Care Quality Commission

Southborough Care Home Limited

Southborough Care Home

Inspection report

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Date of inspection visit:
25 August 2016

Date of publication:
23 September 2016

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

Summary of findings

Overall summary

This unannounced inspection took place on 25 August 2016.

Southborough Care Home provides care and support for up to 12 older people, some of whom may be living with dementia. At the time of our inspection, there were 12 people living at the home. The home had a variety of animals with which people could interact.

The home had a registered manager, as is required by the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our inspection we found that people were safe at the home. Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments in relation to the running of the home. These were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences. There were effective processes in place to manage people's medicines and referrals to other health and social care professionals were made when appropriate to maintain people's health and well-being.

There were enough skilled, qualified staff to meet people's needs. Staffing levels had been based on the dependency levels of the people who lived at the home. Robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. Staff were trained and supported by way of supervisions and appraisals.

People or relatives acting on their behalf had been involved in determining their care needs and the way in which their care was to be provided. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met. People and their relatives were involved in the regular review of people's care needs and relatives were kept informed of any changes to a person's health or well-being.

People had a choice of good nutritious food that they liked and their weight was monitored, with appropriate referrals made to other healthcare professionals when concerns were identified.

There was an up to date complaints policy in place and a notice about the complaints system was on display at the entrance to the home. There was information on the notice boards around the home about the service and organisations that could be contacted for support or to report concerns.

There was a very friendly, family atmosphere at the home. People, relatives and staff were able to make suggestions as to how the service was provided and developed. An effective quality assurance system was in

place.

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.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

People's medicines were administered safely and as it had been prescribed. Arrangements for the ordering, storage and disposal of medicines were robust.

There were enough skilled, qualified staff to meet people's needs

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink

Staff and managers were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

People were provided with information about the service.

Is the service responsive?

Good

The service was responsive.

People's needs had been assessed before they were admitted to

the home to ensure that these could be met.

People and relatives had been involved in the development of care plans which took account of people's preferences and were reviewed regularly.

There was an effective complaints policy in place

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place.

The registered manager was visible and approachable. The provider was involved in the overall management of the home.

There was an effective quality assurance system in place.

Southborough Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 August 2016 and was unannounced. The inspection was completed by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). 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 reviewed the information available to us about the home, such as notifications. A notification is information about important events which the provider is required to send us by law. We also reviewed information about the home that had been provided by staff and members of the public.

During the inspection we spoke with three people and three relatives of people who lived at the home, two care workers, the chef and the registered manager, who is also a director in the provider company. We carried out observations of the interactions between staff and the people who lived at the home.

We reviewed the care records and risk assessments for three people, checked medicines administration and reviewed how complaints were managed. We also looked at two staff recruitment records and looked at how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

People and relatives we spoke with told us that they felt people were safe and secure living at the home. One person told us, "I am absolutely safe. It is the general environment. It is so peaceful and clean." Another person said, "I feel safe. It is all very calm." A relative told us, "As soon as I walked in I saw that it was comfortable and secure. The staff are very attentive. When we were being shown around the care worker left us to go and assist someone who was on their knees looking for something on the floor."

Visitors were required to sign in and out of the building. It was explained that this information would be used if there was an emergency that required the building to be evacuated to ensure that everybody was accounted for. The registered manager showed us the pendant alarms that people were given before they went out of the building to alert staff if they needed assistance. This meant that even when outside, people could attract staff's attention so that they could be supported quickly.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Information about safeguarding was displayed on a noticeboard in the entrance hall, together with details of the telephone numbers to contact should people wish to. The staff we spoke with told us that they had received training on whistleblowing and safeguarding procedures. They were able to explain these to us, as well as describe the types of abuse to be aware of. One member of staff told us, "I had my training not long ago. If I suspected abuse I would go to the manager or speak to other senior staff. I can go on-line to check the policy and procedures."

