Hollyberry Care Limited

Margaret's Rest Home

Inspection report

30-32 Kingsley Road
Northampton
Northamptonshire
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Tel: 01604710544

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10 October 2016

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced focused inspection took place on the 10 October 2016. Margaret's Rest Home provides accommodation for up to 27 people who require residential care for a range of personal care needs. There were 26 people in residence during this inspection. We carried out this inspection as we had received information of concern relating to staffing, the management of people with challenging behaviours and nutrition and hydration.

There was a registered manager in post. 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 did not have suitable systems in place to monitor all aspects of the environment to maintain people's safety. They did not always ensure that the access to the kitchen was secure.

The registered manager had not submitted the required notifications to the Care Quality Commission. The manager immediately provided the notifications and undertook to continue to provide the notifications as required by the regulations.

People who had behaviours that challenged others had risk assessments carried out and staff followed the plans designed to mitigate these identified risks. Staff were vigilant in providing close supervision for people during the times they displayed challenging behaviour. Staff took appropriate action to protect people from others who had episodes of behaviour that challenged. Staff referred people to appropriate healthcare professionals for assessment where people's behaviours had become more frequent.

People's risks were assessed and care plans that mitigated these risks were followed by staff. There were enough staff to provide for people's needs.

People had enough to eat and drink to maintain their health and well-being.

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.

People who had accidents or incidents were appropriately cared for.

People with challenging behaviours were appropriately managed.

There were enough staff to provide for people's needs.

Is the service effective?

Requires Improvement

The service was effective.

People received enough food and drink to help maintain their health and well-being.

People were referred to health professionals and staff followed their guidance.

We could not improve the rating for Effective from requires improvement because we did not inspect the issue relating to the last inspection, and we did not prove that there had been consistent good practice over time. We will check this during our next planned comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a registered manager.

Notifications of accidents and incidents were not always submitted to the Commission.

There were insufficient systems in place to protect people from risks associated with the environment.

Margaret's Rest Home

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Margaret's Rest Home 10 October 2016.

The inspection was undertaken by one inspector. During this inspection we met all 26 people who used the service and two of their families. We looked at the care records of five people. We spoke with the provider, the registered manager, and three staff including two care staff and the cook. We undertook general observations in the communal areas of the home, including interactions between staff and people.

We reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about important events which the provider is required to send us by law. We contacted the health and social care commissioners that help place and monitor the care of people living in the home that have information about the quality of the service.

Good

Is the service safe?

Our findings

We had received information of concern relating to the care and welfare of people who had behaviours that challenged others and staffing levels. During the inspection we did not find any issues of concern relating to people with challenging behaviours or staffing.

Some people who used the service were living with dementia and had episodes of behaviour that challenged others. Staff recorded these challenging behaviours and provided close supervision during these times to help with people's anxieties and protect other people and staff from harm caused by their actions. We observed that staff were providing continual one to one supervision for one person who had been identified as at risk of challenging behaviour. During August and September 2016 staff had recorded, on behaviour charts and handover notes, many accounts of people having altercations with other people living in the home, staff and visitors; some of these incidents had resulted in minor injuries. All of these incidents had been handled appropriately, people had been protected from further harm and relatives were kept informed. Where people's behaviours were becoming more frequent or violent staff had referred them to the appropriate healthcare professionals for assessment of their behaviours and followed the medical advice and treatment prescribed.

People received appropriate care following an accident or incident. Staff recorded the actions they took following any incident which at times required contacting the GP or emergency services for immediate medical assessment. Staff ensured information about the incidents were relayed to the staff arriving on the next shift to ensure that people received continuity of care.

People's needs were regularly reviewed so that risks were identified and acted upon as their needs changed. People's risk assessments were included in their care plan and were updated to reflect changes and the resulting actions that needed to be taken by staff to ensure people's continued safety. For example, where people were identified as being at risk of pressure ulcers people were assisted to move their positions to relieve their pressure areas regularly; equipment such as air mattresses were checked to ensure they were set to the correct level to provide pressure relief.

There were enough staff at the time of inspection to provide for people's needs. We saw that three of the 26 people living at the home were cared for in bed due to their frailty; records showed that staff had regularly attended to these people. The communal areas were staffed at all times. The staff rotas demonstrated that the manager or deputy manager worked every weekday and covered part of the weekend. The staff were experienced in providing care for people with dementia and challenging behaviours; these included nine experienced senior care staff, three of which covered the night shifts. There were care staff vacancies; the manager was actively recruiting more care staff to ensure that people received continuity of care from staff that knew them, and reduce the number of agency or bank staff used.

Requires Improvement

Is the service effective?

Our findings

During our inspection on 15 March 2016 we found that the service required improvements with ensuring that people's mental capacity assessments related to having 'specific decisions' in place. We did not inspect the mental capacity assessments at this inspection as this was a focussed inspection on the concerns that had been raised.

We had received information of concern relating to the nutrition and hydration of people living at the home. During the inspection we did not find any issues of concern.

We found that staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). Staff referred people to their GP and dietitian when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely, for example where people had difficulty in swallowing, staff followed the health professionals advice to provide food that had been pureed.

People were supported to have sufficient to eat and drink to maintain a balanced diet. We observed staff providing fresh fruit and snacks between meals. The kitchen staff had a good knowledge of people's dietary needs and had access to information at a glance which showed people's needs likes and dislikes and were able to adjust meals accordingly.

Where people had been identified at risk of losing weight, their meals were fortified with extra calories and milk shakes between meals. People were encouraged to drink regularly. We observed that people were offered a drink frequently. Staff recorded when people were offered drinks and how much they drank. Staff calculated the amount people drank every 24 hours to ensure that people drank enough every day to maintain their well-being.

Staff maintained records of when healthcare appointments were due and carried out, such as GP review of medicines, eye tests, dentist and the chiropodist. Staff followed the advice of the healthcare professionals; for example in providing care for challenging behaviour.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post since January 2013. They had clear oversight of people's care and they were vigilant in ensuring that staff were deployed to provide care where people's needs changed.

The provider did not have a system of checking that the kitchen door was closed or that access to the kitchen door was secure. They were aware that the kitchen door needed to be closed at all times to ensure the safety of people who had dementia that moved around the home. However, they had not taken enough action to ensure that the door was always closed, and this had led to one person falling in the kitchen. The provider and the registered manager did not take adequate steps to protect people from the risks of accessing the kitchen.

There was no system in place to ensure that people were protected from the risks of using bed rails. We saw that one person in their bed; they had their head rested on the metal bar of a bed rail which had not been protected by padding to prevent injury. Another person who was in bed had a blanket placed over the metal bars which would not have prevented them from trapping a limb between the bars or provide adequate protection from the metal. We brought this to the attention of the manager.

Although the manager had ensured that people received the appropriate care and medical referral when accidents and incidents occurred, they had not submitted notifications to Care Quality Commission in line with the regulations. The regulations require providers to notify the Commission of incidents where people who use the service cause each other harm; this may take the form of shouting or hurting each other as this is a form of abuse. We saw over 20 records of incidents where a people had challenging behaviour where they had harmed others, including throwing furniture or drinks over other people who used the service. Some of these incidents had resulted in minor injuries. Staff had also recorded in handover documents that people had unexplained bruising, scratches or skin tears; which require reporting to the local safeguarding authority and the Commission. We brought this to the attention of the manager who immediately submitted the notifications for the recorded cases. The manager told us they now understood their notification responsibilities and undertook to report these incidents as they happened.