Care South

Maiden Castle House

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

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 18 and 21 November 2014 and was unannounced. The inspection was completed by one inspector. The home was last inspected on the 12 September 2013 and found to be compliant with the outcome areas inspected.

When we visited 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.

Maiden Castle is part of the Care South group of homes. The home provides care and support to 66 older people,

Summary of findings

at the time of the inspection there was 62 people living at Maiden Castle. Many of the staff had supported the people for a long time providing a good level of consistency.

Staff lacked the guidance and support to be able to give medicines safely and in accordance with the relevant legislation. This put people at risk of receiving medicines inappropriately.

People could be confident their care needs were being met and they were involved in the planning of their care. However some people's care records required updating to reflect their current needs. Records relating to the care and support people required did not always give staff the information they required to keep people safe and to meet their needs in a consistent manner.

The provider, Care South, had a system in place to monitor the service offered and to make improvements where required. This system was only partially successful at bringing about change at the home as some issues identified as requiring improvement featured on many service checks carried out by the provider. This meant that whilst issues were identified plans had not been put into place to ensure improvements were made.

People told us staff support them in the way they wished. One person told us "staff never hurry me, they let me do what I can and help with what I can't". Another person told us "I never have to wait long for help, staff may not be able to help straight away but they do come and speak to you and make sure you're alright, they always come back when they say they will".

We spoke with relatives of people living at the home. They told us that the staff and management keep them informed about what is happening through group and individual meetings. Some relatives told us about a 'community feel' to the home and how they felt included in decisions that affected their loved ones, when appropriate.

We observed staff caring and supporting people. We noted that all interactions were kind and empathic. We observed in some areas of the home there was a lot of laughter as staff worked with the people they supported.

People were protected from the risk of abuse because there were clear procedures in place to recognise and respond to abuse and staff had been trained in how to follow the procedures.

People were supported by staff that been employed following a thorough recruitment process and had received appropriate training which was relevant to their roles. Staff told us they felt supported and valued in their roles.

The organisation's values and philosophy were clearly explained to staff and there was a positive culture where people felt included and their views were sought.

Health care professionals told us staff provided a good level of support and care to people living there.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches related to: Administration of medicines, Mental Capacity Act assessments, record keeping and quality assurance at the home. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires Improvement

The service was not safe medicines administration was not safe at the home. People were put at risk of being given medicines inappropriately.

Some people had risk assessments and care plans to keep them safe but not all. This put some people at risk of harm that could have been avoided or minimised.

People were supported by staff that had the skills and experience to meet their needs.

Is the service effective?

Requires Improvement

The service was not effective. The service was effectively meeting the needs of the people who used the service but improvements in the assessment and application of the Mental Capacity Act were required.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs, preferences and choices. Staff training included understanding dementia and positive behaviour approaches. Staff were knowledgeable about the support needs of the people they cared for.

Health and social care professionals were positive about the service and the support that had been put in place for people living at the home.

Is the service caring?

Good

The service was caring. A caring approach was observed by staff. People were respected as individuals. Care was individualised which promoted people's rights. People were treated in a kind and friendly manner.

Staff were aware of people's daily routines and supported them in the way that they wished. People made individual choices about how they spent their time with the guidance of staff. This meant people were treated as individuals and their preferences were recognised.

People were supported to maintain contact with friends and family.

Is the service responsive?

Requires Improvement

The service was not fully responsive to people's needs. Although care plans were in place, which clearly described the care and support each person needed, some of these required updating. People had been consulted about the way they wanted to be supported.

People were encouraged to be actively involved in their care with regular meetings involving family and other health and social care professionals.

Summary of findings

People knew how to raise concerns. Staff knew how to respond to complaints if they arose. One complaint raised by people using the service or by their relatives in the last twelve months had been resolved.

Is the service well-led?

Requires Improvement

The service was not consistently well led. The quality of the service was regularly reviewed. Whilst the systems in place by Care South identified issues that required improvement some of these issues did not have associated plans in place to make the necessary improvements.

There were systems in place to involve health and social care professionals, relatives, staff and the people they supported to ensure an open and transparent approach to the service offered.

