Jigsaw Care Limited

The Village Nursing & Care Home @ Murton

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The Village Nursing & Care Home @ Murton provides personal and nursing care to a maximum of 40 people some of whom are living with a dementia. At the time of the inspection there were 37 people who used the service.

This inspection took place on 9 November 2017. The inspection was unannounced, which meant that the staff and provider did not know we would be visiting. At the last inspection of the service on 30 September 2015, we rated the service as Good. At this inspection the service remained Good.

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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff understood the procedure they needed to follow if they suspected abuse might be taking place.

Risks to people were identified and plans were put in place to help manage the risk and minimise them occurring. In general medicines were managed safely with an effective system in place. However, we did note some areas in need of improvement and the registered manager wrote to us after the inspection confirming these improvements had been made.

Staff competencies, around administering medication, were regularly checked. Appropriate checks of the building and maintenance systems were undertaken to ensure health and safety was maintained.

People and relatives told us there were suitable numbers of staff on duty to ensure people's needs were met.

Pre-employment checks were made to reduce the likelihood of employing people who were unsuitable to work with people.

The registered manager had systems in place for reporting, recording, and monitoring significant events, incidents and accidents. The registered manager told us that lessons were learnt when they reviewed all accidents and incidents to determine any themes or trends.

People were supported by a regular team of staff who were knowledgeable about people's likes, dislikes and preferences. A training plan was in place and staff were suitably trained and received all the support they needed to perform their roles.

People were supported with eating and drinking and feedback about the quality of meals was positive.

Special diets were catered for, and alternative choices were offered to people if they did not like any of the menu choices. Nutritional assessments were carried out and action was taken if people were at risk of malnutrition.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, further work was needed to ensure decision specific Mental Capacity Assessments and best interest's decisions were in place when people lacked capacity.

The premises were clean and tidy and people and their relatives told us they liked the homely atmosphere. The service was well maintained with appropriate furniture throughout. The registered manager had carried out research, attended workshops and training to ensure there were some dementia-friendly aspects to the environment in the 'memory loss' area of the service.

We observed numerous examples when staff were kind, caring and courteous. Privacy and dignity of people was promoted and maintained by staff. Explanations and reassurance was provided to people throughout the day.

Care plans detailed people's needs and preferences. Care plans were reviewed on a regular basis to ensure they contained up to date information that was meeting people's care need. Staff encouraged people to actively participate in meaningful leisure and recreational activities that reflected their social interests and wishes and maintain relationships with people that mattered to them. The service had a clear process for handling complaints.

The registered manager was aware of the Accessible Information Standard that was introduced in 2016. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.They told us they provided and accessed information for people that was understandable to them. They told us their service users guide and other information was available in different formats and fonts.

Staff told us they enjoyed working at the service and felt supported by the registered manager and senior staff. Quality assurance processes were in place and regularly carried out to monitor and improve the quality of the service. The service worked with various health and social care agencies and sought professional advice to ensure individual needs were being met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains safe.	**Good**
Is the service effective? The service remains effective.	**Good**
Is the service caring? The service remains caring.	**Good**
Is the service responsive? The service remains responsive.	**Good**
Is the service well-led? The service remains well led.	**Good**

The Village Nursing & Care Home @ Murton

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 9 November 2017. The inspection was unannounced, which meant that the staff and provider did not know we would be visiting. The inspection was carried out by one adult social care inspector, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service, which included notifications submitted to CQC by the provider.

We had requested 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 used this information to help plan for the inspection.

During the inspection we reviewed a range of records. This included four people's care records and six people's medicines records. We also looked at three staff recruitment files, including supervision, appraisal and training records, records relating to the management of the service and a wide variety of policies and procedures. We spent time observing people in the communal areas of the service and at lunch time.

We spoke with the registered manager, deputy manager, activity co-ordinator, two nurses, three care staff and a team leader.

Good

Is the service safe?

