Country Court Care Homes 2 Limited

Marling Court

Inspection report

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Date of inspection visit: 28 and 29 April 2015
Date of publication: 26/06/2015

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

Overall summary

This was an unannounced inspection that took place on 28 and 29 April 2015.

Marling Court is a care home with accommodation for up to 37 frail elderly individuals and people with dementia.

The home 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 and associated Regulations about how the service is run.

This was the first inspection under new proprietors. At this inspection the home met the regulations inspected against.

People and their relatives told us the home provided a good service and they enjoyed living there and there was enough staff. The staff team were caring, attentive and provided the care and support they needed in a friendly and kind way. The home provided an atmosphere that was enjoyable and people said it was a nice to live.

The records were comprehensive and kept up to date. They contained clearly recorded, fully completed, and

Summary of findings

regularly reviewed information. This enabled staff to perform their duties well. People and their relatives were encouraged to discuss health needs with staff and had access to community based health professionals, as required. They were protected from nutrition and hydration associated risks with balanced diets that also met their likes, dislikes and preferences. Relatives were positive about the choice and quality of food available.

The home was well maintained, furnished, clean and provided a safe environment for people to live and work in.

The staff we spoke with were very knowledgeable about the people they worked with and field they worked in.

They had appropriate skills, training and were focussed on providing individualised care and support in a professional, friendly and supportive way. Staff said they were a little apprehensive as this was a new organisation, although so far the organisation's representative had been, open, honest and supportive.

People using the service, staff and relatives said the management team at the home, were approachable, responsive, encouraged feedback from people and consistently monitored and assessed the quality of the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People said they were safe. There were effective safeguarding and risk assessment procedures that were followed. The home had appropriate numbers of well-trained and appropriately recruited staff.

People's medicine records were up to date. Medicine was audited, safely stored and disposed of.

Good

Is the service effective?
The service was effective.

People received specialist input from community based health services. Their care plans monitored food and fluid intake and balanced diets were provided. The home's was decorated and layed out to meet people's needs and preferences.

The home had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures. Training was provided for staff and people underwent mental capacity assessments and 'Best interest' meetings were arranged as required.

Good

Is the service caring?
The service was caring.

People felt valued, respected and were involved in planning and decision making about their care. The care was centred on people's individual needs.

Staff knew people's background, interests and personal preferences well and understood their cultural needs. They provided support in a kind, professional, caring and attentive way that went beyond their job descriptions. They were patient and gave continuous encouragement when supporting people.

Good

Is the service responsive?
The service was responsive.

People had their support needs assessed and agreed with them and their families. They chose and joined in with a range of recreational activities. Their care plans identified the support they needed and it was provided. People told us that any concerns raised with the home or organisation were discussed and addressed as a matter of urgency.

Good

Is the service well-led?
The service was well-led.

There was a positive culture within the home that was focussed on people as individuals. People were enabled to make decisions by encouraging an inclusive atmosphere. People were familiar with who the manager and staff were.

Staff were well supported by the manager and management team. The training provided was good and advancement opportunities available.

Good

Summary of findings

The quality assurance, feedback and recording systems covered all aspects of the service constantly monitoring standards and driving improvement.

Marling Court

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 checked 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 was an unannounced inspection and took place on 28 and 29 April 2015.

This inspection was carried out by an inspector.

There were 33 people living at the home, during the inspection. We spoke with 10 people, two relatives, 10 staff, the deputy, manager and person from the new organisation with responsibility for the transition. We also spoke to service commissioners and other health care professionals such as district nurses.

Before the inspection, we considered notifications made to us by the provider, safeguarding alerts raised regarding people living at the home and information we held on our database about the service and provider.

During our visit we observed care and support provided, was shown around the home and checked records, policies and procedures. These included staff training, supervision and appraisal systems and home's maintenance and quality assurance systems.

We looked at the personal care and support plans for ten people living at the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We contacted health care professionals such as district nurses, doctors and local authority service commissioning and quality assurance teams to get their views of the home.

Is the service safe?

