The Salvation Army Social Work Trust

Smallcombe 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?	**Good**

Overall summary

We carried out an unannounced inspection of Smallcombe House on 10 and 11 November 2014. At the last inspection we found there were breaches of legal requirements for Care and Welfare Regulation 9, Cleanliness and infection control Regulation12 and Assessing and monitoring the quality of service provision Regulation 10. The provider acted on the actions we asked them to take by devising an action plan on how the regulations were to be met. The provider said compliance with the regulations was to be achieved by 31 July 2014 and we found improvements had taken place.

Smallcombe House provides care and support for a maximum of 32 older people. The home is managed by The Salvation Army Social Work Trust. The home is located close to the city of Bath.

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

Summary of findings

People told us the staff were caring, their rights were respected and the staff knew how to meet their needs. They told us about the day to day decisions they made and told us when they complained the registered manager acted immediately to resolve their concerns. Members of staff said they felt supported by the registered manager and training for staff to fulfil their roles was provided. The staff knew to provide a person centred approach, the care and treatment they delivered had to centre on the person. We observe the interaction staff had with people. We saw staff use an encouraging manner when people were reluctant to eat their meals. We saw the staff approach people discreetly to support them with personal care. When people became frustrated or behaved inappropriately, the staff knew how to help them to settle and moderate their behaviour.

The provider was not meeting Regulation 20 records and Regulation 13 management of medicines. People were at risk of not receiving the care and treatment they needed because the records were not kept to an appropriate standard. Regulation 20. People were placed at risk of potential harm because staff did not always sign the medicine administration record (MAR) chart to indicate they had administered medicines. Failure to sign MAR charts can be confusing because other staff may repeat the administration of the same medicine. Regulation 13. 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 always safe. Medicine systems needed improving and people may be at risk from unsafe management of medicines. We saw staff had not signed the medicine administration record after they administered medicines. Protocols were not in place to direct staff on when to administer medicines prescribed to be taken when needed.

People told us they felt safe at the home. Safeguarding adults training was provided to the staff and policies and procedures were available to the staff for reference. The staff knew the signs of abuse and the actions they needed to take if they had suspicions of abuse.

People told us their bedrooms were clean and there were systems in place to maintain the home clean. Infection control training was provided to the staff but people may be placed at risk from the spread of infection because the vents in en-suite bedrooms and sluice rooms needed cleaning.

Is the service effective?

Requires Improvement

The service was not always effective. People may be at risk from staff who were not supported with their roles and responsibilities. Annual appraisals to review the staff's performance and set developmental goals had not taken place for all staff. The staff we asked told us they felt supported to perform their roles and responsibilities but structured supervisions of staff were not taking place regularly.

People told us the types of day to day decisions they were able to take and who helped them make more difficult decisions. People's ability to understand the consequences to the decisions about their health and finance was assessed. Within the Mental Capacity assessment form, where appointed, was the name of the person with legal authority to help make difficult decisions.

People told us the meals were good and the menu was varied. The staff were able to identify people at risk of malnutrition and during mealtimes we saw staff encourage people to eat their meals. The level of risk of malnutrition was assessed and where people were at risk, care plans were developed to monitor people's health.

People told us they saw their GP regularly and their healthcare was monitored. The records we looked at showed people had access to social and healthcare professionals and received ongoing healthcare support.

Is the service caring?

Good

The service was caring. People told us the staff were caring. The staff we spoke with understood the needs of people and how to respond to them in a person centred way. Care records described the support people needed to manage their care.

Summary of findings

People told us their privacy and dignity was respected. The staff gave us examples to describe the way people's rights were respected. We saw staff approach people discreetly to offer help with personal care. When people showed their frustration in their behaviour staff sat with the person to help them settle.

Is the service responsive?

Requires Improvement

The service was not always responsive. People told us their personal care was delivered the way they wanted. The staff knew the principles of person centred approach. They told us getting to know the person, their preferences and routines ensured they delivered care and treatment that centred on the person. The keyworker system gave staff the opportunity to have one to one time with specific people. Care plans directed the staff on the support people needed and included was their background histories and preferences.