Our findings

People who used the service and their relatives told us they felt safe. One person said, "Yes, we can lock the doors, but we would be safe even if we left them open." Another person told us, "They [staff] are very, very good indeed and they come as fast as they can. I accidentally pressed my buzzer during the night when it had fallen down the side of the bed and was amazed at how quickly the response was. Amazed but secretly really happy, it has put my mind at ease since." Another person commented, "There is no bullying or harassment." A relative told us, "My mind is at ease knowing [person] is so well looked after."

Policies and procedures for safeguarding and whistleblowing were accessible and provided staff with guidance on how to report concerns. Staff we spoke with had an understanding of the policies and how to follow them. Staff were confident the registered manager would respond to any concerns raised.

People and relatives told us there were suitable numbers of staff on duty to meet their needs. During the inspection staff were available in the communal areas of the home, which meant they were able to supervise people and were accessible. One person told us, "They [staff] are always popping in [to their room]." A relative commented, "Yes I think there is enough staff." During the inspection we observed that call bells were responded to quickly by staff.

We checked staff recruitment records and found that suitable checks were in place to help protect people from harm. Staff completed an application form and we saw that any gaps in employment history were checked out. Two references were obtained and a Disclosure and Barring Service (DBS) check was carried out before staff started work at the service. The DBS checks the suitability of applicants to work with adults, which helps employers to make safer recruitment decisions.

Risks to people's safety and health were assessed, managed and reviewed. People's records provided staff with information about any identified risks and the action they needed to take to keep people safe. For example, one person who used the service liked to go swimming and to reduce any risks the person wore non slip socks when in the water and was accompanied by staff whilst swimming. This meant staff had the guidance they needed to help people to remain safe. Staff we spoke with demonstrated a good awareness of these risks.

We looked at the arrangements for the management of medicines. Systems were in place to ensure that medicines were ordered, received, stored, administered and disposed of appropriately. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. Staff knew the required procedures for managing controlled drugs and appropriate records were kept.

PRN (as required medicines) protocols were in place. PRN protocols assisted staff by providing clear guidance on when PRN medicines should be administered and provided clear evidence of how often people

require additional medicines such as pain relief medicines.

Records showed that there was minimal use of medicines to manage behaviours for people displaying challenging/distressed behaviours and we saw that there was a record of diversional techniques to be used prior to administration of anti-psychotic PRN medicines. This meant that there was written guidance for the use of PRN medicines and staff were provided with a consistent approach to the administration of this type of medicine.

We identified some differences with record keeping for medicines. For example some people's medicines were recorded in their medication care plans; however these did not directly match with the medicine records or PRN protocols. In addition one person received their medicines covertly. This is when a medicine is administered in a disguised format without the knowledge or the consent of the person, for example, mixed with food or drink. There was a letter from the person's General Practitioner authorising the administration method, however a best interest meeting with the GP, care home staff and the pharmacist had not taken place. We pointed this out to the registered manager who wrote to us after the inspection and told us they had taken action to address our concerns.

Some people were prescribed medicines that were time specific in terms of drug/food interactions or for medical conditions such as Parkinson's disease. However, there were no specific times noted as to when their medicines were given, which meant they may not have been able to manage their symptoms. The registered manager wrote to us after the inspection and informed us of actions they had taken to address our concerns.

We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety was maintained. We saw documentation and certificates to show that relevant checks had been carried out on the gas safety, fire extinguishers and the fire alarm. We saw records to confirm that the fire alarm was tested on a weekly basis to make sure it was in working order.

During the inspection we looked at some bedrooms, toilets, shower rooms and communal areas and found that the environment was clean and staff followed safe infection control practices. Personal protective clothing such as aprons and gloves were readily available for people to use.

Staff were aware their responsibilities to raise concerns, to record accidents and incidents, concerns and near misses. The registered manager had systems in place for reporting, recording, and monitoring significant events, incidents and accidents. The registered manager told us that lessons were learnt when they reviewed all accidents and incidents to determine any themes or trends. They told us after one person had fallen they had identified a piece of equipment that had needed to be removed. As part of this process they contacted the relevant professionals who were involved in this person's care.

Good

Is the service effective?