Our findings

People and their relatives said they thought the service was safe. One person told us, "A really good place to be." Another person said "I think there are enough staff to look after us." A further person told us, "It is nice, quiet and relaxed, like being at home." Relatives told us they had never witnessed bullying or harassment whilst visiting the home and had not been told of any by the people they were visiting.

Staff had received safeguarding training and were aware of how to raise a safeguarding alert and the circumstances under which this should happen. Safeguarding information was provided in the staff handbook and a safeguarding pathway with local authority contact numbers was on display in the office. There was no current safeguarding activity. Previous safeguarding issues had been appropriately reported, investigated, recorded and learnt from. The home had policies and procedures regarding protecting people from abuse and harm. Staff were trained in them and we saw staff followed during our visit. We asked staff what they understood as abuse and the action they would take if they encountered it. Their response was appropriate. They said protecting people from harm and abuse had been part of their induction and refresher training. The home was in the process of transitioning from the previous provider's policies and procedures to the new provider's. This did not mean people were unsafe as they understood the previous provider's procedure and followed them.

People's care plans contained risk assessments that enabled them to take acceptable risks and enjoy their lives safely. There were risk assessments for health and aspects of people's daily living including social activities. The risks were reviewed regularly and updated when people's needs and interests changed. There were also general risk assessments for the home and equipment that were reviewed and updated at specified intervals. These included fire risks, hoists and other equipment used. The home was well maintained and equipment used was regularly checked and serviced. There was also an emergency evacuation plan.

The staff shared information within the team regarding risks to individuals. This included passing on any incidents that were discussed at shift handovers and during staff meetings. There were also accident and incident records kept and a whistle-blowing procedure that staff said they would be comfortable using. The care plans contained action plans to help prevent accidents such as falls from being repeated.

There was a comprehensive staff recruitment procedure that recorded all stages of the process. This included advertising the post, providing a job description and person specification. Prospective staff were short-listed for interview. The interview contained scenario based questions to identify people's skills and knowledge of the client group they would be working with. References were taken up prior to starting in post. There was also a six month probationary period, at the start of which new staff shadowed experienced staff. The home had disciplinary policies and procedures that were contained in the staff handbook and staff confirmed they had read and understood them. All staff had completed security checks to keep people safe. Staff employed by the previous provider were given the opportunity to continue to be employed by the new organisation and most had done so.

During our visit there were sufficient staff to meet people's needs and the numbers reflected those recorded on the staff rota. Some staff said they felt stretched at times, particularly on units where people's needs were more demanding. Other staff thought there were enough of them to meet people's needs. Our observations on one unit for people with dementia showed that their needs were safely met. The manager told us that the staff rota was flexible to meet people's needs and extra bank staff were provided if required from within the organisation. They had also put an additional night staff in place and there were two activities co-ordinators who covered the seven day cycle.

The staff who administered medicine were appropriately trained and this was refreshed annually. They also had access to updated guidance. The medicine records were colour co-ordinated to denote different times of the day when administration should take place. The medicine for all people using the service was checked and found to be fully completed and up to date. This included the controlled drugs register that had each entry counter signed by two staff members authorised and qualified to do so. A controlled drug register records the dispensing of specific controlled drugs. Medicine kept by the home was regularly monitored at each shift handover and audited. There were also body maps showing the areas where creams and ointments were required to be administered.

Is the service safe?

Medicine was safely stored in locked facilities and the temperature of designated fridges where medicine was stored was regularly checked and recorded. Any medicine no longer required was appropriately disposed.

Is the service effective?

Our findings

When we visited people were supported by staff to make their own decisions regarding the care and support they received, how it was delivered and also things they might want to do in the home. The home acknowledged that they could make better use of local facilities such as shops, a community centre and pub that had previously been used on occasion but had been underutilised recently.

The staff we spoke with were aware of people's specific needs, knew them well and met those needs in a patient and friendly way. They maintained a comfortable, relaxed atmosphere that people told us they enjoyed. People said they made their own decisions about their care and support and that their relatives were also able to be involved. They said the type of care and support provided by staff was what they wanted and needed. It was delivered in a friendly, enabling and appropriate way that people liked. One person said told us, "Easy going and no problems, I enjoy it here." Another person told us, "The garden is nice to potter about in." A further person said, "My family take me to the shops."

