency tool to determine safe staff numbers was not robust.

Is the service effective?

Good

The service was effective.

Appropriate applications were made to the authorising agencies to ensure that people's rights were protected.

Staff were trained to support people. Staff had regular supervisions and appraisals undertaken to ensure that they carried out effective care and support.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were kind, caring and respectful.

People were involved in the decisions about their care.

Staff treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People were supported by staff to take part in activities within the home and in the local community to promote social inclusion.

People's care and support needs were assessed, planned and evaluated. People's needs were documented and met.

There was a system in place to receive and manage people's suggestions or complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems to monitor the on going quality of the service provided. Actions taken or required to improve any shortfalls in the service were not formally documented.

People were involved in the quality of the service being provided to them.

Staff felt supported by manager and they understood their responsibilities in relation to their roles in the home.

St Margarets 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 took place on 28 October 2016 and was unannounced. The inspection was carried out by one inspector and an expert-by experience. An expert-by-experience is someone who has experience of caring for someone who has used this type of care service.

Prior to our inspection we looked at information that we held about the service including the provider's action plan following the last inspection, information received and notifications. Notifications are information on important events that happen in the home that the provider is required to notify us about by law. We also asked for feedback about the service from representatives of the local authority contracts monitoring team and the Cambridgeshire and Peterborough Clinical Commissioning Group. This was to help with our inspection planning.

During the inspection we spoke with the owner/manager; a senior care assistant and a care assistant. We also spoke with four people living at the home, four relatives of people and a visiting community nurse.

We looked at two people's care records; quality monitoring documents; medication administration records, and records in relation to the management of staff.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in August 2015 we found that the provider was not meeting one legal requirement and this area was rated as requires improvement. We found at this inspection that the manager had made enough improvement as they were able to demonstrate that they were following their recruitment policy to make sure that only suitable staff were employed.

At this inspection we looked at the staff recruitment file for the new staff member recruited since the last inspection. We saw that essential pre-employment safety checks were carried out prior to this staff member providing care. Checks included a disclosure and barring service safety check (criminal records), proof of identification, a health declaration (fitness to work) and references from previous employers. This meant that the manager followed their recruitment policy to make sure that new staff employed were suitable to work with the people they supported and were of a good character.

People had risk assessments within their care and support plans which had been reviewed and updated. These records gave information and guidance to staff about any risks identified and the support people needed in respect of these. Risks included people at risk of falls, moving and handling risks, poor skin integrity, poor nutrition and being at risk of heatstroke and dehydration. When people were deemed to be at risk, action was taken by staff to reduce the risk to the person. This included records kept to monitor the measures taken by staff so that they could supervise and take necessary action where concerns had been identified. Although we found that the staff and the manager were minimising people's assessed risks, documents monitoring people's food and fluid intake by staff, were not always a detailed or complete record. We spoke with the manager about this during the inspection and they confirmed to us that they would make the necessary improvement.

People told us that they had no worries about their medication which they received. One person said that they had daily medication and that there, "Had not been any problems." Our observations showed that people were supported by staff with their medication in an unhurried manner. However, we did observe a person being given their medication by a staff member from a plastic cup onto the table for the person to then pick up and take. This did not demonstrate to us that staff always followed robust protocols to reduce the risk of cross contamination.

We saw that the medication trolley was attended at all times and it was noted that the staff member did not sign to say that medication had been given until people were observed swallowing their medication. Staff who administered medication had received training and their competency was assessed by the manager and records we looked at confirmed this.

We found that records of medication administered were complete and we saw that all medication was stored securely and at the correct temperature. Staff we spoke with who administered medication were clear on how medication was to be administered. However, we noted that there were no detailed protocols in place as guidance for staff for medicine to be given 'as required.' We also found that people's handwritten medication administration records did not always have the necessary information on them as a guide for

staff. We spoke with the manager about this during the inspection and they assured us that they would take the necessary action to improve this.

We saw that there were sufficient staff on duty to meet people's care and support needs throughout the day. One person told us that, "[Staff] always come promptly," when they needed them. Staff said that there was enough staff on duty to meet people's needs. One staff member told us that the manager was, "Hands on," and would help cover shifts when required. They went on to say, "If it is too busy the manager would be called and they would come in [to support staff]." Our observations showed that people's care and support needs were met in a timely manner by staff and care call bells responded to promptly.