Our findings

People told us they thought staff were well trained to be able to meet their needs. One person said, "Yes, they [staff] do everything very well, they are very good with moving me. They are brilliant and it now makes getting washed a pleasure instead of a challenge and a chore." Another person said, "They [staff] must have good training because they look after me very well indeed."

Staff confirmed that they had regular supervision; this is a one to one meeting with the registered manager or another senior member of staff. Staff told us the registered manager and other senior staff were always available for support. Through supervision it could be identified if further support was necessary to help staff in particular areas they may struggle with. Supervision also gave staff the opportunity to identify any areas they wanted to develop further or training they wanted to receive. One staff member said, "I feel supported and [registered manager] is very approachable ."

Records we looked at showed staff had received the training they needed to meet the needs of the people using the service. This training included, safeguarding, first aid, infection control, moving and handling, medication and fire training. Where there were gaps the registered manager was aware of this and had taken action to address this. Staff complimented the training. The service employed both registered general nurses and registered mental health nurses. The registered manager confirmed that all nurses were up to date with their clinical skills.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. For some people it was not deemed necessary for a DoLS application to be submitted to the local authority. For other people applications had been submitted to the 'supervisory body' for authorisation to restrict a person's liberty, as it had been assessed that it was in their best interest to do so. In this way the provider was complying with the requirements of the Mental Capacity Act.

For people who did not always have capacity, mental capacity assessments had been completed for their care and treatment, for example from every day choices about what to eat, drink or wear, the use of the lap strap, the bath hoist and bed rails. However, mental capacity assessments were not undertaken for a wider range of decisions, for example choices about healthcare, personal care and covert medication. We pointed

this out to the registered manager who told us they would take action to address this.

Throughout the inspection we saw examples of staff making decisions that were clearly in the best interests of people they knew well, for example supporting people with their personal care. Our judgment was that staff did act in the best interest of the people they supported but that processes had not been followed to formally assess and record this.

We looked at the menu plan which provided a varied selection of meals and choice. People were supported to make healthy choices and ensured that there was a plentiful supply of fruit and vegetables included in this. We asked people if they enjoyed the food that was provided. One person said, "The food is really good and we always get a choice you know. Fish and chips is my favourite."

We saw records to confirm that nutritional screening had taken place for people who used the service to identify if they were malnourished or at risk of malnutrition. Discussion with the registered manager and examination of records informed that when people had lost weight they had been referred to the dietician. Dietary requirements for health or culture were provided for when needed.

People's care records showed details of appointments with, and visits by, health and social care professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. For example, their doctor, community nurses, advanced nurse practitioners, social workers, speech and language therapists and chiropodists. Care plans reflected the advice and guidance provided by external health and social care professionals. This demonstrated that staff worked with various healthcare and social care agencies and sought professional advice, to ensure that the individual needs of the people were being met.

The service was well maintained with appropriate furniture throughout. Some changes had been made to the 'memory loss' (for those people living with a dementia) area of the home to make specific areas more recognisable. The registered manager told us they had researched Sterling University website, attended workshops and undertaken training to ensure the environmental needs were suitable for those people living with a dementia. We found the lounge within the 'memory loss' are to be quite small, however, one relative commented, "Yes, it is a small lounge but because the lounge is small [person] has now opened up a bit and has come out of [their] shell. [Person] is a different person to when [they] came in."

Good

Is the service caring?

Our findings

People told us they were happy and that the staff were very caring. One person said, "Yes, they are good. I wouldn't like to be anywhere else. I'm happy here, this is my Home." Another person told us, "The carer's can't be faulted; I can have a laugh with them." A relative commented, "Its exceptional care."

Care plans indicated that people or their relatives were involved in the development of their care plans and in their review. Care records contained information regarding people's life history and their preferences. One person said, "My care plan is here. My son and I sorted it, I've seen it many times and I can see it at any time." Relatives told us they were always made to feel welcome when they visited. One relative commented, "I visit regularly and always feel very welcome."

