Care South

Maiden Castle House

Inspection report

12-14 Gloucester Road
Dorchester
Dorset
DT1 2NJ

Tel: 01305251661
Website: www.care-south.co.uk

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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

This inspection took place on 12 October 2016. It was carried out by one inspector.

Maiden Castle House provides nursing and residential care for up to 66 older adults. There were 61 people living in the home at the time of our visit, some of whom were living with dementia. Accommodation is based on two floors. The ground floor consists of three separate areas known as Casterbridge which has 13 rooms for people living with early stages of dementia. Duberville has 14 rooms and Hardy nine, both provide accommodation for frail older people. Upstairs is one larger space which accommodates up to 30 people who are living with dementia. There was a service improvement plan to create two smaller areas upstairs.

There was a registered manager in post; they were in their last week of employment in the home. A new manager had been appointed and they were working alongside the registered manager to ensure a smooth transition. 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.

At our last inspection of Maiden Castle in November 2014 we had concerns that the quality assurance systems were not effective and that peoples' records were not always accurate and up to date. As well as this we had concerns that the service had not followed correct procedures as required by the Mental Capacity Act 2005 (MCA) and medicines were not always administered appropriately. We found the provider had made improvements since our last inspection in November 2014.

During this inspection there was a service improvement plan which was monitored and updated at least monthly in a quality assurance group meeting. The quality group checked that actions had been completed or were in progress. As well as this other improvements which were identified were included in the plan. For example the accommodation on the top floor was considered by the provider to be too large a space and there was an improvement plan to create two smaller units. There was an audit schedule and we saw that issues or concerns were followed up on.

The provider had introduced a new electronic system which involved a hand held device for administering medicines. Staff were alerted if an error had taken place so that they could rectify it promptly. Staff were positive about the system and told us they had received sufficient training.

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 by 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. Staff understood their responsibilities according to the MCA and the correct processes were followed when making a decision in a person's best interests, which included consulting with a healthcare

professional and the person's relatives.

People had opportunity to participate in a range of activities which included poetry, baking, crafts and board games. There were two–three social support staff working each day and they planned activities and clubs based on people's interests and needs. Activities were moved around the home so that people from different areas could participate if they chose to. There were resources available for care staff to utilise when social support staff were not available such as crafts and games.

There was a commitment to maintaining links with the community and this took shape in a variety of ways. For example local schools were invited into the home to be involved in activities and the home entered a float in a local carnival. People were supported to participate in community events such as local walks and woodland skills training. The provider had also formed a community partnership with a premiership football team who had visited the home.

The provider recognised staff achievements through a value based award scheme and staff told us they felt valued when their work was recognised. For example the home had won best activity programme 2016.

People and their relatives told us the home was a safe place to live. Relatives were consistently positive about staff and described them as caring and sensitive to their relation's needs as well as to them. One person told us that staff held difficult conversations with them sensitively and with consideration.

People were at reduced risk of harm. Staff were able to describe to us how they would recognise actual or potential abuse and how they would report it. People had their risks assessed and plans were developed to minimise the risk of them coming to harm. People scare plans and risk assessments were reviewed according to the frequency stipulated.

People had personalised care plans which reflected what was important for them. It included peoples likes, dislikes and preferred routines. Staff were knowledgeable about people's preferences and we saw care records reflected that people received care and support in the way that they or their relative had requested.

People had nutritional and hydration assessments to identify if they were at risk of not having enough to eat or drink and whether they had any particular dietary requirements. People were supported with their food and drink when required. People had a choice of where they would like to sit at meal times and there were alternatives to the menu. For example one person was having an omelette which was not on the menu that day. People told us they enjoyed the food.

Staffing was provided at the assessed levels. There was regular use of agency staff and appropriate checks were made to ensure they were safe to work with vulnerable adults and that they had the appropriate training. The provider told us they were monitoring the use of agency and it had decreased. The home was actively recruiting and had recently had a recruitment day. The registered manager was confident vacancies would be filled.

Staff told us they had sufficient training to support the carry out their job roles. Staff told us that as well as essential training they were supported to complete training that was specific to their job role. Staff told us they felt supported and received regular supervision which they told us gave them opportunity to talk about their ideas and make suggestions.

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 and their relatives told us the home was a safe place to live.

People were at reduced risk from harm and abuse. Staff had received training and were able to tell us how they would recognise abuse and how they would report it.

People's risks were assessed and plans developed to minimise their risks.

There were enough staff to meet people's needs and staffing levels were reviewed and amended according to people's needs.

Medicines were administered and stored appropriately.