Risks posed to people by the care and support they received had been assessed, and personalised risk management plans put in place to minimise potential risks to people. For example, one person had risk assessments which included how to manage risks associated with their mobility, the risk of them falling and the use of a portable radiator in their room. The registered manager told us that they had tried to dissuade the person from using this radiator as the home was heated efficiently. They had explained the risks associated with its use to the individual. However, the person was happy to accept the level of risk this posed to them. The portable radiator offered them comfort and reassurance as they had used it in their own home. The appliance was tested regularly to ensure that it was safe to use.

Where people had been assessed as at risk of falling, a record was kept of every fall that the person experienced to enable potential causes to be identified. The control measures for each of the identified risks were detailed in order for the staff to know how to support people in a way that minimised risks. We saw that people or their relatives had been involved in developing and reviewing their risk assessments, which had been reviewed monthly or when people's needs had changed. Staff told us that they were made aware of the identified risks for each person and how these should be managed by looking at people's risk assessments, their daily records and by talking at shift handovers. Staff therefore had up to date information and were able to reduce the risk of harm. Each person had a personal emergency evacuation plan (PEEP) in place, which had been reviewed and updated as people's needs had changed.

The registered manager had carried out annual assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the handling of potential hazardous substances, as well as the individual risks identified for each area of the home, such as in people's bedrooms, the staff room and kitchen. Checks were also carried out to ensure that equipment had been serviced and portable appliances had been tested. There was an emergency plan in place, which included information of the arrangements that had been made for major incidents such as the loss of all power or water supply. Accident and incident forms were completed appropriately and were analysed monthly to identify any trends or changes that could be made to reduce the risk of harm to people who lived at the home.

People and relatives told us that there was always enough staff on duty to care for people. One person said, "There is always someone around." Staff seemed to have time to spend with people without appearing to be rushed or stressed.

Staff told us that there were always sufficient staff on duty and if they were short, staff from an adjacent home owned by the provider would provide cover. One of the senior care staff lived in an accommodation in the grounds of the home and provided urgent cover when needed. The registered manager told us that the staffing levels had been determined by the dependency levels of the people who lived at the home. Of the 12 people who lived at the home,10 were relatively independent with low dependency levels. Only two people had high dependency levels. Staffing levels had been set at two care staff at all times. This ensured that there were sufficient staff to provide the support of two members of staff for people who required transfer by a hoist.

We looked at the recruitment files for two members of staff who had recently started work at the home. The provider had robust recruitment and selection processes and we saw that appropriate checks had been carried out. These checks included Disclosure and Barring Service Checks (DBS), written references, and evidence of their identity. This assisted the provider to make safer recruitment decisions and confirm that staff were suitable for the role to which they were being appointed.

We saw that people received their medicines as prescribed and that medicines were stored and administered in line with current guidance and regulations. Only trained staff administered medicines and they confirmed they had received regular training updates.

Each medicines administration record (MAR chart) included an advice chart with information about any 'as required' (PRN) medicine. However there were no individual protocols which would advise staff of when the medicines should be given or of any interaction that may occur with other medicines that the person took. We looked at the MAR charts for all of the people living at the home and saw that these had been completed correctly and medicines taken by people had been recorded. We checked stocks of medicines held for two people which were in accordance with those recorded. There were robust processes for auditing medicines administration.

Good

Is the service effective?

Our findings

People and relatives we spoke with were confident in the ability of the staff to provide effective care for the people who lived at the home. One person told us, "I think the staff are well-trained. They deal with any problems very well indeed." Another person said, "The staff know how to take care of me." A relative said, "I can't fault them. They look after [relative] very well."

Staff told us they had received induction training and had on-going training to help them undertake their roles. One member of staff said, "I shadowed (observed experienced staff) for three shifts at the sister home before I started here. There was no time limit [to the shadowing]. I was confident to start here." Another member of staff said, "I started as an apprentice. When I started this role I had induction and shadowed for about two weeks." They went on to say, "There is always training coming up. I get emails to remind me and it is down to us to check. All the training is done on-line. We discuss training needs during supervision." They told us of the benefits they had noticed following training in dementia care. They said, "It made me understand what they are going through. It makes it easier to understand how to help them."

The registered manager checked that members of staff were up to date with their training during their supervision meetings. This enabled them to have confidence that people were supported by staff who had the necessary skills to do this effectively.