Observations throughout the inspection showed staff were polite, friendly and caring in their approach to people. People were relaxed and happy and were able to freely move around all areas of the service. There was good rapport between people and staff. Staff sat with people and engaged in an unhurried way chatting about common interests and what was important to the person.

Where people were anxious or in need of reassurance we saw staff interacted with them in a kind and compassionate way. One person wasn't feeling very well and put their head on staff's shoulders. Staff responded by moving their head to the person and stroked their face to provide reassurance. We saw how this person clearly appreciated this affection. Staff were able to distract people from anxieties by chatting with them and providing reassurance or by taking part in an activity. Staff demonstrated a good knowledge of people's individualities and how best to support them. Whilst people had a wide range of needs and at times anxieties, we found the atmosphere to be calm during the inspection. People's rooms were personalised with photographs and mementos.

People and staff engaged in conversation, general banter and there was laughter. We observed staff accepting physical contact such as holding hands and hugs to ensure people were emotionally supported.

Staff were patient when speaking with people and took time to make sure that people understood what was being said. On the morning of the inspection we saw how one member of the care staff spent time with people giving them choices about what they would like to drink. The staff member made sure each person was aware of the individual choices available for them.

Staff respected people's dignity and lowered themselves to eye level when speaking with people who were sat down. Staff explained where they were going with people, or how they intended to help them. People were supported to be independent with their mobility. Staff provided reassurance and support when people were walking with their mobility aids such as walking frames and sticks.

A Christian chaplain and a representative for the Salvation Army regularly visited the care home to carry out

services. In addition, staff were able to show us how they had previously met (and could in the future) the individual needs of people with a range of religious beliefs, for example relating to individual spiritual support, dietary requirements and personal care.

It was clear staff knew people's care needs well. Staff were able to give detailed history of people who used the service, including likes, dislikes and the best way to approach and support the person. It was clear, from the interactions between staff and people who used the service that positive relationships had been built.

Advocacy information was available for people if they required support or advice from an independent person. An advocate acts to speak up on behalf of a person, who may need support to make their views and wishes known.

Good

Is the service responsive?

Our findings

People and their relatives told us they felt the service provided personalised care. One person said," I feel I have improved since coming here and my confidence has increased." Another person said, "They [staff] are just the job and make sure I have everything I need."

People who used the service and relatives we spoke with were content with the level and range of activities available. The service employed two activities co-ordinators who shared 40 hours a week and covered the full seven day week with activities. One person told us, "I like to crochet squares to make a blanket which I then donate to the Salvation Army. I also like to knit and play bingo. Anything that's going on I like to join in with."

The activities co-ordinator told us about the range of activities that people took part in. They told us that people enjoyed music, singing, handball, dominoes, arts and crafts and reminiscing. Staff had also researched meaningful activities for people living with a dementia. This included 'Twiddlemuffs', which were knitted woollen muffs with items such as ribbons, large buttons or textured fabrics attached that people living with a dementia can twiddle in their hands. People living with a dementia often have restless hands and like something to keep them occupied.

The activities co-ordinator told us they were planning for Christmas. A party had been arranged at a local community centre which people were to attend. We were told that many other local people from Murton also attended this event which gave people the opportunity to catch up with their old friends. In addition a party had been arranged for New Year's eve. People, relatives and their friends were to be entertained by a singer and enjoy a buffet.

People had been assessed prior to their admission to the service and these assessments helped to inform care plans. People's preferences, their personal history and any specific health or care needs they may have were documented. This allowed all staff to have a clear understanding of the person's needs and how they wanted to be cared for. Information was available in each person's care records to identify specific likes and dislikes and the personal abilities of people to manage their own care, along with the support they required from staff.

Care plans were personalised and gave clear information for staff on how to meet people's needs. People's care plans in relation to behaviour that challenged were very personalised and specific. They detailed the exact support staff were to provide to people and who they should contact for additional support if needed. Triggers for the behaviour were well documented so staff could recognise them and offer intervention before the person became increasingly anxious and distressed. Staff were directed to offer support to resolve the problem by offering the person time, using verbal and nonverbal cues to communicate and to show they were listening to the person. For example, for one person, their care plan gave guidance to staff to start talking about their relative as this was effective in calming them. This provided guidance to staff so that

they supported people in a consistent and positive way, which protected people's dignity and rights.

