West Berkshire Council

Notrees

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

Notrees is a small home which accommodates up to 18 people with needs relating to old age. The service does not provide nursing care.

At the time of this inspection 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.

The service provided safe and effective care. Health and safety issues were managed well and plans were in place to respond to foreseeable emergencies.

People felt they were listened to and they had been involved in their care as much as possible.

People's legal rights and freedom were protected by the staff. Staff looked after people's dignity and privacy in the course of providing their care.

People's physical health and dietary wellbeing were supported. Suitable activities were offered and people's spiritual needs were provided for. People could choose to what extent they were involved in group or individual activities.

Care plans were individualised and regularly reviewed. They contained the information needed for staff to meet people's needs.

The service had a robust recruitment process to help make sure that the staff recruited had the necessary skills to meet people's needs. Staff received training, ongoing support and supervision although not all training was up to date.

The service was well led, and the registered manager provided clear expectations about standards of care. Appropriate systems were in place to monitor the operation of the service and to seek and respond to the views of people and their relatives.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe and staff had been trained and understood how to safeguard people from harm.

Appropriate risk assessments took place to identify risks and actions were taken to minimise the risk of harm.

Appropriate health and safety-related checks and servicing had taken place to ensure environmental safety.

A robust recruitment process helped ensure the suitability of staff and staff managed people's medicines safely.

Is the service effective?

Good

The service was effective.

People felt they were well cared for and that the service met their needs.

Staff received induction, training and support although not all had received recent updates of all core training.

The service protected people's rights and freedom appropriately.

Peoples' health and nutritional needs were effectively met.

The environment had been significantly improved and met people's needs.

Is the service caring?

Good

The service was caring.

People were happy with the quality of care provided.

Staff were attentive to people's needs and engaged well with them. People's dignity and privacy were supported.

People were involved in their care as much as possible.

Is the service responsive?

Good

The service was responsive.

Care plans and other documents provided the information needed for staff to meet people's needs and identified when it was no longer possible for the service to do so.

The environment and available adaptations helped enable the service to meet people's needs responsively.

People were supported to make choices about aspects of their daily lives and at mealtimes.

A range of activities were provided to meet people's social and emotional needs and their spiritual needs were provided for.

Is the service well-led?

Good

The service was well led.

The service had a registered manager at the time of this inspection although she had given notice of her resignation.

The registered manager had facilitated a positive care culture and provided clear expectations for staff.

Appropriate systems were in place to monitor the operation and effectiveness of the service and the views of people and their relatives had been sought and acted upon.

Notrees

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.'

We last inspected the service on 7 May 2014. At that inspection we found the service was compliant with the essential standards we inspected.

This inspection took place on 11 and 12 April 2016 and was unannounced. This was a comprehensive inspection which was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR) which we received in February 2016. 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 looked at the information provided in the PIR and used this to help us plan the inspection. Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

During the inspection we spoke with three staff and the registered manager. The service is registered for up to 18 people with needs arising from old age. Some people using the service were able to give us verbal feedback about their experience. We observed the interactions between people and staff and how staff supported people to meet their needs. We had lunch with people on the first day of the inspection to help us understand their experience. We spoke with five people using the service and three relatives during the inspection. Prior to the inspection we contacted the placing local authority and healthcare professionals to seek their views.

We reviewed the care plans and associated records for five of the people supported, including risk assessments and reviews, and related this to the care observed. We examined a sample of other records to do with the home's operation including staff records, complaints, surveys and various monitoring and audit tools. We looked at the recruitment records for one recently appointed staff.

Good

Is the service safe?

Our findings

People and relatives told us people were safe within the service. One person said: "I always feel safe here", another said: "Yes, I do feel safe". People and relatives felt there were generally enough staff on duty.

Relevant servicing and safety checks had taken place and documents were available confirming these. Hoists for moving and handling had been serviced and also examined by insurers. Fire safety equipment was regularly serviced and tested. The water supply had been tested to confirm there was no risk from Legionella. Hot water temperatures were tested weekly and safety valves regularly serviced. No infection control concerns were identified.

No safeguarding event had occurred in the previous 12 months and no staff had raised any concerns via whistle-blowing. Staff understood their duties to record and report any concerns about abuse or safeguarding and were aware of the potential signs of abuse. They had received training updates on safeguarding vulnerable adults in the last two years or so. Recent refresher training had tended to be via computer-based on-line learning, rather than classroom based.