People told us they were able to make complaints. They told us the manager acted immediately to resolve their complaints. The complaints procedure was on display which described how the organisation managed complaints.

Is the service well-led?

Good

The service was well led.

The views about the home were gathered through surveys from people, their relatives and social and healthcare professionals. The manager acted on their comments to improve the quality of service people received.

The staff and people we spoke with knew the organisation was a charity with a religious background. We were told the registered manager was approachable.

There were a range of systems and audits used to assess the quality of care and treatment provided to people. The set standards of care were audited and where gaps were identified an action plan was devised to ensure there were improvements.

Smallcombe House

Detailed findings

Background to this inspection

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

This inspection took place on the 10 and 11 November 2013 and was unannounced.

Before the inspection, we asked the provider to complete 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 also looked at notifications (important events that affect people's health and welfare that must be reported to the Care Quality Commission) received and information from commissioners of the service. During the inspection we spoke with six people, three relatives and a Community Psychiatric Nurse (CPN). We spoke with the area manager, manager, members of staff including housekeeping staff and we observed the interaction staff had with people.

We looked at the care records of six people, policies and procedures, schedules and monitoring charts, staff rotas and training records, audits of systems, reports of accidents and incidents and medicine administration records. We contacted the commissioner of the service following the inspection.

Requires Improvement

Is the service safe?

Our findings

Medicines were stored correctly and disposed of safely but records of administration were not accurate. People told us that staff administered their medicines. We saw staff were not completing the medicine administration record (MAR) charts correctly. Staff were not signing the MAR charts when they administered medicines and on one occasion had signed the MAR chart but the medicine was not administered. People were placed at risk of potential harm because staff did not always sign the medicine administration record (MAR) appropriately to indicate they had administered medicines. Failure to sign MAR charts can be confusing because other staff may repeat the administration of the same medicine. The manager told us further medicine training was to be provided to ensure staff were using the correct procedure for recording medicines administered. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

When required medicines were prescribed to some people. The team leader knew the purpose of when required medicines were prescribed to people and when it was appropriate to administer them. Protocols for administering when required medicines were not in place. People may not be having their when required medicines consistently administered by the staff.

Supplies of homely remedies (medicines bought over the counter medicines and used to treat minor ailments) were not kept in the home. A team leader told us GP were asked to visit and prescribe the appropriate treatment for the person's medical conditions.

A record of medicines no longer required was maintained and signed by the member of staff making the entry. A team leader told us the procedure for disposing of medicines refused. Refused medicines were placed in individually labelled bags with the name of the person, the date and the medicine refused. A record was also made on the MAR chart to show the medicine was refused.

People told us their bedrooms were kept clean. Housekeeping staff showed us the cleaning schedules in place which specified the way each area of the home was to be kept clean and the frequency for cleaning. Infection control audits were undertaken to ensure the home was kept clean and minimised the risk from the spread of infection. We toured the property and looked in people's bedrooms, communal areas, sluices and laundry room. All areas were clean except for the vents in en-suite bathrooms and sluices. The vents were dusty and needed to be cleaned. This meant people may be at risk from the spread of infection. The staff told us they had attended Infection control training. Infection control procedure underpinned the organisations approach to minimising the spread of infection. The policy covered the staff responsibilities towards other legislations such as COSHH and RIDDOR. The standard principles of hand hygiene, protective clothing and the management of waste were included in the policy.

People told us they felt safe at the home. One person said "they check on me" and another said " I never feel frightened." The two relatives we spoke with said their family members were safe from abuse and one relative said "the staff are caring, no worries about my parent being abused."

Staff knew the expectations on them to safeguard people from abuse and the duty they had to report poor practice. They knew the signs of abuse and the actions they needed to take if they suspected abuse. Staff told us they discussed safeguarding people from abuse at team meetings. One member of staff was able to describe an incident where the safeguarding procedure were followed. We saw the Bath and North East Somerset Council Safeguarding procedure was on display in the home. This meant the people at the home, the staff and visitors had access to the procedure for reporting suspicions of abuse.