Communication care plans were in place and were appropriate for the person. We saw specific information for staff to follow in relation to how they engaged with people. For example, for one person staff needed to speak loudly and clearly to the person to help them hear their conversation. And to make sure they wore their glasses. In addition the family provided a magnifying glass for the person which they used to help their vision. As the person had a poor short term memory and was unable to retain information given to them, any relevant information was to be written on their calendar in their bedroom. This approach meant staff provided responsive care, recognising that people living with communication needs could still be engaged in decision making and interaction.

The registered manager was aware of the Accessible Information Standard that was introduced in 2016. They told us they had always striven to provide information to people that is understandable to them. They told us their service users guide and other information was available in different formats and fonts.

Daily communication notes were kept for each person. These contained a summary of support delivered and any changes to people's preferences or needs observed by staff. This helped ensure staff had the latest information on how people wanted and needed to be supported.

Handover records showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty at the beginning and end of each shift.

The service had a complaints policy and procedure, details of which were provided to people when they first joined the service. Complaints records showed any form of dissatisfaction was taken seriously. Investigations were completed and responses provided to complainants of the action taken by the service in response to concerns.

At the time of our inspection no one was receiving end of life care. However, the support of health care professionals was available to ensure people could remain at the home at the end of their life and receive appropriate care and treatment. We saw in the care records that end of life care plans were in place for people, which meant information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected. The service had received a compliment which read, 'You made the lasts weeks of [person's] life much more bearable. [Person] told us how happy [they] were to be with you in the village where [person] had spent all of [their] life and you gave [person] a dignified passing.'

Good

Is the service well-led?

Our findings

People and their relatives told us they thought the service was well led. One person said, "This is our home. It's well managed and I'm happy here." A relative commented, "The manager and staff are lovely and nothing is too much trouble."

Staff told us the service was well-led and the registered manager was approachable and supportive. One staff member said, "I really enjoy my job and coming to work. I think this is well led."

The registered manager carried out a number of quality assurance checks and audits to monitor and improve standards at the service. This included audits of care records, recurrent infections, medicines, infection control, kitchen, mattresses, environment and health and safety. On the health and safety audit in September we saw that 'chipped baths' had been noted and the registered manager showed us the invoice confirming the purchase of the replacement baths. Remedial action was taken when audits identified issues. The registered manager told us the provider carried out regular visits to the service to monitor the quality, however did not keep a written record of checks made or their findings. The registered manager told us they would speak with the provider and take immediate action to ensure a written record of the checks and findings were maintained.

The registered manager showed us the home development action plan, which detailed the corridor carpets were to be cleaned monthly; sockets were to be replaced in the kitchen, to fit more external lights and others. We saw there was record of when the actions had been resolved. However, we were unable to see a plan of who was going to undertake the actions and the timescale and some actions were on-going from 4 July 2017. The registered manager told us they would include this in the action plan.

Regular staff meetings had taken place and minutes of the meetings showed that staff were given the opportunity to share their views. Management used these meetings to keep staff updated with changes effecting the service, infection control measures, feedback from questionnaires, staffing levels and more. This meant that effective mechanisms were in place to give staff the opportunity to contribute to the running of the service. In addition, care issues were discussed which meant that any key risks were communicated to staff about people who used the service, thus care provision was enhanced.

Surveys for people who used the service had been undertaken in September 2017. We were provided with individual survey responses which were positive. This meant that there were mechanisms in place to communicate with people and their relatives and involve them in decision making in relation to the service.

We looked at the culture of the service, including if it was open, transparent and accountable. Throughout the inspection staff were open and cooperative, answering questions and providing the information and documents that we asked for.

The registered manager understood their role and responsibilities, and was able to describe the notifications they were required to make to the Commission and these had been received where needed.