Solent Cliffs Nursing Home Limited

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Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 20 July 2016 and 21 July 2016. It was unannounced. At our previous inspection in May 2015 we found breaches of four of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not consistently provide care and support that met people's needs; the provider did not always follow the principles of the Mental Capacity Act 2005 where people lacked capacity; the provider did not always support people in a safe manner by means of effective risk assessment; and people were not always treated with dignity and respect. The provider sent us an action plan describing how they intended to meet the requirements of these regulations by March 2016. They kept us informed about their progress by means of monthly updates. At this inspection we found the provider had made sufficient improvements in these areas and was now meeting the requirements of the regulations.

Solent Cliffs Nursing Home Limited is registered to provide accommodation, personal care and nursing care for up to 40 older people and people living with a physical disability. At the time of our inspection the home was fully occupied. People had a variety of nursing needs, including some with very complex needs, and some who were receiving end of life care.

Accommodation was on two floors. There were three shared rooms. One was occupied by a couple. Shared areas included a sensory room, dining room, conservatory and a quiet lounge. There were facilities for people and their visitors to make hot drinks in the sensory room.

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

The provider had arrangements in place to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely. Recruitment processes were in place to make sure the provider only employed workers who were suitable to work in a care setting. There were arrangements in place to store medicines safely and administer them safely and in accordance with people's preferences.

Staff received appropriate training and supervision to maintain and develop their skills and knowledge to support people according to their needs. Staff were aware of and put into practice the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were supported to eat and drink enough to maintain their health and welfare. People were supported to access healthcare services, such as GPs and specialist nurses.

Care workers had developed caring relationships with people they supported. People were encouraged to take part in decisions about their care and support and their views were listened to. Staff respected people's independence, privacy and dignity.

Care and support were based on assessments and plans which took into account people's abilities, needs and preferences. People were able to take part in leisure activities which reflected their interests. People were kept aware of the provider's complaints procedure, and complaints were managed in a professional manner.

The home had a warm, welcoming atmosphere. Systems were in place to make sure the service was managed efficiently and to monitor and assess the quality of service provided.

We have made a recommendation about making sure information in people's care records is complete and consistent.

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 were protected against risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and carried out recruitment checks to make sure workers were suitable for work in a care setting.

Processes were in place to make sure medicines were administered and stored safely.

Is the service effective?

Good

The service was effective.

Staff were supported by training and supervision to care for people according to their needs

Staff were guided by the Mental Capacity Act 2005 where people lacked capacity to make decisions.

People were supported to maintain a healthy diet and had access to other healthcare services when required.

Is the service caring?

Good

The service was caring.

People had developed caring relationships with their care workers.

People were able to participate in decisions affecting their care and support.

People's independence, privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's care and support met their needs and took account of their preferences.

There was a complaints procedure in place, and complaints were dealt with professionally.

Is the service well-led?

Requires Improvement

The service was not always well led.

People's care records were not always complete and consistent.

A management system and processes to monitor and assess the quality of service provided were in place. However care plan reviews had not identified inconsistencies in people's care plan records.

There was a warm, welcoming culture in which people were treated as individuals and could speak up about their care and support.

Solent Cliffs Nursing Home Limited

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 20 July 2016 and 21 July 2016. It was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law. Before the inspection, the provider completed a Provider Information Return. 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 spoke with four people who lived at Solent Cliffs Nursing Home Limited and three visitors. We observed care and support people received in the shared area of the home.

We spoke with the operations director, registered manager, head of care, and administration manager. We spoke at length with a registered nurse, two care workers, an activities coordinator and a cook. We also spoke more briefly with other members of staff about particular aspects of people's care and support.

We looked at the care plans and associated records of 11 people. We reviewed other records, including the provider's policies and procedures, internal checks and audits, quality assurance survey returns, training and supervision records, meeting minutes, staff rotas, and six staff files for recruitment records.

Good

Is the service safe?

Our findings

At our previous inspection in May 2015 we found the service did not always assess and manage risks to people's safety and welfare. People's call bells were not always within reach and powders used to thicken people's drinks were not stored safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements in this area and was now meeting the requirements of the regulation.