Staff told us that they had regular supervision meetings. One senior member of staff told us, "We have regular supervision and discuss performance and training needs. We discuss what needs to be improved and reflective practice." We saw that supervisions and appraisals for staff were scheduled throughout the year.

People's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked at the home's records around the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and saw that these had been followed in the delivery of care. One relative told us, "We held a meeting and made a best interest decision for [relative] not to be admitted to hospital again. [Relative] was pleased to come back here to their home [following their last discharge from hospital]." Care records showed that staff had carried out mental capacity assessments for one person that had addressed choosing their clothes and dressing, personal care and choosing meals. These assessments had been followed by meetings to make decisions on the person's behalf. This made sure that these decisions were made within the legal framework to

protect people's rights.

Staff told us of ways in which they gained consent from people before providing care. They explained that they understood non-verbal methods of communication by observing facial expressions, gestures and showing people items to gain consent and give them choices. One member of staff told us, "We get to know their actions and their personalities. We interact with them all the time and they can interact with us on some level, even if it is just making eye contact." Another member of staff told us, "I ask them a lot. Such as when they would like to get changed [for bed]. If they do not want to I would try again later." Our observations confirmed that these methods were used effectively to gain consent and understand people's needs.

People had mixed comments about the food but they appeared to enjoy their meal at lunchtime. One person told us, "I get three good meals a day and sweets all day if I want them." Another person said, "the food is very good. It's also a bit like the food I would have at home. There is enough choice and variety." However one person said, "I don't think a lot of the food. They don't cook very well." We had however, observed this person eating their lunch. They had eaten it all and had appeared to enjoy it.

We saw from menus on the tables that people were offered a wide choice for breakfast. This included full English breakfast, bacon sandwiches, toast and cereals. Cooked food at breakfast time was prepared by the care workers. We spoke with the chef who told us that the meals, other than breakfast, were cooked at the neighbouring home and transported in sealed dishes to hot plates within the kitchen area at the home. The care workers offered people a choice of two main meals the day before and people could order alternative foods if they wished. We saw that some people had requested and been provided with alternative meals and in the afternoon the care workers asked people what they wanted for the following day. A choice of three home-made desserts was available, as well as yoghurt and ice cream.

Where people needed assistance to eat their meal, this was provided in a caring and sensitive way. People were assisted to eat their meals at their own pace. Staff waited until they were ready before offering them more food. Throughout the time they assisted people, staff spoke with them and offered gentle encouragement to eat sufficient quantities to maintain their health and well-being. When one person complained that they were too hot and it was noisy in the dining room, staff suggested that they move to a lounge area where it was quiet and cooler. Although initially reluctant, the person agreed to move and ate all their meal in the quieter, cooler surroundings.

The chef told us that the menus were planned on a four week cycle using people's food preferences as a basis for the food choices. The menus changed on a seasonal basis. All food was freshly prepared. They used only fresh fruit and vegetables which was delivered from a local source. Basic cupboard foods were delivered by a local supermarket whilst they shopped at a cash and carry for meat, sweets and biscuits. People's personal choices were catered for. One person did not like to eat cakes or dessert, so after a conversation with the chef, they were provided with a choice of fresh or a variety of stewed fruit or cheese and biscuits.

We saw that drinks, biscuits and sweets were always available in the communal areas. Staff encouraged and supported people to drink frequently. Hot drinks and snacks were provided both mid-morning and mid-afternoon, but staff were happy to make people a hot drink at any time. Care records included nutrition assessments and associated eating and drinking care plans. People's weight was monitored, and food and fluid charts were completed for people where there was an identified risk of them not eating or drinking enough. This provided detailed information on what they had consumed. Where people had been identified as at risk of weight loss, they were given fruit shakes to build them up. These were made from strawberries,

condensed milk, cream and honey. We saw that although one person's food chart showed that they ate very little they had not lost any weight because they had been drinking the fortified fruit shakes. Where required, appropriate referrals had been made to the GP and Speech and Language Therapists (SALT) for advice on how to support people effectively with their nutrition.