There were people who at times behaved in a manner others found difficult. The staff's knew how to respond to behaviours which placed people and others at risk. The staff knew how to recognise triggers and the medical conditions that may cause the person to behave in a way the staff found difficult to manage. We were told the techniques used to diffuse the situation. Staff told us when people were reluctant to accept personal care they were given time or other staff were asked to approach the person.

People's dependency levels were assessed to determine the risk associated with developing pressure ulcers, malnutrition or falling. The risk assessments we looked at did not include an action plan to lower the level of risk identified.

Requires Improvement

Is the service safe?

One person told us they had a fall and staff "checked me over." We saw the staff used appropriate and safe moving and handling techniques to support people at risk of falls or with physical disabilities. The staff told us the people at the home needed support from one member of staff to move around the home and to transfer. We saw hoists were available and the staff we asked knew when people needed additional support with moving and handling from the hoists provided.

People told us there were sufficient numbers of staff on duty to meet their needs. One person said, "the staff keep an eye on me." Another person told us the staff answered the call bells promptly. The staff told us the staffing levels were adequate to meet the needs of people. We looked at the rota in place and saw the staffing levels during the week and at weekends were maintained by permanent staff. We saw with the manager there was a team leader on each shift to supervise caring staff, administer medicines and liaise with social and healthcare professionals. However, activities were not taking place regularly. The manager told us the way staffing levels were to be organised to provide a member of staff designated to provide activities.

Requires Improvement

Is the service effective?

Our findings

People told us staff had the skills needed to meet their needs. The staff told us there was an induction when they started work at the home. The three new staff we spoke with said their induction programme took two weeks to complete and it covered all aspects of their role. They told us their induction included shadowing more experienced staff, reading policies and procedures and that some topics were on tape which they watched. One member of staff said "my induction was spot on I was given a booklet that had everything I had to learn. The team leader and other carers helped me cover all the topics."

The training records listed the essential training staff must attend to work at the home. Essential training included moving and handling, health and safety, food hygiene, infection control, safeguarding adults, and first aid. We saw from the training records that not all staff had up to date moving and handling training. The area manager told us staff were to receive refresher moving and handling from a member of staff with training experience. The staff confirmed they had attended essential and other specific training for them to meet the specific needs of people at the home. For example, dementia training and for team leaders medicine training. They told us a healthcare professional visiting the home had facilitated training to the staff in dementia and managing difficult behaviours.

New staff told us they had one to one supervision (meeting with the line manager to discuss the staffs' performance and personal development) with a team leader during their induction. Staff told us supervision was from the line manager. However, structured supervision for all other staff had not happened regularly. The manager told us supervision had lapsed due to senior staff shortages. We were told the timescale for all staff to have one to one supervision with a line manager was the end of November 2014. It was explained with the exception of four all staff had an annual appraisal.

People told us the types of day-to-day decisions they made and where difficult decision had to be taken who helped them to make these decisions. They told us the decisions they made centred on meal choices, their appearance, and the times they got up or went to bed. One person living with dementia said, "I make decisions about what to wear." Another person said, "I make all my decisions including complex ones." A third person told us their solicitor helped them make decisions about their finances and about where they lived. Staff gave us examples to explain how people were encouraged to take decisions. During the lunchtime meal We saw staff offering people a choice of meal and refreshments. We saw staff help people make decisions about their meal by saying and showing choice of meals to the person.

We looked at the mental capacity assessments records for six people. Mental Capacity Act 2005 (MCA) assessments were used to identify the level of decisions people were able to make and who helped people with more difficult decisions. We saw the mental capacity assessments were partially completed. This means the staff may not be aware of the person's level of capacity to make decision because types of decisions people were able to make or who helped the person make more difficult decisions were not recorded.

The manager told us Deprivation of Liberty Safeguards (DoLS) applications were made to prevent harm to three people who lacked capacity to make decisions. DoLS 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. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom. The DOLS applications we saw had been submitted by the manager but authorisation from the supervisory body was outstanding.

People told us the meals served were good and they had a choice of meals at all mealtimes. One person told us they had gained weight since their admission to the home. Another person told us their meals were textured because they were at risk of choking. We were told the textured diets were presented in an appetizing way. We observed a relaxed pace at meal times and staff encouraged people to eat their meal. We heard staff say, "try a little bit more "or "do your best." We saw when people attempted to leave without eating staff encouraged the person back by saying "you haven't had your dessert, what about a yogurt?"