Staff were fully trained and received induction and annual mandatory training. New staff spent time shadowing experienced staff as part of their induction to increase their knowledge of the home and people who lived there. The communication skills that staff used demonstrated that they knew people as individuals and understand the methods needed to understand people's immediate needs and make themselves understood by people.

There was a training matrix that identified when mandatory training was due. The training provided was based on the Skills for Care, 'Common Induction Standards' (2010). It infection control, behaviour that may be challenging, medication, food hygiene, health and safety, equality and diversity and person centred care. There was also access to specialist service specific training such as dementia awareness. Trainers returned unannounced to check that the training was being followed.

Monthly staff meetings identified group training needs and also focussed on communication. Monthly supervision sessions and annual appraisals took place. These were partly used to identify any gaps in individual training. There were staff training and development plans in place.

Staff received mandatory training in The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Mental capacity was part of the assessment process to help identify if needs could be met. The Mental Capacity Act and DoLS required the provider to submit applications to a 'Supervisory body' for authority. Applications under DoLS were in the process of or had been submitted by the provider. Some were awaiting authorisation, others had been authorised as evidenced on their files. Best interests meetings were arranged as required. Best interest meetings took place to determine the best course of action for people who did not have capacity to make decisions for themselves. The capacity assessments were carried out by staff that had received appropriate training and recorded in the care plans.

The home used the 'Malnutritional universal screening tool' (MUST) to regularly assess nutritional needs. Where appropriate weight and hydration charts were kept and staff monitored how much people had to eat and drink. There was also information regarding the type of support required at meal times. Nutritional advice and guidance was provided by staff and there were regular visits by local authority health team dietician and other health care professionals in the community as required. People had annual health checks. The records demonstrated that referrals were made to relevant health services as required and they were regularly liaised with. Staff said any concerns were raised and discussed with the person's GP. There was a GP practice that attended the home every Monday. People were also able to retain their own GP if they preferred. The records we saw were up to date, although some were using the old system whilst being transitioned.

If people required a hospital visit, they were accompanied by a member of staff and written information was provided for the hospital.

Meals took place on the individual units to make them more intimate. People told us they enjoyed the meals provided. A person using the service said, "Always have nice food and carers." Another person told us, "If you fancy something, they will get it for you." During our visit people chose the meals they wanted, there was a good variety of choice available, the meals were of good quality and special diets on health, religious, cultural or other grounds were provided. The lunch we saw was well presented, nutritious and hot. Meals were monitored to ensure they

Is the service effective?

were provided at the correct temperature. The chef visited each unit to ask if people had enjoyed their meals. There was also a kitchen communication book where people could make suggestions.

The home had de-escalation rather than a restraint policy that staff had received training in. They were aware of what constituted lawful and unlawful restraint. There was individual de-escalation guidance available. There were no instances of restraint recorded.

People's consent to treatment was regularly monitored by the home and recorded in their care plans. Staff continually checked that people were happy with what they were doing and the activities they had chosen throughout the visit.

Is the service caring?

Our findings

People told us that the service treated them with respect, dignity and compassion. The staff made an effort to make sure people's needs were met and this was reflected in the care practices we saw. They enjoyed staying at the home and were supported to do what they wanted to. Staff listened to what people said, their opinions were valued and we were told staff were friendly and helpful.

One person we spoke to told us, "It feels like a family and the food is like I do myself." Another person said, "My sister is here too and also very happy." Someone else said, "Everyone knows everybody else and that is nice." A further person said, "The staff are great, so caring." A relative told us, "I'm always made very welcome when I visit."