Information about safeguarding and whistle blowing were available on a poster on the wall of the manager's office.

People's files contained appropriate individual risk assessments which identified any actions necessary to reduce the risk of occurrence of identified hazards. Some risk assessments required review as documents suggested this had not taken place since 2014.

As well as formal accident recording, people's care plans contained individual accident record sheets to enable key workers to see their accident history at a glance. Accidents were monitored by the manager and centrally by the provider.

We saw that the duty rotas indicated there were sufficient staff to meet people's current needs and dependency levels. Staff pointed out that, where individuals required additional care due to illness or were receiving end-of-life care, this could leave them more stretched to meet everyone's needs.

Some agency staff had been used at times to meet rota shortfalls. However, the registered manager told us that shifts were offered first to existing staff and she had covered some shifts herself. Where shortfalls remained cover was sought via the provider's in-house relief staff 'bank'. Only if cover could not be found was agency staffing used. The registered manager said she tried to maximise consistency where possible by using staff mostly from one agency, who had previous experience in the service. The registered manager felt the service had not experienced any recruitment difficulties recently despite its village location. The main agency used, provided transport for its staff where necessary, to enable non-drivers to get to the service.

Only one staff member had been recruited in the previous 12 months. The recruitment records contained evidence of the required checks and procedures and demonstrated a robust process. The service had a file

containing the required information about any staff provided by an external agency. Information sheets confirmed that criminal records and reference checks had taken place and identified training and experience, as well as including a recent photograph to confirm identity. The service had recently devised a more comprehensive induction for agency staff to ensure they were aware of necessary information.

The service managed medicines safely in accordance with national guidelines. Appropriate records were maintained which provided an effective audit trail of medicines. Medicines were appropriately stored in locked drug trolleys and medicines cabinets. Administration was carried out and recorded well. The recommendations from the last pharmacist monitoring visit were being actioned, including the provision of individual protocols for as required (PRN) medicines. All of the people supported were able to give day-to-day consent to their medicines and people's medicines were regularly reviewed by GPs.

One medicines error had occurred in the previous 12 months, which related to a delay in the delivery by the pharmacy. An appropriate investigation was carried out to identify any learning. Discussions took place with staff and the supplying pharmacy, and the medicines competency of relevant staff was re-assessed.

People's care plans identified any specific preferences regarding how to take their medicines. The manager agreed to consider including this information in the medicines administration file to support staff to follow people's wishes when administering them.

An appropriate emergency contingency plan was available. This included the necessary contact details and actions in the event of various predictable emergencies and an evacuation plan, together with the keys to gain access to the place of safety. An emergency 'grab-bag' was also available, containing the contingency plan and relevant information about people's needs. The service also had individual evacuation plans for each person, in the event of fire.

Good

Is the service effective?

Our findings

People were positive about the care and support they received. One person said they were: "Well looked after, everyone is very helpful, it's a lovely place". Other comments included: "It couldn't be better here" and it's: "very good here [thanks to] the quality of the carers" People told us their consent was sought before staff provided care. One person commented: "They check consent and are very patient". A relative described the care provided as: "Excellent" and explained that records showed how people's health needs were met, their wellbeing regularly monitored and their dietary preferences catered for. A local authority care manager told us they had no concerns about the service.

The most recently appointed staff member was completing the national 'Care Certificate' induction. Existing staff were being assessed to ensure they met the minimum competencies. Residential care officers had been assessed and care assistants were now being assessed for 2016. (The process had also been completed in 2015). The registered manager agreed staff training updates were not all fully up to date, partly due to the local authority's reduction in training hours. This was reflected in the training matrix which showed a number of staff who had not completed core training refreshers since 2013 and in a few cases, 2012. The matrix showed some staff were booked to attend key training and others were on a "waiting list", so it was evident a training programme was in place. However, it was not sufficient to ensure all core training was updated regularly for all staff. The registered manager was pursuing this via the local authority.

Staff received supervision on a 6-8 weekly basis and an annual performance appraisal. We saw examples of the records of these which demonstrated an appropriate process. Staff felt they received the necessary training and told us they could update this via the on line training system. One staff member said it was good that two of the team were trained to deliver moving and handling training to staff, so it could be updated when necessary. Some commented they had not always had supervision or appraisals within the stated frequency but felt generally well supported.

The service understood the principles of the Mental Capacity Act 2015 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). A poster providing information about DoLS was posted in the manager's office. 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.