Staff confirmed the registered manager was approachable and they felt listened too. Regular staff meetings took place; staff told us they felt supported by the management of Care South.

Maiden Castle House

Detailed findings

Background to this inspection

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about. We reviewed the Provider Information Record (PIR) and previous inspection reports. 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. This enabled us to ensure we were addressing potential areas of concern.

We looked around the premises and observed care practices throughout the inspection. We reviewed six people's care records and the care they received. We reviewed records relating to the running of the service such as environmental risk assessments, fire officer's reports and quality assurance monitoring audits.

We contacted three health care professionals involved in the care of people living at the home to obtain their views on the service and how it was being managed.

We spoke with the 11 people living at the home and four visiting relatives. We spoke with the registered manager and their deputy and seven members of staff.

Due to people's enduring mental health illness some people could not inform us how they experienced care at the service. We therefore carried out a Short Observational Framework Inspection (SOFI) over the lunch time period. SOFI is a tool to help us assess the care of people who are unable to tell us verbally about the care they receive. Observations, where they took place, were from both the SOFI and general observations.

Requires Improvement

Is the service safe?

Our findings

The administration of medicines was not safe. We looked at the medicines administration records (MAR) for six people living at the home. These records showed us that people were dispensed medicines to take on a 'required needs' basis. The reasons for giving the medicines on this basis did not provide staff with clear guidance on when to administer medication for example; one person could be given medicines when needed for anxiety. The care records did not describe what was meant by anxiety and how the person may display this anxiety to the level that would require medicines to help them. The records also did not provide detail of what alternatives to try first and what the triggers might be. This meant that staff may give medicines when other actions may have been just as effective.

We looked at one person's care records and medicines administration records (MAR) to see if the medicines administered on a required needs basis was appropriate. The person had been administered medicines for anxiety on three separate dates. The daily recording made by staff about the person's wellbeing on these days did not indicate that the person had any episodes of anxiety that may require medicines to support them. The staff we spoke with were unable to explain this discrepancy. In another person's MAR it stated that one medicine were to be given covertly. We spoke to staff about how they achieved this; they told us by putting the medicines in their drink. The person's care plan stated that only one medication of two medicines could be given covertly and this one medication was not to be put in their drink. Therefore staff were administering one medicine without due regard to the care plan and one medicine without authorisation to do so. This is in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The risks people faced were managed and assessments were in place to keep people safe. Staff described how they kept people safe without restricting them and supporting them to have control over their life. People's care records illustrated the risks they faced and described what action to take to minimise these risks. However, not all risks had a plan to minimise the risk, for example; one person who had recently taken up residence stated the person had expressed a wish to end their life. The person's care records did not show this as a risk or provide guidance to staff on how to manage this. This meant that the risks the person posed may not be managed in the most appropriate way. Another example was that a person who returned to the home for respite care did not have their risk assessments reviewed to take explore if there had been changes in the risks they faced in their time away from the service. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us, and records confirmed that they had recently received training in safeguarding adults. We spoke with four members of staff who told us how they would respond to allegations or incidents of abuse. In addition, we saw evidence that the registered manager had notified the local authority, and CQC, of safeguarding incidents. People told us they felt safe and did not have concerns about abuse or bullying from staff.

Four relatives also said that they were not concerned about their loved ones' safety at the home. One relative said "there has been an issue; I was kept informed about what had happened and told what the home was doing to protect my relative. I was happy with the action taken and the outcome of the investigation; the staff were very open with me and told me everything I needed to know".

There were sufficient numbers of staff to meet people's needs. People told us there were enough staff to support them when required. One person said, "I never have to wait long for help to get up, staff may not be able to help straight away but they do come and speak to you and make sure you're alright, they always come back when they say they will". Another person told us that "they (staff) can seem a bit too busy at times, but I am always helped when I need it, sometimes I have to wait but I don't mind". One relative told us "they could always do with more staff but that's not always possible, there is always someone when you need them". Another relative said "The staff are busy but always stop and have a chat; there is always someone to talk to if you need too".