Is the service effective?

Good

The service was effective.

People were cared for by appropriately trained staff.

People had nutritional and hydration assessments to identify if they sufficient food and drink. They were provided with choices.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and appropriate applications for DoLs had been made to the local authority.

People had access to and received healthcare as and when they needed it.

Is the service caring?

Good

The service was caring. People and their relatives were consistently positive about staff and described them as caring.

Staff were knowledgeable about people and were familiar with people's preferred routines.

People had their privacy and dignity maintained.

People and their relatives were involved in decisions about their care and people had access to advocacy when required.

Is the service responsive?

Good

The service was responsive. People had opportunity to engage in a range of social and leisure activities.

People were supported to maintain contact with the community.

People had personalised plans which took into account their likes, dislikes and preferences.

Concerns and complaints were managed appropriately and responded to in line with the provider's complaints policy.

Is the service well-led?

Good

The service was well led. The registered manager had resigned and a replacement manager had been appointed. The new manager and registered manager were working jointly together to ensure a smooth transition.

Staffing was organised in such a way to ensure there was senior cover each day. The care team leader coordinated staff deployment throughout the day to ensure people's needs were met. Staff understood their roles and responsibilities.

People and staff told us the registered manager was accessible and available.

There were systems in place to monitor the quality of the service and to ensure improvements were ongoing.

Maiden Castle 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 12 October 2016; it was carried out by one inspector.

Prior to the inspection we requested and received a Provider Information Return (PIR). A PIR 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 considered information we held about the service which included notifications regarding safeguarding, accidents and changes in the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

We spoke with six people and four people's relatives. We also spoke with nine staff which included the registered manager, the newly appointed manager as well as the head chef, social support staff and care staff. We spoke with the director of residential care during feedback. We looked at four care records and three staff files. We also spoke with two healthcare professionals and contacted a representative from the quality improvement team. We saw four weeks of the staffing rota, the staff training records and other information about the management of the service.

We used the Short Observational Framework for Inspection (SOFI).This is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

We found the provider had made improvements to medicines and people's risk assessments since our inspection in November 2014.Our previous inspection found that there was insufficient guidance to advise staff when people needed medicines which were prescribed on an as and when required basis. Some people had risk identified, however there was not a plan to minimise the risk.

During this inspection we found medicines were stored and administered appropriately. There was a new system for administering medicines which consisted of the use of an electronic hand held device which was an electronic version of the Medicine Administration Record (MAR). Senior staff who administered medicines had completed training and were assessed as competent. Staff told us they had received enough training in the new system and considered it a positive development. One member of staff showed us how errors were reduced as each medicine was scanned before being administered. If it was incorrect the device would alert the member of staff. It also listed medicines to be given as required and there was guidance for staff to follow. One member of staff told us the persons' care plan described how to recognise if the person was in pain and it was noted on the device including if the person was unable to express to staff if they were in pain. We saw staff following guidance and the person received pain relief as required. Medicines were subject to monthly checks which meant errors were identified and rectified. For example an audit in June 2016 showed that a member of staff had completed medicines training which was waiting to be marked, this had been escalated to a manager and was resolved.

People had a full assessment of their needs which included specific risk assessments, such as skin damage, eating and drinking and mobility. Where a risk was identified a plan was developed to minimise the risk of the person coming to harm. For example one person was at risk of falling at night time. Their care plan was planned with them and included use of a pressure mat to alert staff when the person had got out of bed. The person told us they felt reassured that at nights if they forgot to use their call bell to ask for help that staff would respond as the pressure mat would alert staff. This meant the person was at reduced risk of having a fall at night time. There were reviews of people's risks which were at a frequency identified as appropriate for the individual. Where there was a change to the risks people faced we saw that care plans were updated. For example one person's risk of skin damage had increased due to a change in their health; their care plan reflected increased support to reduce their risk of developing a pressure sore.

People and their relatives told us the home was a safe place to live. One relative told us "I'm as sure as I can be that (name) is looked after and kept safe." One person explained to us they had to move to the home in an emergency as they were not safe on their own, they told us "I'm safe now."

There were sufficient staff to meet people's needs. Staffing was planned using a recognised staffing model and was subject to regular reviews and amended as necessary. For example following one review of people's care and support needs staffing levels were increased. The registered manager told us they had vacant positions which they were in the process of recruiting to. They had held a recruitment open day the weekend before our inspection and had already completed some interviews and were confident vacancies would be filled. Staff and people told us there was regular use of agency, we spoke with the provider who

told us they were monitoring agency use and showed us that it was deceasing.