Two people had movement sensors located in their bedrooms due to their risk from falls when alone. One person had capacity and had consented to the sensor. Best interests discussions had taken place in relation to the second person, who lacked capacity to consent themselves. Best interests decisions had also been made regarding the use of raised bed-sides, regarding a flu injection and the need to move someone from their bedroom to allow redecoration. Key items of this person's furniture had also been moved with them to minimise the impact of the temporary relocation. Others had consented to the use of raised bed-sides or to having the flu injection or to their care plan as a whole. Care plans documented arrangements which were

the least restrictive option, consistent with protecting the person from avoidable harm. Where people had 'Do not resuscitate' (DNACPR) forms on file, the form identified that this had been discussed with them or appropriate others. The GP was asked to review the relevance of these forms annually.

Where people who lack capacity would be unable to leave the service safely without supervision, a service must apply to the local authority for a 'Deprivation of Liberty Safeguards' (DoLS) authorisation. DoLS authorisations are provided under the MCA to safeguard people from illegal restrictions on their liberty. Three people were subject to DoLS orders and extensions to their orders had been applied for in a timely way.

Along with the recent premises refurbishment, keypad locks had been attached to exit doors to improve security. The registered manager had not yet reviewed whether they would impact on DoLS and agreed to explore people's consent with regard to them.

Malnutrition/hydration risk assessments were completed on each person and reviewed. Where concerns had been identified, the advice of a dietitian had been sought. Two people were prescribed dietary supplements and were given a pureed diet. Other individual dietary preferences were accommodated. People were weighed monthly unless risk assessment identified the need for more frequent monitoring. People were provided with adapted cutlery where necessary, to help them remain independent.

One person said the mealtimes were sociable and said the staff: "Chat to people at mealtimes". Others complimented the meals and the choices available daily. One said: "I am on a special diet, which suits me, I have supplements and my choice of meals". People told us staff asked them about their choice of meal in the morning. If they didn't want one of the three options (including a vegetarian option daily), they could choose from a range of sandwiches. These options were clearly displayed pictorially on a whiteboard in the lounge/dining room.

One person told us they had seen the GP promptly when needed and been prescribed medicines. Three others also said the GP was called quickly by staff when needed, and usually saw them the same day. One relative felt the GP had sometimes been slow to respond. People's health appointment records showed ready access to healthcare professionals. Care plans made appropriate reference to healthcare related support. People' healthcare needs were met effectively and the service consulted appropriately with external health care specialists. One person had prepared an advance care plan regarding their wishes in the event of life-threatening illness. GP's had prescribed appropriate pain control medicines to enable this to be respected. One person managed their own diabetes medicines with staff observation in case their ability to manage this should deteriorate. Records were kept of blood tests and observations. Should a person on respite require insulin, this was managed by the community nursing service.

The service accommodated up to 18 people in single bedrooms, all on ground floor level. Two bedrooms were used to provide respite accommodation. All bedrooms had been provided with fully adjustable 'profiling' beds, which could be adjusted to meet individual needs, except where individuals preferred their own bed. Fourteen bedrooms had ensuite toilets. The remaining four rooms had shared used of a toilet in pairs. Two bathrooms were provided, each equipped with a shower. One had a standard bath, the other a specialist bath to meet additional needs. Each room had recently been refurbished and upgraded to include a toilet. One staff member felt the bathrooms needed additional handrails as they made people feel safer and more confident.

The homes communal areas had been refurbished and provided with a selection of seating to meet various needs, including two riser-recliners, which could be used, following an OT assessment, until the persons

own item was delivered. Two people had their own specialist seating designed around their needs. Two bedrooms had been fitted with overhead hoists and tracking to enable transfers to and from bed.

Good

Is the service caring?

Our findings

People were happy with the way staff looked after them. Staff were described as: "Very caring", "Caring and gentle" and "Caring and friendly". Another person said staff were: "All kind and gentle, they take care of us" and added: "They couldn't do more". People were happy that the generally low staff turnover meant they got to know staff, and they got to know them and their needs. Relatives were also positive about the care provided by the staff.

Staff referred to people by their name or their preferred form of address. Staff were attentive to people's needs, reminded them to take fluids and spoke calmly and kindly to people, giving them the time they needed. They chatted readily with people in the course of providing support and also in passing. People were involved in their care and encouraged to do things for themselves. They were asked where they wished to go after lunch, where they needed support with this. Relationships between people and staff showed warmth and respect and people knew and were on first name terms with the manager.