People were assisted to access other healthcare professionals to maintain their health and well-being. A relative told us, "They got the physio in to ensure [relative] had the right size frame and they got the doctor to check their medication." When healthcare professionals visited people at the home, the reason for the visit and the outcomes had been included in the care records. There was evidence that staff had appropriately responded to people's needs as they arose, such as making referrals to their GP and the occupational health services.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us that the staff were kind and considerate. One person said, "The staff are always very pleasant and very helpful." Another person commented, "I am very well looked after. I can't fault it. It is a very, very good place." A relative said, "I would recommend this place to anyone."

Positive and caring relationships had developed between people who used the service and the staff. One person told us, "They know what I like." Staff were able to demonstrate that they knew the people they cared for well, were aware of their life histories and were knowledgeable about their likes and dislikes. One member of staff told us, "The life history helps with conversation topics. It helps to get to know them as a person. It really does help. They appreciate it and it helps them remember stuff too." We observed the staff interacting appropriately and continually with people throughout the day.

We saw that people were able to make decisions about their care. One person told us, "I get up when I want to." A member of staff said, "A lot of people like their routine. They like certain things at certain times and are used to their routine." People could choose where they sat or if they wanted to take part in any of the activities that were on offer. People had a choice of two lounge areas, which both had television sets, and they could choose which channels to watch. People moved from lounge to lounge and out into the garden as they wished.

People told us that the staff protected their dignity and treated them with respect. One person told us, "They come in to help if I am in the bath. They don't leave me in the bathroom on my own but they always treat me with dignity."

Staff told us of how they respected people's privacy and dignity by knocking on their door and, where possible, waiting for permission before they entered. They also ensured that before personal care was provided they closed doors and curtains were drawn. We saw that when staff spoke with people about whether they needed support with personal care in the communal areas, this was done discretely.

People were encouraged to be as independent as possible. One person told us, "I go out walking whenever I want to. I go for a stroll most days." People and relatives told us that relatives were free to visit at any time during the day and evening. One person told us, "My [relative] comes most days on their way home from work. They can come at any time. We never have a problem." Another relative told us, "We can come at any time. We always get a drink and staff are willing to chat."

Information about the service, safeguarding, the complaints policy and fire evacuation instructions was clearly displayed on notice boards around the home. Contact details for an advocacy service to assist people if they needed this were displayed on a notice board in the dining area. Photographs of various events and birthday parties held at the home were also displayed. The registered manager told us that people and staff liked to use these to remind them of the events that took place and the people who no longer lived at the home.

Good

Is the service responsive?

Our findings

People and relatives told us that they had been involved in assessing their needs before they were admitted to the home. A relative told us, "We talked about what [name] needed before they came. I told them that [name] was very quiet and would sit in a corner and needs to be drawn out."

People had been visited by one of the managers who had assessed whether the provider could provide the care they needed before they moved into the home. They undertook a thorough pre-admission assessment that determined the care plans that were necessary to meet their needs.

These care plans followed a standard template which included information on their personal history, their individual preferences and their interests. Each plan included information about their life history and a section about 'factors to maximise contentment' and had been completed with the assistance of relatives. One relative told us, "They definitely listen to us." One record detailed that the person liked reassurance from staff and family. We observed that staff frequently reassured this person during our inspection. Although they chose to spend most of the day in their room, staff checked on them regularly and spent time talking with them and supporting them.

There were individualised care plans to reflect people's needs and included clear instructions for staff on how best to support people with specific needs. These were reviewed on a monthly basis or as people's needs changed. One person told us, "They talk to me about what help I need." A relative told us that a care plan was in place to reduce the risk of their relative developing a urinary tract infection. Following their recent discharge from hospital this had been amended to include waking them during the night to drink fluid in order to flush their kidneys. Relatives told us that they were kept informed of any changes to people's health or well-being. One relative told us, "If I ring they tell me how [relative] is and even what [they] had for breakfast." Another relative said, "They tell me everything that is going on."