There were sufficient pre- employment checks to ensure that staff were safe to work with vulnerable adults. For example references were obtained and checks were made with the Disclosure and Baring Service (DBS). We saw checks had been made for agency staff and that there was an induction checklist to ensure agency staff were orientated to the home and were safe to work with people.

People were at reduced risk of harm and abuse. Staff had received training in safeguarding vulnerable adults and were able to describe to us how they would recognise abuse. Staff were aware of the correct processes to follow in order to report abuse, including how to report concerns about poor practice. One member of staff told us they had seen a member of staff using incorrect moving and assisting techniques. They told us they spoke with member of staff at the time as well as raised it with a manager and trainer. They told us it was a positive experience and the member of staff experienced it as a learning opportunity. This showed us that staff raised concerns about poor practice.

Accidents and incidents were reported and logged according to policy and trends and patterns were monitored to ensure that measures were put in place to reduce the risk of reoccurrences. For example one person had increased incidences of falls which were attributed to a urinary tract infection. Their care plan was updated to reflect the support the person required to reduce the risk of them having a fall as well as to reduce the risk of them having repeat urinary tract infections.

The home was well maintained and there were appropriate health and safety checks carried out to ensure the utilities and equipment were in working order and maintained. There was a full time maintenance worker in the home which meant repairs were carried out promptly. There was a business contingency plan which provided a plan to accommodate people in an emergency as well as personal evacuation plans which were individualised plans which provided guidance to support people to leave the premises in an emergency situation such as a fire. This showed us that the provider had plans in place to support people in emergency situations.

Good

Is the service effective?

Our findings

We found the provider had made improvements concerning the Mental Capacity Act 2005 (MCA). At our last inspection the provider was not always following correct procedures when administering covert medicines.

People had nutritional and hydration assessments. This meant people's specific dietary and hydration needs were identified and plans were developed to ensure people had sufficient to eat and drink. For example some people required a diabetic diet or a soft diet. People were provided with a choice of food and a choice of where to sit. During a SOFI which was carried out during lunch on the top floor we observed one person was sat separately from others. We asked staff about this and they told us the person preferred to sit alone and they became agitated if sat in the dining room. We saw their care plan reflected this. One person was asking for salt and repeated their request. Staff responded and got the person salt. We spoke with staff following the meal. They told us that they did not usually keep salt on the tables and it was not offered routinely. They agreed to address this. We spoke with the manager following our inspection who told us they had ordered more salt containers so that salt would be readily available for people during meals.

People and relatives told us the food was good. The chef told us they asked people for suggestions and obtained feedback informally by being around during and after meals. They told us staff gave them feedback as well. Alternatives were available; one person was having an omelette instead of a roast dinner. 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 by themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had made applications for DoLs authorisations for a number of people using the service. There was a record of DoLs which had been authorised and the review dates as well as DoLs applications awaiting assessment. The manager was able to tell us about any conditions attached to people's DoLs.

Staff had received training in the MCA and were able to explain to us how they integrated the act into their daily work. For example one member of staff told us that if they thought a person lacked capacity they involved the person's family and social worker in the assessment process and a care plan was developed to support the person in their best interests. We saw that one person lacked capacity to consent to being supported with personal care. A best interest decision had been agreed with family and a social worker who provided guidance for staff on how to support the person in the least restrictive way. This included guidance for if the person refused personal care. Staff explained to us how they followed the guidance in people's care plans and told us they would use various approaches to ensure that people received personal care when needed. For example using distraction or giving the person time or trying a different member of staff.

People received care and support from staff who had the appropriate skills and training.
The provider identified some training as essential training for example, first aid, health and safety and infection control. New staff were enrolled on the Care Certificate. This is a national recognised industry specific training aimed at new staff with no previous caring experience.
The manager explained they had received role specific training in order to support them in the role of manager. One other member of staff told us they were supported with their professional development and they had been promoted and received training to support them in their new role. Other staff told us they had received a range of training which included dementia care. One member of staff explained they had received training to help them gain greater understanding of what it was like for people living with dementia. New staff completed an induction period to ensure they were competent to work unsupervised.

Staff received regular supervision and appraisals in line with the supervision and appraisal policy. Staff told us they felt supported during supervision and were able to make suggestions and bounce off ideas.