We observed numerous positive interactions between staff and people using the service. Staff spent time engaging with people, talking, reassuring them about time and place and any visitors that may be expecting. They were familiar with people's preferred names, introduced them to us and asked if they wished to speak with us. Staff respected confidentiality and had discreet conversations with people privately without other people listening to their conversations. Personal care was delivered behind closed doors and staff discreetly enquired if people needed the toilet. They were skilled, patient, knew people, their needs and preferences very well. They took time and made an effort to ensure that people were happy, joined in and enjoyed lives. Staff engaged with people in a friendly, kind and compassionate way. They treated people equally, talked to them as equals and listened to what they had to say. Staff took time to find out about people's lives and what they were interested in. This was supported by the life history information contained in care plans that people, their relatives and staff contributed to and regularly updated. One person was a big fan of a football club and there was much good natured banter between staff and this person that everyone clearly enjoyed. People's personal information including race, religion, disability and beliefs was also clearly identified in their care plans. This information enabled staff to respect them, their wishes and meet their needs. The care plans contained people's preferences regarding end of life care.

The home had an approach to delivering care and support in an individualised way and staff had been trained to promote a person centred approach that was reflected in the care practices we saw. Everyone was treated as a person in their own right rather than a task to be completed. A staff member said that the numbers of people on the units was quite small and this made it easier to be aware of everyone using the service in that area and become more familiar with them. People were involved in discussions about their care and care plans were developed with them and had been signed by people or their representatives. Staff practice we observed demonstrated that staff had a reasonable understanding of caring for people with dementia. Health care specialists said that whilst the general care provided was good and the staff team were caring, there were some concerns regarding the home's ability to deliver later stage dementia care and timing of transfer of people with later stage dementia if needs could not be met. They said this could result from people not wishing to move as this was now their home or difficulty identifying suitable alternative accommodation.

There was an advocacy service available through the local authority and people had been made aware of it. Currently people did not require this service.

The home had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction and on going training and contained in the staff handbook. There was a policy regarding people's privacy, dignity and right to respect that we saw staff following throughout our visit. They were very courteous, discreet and respectful even when unaware that we were present.

There was a visitor's policy which stated that visitors were welcome at any time with the agreement of the person using the service. Relatives we spoke with confirmed they visited whenever they wished, were always made welcome and treated with courtesy.

Is the service responsive?

Our findings

People said that they were asked for their views, opinions and choices by staff and the home both formally and informally and this happened during our visit. This was when staff were aware of our presence and when they were unaware. Staff enabled people to decide things for themselves, listened to them and took action when required. They made themselves available to talk about any problems and wishes people might have and needs were met and support provided appropriately. One person said, "We have everything we need." Another person told us, "You only have to ask staff for something and they will provide it for you." A relative said, "I was involved in the assessment process."

Throughout our visit people were consulted by staff about what they wanted to do and when. They were reminded of and encouraged to join in activities and staff made sure no one was left out. People were also encouraged to interact with each other rather than just staff. There were daily activity plans and two activities co-ordinators. One person said, "The staff are very good and I have enough to do." Another person told us, "The staff are great and I enjoy myself." There was a weekly activities list. The activities included exercise to music, knitting, hairdresser, visiting singer on a Friday, visits to the park, and weekly 'sparkle' reminiscence sessions that highlighted events from the past that took place on specific days of that week that were discussed. There was also a reminiscence area, in the home. People were also encouraged to participate in tasks they would have carried out at home such as drying dishes and setting tables. The home had recently held an Easter fair and a summer one was being planned. One person said, "I'm looking forward to going into the garden when the weather gets better."

Before moving in people were provided with written information and a service guide about the home and what care they could expect. People, their relatives and other representatives were fully consulted and involved in the decision-making process. They were invited to visit as many times as they wished and have meals before deciding if they wanted to move in. Staff told us the importance of considering people's views as well as those of relatives so that the care could be focussed on the individual.

People were referred by local authorities and privately. Assessment information was provided by local authorities and sought for the private placements where available. Information was also requested from previous placements and hospitals. This information was shared with the home's staff by the management team to identify if people's needs could initially be met. The home then carried out its own pre-admission needs assessments with the person and their relatives during visits to the home. As well as identifying needs and required support, the home's assessment included meal observation and interaction with staff and people already using the service. New placements were reviewed after six weeks and then annually.