Some people told us that they were supported to maintain their hobbies and interests. One person told us, "I really enjoy just sitting watching the television. There is always something I like on." However, another person said, "There is not enough to do. I have books and enjoy reading but my eyesight isn't very good. I can't see the television very well. I sit in the garden. I used to enjoy gardening." We saw a member of staff give them a selection of books that had larger print and were easier to read. They appeared to be much happier after receiving the books.

The registered manager told us that the care staff supported people in maintaining their hobbies and interests. There were large print copies of puzzles and word search games in the entrance hall that people could take. These were replaced regularly to give people a variety. There were also other games, such as cards, bingo and throwing bags that staff used to interact with people. The activities programme showed that there were different activities scheduled each day for morning and afternoon sessions. These included music therapy, colouring and puzzles. We saw people playing cards and completing puzzles. During our inspection, a priest visited to give communion to people. The registered manager told us that children from a local school also visited regularly to sing and play the recorder.

The registered manager told us that one person had been interested in woodwork before they were admitted to the home. The registered manager had purchased equipment suitable for the environment so that they could continue with their hobby but they no longer wished to use it. People were discouraged from having televisions in their rooms. The registered manager told us that the aim was to prevent people from becoming isolated in their rooms. We saw groups of people sitting chatting together in the lounge areas.

People and staff at the home were very keen on keeping animals. As well as two dogs, a cat, two budgerigars, tortoise and turtles that lived at the home, there were three visits a year by an organisation called 'Animal Allsorts'. These gave people the opportunity to handle other animals, such as bearded dragons. We saw photographs which evidenced people's obvious enjoyment at this activity.

There was an up to date complaints policy in place and a notice about the complaints system was on display in the home. People told us that they were aware of the policy but had not needed to make any complaint. One person told us, "I haven't had any problem. If I did I would go to the manager." Another person said, "If I had any problem I could go to any of the staff." A relative told us, "I have not had any complaint." We looked at the record of complaints received but there had been no entries for the last three years.

Good

Is the service well-led?

Our findings

People, relatives and staff told us that the registered manager, who was also a director of the provider company, was supportive and approachable. One person said, "The manager comes in and asks if everything is okay. She comes in every day and if I wanted to talk to her I could." A relative described the registered manager as "Very approachable." Another relative told us, "The registered manager has said if I want anything then it is no problem."

We noted that there was a very friendly, family atmosphere about the home. There was good rapport between staff, relatives and the people using the service which gave a very homely feel and helped to stimulate people.

The manager held meetings with the people and their relatives to enable them to contribute ideas for ways in which the service could be improved. In addition, the registered manager had sent questionnaires to gain feedback on the service and improvements that people wished to see. The last set of questionnaires had been sent in September 2015 and suggestions, such as changes to the menus, had been actioned. People had requested that fish and chips be included on the menus on a regular basis. It was one of the options for lunch on the day after our inspection.

In addition, the registered manager had implemented a system where people and visitors were invited to make comments and suggestions for improvements to the service. Cards were provided on which people could make their suggestions which they then posted in a red box in the entrance hall. The registered manager told us that this was emptied regularly and all comments and suggestions were reviewed. They had made changes to the garden area and obtained a gazebo to offer a sheltered area following suggestions received. This showed that the registered manager had listened to and acted upon suggestions made for improvements to the service.

There were regular meetings with staff which all staff were encouraged to attend. These meetings gave staff the opportunity to make suggestions as to how the service could be improved and the registered manager also used them to update staff on policies and procedures. This demonstrated that people were supported by staff who were committed to driving improvements in the service.

The registered manager told us of planned improvements and possible expansion of the home. These included the provision of more staff accommodation on site which would improve access to staff in an emergency.

The registered manager had carried out a number of audits of the quality of the service. These had included checks on their infection control measures, the environment, care plans and medicines. Areas for improvement identified following these checks were discussed with the relevant staff and the registered manager checked that the actions were completed. Senior care workers worked with more junior staff to review their working practices and give advice and guidance when this was needed. The registered manager was also very 'hands on' and worked with staff at all levels. This meant that she was able to identify any

improvements that could be made to working practices.

People's records were stored in a locked cupboard within an office used by staff and this was accessible only by using a key pad. This meant that people's records were secure and could only be accessed by persons authorised to do so.