The manager told us that they assessed the number of staff required to assist people with higher dependency support and care needs. Although at this inspection we saw that there was a sufficient number of staff to meet the needs of people living in the home, the manager could not provide robust written evidence that the decision making process to determine safe staffing levels, was in conjunction with people's assessed dependency levels.

At this inspection we found that some of the chairs people were sat in in the lounge areas were stained. We also noted dirty wheelchair foot plates. The manager told us that the home was currently under refurbishment and that they were replacing the chairs within the next few weeks. They also said that they would look at the cleaning schedules of furniture and equipment in the home and make the necessary improvements.

People and their relatives told us that they or their family member felt safe because of the care that was provided by staff. One person said, "I feel safe here."

Staff demonstrated to us their knowledge on how to identify and report any suspicions of harm or poor care practice. They were able to give us examples of the different types of harm and what action they would take in protecting people. This included the reporting such incidents to their manager and/or any external agencies such as the CQC and social services (local authority). Training records we looked at confirmed that staff received training in respect of safeguarding adults. We also saw that the topic of safeguarding was discussed during staff supervisions with the manager. This was to test the staff members' knowledge of the provider's safeguarding and whistle-blowing policies. This showed us that there were processes in place to reduce the risk of harm to people living in the home.

Staff showed us their understanding of the whistle-blowing policy. They knew the lines of management to follow if they had any concerns to raise and were confident to do so and feel listened to. This showed us that staff understood their roles and responsibilities to protect the people who lived in the home.

The manager was unable to provide evidence that there was an overall business contingency plan in case of an emergency. However, we found that people had a personal emergency evacuation plan in place in the care records we looked at. This showed that there were arrangements in place to assist people to be evacuated safely in the event of an emergency such as a fire.

We looked at the records for checks on the home's utility systems and the buildings fire risk assessment. These showed us that the manager made regular checks to ensure people were, as far as practicable, safely cared for in a place that was safe to live, visit or work in.

Good

Is the service effective?

Our findings

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 applications for this in care homes are called the Deprivation of Liberty safeguards (DoLS).We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

During this inspection we spoke with the manager about the MCA and changes to guidance in the Deprivation of Liberty Safeguards (DoLS). We found that they were aware that they needed to safeguard the rights of people who were assessed as being unable to make their own choices and decisions. Applications had been made for people, who required this safeguard, to the local authority supervisory body and were awaiting authorisation pending a decision.

Staff told us and records showed that staff had training on the MCA. We also noted that staff were tested on their knowledge of MCA and DoLs during their supervision with the manager. This was in place to help embed staff knowledge. On speaking with staff we noted that they had a basic knowledge about the MCA and understood this in relation to the care and support they provided. One staff member said, "The MCA is whether the person is capable of making a decision that is best for them. Just because someone has dementia does not mean that they can't make day-to-day decisions. You use picture cards to help people with their meal choices…try to encourage a sensible choice." This understanding reduced the risk that any decisions made on people's behalf by staff would not be in their best interest and as least restrictive as possible. However, care records we looked at did not always document where appropriate, guidance for staff around decisions to be made in people's best interest. We spoke with the manager during this inspection and they assured us that they were planning to update people's care records and make the necessary improvement.

People said that staff respected their choices. People told us that they felt listened to by staff. One person said about the menus, "You get a choice; you can eat in the dining room, your own room or the lounge." Another person told us, "If you dislike anything they [staff] always get you an alternative." People said that they were happy with the food they received and that there was always plenty to eat. The meal served during this inspection was fishcakes or chicken with chips, peas, and bread and butter. We saw that staff offered people condiments and sauces should they wish. Dessert was a choice of apple pie and ice-cream or trifle.

Senior staff were responsible for cooking. A senior staff member confirmed that currently there was nobody who required a specific cultural, health condition specific or specialist diet. They told us that they would be

able to provide this if needed. People where appropriate, were assisted by staff with their meal and drinks. We also saw that people were supported to eat in their rooms should they choose to do so. One relative said, "[Family member] is eating very well and always has plenty to drink." A person told us, "Oh gosh yes, there's plenty to eat and drink." They went on to say that if they required some assistance staff would cut their food up into smaller bite size pieces to help them. We saw that people were offered drinks and snacks including fruit. One person said, "There's always jugs of blackcurrant, orange and water." This was confirmed by our observations as we noted that there were plenty of jugs of water and squash in the communal areas of the home for people to help themselves to if they wished.