People had access to a range of healthcare professionals based on their health and social care needs. One relative told us they had been contacted that day to inform them their relation was unwell, they told us they were kept informed and a GP visit had been arranged. Healthcare professionals told us the staff team were good and referred people appropriately. They were confident staff followed through with recommendations they made. They considered that staff communicated with them well. We saw that when staff needed additional advice on how to support people they had requested specialist advice. For example a specialist referral was made to a service which specialised in supporting people living with dementia who had specific needs.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and considerate. One person told us staff were very good and they felt staff knew them well. Comments received from relatives were all positive and included: "Can't fault it, staff are very good, marvellous." "It's home from home, I wouldn't want (name) anywhere else" and "Staff are brilliant." Relatives felt staff were welcoming to them. One relative told us, "I'm always made welcome, immediately offered a drink, it's a nice bright airy place to be." Another relative told us, "Staff are very considerate to our feelings." They explained that when difficult discussions were needed such as to talk about resuscitation, staff were sensitive and dealt with the conversations in a supportive way.

There was a relaxed atmosphere in the home, staff spoke with people informally and people recognised staff and used their names when addressing them. This showed that people were being supported by staff who were familiar to them. We saw staff talking with people on a one to one basis and to people as a group during activities and as staff were carrying out their jobs. Staff checked with people if they were okay and if they needed anything.

Staff were able to describe to us how they supported people to maintain their privacy and dignity. For example one member of staff told us they ensured they supported people with personal care discreetly, they explained how they ensured curtains were closed and they supported people to make everyday decisions such as choosing what to wear and encouraged they do as much for them self as possible. One relative told us that staff treated their relation with dignity and respect. They explained their relation was living with dementia and sometimes shouted out or used language which some people might find offensive. They explained that staff used a consistent approach and were mindful of the feelings their relation may be experiencing. They told us they were reassured that staff supported their loved one in an accepting way.

People who were living with dementia had care plans which indicated to staff the feelings that people may be experiencing. Staff told us they understood what this meant for people and one member of staff told us about one person who sometimes became distressed and may shout. Staff told us they considered whether the person was frightened, confused and disorientated. This demonstrated staff were sensitive and had an understanding of dementia.

Staff spoke about their work positively. All staff we spoke with told us they enjoyed their work and talked about job satisfaction. One member of staff told us they had worked in the home for several years and described the home being like family. They told us "There has to be laughter, it doesn't feel like work it feels like home."

People and their families had involvement in decisions about their care. Relatives confirmed they felt involved in decision making and were invited to reviews and asked for their opinions. One relative told us their relation was unable to tell staff what they liked. They explained they talked with staff about their relation's likes, dislikes and preferences and that a care plan was developed to include important information. They gave us an example that their relation did not like male care staff to support them with personal care and confirmed to us this was respected. One person had support from an advocate to support

them with decision making.

Good

Is the service responsive?

Our findings

We found the provider had made improvements since our last inspection in November 2014 when we had concerns that some people's records did not reflect their preferred daily routines.

People received personalised care and support based on their individual's preferences, likes and dislikes. People had a detailed pre assessment which identified what was important for them and their care and support needs. This meant that they had a personalised care plan which provided guidance for staff how to support the person in a way which they expected. For example one person had previously worked in a job which they got up early for, it was important for them to continue with their usual routine. Their daily records showed that staff supported the person to maintain their preferred routine.

Staff could describe to us peoples likes and dislikes, such as particular foods. One member of staff told us that one person did not like too much food on their plate. We saw their care plan reflected this.

People and their relatives were involved in a review of their care plan. During our inspection we noticed one person's care plan had not been reviewed during the timeframe indicated. We spoke with staff who were able to confirm they were aware the review was due. They had started the paperwork and had arranged a time for relatives to attend a meeting before completing the process. This showed us that people and relatives were involved in reviews.

People had access to a wide range of social and leisure activities. There were two- three social support staff on each day. They organised activities across the whole home. One of the social support staff told us that they found out people's interests and hobbies when they moved into the home and used this information for planning. There were a range of activities on offer which were put up on noticeboard including in pictorial form. For example poetry, ball games, art sessions, baking, gardening and discos. One of the social support staff told us that they used the term clubs to describe some of the opportunities available. They explained that some people were put off if asked to join an activity as this wasn't something people were generally used to. Clubs which they had set up included a ladies discussion club and gardening. We asked how all people in the home befitted from social activities. Staff told us they based different activities in different areas and people could be supported to attend an activity in a different part of the home. During our inspection some people were involved in baking cakes downstairs. In the afternoon karaoke was taking place upstairs. People told us they had enough to do. One person told us they preferred to entertain them self and some people chose not to participate in organised events. Staff told us they asked everybody whenever possible so that everyone had a choice. We saw that staff talking with people on a one to one while other activities were taking place.

There were a range of resources available for care staff to utilise when social support staff were not available such as games and craft materials.