The care plans showed that people had been involved and had a say in the provision of their care and their individual wishes and preferences were noted. Daily task plans also reflected people's individual preferences around such things as rising and bedtimes.

People were able to make decisions about how and where they spent their day and these were respected. At admission, people and their representatives were asked to complete an "All about me" document to obtain information about people's lives, experience, needs and wishes, so these could be provided for. Unfortunately they had not always been fully completed or returned so this valuable background information wasn't always available. The registered manager agreed they might usefully refer back to the form with people and relatives once people had settled in to try to obtain as much supporting information as possible. People had been involved in discussions around the redecoration of the premises and where they had been unable to contribute, appropriate discussions had taken place with family to address their best interests.

We saw that staff knocked on bedroom doors before entering and people told us the staff helped look after their dignity when providing personal care. People told us: "My dignity is looked after", "Staff look after our dignity, but agency staff don't always know the details of our needs".

Staff were aware of the need to have conversations about people in appropriate places behind closed doors and not out in communal areas within people's earshot. They told us how they also ensure that visiting health professionals respected people's privacy and dignity. Consultations took place in people's bedrooms and discussions with staff about people's health needs took place in the office, while written records of the visit were completed. Care plans noted things such as: "Ask before opening [name's] drawers and wardrobe", where people had particular expectations. The staff handover between shifts also took place in the office and files were kept securely.

The premises supported people's dignity and privacy with each person having their own bedroom and most

also having an ensuite toilet. Where people didn't have an ensuite toilet, this was only shared by one other person. The provision of toilets within the bathrooms had also improved dignity since people would not have to leave the bathroom to use the toilet. People or their representatives were asked about their wishes regarding end of life care so the service could respect these. People's expressed wishes were recorded in end of life care plans.

Good

Is the service responsive?

Our findings

People told us that the service responded positively to their need and wishes. One person said "They know my habits". People were happy that the staff responded promptly to the call bell and they were not kept waiting unduly. People described the call bell response as: "Very good", "Good, staff come as quickly as they can" and: "The staff respond fast". A relative told us staff had been flexible and: "Always accommodated [name]".

Care plans provided the necessary information for staff to meet people's needs and were reviewed regularly to ensure the service continued to do so. The care plans identified how people preferred their support to be delivered and reminded staff about how to approach individuals. The registered manager was aware which people had others with authority to make decisions on their behalf and they were appropriately consulted for formal reviews as well as the person themselves, wherever possible. Although copies of Power of Attorney or deputyship were not held by the service they were available centrally on the authority's computer system.

The service provided for people's varied needs through the equipment and furnishings provided. For example, the ceiling hoists and the variety of seating in the lounge, including riser/recliners. The environment offered people the choice of a large communal lounge/dining room or two smaller lounges for those who preferred a quieter space. People who preferred to could spend time in their bedroom. They were appropriately encouraged to join the group for meals to help reduce the risk of isolation, but could opt to eat in their room if preferred.

Reviews of one person's needs had demonstrated the service could no longer meet them. The service was appropriately seeking a more appropriate placement to ensure their changing needs would be met. One person on respite care continued to receive some support from the previous external care supplier, to maintain consistency of care. People's needs had been considered when planning redecorations to ensure that disruption was minimised. The contractors carrying out works had been flexible in programming work in response to people's needs.

The service had devised new monthly record books to contain all of the regular records and monitoring for a person, to replace the previous range of separate forms and records. This meant the overall picture of their needs and wellbeing was readily available in one place and encouraged staff to complete all relevant records. It also made it easier to monitor their completion.

People's preferences around the provision of their care and end of life wishes were sought and addressed. The community nursing team were supportive of this and other external healthcare specialists had also been flexible in meeting needs. For example, one hospital consultant had visited a person at the home with the GP where they might not have agreed to a hospital visit. Advance care plans were being developed to formalise the recording of these issues. The service had sought support and advice from external specialists when necessary to enable them to better meet people's needs. In one case the Health Authority care home support team had been consulted to develop a suitable behaviour support plan.

People's involvement in activities varied by individual choice. One person told us: "I haven't really joined in with activities yet. I look forward to the nice weather so I can sit in the garden". They had asked for a bird table to be located outside their bedroom window, which the handyman was due to do on his return, as well as hang some pictures. Other people told us which activities they liked and those they preferred not to engage with. One person proudly showed us some of the products of their craft sessions, so it was evident the activity had benefitted them.