The home's pre-admission assessment formed the initial basis for care plans. The care plans were comprehensive and contained sections for all aspects of health and wellbeing. They included consent to care and treatment, medical history, mobility, dementia, personal care, recreation and activities and last wishes. They were focussed on the individual and contained people's 'Social and life histories'. These were live documents that were added to by people using the service and staff when new information became available and if they wished. The information gave the home, staff and people using the service the opportunity to identify activities they may want to do. The home was transitioning from the previous provider's recording system to that of the new provider whilst ensuring there were no gaps in the recording of care given. The home operated a keyworker system and the care plans were reviewed by the keyworker, supervisor and person using the service, if they wished, monthly.

People's needs were regularly reviewed, re-assessed with them and their relatives and care plans changed to meet their needs. The plans were individualised, person focused and developed by identified lead staff and people using the service. People were encouraged to take ownership of the plans and contribute to them as much or as little as they wished. They agreed goals with staff that were reviewed and daily notes confirmed that identified activities had taken place.

People and their relatives told us they were aware of the complaints procedure and how to use it. The procedure was included in the information provided for them. There was a robust system for logging, recording and

Is the service responsive?

investigating complaints. Complaints made were acted upon and learnt from with care and support being adjusted accordingly. There was also information provided to contact an Ombudsman, if required.

People and their relatives were invited and encouraged to attend regular meetings to get their opinions. The house meetings took place monthly, were minuted and people were supported to put their views forward including complaints or concerns. The people using the service and relatives meetings and food forums took place quarterly.

Is the service well-led?

Our findings

People and their relatives told us there was an open door policy that made them feel comfortable in approaching the manager and staff. They also said they had good dialogue with the person responsible for the smooth transition to the operational methods of the new provider. Staff also commented that the person responsible had been approachable, helpful and responsive to their concerns, but they were still apprehensive about the change and the organisation could have provided more information. One staff member told us, "The manager is really supportive and lovely to work for." Another staff said, "This is a home from home, I take four buses to get here and wouldn't do it if I didn't love working here and the people." A further staff member told us, "I really feel part of the team." People were actively encouraged to make suggestions about the service and any improvements that could be made during our visit.

The new provider's vision and values were clearly set out. Staff we spoke with were trying to get to grips with them the new procedures that underpinned those values whilst providing day to day care. They said the methods of providing daily care had not changed although there were new methods of recording that they were not yet fully conversant with. They said these were being revisited during staff meetings and the transition manager and home manager were available to advise. The management and staff practices we saw reflected that people's care and support was the primary concern as they went about their duties.

There were clear lines of communication within the organisation and specific areas of responsibility and culpability. There was a transition manager in place from the new provider to facilitate smooth change to new work systems with least disruption to people using the service and staff providing care and support. The managing director of the new providers had also visited to explain how the organisation worked and its philosophy to the people using the service and staff. There was a staff handbook and summary booklet entitled, 'support through your employment' that had been made available to staff.

There was also a whistle-blowing procedure that staff said they were aware of and would be comfortable using. They were also aware of their duty to enable people using the service to make complaints or raise concerns.

Staff told us the support they received from the home manager was good. Most thought that the suggestions they made to improve the service were listened to and given serious consideration by the home. They said they really enjoyed working at the home. A staff member said, "I know the people and they know me, that's why it works".

Records showed that safeguarding alerts and accidents and incidents were fully investigated, documented and procedures followed correctly. This included hospital admissions where information was provided and people accompanied by staff. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

There was a robust quality assurance system that contained performance indicators, identified how the home was performing, any areas that required improvement and areas where the home was performing well. Concerns about staffing levels were picked up, the manager said staffing levels were adjusted as required and there was access to extra staff should they be needed.

The home used a range of methods to identify service quality. Information from house meetings, people using the service and relatives meetings and food forums was monitored and compared with that previously available to identify that any required changes were made. Three surveys per month had been introduced for people using the service, staff and visitors that concentrated on areas such as cleanliness, laundry, staffing, activities and dignity and privacy. There were weekly reports covering areas such as occupancy, staff retention and significant events. Monthly audits included infection control, falls, pressure sores, number of (DoLS) referrals, care plans, risk assessments, the building and equipment. The medicine records were checked at the end of each shift. There were also shift handovers that included information about each person. There were six monthly key point indicator checks proposed in line with the new provider's procedures. The new providers had taken over two months prior to the inspection and these were not yet due.