Staff told us that they were supported by the manager. One staff member said, "The manager listens. They will listen to staff experiences and welcomes suggestions." Records we looked at showed us that staff had supervisions with the manager. Staff said that when they first joined the team they had an induction period which included training and support. This was until they were deemed competent and confident by the manager to provide effective and safe support and care. One senior staff member told us that they were being supported by the manager to complete a nationally recognised training course in management to expand their skills and knowledge.

Staff talked us through the training they had completed to make sure that they had the skills to provide the individual support and care people required. Examples of training included; an induction programme; basic fire awareness; infection control; and health and safety. Training was also carried out on food hygiene; basic life support; basic dementia awareness; safeguarding and, moving and handling. This showed us that staff were supported to provide effective care and support with regular training.

People were supported by staff who ensured that they could see a range of healthcare professionals when it was required. These included GPs, community nurses and emergency services. One relative said, "If they [staff] have any concerns at all they will ring the GP." This meant that people were supported with their healthcare needs.

Good

Is the service caring?

Our findings

People were complimentary about the care they received from staff. One person said, "They [staff] always speak to me in a nice way." Another person told us, "They [staff] are all nice people." A relative said, "The staff here are wonderful."

Observations showed that people were clean and well-presented which maintained their dignity. People were also seen to be wearing hearing aids and spectacles when needed to promote their independence and well-being. When staff helped people with their mobility and moving and handling support needs we saw that this was done with respect and care to the person they were assisting. Time was taken to make sure that the person was comfortable and clothing rearranged when necessary to maintain the person's dignity.

We saw that people were assisted by staff to be as independent as possible. Staff encouraged people to do as much for themselves, and prompt people when needed, in a respectful manner. One person said, "I shower myself and look after myself. I don't need any help at all." Another person told us, "I am very independent, I do things my way."

On the day of our visit we saw people's relatives visiting the home and that they were made welcome by staff. A person told us that, "Visitors can come for as long as they want and at any time."

We saw that staff supported people in a kind and patient manner. They demonstrated to us that they knew the people they were assisting well. Some people living at the home were unable to verbally communicate their wishes. One relative told us, "They [staff] know [family member] so well and understand her body language." This was confirmed by our observations.

Staff took time to support people when needed. We saw staff take time to reassure people with distraction techniques, who were becoming anxious, in an understanding manner to try to help them settle. We also noted good examples of how staff involved and included people in their conversations throughout our visit.

People told us that staff respected their privacy and dignity when supporting them. Care records we looked at that had prompts for staff to respect people's dignity at all times Our observations throughout the day showed that people were dressed appropriately for the temperature within the home. One staff member described to us how they enabled a person to choose their own clothes to wear. They told us how they would get weather appropriate garments out of the wardrobe and showed them to the person as a visual prompt so they could make their own choice. This demonstrated to us that people were supported by staff to be involved in making their own decisions and that staff respected these choices. However, we did observe that the two communal ground floor toilets did not have a lock [which could be opened from the outside in an emergency] for people able to use them independently. Therefore we were not fully confident that people were enabled to maintain their privacy and dignity when using these communal facilities.

People told us that they were aware of their care record. Care records we looked at were written in a way which collected social and personal information about the person, including their individual needs.

However, it had been identified at a previous visit that these records needed to be written in a more person centred way with less generic terminology used and more individual information as guidance for staff. The manager told us that they planned on updating people's care records to make these improvements
.
People also had their end of life wishes documented should they choose to. These plans included any wishes to not be resuscitated. Records we looked at showed that people or their relatives were involved in the setting up, agreement and review of their/ their family members care and support plans. People's care and support plans were in place for staff to refer to so that staff had an understanding of the requirements of the person they would be assisting.

People were able to speak up on their own behalf or were supported by a relative who would speak up for them if it was necessary. Advocacy services were available for people on request. Advocates are people who are independent of the home and who support people to make and communicate their wishes.

Good

Is the service responsive?

Our findings

During this inspection we saw people maintaining their interests by reading books, knitting and watching television. We also saw that the home had a pet budgerigar that people could interact with and help take care of should they wish to do so. However, there appeared to be few organised activities for people to take part in during each day. We also received mixed comments from people living at the home about the activities available to them. One person told us, "I like to read and knit, I'm quite happy with what I've got." Another person said how they had taught a staff member to make pancakes and that they had enjoyed this activity. They said that they had particularly liked this when the pancakes they had made had been shared with other people living in the home. However a third person told us, "I'd like to have more quizzes," and a fourth person said, "I'm bored stiff, there's nothing to do here."