People on the ground floor had access to court yards which included sensory beds containing herbs and roses. People living with dementia who were on the top floor had access to fresh air via two balcony areas.

These were small areas which contained a table with seating. People were able to access these areas independently.

The social support staff were motivated enthusiastic and explained that when people were participating in an activity it was an opportunity to talk and reminisce. One social support member of staff told us they were committed to involving the local community in the home. They gave examples of local schools having a teddy bears picnic and singing to people. They also had plans to create a mother and toddlers group in the home which they anticipated would have a positive impact on people living there. They were part of a dementia alliance group and also a dementia friend and champion. They felt this benefitted people in the home as they were able to share knowledge within the home as well as raise awareness about dementia in the local community. They also informed us they were part of a committee organising a local carnival which the home had provided a carnival float for.

The registered manager told us they gathered feedback form a variety of sources which included talking with people and observing staff. They told us they welcomed comments and suggestions and explained sometimes it was the smaller things which made a difference. For example ensuring one person had the right newspaper. The provider told us they were currently researching different ways of gaining people's feedback. The last survey was completed in 2014 and the provider told us it was not easily accessible for people living with dementia and was not reliable in terms of the quality of information obtained. They were working in partnership with a university towards a bespoke survey for people living with dementia. Feedback had been obtained from stakeholders which was mostly positive and included comments such as "Staff are always looking to improve the service. Feedback was also obtained in monthly meetings for people and their families. We saw they were not well attended. Staff had asked for feedback and one relative told them that they felt they didn't need to attend as they were happy with how things were.

Concerns and complaints were managed appropriately and according to the provider's complaints policy. How to make a complaint was clearly visible in the reception area. People and relatives told us they knew how to raise concerns and were confident management would take action to resolve any issues.

Good

Is the service well-led?

Our findings

At our last inspection in November 2014 we found the provider had audit systems in place but there were insufficient action plans to improve the service. At this inspection we found improvements had been made.

During this inspection the registered manager told us there was an on-going service improvement plan with was monitored through a monthly quality assurance meeting. The group was supported by the senior staff within the company as well as the registered manager. The purpose of the group included dissemination of results from audits and to check actions had been completed or were in progress, as well as consideration of issues as they arose. For example the service identified that there was an increase in people's support needs which led to a review of all peoples nutrition and skin integrity assessments. A further action arose from this and the provider was in the process of accessing specialist resources to provide people with the right care to ensure their risk of skin damage was reduced. Improvements were identified to the top floor which in the improvement plan was considered a vast space which would work better as two smaller units. Work to address this had been started and was being monitored through the quality group. There was an audit schedule which indicated the frequency of each audit. For example care plans, mattresses and nutritional assessments were audited monthly and health and safety and infection control was quarterly. The registered managers showed us other actions which had been followed. For example following an infection control audit two wheelchairs were identified as being soiled, actions were taken immediately to clean them and to put preventative measures in place to avoid reoccurrence.

The registered manager was in the last week of their employment within the home. They told us they would cancel their registration with the CQC once they had completed their last day. A new manager had been appointed and was working alongside the registered manager to ensure there was a smooth transition. The new manager had applied to be registered. The registered manager was supported by care team leaders who coordinated the shifts and ensured staff were deployed appropriately. Their responsibilities also included organising people's reviews and liaising with health care professionals. There were also senior care staff who worked alongside care staff to ensure people had their care and support needs met. Staff understood their individual roles and responsibilities and were aware of who they reported to. This showed us there was effective leadership and staff were clear who they reported to.
The management team were visible and accessible and staff told us they felt supported. The registered manager told us they had an open door policy and attended handovers to ensure they were aware of what was happening within the home and to give staff feedback. One relative told us they considered the home was well run and they were comfortable talking with the registered manager or other staff.

Information was communicated to staff through meetings and during handovers and training. Staff told us they were kept up to date with developments in the home. The provider told us they recognised staff achievements through a values based award system and we saw the home had won the company's best activities programme for 2016 as well as care team/night leader winner 2016. One member of staff told us that winning an award made them feel valued and gave them recognition for the work they carried out. This demonstrated a positive culture in which staff achievements were recognised.

The provider told us about a community partnership the company had with a premiership football team. The team has visited the home in October 2016 and the provider told us they considered the high profile link reflected appositive attitude towards care homes and also staff.

The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

The home engaged with local stakeholders to ensure effective working relationships. For example the registered manager met with the local mental health team to improve how the home accessed advice from mental health services to ensure people with mental health needs were provided with the right care and support.