We carried out a SOFI during the dinner period in one area of the home. We observed that the staff were well organised and all of the people got the support they required in an unhurried manner. We spoke to staff who told us that at times they could do with an extra person. They also told us that the management had deployed staff in different ways to increase the amount of staff at key times of the day to help out. Two staff members told us the current deployment of staff (to each area) was about right and things were working well. Another staff member shared

Requires Improvement

Is the service safe?

their concerns that if people's dependency increased the current staff levels may not be sufficient. We spoke to the provider about how they assessed staffing levels. They told us they use the following ratio as a guide: Daytime one staff member to five people and one staff member to eight people at night. They informed us that they take into account factors such as "layout of the building, dependency levels, staff and relative feedback and then increase staff levels in line with feedback received".

Requires Improvement

Is the service effective?

Our findings

Mental capacity assessments were not meeting the requirements of the Mental Capacity Act (MCA) 2005. For example one person had been assessed using MCA to have one medicine given covertly. This means the medicine was hidden in food or drinks without their knowledge. This was agreed to be in the person's best interest. However, we found the person was having all their medicines covertly instead of just the one. This had not been agreed it was in their best interest which meant the provider was not following the MCA codes of practice. The provider also had a policy on giving medicines covertly and in this case, had not followed it. The provider had identified this person was receiving all medicines covertly on two separate occasion, though their quality assurance system, but had not taken action to ensure this was in line with their own policy and MCA codes of practice. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The PIR informed us that two Deprivation Of Liberty safeguard (DOLs) authorisations had been made to protect people living at the home from harm. (A DOL's authorisation provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely). We observed that people living with dementia could not leave the area of the building they lived in because the doors were locked. In order to leave the area people therefore had to ask staff to open the door. (A recent court ruling extended when a DOLS may occur to include occasions when people who were unable to leave a building unsupervised may be being deprived of their liberty albeit to keep them safe. In these circumstances application to assess and authorise the DOLS should be made). We spoke with the registered manager to find out if applications had been made in reference to DOL's. They told us they had received advice from the provider, Care South, and had submitted applications to the local authority where required. The registered manager evidenced this and showed us a spreadsheet that indicated when applications had been made and the outcome, if known.

People were registered with a local GP. Care records included information about appointments people had attended and any follow up information. There were systems in place to monitor people's health and to review their health care needs. This included visits to the dentist and opticians. Some of the people we spoke with were aware of the care and treatment they received. Others were not due to their enduring mental health illness. This showed that people's health needs were being met effectively.

People were supported to have sufficient to eat and drink and maintain a balanced diet. We spoke to one person who told us the food was good and they were consulted about what was on the menu. The care records demonstrated how people's preferences were taken into account and recorded their likes and dislikes. Staff described how they were supporting people to make decisions choices and encouraging them to make healthier choices. Staff described how they offered choices at meal times to people living with dementia. They told us that they will show people what is on offer so that they can have a choice. We observed this happening during the inspection.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs and choices. Staff completed induction training when they first started working at the service. We spoke with one member of staff who had recently been employed. They told us that the training they had received gave them good insight into the requirements of the role and the needs of the people living at Maiden Castle.

Staff told us there was sufficient training available such as health and safety, dementia care, end of life, activities and person centred care training. We were told training was a combination of e-learning and face to face training with some training being provided by external providers. Three members of staff confirmed they had regular one to one meetings with a senior member of staff, where they could discuss their role and their training needs. They also explained that there had been a period when these meetings were not being carried out but things had improved recently.

Good

Is the service caring?

Our findings

People were well cared for. We carried out a SOFI over the lunch period in the area for people living with dementia. We observed that staff ensured that people's needs were met in a caring and unhurried manner. When people made requests the staff responded without fuss, for example, one person asked staff to sing, the staff member sang a song that made people smile and relax. Another person told staff they did not want to eat; the staff respected this but returned within two minutes and asked again if they would like a meal, bringing with them a small plate of food for them to see. The person agreed it looked nice and ate the meal. We noted that there was a lot of laughter and positive interaction between the staff and people over the meal period making the experience pleasurable. People were treated with dignity and respect.