People told us they felt safe and comfortable at the home. They said they would speak to staff if they were worried or unhappy about anything. They told us there were enough staff to look after them safely and they received their medicines at the right times. A visitor said they had "no issues" with respect to people's safety.

The provider took steps to protect people from the risk of avoidable harm and abuse. Staff were aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. Staff were confident any concerns would be handled promptly and effectively by the registered manager. One care worker said they had received "lots" of information about safeguarding people.

The registered manager was aware of processes to follow if there was a suspicion or allegation of abuse. They had followed up concerns raised by people and their relatives at a relatives' meeting. They had involved the local safeguarding authority and notified us where necessary. We discussed an allegation which was being investigated at the time of our visit. The manager had involved external professionals due to the severity of the allegations made. They were also taking advice from their personnel consultancy service about appropriate sanctions if allegations against a staff member were corroborated. People were protected because the provider had suitable policies and procedures in place and staff followed them.

The provider identified and assessed risks to people's safety and wellbeing. These included risks associated with falls, skin health and nutrition. Where people were at risk of falls there were records of monthly falls audits which staff took into account when reviewing people's care plans. Where people were at risk of poor skin health, there were audits in place and actions taken to reduce the risk, such as pressure mattresses, use of prescribed barrier creams, and monitoring of people's food and fluid intake. In one person's case the risk assessment process had identified that bruising was a side effect of their prescribed medicine which had been reviewed by their GP and changed.

Risk assessments were reviewed monthly using standard tools to assess people's risks of poor skin health and poor nutrition. Nurses carried out monthly clinical observations including blood pressure, heart rate and temperature. There were monthly assessments of people's ability with respect to a standard set of activities of daily living. Systems were in place to identify changes in people's risk assessments.

Staff had carried out risk assessments with respect to people's rooms. Where people were unable to use the call bell system, or if they were at risk of harm from the call bell cord, arrangements were in place for regular checks by staff. The frequency of these depended on the person's needs and level of risk. One person had received permanent personal support when they first arrived at the home. However records showed they

were now more "settled" and the frequency of their checks had been reduced.

Contingency plans were in place for emergencies, such as fire, gas leak or electrical faults. People had individual, personal emergency plans which showed the support they would need in the event of an evacuation. The service had information from the local authority about how to keep people safe during hot weather and was acting on it. Staff checked temperatures in people's rooms and moved in mobile fans if necessary. Staff moved people out of the conservatory and into shaded areas in the garden as temperatures rose. Drinks and ice were available to help people cool down. The provider took practical steps to keep people safe during unusually hot weather.

There were sufficient numbers of suitable staff to support people and keep them safe. People were satisfied there were enough staff, and staff told us their workload was manageable. We saw staff were able to carry out their duties in a calm, professional manner. The registered manager told us they had changed shift times since our last inspection. Based on people's needs and dependencies they were operating a day shift of two registered nurses and ten care workers, which included a senior care worker acting as shift leader, and a night shift of one nurse and six care workers. Domestic and kitchen staff, together with the management team, were in addition to these numbers.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, professional registration for nurses, and good conduct in previous employment. The registered manager told us they used interviews to identify and screen candidates who were not suitable to work in a care setting. They looked for at least one year's experience and preferred candidates who lived nearby to avoid difficulties traveling to work.

Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable staff from working with people.

Recruitment since our last inspection had reduced the service's dependency on agency staff. All registered nurses were employed by the service. Where agency care workers were used, the registered manager had documented evidence from the agency that the workers met the service's criteria.

Medicines were stored, handled and disposed of safely. There were suitable storage facilities for medicines, including controlled drugs and medicines requiring refrigeration. A nurse had contacted the service's pharmacy to make sure these arrangements were sufficient during hot weather. Tablets and capsules were administered from colour coded blister packs. Medicines in other containers such as bottles and eye drops were clearly marked with the date the container had been opened. There were regular checks to make sure expiry dates of medicines had not passed.

People's medicine administration records were pre-printed with the person's name, photograph and information about any allergies. Records of medicines administered, including prescribed creams and ointments, were accurate and up to date. Where people were prescribed medicines to take "as required" staff noted the time and dose administered which meant there was a full record of what people had taken. Where the service held over the counter remedies for people, staff had checked with their GP or pharmacist that these remedies were safe to take alongside their prescribed medicines.