The staff were able to identify the people at risk of poor nutrition and hydration. The staff said where people were at risk of malnutrition, they monitored their food and fluid intake. We looked at the care records of six people and assessments were undertaken to determine the person's level of need. The Malnutrition Universal Screening Tool

Requires Improvement

Is the service effective?

(MUST) assessments we saw were not fully completed for each person. Where the MUST assessments were completed correctly included the person's body mass index (weight and height) to identify the risk level of malnutrition. Where People were at high risk of malnutrition the action plan included monitoring food and drink, offering snacks and fortified drinks. We were told people were weighed monthly to help the staff with early detection of possible deterioration in health. However the monitoring records we viewed showed people at high risk of malnutrition were not weighed monthly or where appropriate more regularly. Care plans did not reflect the results from the MUST assessments and monitoring charts. For example, MUST assessments were not used to develop care plans for eating and drinking and the monitoring charts were not used to review or evaluate the care plans.

People told us they saw their GP regularly. One relative told us they supported their family member on dental appointments. This relative said the home kept them informed about important events such as falls and changes in medicines. Team leaders told us part of their role involved liaising with social worker, district nurses, GP, and physiotherapists. We saw staff recorded the visits from social and healthcare professionals and the outcome of the visits. For example, occupational therapists, district nurses, chiropodists and social workers. A Community Psychiatric Nurse (CPN) told us the staff had request a visit for support with managing behaviours others found difficult to manage. The CPN told us the purpose of the visit was to provide guidance to the staff on how to respond to these behaviours. We saw the CPN had recorded the guidance given to staff on the person's daily record.

Good

Is the service caring?

Our findings

People at the home were able to communicate verbally with the staff. The staff told us people were able to understand people's preferences. One member of staff said "we ask people."

People told us the staff were caring. One person said "the staff are caring, they keep an eye on me." A community psychiatric nurse (CPN) present during the inspection said the staff were compassionate and "hold people in high regard." A relative told us the staff were caring and staff cared for people as individuals. The staff understood people's needs and how to respond to them in a person centred way. One member of staff said the principles of person centred care included having a keyworker role which involved providing personal care, helping the person maintain relationships with family and friends and making healthcare appointments.

The care records we looked at included people's background histories and "who am I" booklets but the records were not always fully completed. Care plans included information about how the person was able to manage their care and the support they needed from the staff to meet their needs. A member of staff said when they were delivering personal care they discussed with the person what was important to them. We saw staff explain to people the choices available and encouraging them to make choices. For example where to sit and refreshments.

People told us they were not involved in the reviewing process of their care plans. A relative we asked said they discussed the care needs of their family member with the keyworker. The manager told us once the head of care was appointed the care planning system was going to be reviewed and updated.

Staff respected people's rights. People told us the staff respected their privacy and dignity and gave us examples to show the way they were respected. For example, knocking on doors and having en-suite facilities. One person living with dementia confirmed the staff knocked on their bedroom door before they entered. A relative said staff showed respect because their family member was always addressed appropriately. We saw staff approach people discreetly to help them with continence needs and when people attempted to remove their clothes. We saw staff sitting in the lounge with people which helped them settle and keep calm.

Requires Improvement

Is the service responsive?

Our findings

People told us the staff always delivered their personal care the way they wanted but a meeting to discuss their care needs did not take place. The personal routines and background histories were not included in one of the six care plans we read. Where this information was documented the first person (from the author's point of view) was used. The staff told us the keyworker system and talking to the person ensured they got to know people's preferences and routines. One member of staff told us there was a person centred approach to meeting the needs of people at the home. This member of staff said the person centred approach ensured all staff were able to meet the person's need in their preferred manner. For example, asking people how they wanted their care to be delivered. A Community Psychiatric Nurse (CPN) consulted during our visit said the staff used a person centred approach to meet people's needs.