People were relaxed in the company of the staff and staff supported them when required.

We observed that staff knew people well and understood the support they needed. An example of this was that when a person became anxious and upset, the staff member just put their arm around them and gently rubbed their back, reassuring them that all was ok. We observed these types of interactions many times during the inspection.

One relative told us that they originally felt the need to come in and check that their relative was being well cared for at different times of the day. They told us that they no longer do this as they were confident in the staffs ability to care for their relative. Another relative told us "when I leave after visiting I have no anxiety because I know people are being well cared for".

We spoke with people who told us the staff supported them in the way they wished. One person said, "staff never hurry me, they let me do what I can and help with what I can't". Another person said, in relation to being assisted to move by way of a hoist, "staff are very caring and ensure I know what they are going to do before they do it, which reassures me". Our observations confirmed that this was normal practice at the home.

We observed that people were treated with dignity and respect. Examples of this was we observed that when a person required assistance with their personal care the staff were discrete and assisted them in such a way as not to undermine their dignity. We heard staff speak to people clearly and at a pace they could follow what was being explained to them. We also observed that when a person told the staff that they did not require any help to stand the staff member withdrew, but kept a watchful presence, close enough to give support if required.

We spoke with people about how staff demonstrated they were respectful to them. One person told us "when I first came to live here they always called me by my surname, but I told them that was not necessary, that was my choice, they now call me by my Christian name". Another person told us that "staff know I like to lie down and rest in the afternoon, they will not come into my room unless I press my call bell for help". Relatives also told us they were treated with respect. One relative told us "although I visit a lot the staff always ask if there is anything that would help to make their loved one more comfortable, they (staff) think about what they are doing and try to make life as pleasant as it can be".

Requires Improvement

Is the service responsive?

Our findings

People's needs were not consistently assessed prior to taking up residency on either a permanent basis or for respite. We looked at one person's care needs assessment who had come into the service for respite. Although this respite arrangement had a degree of regularity the assessment of need that had been carried out prior to this admission only stated "telephone call" but had not recorded the contents of the telephone call to ensure that the service had the most recent information available to support their needs.

We looked at people's care records, some showed that people had been consulted others had not. The words used in people's care records demonstrated that people were treated with respect. Whilst it was clear that staff knew people's individual support needs well, the records themselves did not consistently reflect what we had been told. For example one person's records did not give staff guidance on the person's daily routine, yet by talking with staff and the person concerned it was clear that the person was being supported as they wished. We looked at five people's care records which also did not record people's daily routines, some of these five people were unable to tell staff what their preferences were due to enduring mental health issues. This meant that the care records were not accurate and therefore meant that people may not have had their needs meet in a consistent manner as staff did not have the guidance. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people were aware of their written care plans, some said they had been consulted others could not remember. We spoke to visiting relatives who told us that they considered that their loved ones were well cared for. One relative told us that their relative was living with dementia and needed help in making decisions about their support needs. They told us they had been involved in their care planning and ongoing care reviews. They told us they felt listened too and could raise any issues with the staff or management.

people told us that they were involved in decisions about how they are supported. One person told us that staff had asked them about their daily routines and said "staff know what time I like to get up, what I like to eat and how I spend my day". We asked staff about the person's routines, they were able to describe the person's preferences and how they ensured they were involved about decisions that affected them. One staff member told us "although they (the person) state they like to get up before 7.30am this is actually the time they like to have a cup of tea in bed, they rarely get up before 8am". Other staff described how they ensured people can choose how they are supported. They told us about people's rights to choice in respect of who should care for them, how to ensure people had choices about what to wear and how the person wished to look for example. Staff told us that one person liked to have their nails manicured and polished weekly and to ensure they have their make up on before leaving the privacy of their room as this was important to them.

We spoke to health care professionals who had contact with the service. One professional told us that on a health care basis people's needs were met but they had concerns about the staff's ability to meet people's welfare needs. We spoke to people living at the service about this. Most people told us there were things to do if you wanted. One person told us about the summer garden project and how they had enjoyed being involved in choosing and planting vegetables and flowers. We observed a group activity for people living with dementia which appeared to be appreciated by those involved. We also observed that staff took time to sit and speak with individuals and groups at regular intervals. However there were also times when people living with dementia were alone without direct staff support. At these times the people became quiet and withdrawn.