The service provided a range of activities and entertainment which were advertised on a notice board in the lounge/dining room. The local adult education college provided periodic six-week blocks of planned craft projects, such as pottery or papier mache which people could opt to take part in. One person went out weekly to an external specialist day service. Outside musicians had provided entertainment including a recent cello recital and a local "Pat dog" had visited with their handler in February. Where people opted to spend a lot of time in their bedroom, staff checked on them regularly and offered regular refreshments. One person said: "They check and pop in regularly with coffee and meals, to clean and chat". People's spiritual needs were met through visiting clergy who offered individual and group support.

People told us about the meal choices and said they were asked daily what they wished to eat. One person said: "I don't eat much, but the chef always offers an alternative". They added that they preferred to eat in their bedroom and this was respected. People also confirmed they could choose when to get up and go to bed. One said "I choose my get up time, it's my choice". People also chose whether they wished their wellbeing to be checked at night and their preference was noted in night care plans. The call system enabled staff to log room visits for the record.

Most people were able to make day to day decisions and choices about such things as clothing, meals and activities. Two people had more limited ability to make such choices. Pictorial menus were provided to assist people with meals choices. Staff encouraged people to be involved in their own care and to make whatever decisions they were able. The services of two hairdressers had been sought and comparable fees had been agreed to offer people choice in this area.

Where people had individual wishes, outside the service's usual provision, they still sought to meet these wherever possible. For example, one person's very specific wishes around a food item had been provided for by obtaining the particular item outside the usual food ordering process.

People told us they had not had to complain but were aware how to and felt the registered manager would respond positively. Two relatives had raised complaints in the past but these had been addressed.

The service's complaints procedure was posted in the entrance hall way. There was also a suggestions board where people's suggestions about the service were posted, together with the details of the action taken to address them, to demonstrate that people's views were listened to.

Complaints recorded in the complaints record had been investigated and addressed appropriately. Records detailed the process and the action taken to resolve the matter.

Good

Is the service well-led?

Our findings

People and relatives were positive about the registered manager and found her to be available and approachable. The registered manager told us she spent time around the service talking with people, relatives and staff. This was evident, because people were on first name terms with her.

A registered manager was in place at the time of inspection but she informed us she had handed in her notice to leave. The home had experienced a period of stability under her management, following a period of management changes and inconsistency. It was too soon to know how the provider would address the need for a replacement registered manager.

The current registered manager had facilitated a positive care culture and set clear expectations about the quality of care. Staff confirmed she had maintained clear expectations and communicated these to them. One said there was a: "Clear steer on expectations". One staff member described the current manager as: "Brilliant" and expressed disappointment about her leaving. Others said: "I enjoy it here, it is very positive", and: "The current manager is very good and listens".

They felt the previous manager had not been effective and the service had suffered from a period of inconsistent management. Staff felt the service needed a full time manager, rather than sharing one with another service, especially as there was no longer a deputy manager post as part of the team. Staff were pleased the provider had invested in improvements to the premises. Staff felt team spirit was good and everyone pulled together. One said: "I feel as though I belong," and added: "I can ask for help here, the manager cares for staff and is approachable".

Communication with staff was clear. Team meetings took place periodically, most recently in January 2016 and decisions were minuted. Staff were supported through supervision and performance appraisals.

The registered manager monitored a range of records to oversee their completion and checked that care expectations were being met. These included the daily notes and other wellbeing records, call bell responses, care plans, accidents and incidents. She had also worked a recent night shift to see for herself the night-time care demands. Dependency levels were reviewed periodically and monthly audits completed, which were sent to the area manager. The area manager also carried out quarterly audits of the service which included action plans for any identified issues.

An annual report of 'service area priorities' had been completed by the registered manager as part on ongoing business planning and monthly reports about the service were made to elected county councillors. These resulted in an annual service development plan. Last year's focus had been on improvements to recording and had led to the development of the individual records booklets to collectively record all information about people's ongoing wellbeing. A new development was of 'additional care booklets' to be located in people's bedrooms where they received additional care support such as food and fluids monitoring or regular turning.

The service had notified events as required to the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law.

A survey of people and relatives views had been carried out in April 2015 and another was due to be carried out. The views of external health professionals had also been sought via survey. One relative felt that administrative support cuts had impacted on the quality of service in some areas and one GP had felt they hadn't been given sufficient background information on people before seeing them.