There were internal and external reviews and audits, and records of staff members who were signed off as competent to administer medicines and handle controlled drugs. Actions arising from audits and reviews were followed up and actioned. One person's records had changed from "crushed" medicines to "can be crushed if the person chooses". Staff took steps to make sure people had their medicines safely and in a

manner that respected their choices and preferences.

Good

Is the service effective?

Our findings

At our previous inspection in May 2015 we found the service did not always follow the principles of the Mental Capacity Act 2005 where people were not able to consent to their care and treatment. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements in this area and was now meeting the requirements of the regulation.

People living at the home and their visitors were confident staff had the skills and knowledge to support them according to their needs. People were happy with the food provided and the choice offered. One person said of the lunch menu, "There is a choice, but I don't always like it. But then you can have something else."

Staff received appropriate and timely training and had regular supervision meetings with a senior staff member. Staff told us they had induction training which prepared them to support people according to their needs. There was regular refresher training in subjects the provider had identified as mandatory. Where the provider's training tracking system had identified staff who were due refresher training, this had been scheduled.

Induction for new staff was based on the 15 standards of care in the Care Certificate. The Care Certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. The head of care also used the Care Certificate standards when carrying out supervisions and observations of staff practice.

Training was primarily classroom based with the head of care having attended "teach the teacher" courses including safeguarding and mental capacity. There was e-learning for medicines training and courses about specific medical conditions. Other training included end of life care and bereavement, which was delivered by an external supplier. The provider had access to a registered mental health nurse who gave practical advice on the latest standards and behaviours staff might find difficult to manage. Training was followed up at the next supervision session to make sure the appropriate lessons had been retained.

People were cared for by staff who were supported to maintain and develop their skills and experience. There were examples of the provider's development leading to career progression for individual staff members. One staff member who started as a care assistant qualified as a registered nurse. A housekeeper had progressed to become administration manager, and a deputy manager had left to become the registered manager at a different service. Staff were encouraged to work towards relevant qualifications.

Staff were aware of the need to only provide care and support with the person's consent. We saw examples of staff explaining what they were about to do and making sure the person understood. Care plans contained records showing people had consented to their care plan where they had capacity.

The Mental Capacity Act 2005 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 the least restrictive 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 Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the Act, and whether any conditions on authorisations to deprive a person of their liberty were being met.

All staff had training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This was followed up by a 20 question quiz to make sure the lessons of the training were retained. Staff used a template provided by the local authority when carrying out capacity assessments. Those we saw complied with the principles of the Act and demonstrated that staff supported people during the assessments. Where appropriate, assessments that a person lacked capacity led to an application for authorisation under the Deprivation of Liberty Safeguards. Some applications were still in process by the local authority, and the authorisations we saw did not have conditions imposed.

Where people were assessed as lacking capacity staff amended their care plans accordingly. They used a standard form to document the care plan topic: "To promote independence and choice within my individual care plans based on my mental capacity." Staff followed the principles of the Mental Capacity Act 2005 and developed people's care plans to put those principles into practice.

People were offered a choice of hot meals, and dietary needs arising from medical conditions such as diabetes were catered for. At the time of our visit nobody living at the home had religious or cultural needs that affected their diet.

Kitchen staff were aware of people's needs and preferences. These were recorded in a folder which contained information on all people's nutrition requirements, such as thickened fluids, pureed diet, and where people needed support from staff to help them eat. Where thickened fluids were indicated, the actual amount of thickener required was stated. People's preferred cold drink, such as blackcurrant or orange squash, was noted.

Staff asked people about their choices for meals in the period before the meal in question which meant people were more likely to remember their choice when it was served. We saw that pureed foods were re-formed into shapes to look as much like the original ingredient as possible, which made them more appetising for the person. Where people were supported to eat, this was done in a sensitive manner. One person's records showed they should be given the opportunity to eat independently before staff offered to assist them, and we saw this was done in line with their care plan.