We spoke with one of the activity coordinators and two members of staff engaged in social support. They acknowledged that more needed to be done to offer activities that support people's interests and abilities. As such they were able to demonstrate that they were carrying out individual assessments of people's abilities and interests in order to tailor activities based on individuals. This meant that staff acknowledged the need to provide more meaningful activities and had a plan to address this.

The people knew who the registered manager was and how to raise issues if they needed to. All those we spoke with told us that they had not needed to make a complaint and that if there was an issue they would tell staff who would address this.. People's relatives told us there were relative's meetings where they could raise issues if needed. One relative told us that they "felt part of the community at

Requires Improvement

Is the service responsive?

the home, I can join in activities and make suggestions knowing I will be listened to". Another relative told us they had raised an issue with the registered manager about the laundry service stating, "it was sorted out there and then". The provider had policies and procedures for dealing with complaints or concerns. This was made available to people and their families. There had been one formal complaint in the last year. We saw evidence that the registered manager took a proactive approach and responded to the issues raised according to the policy.

Requires Improvement

Is the service well-led?

Our findings

The operations manager of Care South produced an overall audit of the home in November 2014 which we looked at. This report commented on the quality of service provided at Maiden Castle for the provider. The audit evidenced that where the operations manager had cause for concern action was taken to address the issue such as; in August 2014 the number of formal staff supervision was below what was expected but in the October 2014 it was reported that arrangements had been made and staff were receiving supervision as expected. This evidenced areas of improvement where action had been taken. However, it also highlighted areas of concern where no action had been taken since the previous audit such as concerns over medicine administration, care planning reviews and gaps in recording safety checks on equipment.

We spoke with the registered manager about the plans in place to address these concerns. They acknowledged that there was "still work to be done" but there was no recorded plan of how this was going to be addressed. This meant the provider had identified issues at the home, but action plans had not been made to address these and improve the service. This is in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

There was management structure in place at the home. The people living at the home could identify who the registered manager was, some told us, "that's who you go to if you are unhappy". One person told us about visits from the operations managers and knew that they could speak to them if they had concerns. This was also mentioned by one visiting relative. Staff were aware of the roles of the management team and they told us the registered manager was approachable and available to discuss issues most of the time.

Staff told us that the organisation's values were clearly explained to them through their induction programme and training. Staff were given handbooks which described the aims and philosophy of the service. There was a positive culture where people felt included and their views were sought. One visiting relative told us, "it's like a community here and I feel part of it". There was evidence of regular meetings taking place between the people who used the service, their relatives and other professionals involved in their care. Staff meetings were organised and there were minutes of the discussions and actions agreed.

Staff confirmed they understood how they could share their concerns about the care and support people received. Staff also told us the registered manager and senior staff was responsive to suggestions about improvements to the service

Staff told us of the value of regular team meetings where they could share their experiences and talk about how they had approached emerging situations. Two staff members told us these meeting were used to debrief them if there had been a significant incident so that lessons could be learnt. Staff explained the value of team work, one staff member told us about the importance of team work stating, "positive relationships between the team (of staff) result in positive relations with the people we support".

We received feedback from three professionals who commissioned services on behalf of the people who used Maiden Castle. They told us they found the organisation had an open culture and had kept them informed about incidents that had occurred. They described the culture of the organisation as 'reflective' which listened and responded appropriately. One professional said, "they provide a good service in a nice environment. They work well with us and provide the care we purchase".

Records showed that staff had recorded accidents and incidents. Where people had been involved in an incident or an accident, for example a fall, the staff recorded the cause, the injuries and the immediate actions or treatment that had been delivered. The records were checked by the registered manager, who assessed whether an investigation was required and who needed to be notified.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider had a system to regularly assess and monitor the quality of service that people receive but this was not fully effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with medicines because the provider had not made appropriate arrangements to manage medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Where people did not have the capacity to consent, the provider had not acted in accordance with legal requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.