People told us they were not involved in their care plan reviews. One relative told us discussions had taken place with the keyworker about the needs of their family member. Members of staff told us the team leaders developed the care plans and the key workers updated the information in the care plans.

The care plans we looked at lacked detailed and did not reflect people's current needs. Care plans were not devised for all areas of need, for example how to meet the needs of a person living with dementia. All aspects of needs were not assessed as part of the monthly review. For example, the care plan for personal hygiene said one person was able to manage their personal care, the monthly review notes said there was "no change" but the daily reports showed the staff were at times experiencing difficulties. The monitoring charts such as food and fluid intake were not used to update the action plans on how to meet people's changing needs. The staff told us during handovers they were told about people's changing needs. The manager said the staff were to have support to develop person care plans from a Head of Care. This would happen once a member of staff was in this post.

People were not protected against the risk of unsafe or inappropriate care and treatment because records were not accurately maintained. For example, care plans lacked detail on how the staff were to meet the identified need. Risk assessments did not tell staff how to respond to the risk identified. Other records such as monitoring charts and medicine administration records were not consistently completed by the staff. This is a breach of Regulation 20 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010

People told us they were able to keep themselves occupied during the day with such activities as reading, walking and watching the television. A relative told us activities were not organised regularly. A schedule of activities was on display and included religious services but the range of activities was limited. People told us their attendance to the religious services was voluntary. The manager told us the plans to appoint a member of staff to provide structured activities for people. People told us the staff helped them maintain contact with family and friends. On the day of the inspection we saw administrative staff help one person contact their relative overseas.

People told us they approached the manager with their concerns. One person said "if you say they act immediately." Two relatives told us they had complained and the manager helped resolve their complaints. We saw the complaints procedure on display in the home which informed people how to raise their concerns. The staff told us they passed complaints they received to the manager. The manager said the aim was to resolve complaints informally and as they arose. We looked at the log of complaints and the most recent complaint made was in 2010. The manager told us minor or verbal complaints or concerns were not recorded in the complaints log.

Good

Is the service well-led?

Our findings

The views of people, their relatives and professionals that visit the home were sought through surveys. The manager told us people, their relatives and professional were asked for their feedback about the home twice yearly. We saw the feedback from the most recent survey was good but the responses were not analysed. The manager told us they intended to work through each comment made in the survey. One relative told us they were invited to house meetings and their views were sought during these meetings.

The staff told us the organisation had a religious background with an aim to help the needy in a kind way. One member of staff said the organisation had charity status. They told us the manager was always available and they were able to bring issues to the attention of the manager. Staff said the manager used staff meetings to keep them informed about policy changes and shared with them information that impacted on the running of the home. For example the staff were aware of the findings from the Care Quality Commission report.

Visits by the area manager to monitor the quality of care delivered to people at the home by the staff took place monthly. We saw the area manager audited the systems in place and devised an action plan where gaps were identified. It was the responsibility of the manager to ensure the action plan was met. We saw the manager was working through the action plan. For example auditing medicine systems.

Incidents and accidents were analysed to identify trends and patterns. An electronic system was used to record accidents and incidents which the area manager told us was able to identify trends with the times of the accident, the staff involved the person and the cause of the accident.

Safeguarding referrals and Deprivation of liberty safeguards (DOLS) were analysed by the manager. A record of the nature of the incident, the organisation contacted and the outcome was recorded with supplementary detailed information about the incident.

We discussed with the manager the plans in place to improve the person centred approach to meeting people's needs. We were told senior staff were to be employed to oversee shifts and to help staff develop care planning systems. It was also explained the restructuring of staff taking place to provide people with more structured and meaningful activities.

The manager audited the medicine systems and the care planning and staff performance processes. The manager told us medicine systems were audited at the end of the month, care plans were audited to ensure people's needs were reviewed regularly and supervision to ensure staff received the support they needed. The manager told us individual supervision and appraisals were not up to date and gave us the timescales for ensuring staff had supervision and an annual appraisal.

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected against the risk of unsafe or inappropriate care and treatment because records were not accurately maintained. Regulation 20 (1) (a).

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 placed at risk from unsafe recording of medicine administered. We saw staff were not completing the medicine administration record (MAR) charts correctly.