People told us they were able to see their doctor and other healthcare services when they needed to. Staff kept records of visits by GPs, specialist nurses and other healthcare professionals. People were supported to maintain good health through access to other healthcare services.

Good

Is the service caring?

Our findings

At our previous inspection in May 2015 we observed interactions with staff where people were not treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we only observed positive examples of interactions between people and staff. The provider was now meeting the requirements of the regulation.

One person we spoke with made a distinction between dignity and respect but was complimentary about the caring relationship they had with staff. They said, "I feel I lost my dignity a long time ago, but staff respect me. We get on well." Another person said, "[Staff] are friendly. I get a choice of either staying in my bed or going to the lounge. I prefer my bed."

Staff spoke to people in a respectful way. They made sure people could make eye contact with them, and they used people's preferred names. They explained what they were about to do, for instance "I am going to hold your hand." Staff had time to engage with people in a cheerful and friendly way. One staff member said they liked to "make people smile". There were caring relationships between people and staff. People were assigned a "named nurse" which meant there was an identified staff member who understood their needs and preferences and who people and their families could speak to about aspects of their care.

The service took into account the needs of people's visiting relations. Visitors were offered meals and a bed if they needed to stay near their family member. One person's partner volunteered to work in the home's garden and could bring the family pet with them. People were supported to maintain their family relationships.

People were involved in decisions about their care and support. Records showed the views of people and their families were included in care plan reviews. Staff asked people if they wanted to move out of the conservatory into the garden or back to their rooms when the temperature rose during the day. When they changed the music being played in a communal room, staff asked everybody there what type of music they would like to hear. One person told staff they did not want to be supported to move to a chair using a hoist, and staff made arrangements so they could stay in their wheelchair for lunch.

Records showed that supervisions and observed practice sessions included treating people with dignity and respect. The registered manager told us their recruitment process selected candidates who showed an understanding of the need to treat people with dignity. They said it was one reason why they preferred to employ people with experience of working with people in a care setting. "Thank you" emails and cards received by the service showed people's families appreciated that people's dignity and individuality were respected.

Nobody living at the home at the time of our inspection had particular needs or preferences arising from their religious or cultural background. Records showed this was taken into account during assessments of people's care needs. Equality and diversity were included in staff induction, which meant staff were aware of what to take into account if they should support people from a different cultural background.

Good

Is the service responsive?

Our findings

At our previous inspection in May 2015 we found people's care plans did not always lead to care and support which met people's needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was now meeting the requirements of the regulation.

People and their visitors were satisfied with the care and support people received. One visitor told us, "I am quite impressed with the home. They always meet [Name's] needs. Communication is good." Another visitor said they had no complaints, they were very happy with their relation's care and support and confident it met their needs and preferences. They said, "If I have a problem I just have to ask."

People's care and treatment were based on assessments and care plans which were designed to meet their needs and take into account their preferences. Care plans followed a format which identified people's abilities, needs, preferences, aims and goals, and specific actions required to support them. Care plans were in place for various areas where people needed support, including emotional needs, communication, nutrition, skin care, end of life care and activities.

There were specific care plans for individual medical conditions and identified risks. These included plans to manage a person's epilepsy, and falls risk action plans. One person's plan had instructions for staff to support them with passive exercises. Plans for people's end of life care were detailed, individual and showed where people's families or other advocates had been involved, such as a specialist nurse. There were records of monthly care plan reviews by staff. Every six months people's care plans were reviewed with the person and their family.

Care plans were written in a way that took account of people's individuality and personal needs and preferences. For instance, "I tend to settle down quickly once shower is given" and "I like to have tea with half a teaspoon of sugar in a beaker with a straw before bed as it helps to settle me." Plans included information about people's preferred routines. Staff were aware that one person preferred to stay in bed until lunchtime. Where appropriate staff used a template developed by the Royal College of Nursing and Alzheimer's Society entitled "This is me". This was designed to help different services support people living with dementia when they were in an unfamiliar place.

Care and support provided by staff was recorded in daily logs and other records, such as records of food and fluid intake. Other records showed where treatment had resulted in positive outcomes. For example, one person's pressure injury had healed, and another person with a care plan for managing epilepsy had no recent recorded seizures.