Records and our observations showed that people were supported to maintain their links with the local community. On the day of inspection we saw people with their relatives going for a trip out into the community.

We looked at two people's care records during our inspection. These documented that people and/or their relatives had been involved and had signed to agree their/their family member's plan of care and support. Reviews were carried out each month to make sure that people's current support and care needs were documented and up-to-date. Records included basic information on people's social history and any interests they may have documented in an 'all about me' booklet. We saw that people's preferences were recorded and how the person wished their care to be provided was documented. This information enabled staff to understand and get to know the individual they were assisting and what was needed to maintain a person's independence. One person told us, "I manage most things myself but I have to have someone [staff] with me in the bathroom when I have a shower." They went on to say that staff responded positively to their request for a shower and supported them happily when needed.

Staff showed a good understanding of each individual persons support and care needs. One relative told us that, "They're [staff] looking after [family member] very well."

People and relatives we spoke with told us that that they knew how to raise a concern but had not had to do so. They said that they would speak to staff or the manager if they were concerned about anything and they felt that they would be listened to. One person told that they had no complaints, but if they did they, "Would have it out with the person concerned." We asked staff what action they would take if they were aware of any complaints. Staff said that they knew the process for reporting concerns/ complaints and would inform the manager so it could be resolved. One staff member told us, "I would let the person know that the manager would be informed [of their concern]." Records of compliments showed that people and their relatives were complimentary about the care they or their family member had received. Records of complaints received showed that they had been investigated by the manager and the complainant responded to, to their satisfaction. Any actions taken were also recorded by the manager to reduce the risk of reoccurrence.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was not in post during this inspection. They had made an application to voluntarily cancel their CQC manager's registration. The owner of the home was undertaking the day-to-day running of the home. They had started their application process with the CQC become the registered manager.

The manager said there was on-going quality monitoring process with actions taken on any improvements needed. Monitoring included; medication administration records; people's care and support plans; people's nutrition and hydration requirements. Checks were also carried out on people's falls and the forms documenting people's wishes to not be resuscitated. However, the improvements required found during this inspection, had not been identified by these management checks. We also found that as per the previous inspection, improvements found during the manager's checks on the service provided did not always have an action plan in place. This would have provided robust written evidence of any actions required, who was to lead on making the improvement and by when this was to be achieved.

During our review of a staff recruitment file, we also noted that the provider had made some improvement to this previous breach of the legal requirements. However, they had not followed their CQC action plan in full, as gaps in the person's employment history were known about but were not formally recorded. We spoke with the manager about this during this inspection and they confirmed that they would ensure that the necessary actions would be taken to improve this. They also showed us the new and improved policies and procedures for the home and service provided. These new policies and procedures were intended to improve the quality of the service provided and documentation within the home.

The manager was not always aware of the incidents that occurred within the home that they were legally obliged to inform the CQC about. At this inspection we found that the manager had failed to inform the CQC of a serious injury. This lack of knowledge meant that there was an increased risk that the provider was not working in conjunction with the duty of candour to act in an open and transparent manner. We spoke with them about this during the inspection and they assured us that they would notify the CQC of all incidents that occurred that they were legally obliged to inform us about in a timely manner.

Observations showed that people who lived at the home and staff interacted well with the manager. People and their relatives with had positive comments to make about the staff and manager. One person told us that, "[Manager] is very, very nice." Whilst a relative told us that they had been able to have several talks with the manager. This demonstrated to us that the manager made themselves available to the people living at the home and their relatives.

Staff told us that the culture in the home was 'open' and that the manager was supportive. One staff member said, "I like working here. The manager asks staff for suggestions and opinions [on how to improve the service.]"

Records showed that people could attend residents' meetings to discuss and update what was going on within the home. These meetings discussed the refurbishment of the home, the menu, quality of care and

activities. Minutes from these meetings showed that people's feedback was positive overall.

People, their relatives and professional stakeholders were given the opportunity to feedback on the quality of the service provided. Surveys for people were in an easy read/pictorial format to ensure that the majority of people could give their opinion. Feedback which had been received showed positive comments about the quality of the service provided. The provider took note of suggestions raised by this feedback. This included a reminder to people and their relatives that the manager was available to speak to them should they wish to do so.

Staff meeting records showed that staff meetings happened and that they were an open forum where staff could raise any topics of concern they wished to discuss. Meeting minutes demonstrated to us that staff were encouraged at the meeting to make any suggestions that they may have to improve the quality of the service at the home.