People were supported to take part in a variety of leisure activities, hobbies and entertainments if they wished. These included gardening, bowling, visits to cafés and pubs, attending church and shopping. There were regular visits by the charity Pets as Therapy. Recent improvements to the garden had made it more accessible for people with mobility problems. The service had received positive feedback from people and

their families about the changes to the garden.

Staff organised parties to celebrate people's birthdays and anniversaries. Activities were arranged to coincide with notable calendar events such as St George's Day and St Patrick's Day and to reflect popular television programmes where these could be linked to people's interests such as cooking and baking. There had been fund raising events at the home for charities such as Dementia UK, RSPCA and a local hospice. These events helped to maintain people's interest in the wider community.

The provider's complaints procedure was on display near the entrance to the home. People received a personal copy of it in their "Welcome to Solent Cliffs" booklet which they received to help them find their way round the location and services offered. Minutes of meetings for people living at the home showed they were reminded regularly about the complaints process.

The head of care was responsible for managing complaints when first raised. Records showed six complaints had been raised in the previous year. Five of these had been followed up and resolved to the satisfaction of the person making the complaint. One complaint which referred to arrangements for a period of respite care for a person no longer living at the home was still in progress. People were aware of and made use of the complaints process, and complaints were dealt with in a professional manner.

Requires Improvement

Is the service well-led?

Our findings

People and their visitors were satisfied with the way the service was managed. One person said, "It is all right." Another person said, "I have no complaints." Staff described the management of the service as "caring" and "progressive", and the atmosphere in the home as "warm", "welcoming" and "homely".

The provider had systems and processes in place to review the quality of care people received, but we found the regular reviews of people's care plans had not identified examples of incomplete and inconsistent information in the plans. One person's care plan instructed staff to use one type of equipment when supporting them to move, but their moving and handling risk assessment described the use of a different type of equipment. There was inconsistent information about whether one or two members of staff should assist the person. People's preferences were not always recorded, and in some cases instructions for staff did not describe how the person preferred to be supported. There were blank "This is me" templates in some people's care files. Care plan records were not always dated, which meant it was not possible to tell how up to date the information was.

We recommend the provider make sure care plan reviews focus on identifying inconsistent and missing information.

The provider had displayed their ratings from the previous inspection in the home. However the ratings were not displayed on the provider's website as required by Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We spoke by telephone with the person responsible for maintaining the website. In the days following our inspection the ratings information was displayed on the web site as required by the regulation.

Since our previous inspection the registered manager had changed the structure of their management team with the role of head of care replacing that of deputy manager. The head of care had responsibility for induction, training and supervisions, and worked alongside a clinical manager whose responsibilities included care planning and revalidation of registered nurses. The registered manager told us they had learned the lessons of their previous inspection and that they had the correct management to take the service forward. There had been a visit by the local clinical commissioning group in February 2016 as part of their quality monitoring processes. Their report noted the appointment of the head of care as a positive development.

The registered manager told us they had daily contact with and were supported by the operations director who visited the home regularly and attended meetings, such as the monthly relatives meeting of May 2016. There was a system of regular meetings with staff, heads of department and relatives. These were minuted and actions identified which were followed up in a report from the registered manager to the operations director.

The provider's organisation allowed the registered manager to share ideas with managers of other homes. The registered manager also actively sought advice on good practice from external sources. An example of

this was the home's new sensory area which had been planned based on advice published by Southampton University. They had commissioned a report by an external consultant in February 2016.

There was a system in place to actively monitor and maintain the quality of service provided. This included regular spot checks on nursing and care staff, including those on night shift. The registered manager told us they had worked a night shift and had identified areas for improvement as a result. There were daily audits of housekeeping, tidiness and infection control. There was a weekly audit of call bell responses, and monthly audits of health and safety, falls, pressure injuries in addition to care plan reviews. Where these identified areas for improvement they were included in the service's ongoing action plan or the maintenance book as appropriate.

The monthly health and safety audits included checks on kitchen refrigerator temperatures and people's furniture and mattresses. There were separate audits for the medicines room and cabinets. There were six monthly reviews of infection control and prevention, with the most recent of these in June 2016.