Helen Mcardle Care

Melbury Court

Inspection report

Old Dryburn Way
Durham
DH1 5SE
Tel: 0191 3830380
Website: www.helenmcardlecare.co.uk

Date of inspection visit: 16 & 18 February 2015
Date of publication: 11/05/2015

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

Overall summary

We carried out this inspection on 16 and 18 February 2015 and it was unannounced.

Melbury Court Care Home is registered to provide accommodation, personal and nursing care for up to 87 people. The home is set over three floors and has 37 beds for people who have advanced dementia and require nursing care. The home is situated in its own grounds on the outskirts of Durham. The home is owned and run by Helen McArdle Care Limited.

At the time of our inspection the home had a registered manager in place that had been in post since March 2008. 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.

People who used the service were involved in planning their care and assessing the level of support they needed.

There were robust recruitment and selection processes in place and staff were subject to pre-employment checks and took part in an induction process when they started work.

Summary of findings

There were policies in place for prescribed medicines, homely remedies and when required medicines. Body maps were in place and completed to show where topical medicines should be applied.

Staff received regular supervisions and appraisals where they were able to discuss concerns and receive feedback on their working practice.

Care and support provided was person centred and tailored to meet people's individual needs.

There was a formal complaints procedure in place and information on how to make a complaint was available to people who used the service and visitors to the home.

The provider had invested in a revolutionary gelling agent to assist people who had difficulty chewing and swallowing.

Staff had been trained in special techniques to help people who used the service relax.

Advocacy services were available and information was displayed in the home on how people could access these services.

There was a quality assurance system in place to ensure people who used the service received the best care possible.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff working in the home were trained in infection prevention and control.

Staff we spoke with knew how to identify and report safeguarding concerns.

Medicines in the home were stored and dispensed correctly by properly trained staff.

Good

Is the service effective?
The service was effective.

Staff were given training to ensure they had the appropriate skills and knowledge to provide effective care to people.

The registered manager and staff received training in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards and the registered manager was aware of her responsibilities in relation to these.

Information about advocacy services was displayed in the service and people were supported to use these if required.

Good

Is the service caring?
The service was caring.

People were supported by staff that were caring and respected their privacy and dignity.

People who used the service, their family or representatives, were involved in decisions about their care and support needs.

Regular meetings were held with people who used the service and staff employed to support them.

Good

Is the service responsive?
The service was responsive.

People who used the service were referred to other healthcare providers when there were changes to their health.

An activities co-ordinator was employed in the service and people were supported to take part in individual and organised activities.

There was a complaints procedure in place and information on how to make a complaint was provided to people who used the service.

Good

Is the service well-led?
The service was well-led.

The home had clear values and the registered manager led by example creating a positive and professional environment.

Good

Summary of findings

The registered manager had an open door policy meaning people were able to speak with the registered manager or other member of staff without making an appointment.

The provider had a quality assurance system in place which was used to ensure people who used the service received good quality care.

Melbury Court

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.

The inspection took place on 16 and 18 February 2015 and was unannounced.

The inspection team consisted of an Adult Social Care inspector 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. For this inspection the expert-by-experience had expertise in dementia care.

Before we visited the home we checked the information that we held about this location and the service provider. This included reviewing statutory notifications submitted by the service, information from staff, members of the public and other professionals who visited the home.

During our inspection we spoke with twelve people who used the service, seven relatives who were visiting people in the home, one nurse and four carers. In addition we spoke with the Core Operations manager, the catering development manager and the chef. We reviewed records that were part of the provider's quality assurance tool and tracked the cases of five people.

For this inspection, the provider was not asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the registered manager about planned improvements or changes she wanted to make to the service.

Good

Is the service safe?

Our findings

People who used the service and their relatives told us the home was a safe place to live. People who used the service told us the staff were very helpful and pleasant with one person saying, "The care is excellent and the staff are pleasant and supportive". A relative told us, "I am very content with the care my [relative] receives, nothing is a problem".

The provider had policies and procedures in place for recognising and dealing with allegations of abuse. We spoke with five members of staff. All the staff we spoke with told us they had received training in safeguarding and the protection of vulnerable adults. Staff told us they had been trained to recognise the signs of abuse and when asked were able to identify different types of abuse. We looked at the files of five members of staff and confirmed they had all received the relevant training. This meant people who used the service were protected from the risk of abuse.

We looked at the care plans of five people who used the service. We found risks to people had been identified and strategies had been put in place to minimise the chance of harm to people who used the service, their family, friends and staff working in the service. For example one person had been identified as being at risk from choking. We saw the care plan and risk assessment contained information on how staff could minimise the risk and the procedures they should follow if the person did choke.

We spoke with the registered manager about staffing levels in the home. We were told the number of staff on duty was under constant review. The registered manager used a dependency tool to help assess the number of staff needed, however the provider also carried out a regular 'time in motion' study to show how much real time was used carrying out tasks. This was used to further establish if the staffing levels in the service were correct and to make changes to these if needed.

We looked at the provider's recruitment and selection policy and found there was a robust system in place to help ensure people who wanted to work in the home had the right skills and experience. Staff files contained application forms which had been fully completed with detailed education and employment histories. We also found applicants were required to give the names of two people who could provide references. These references were requested and verified before people were allowed to start working. Prior to starting work Disclosure and Barring Service (DBS) checks were completed. DBS checks are used to help the provider ensure that people they wanted to employ were not barred from working with vulnerable people.

We looked at the policies in place for the storage, administration and disposal of medicines. We found the provider had clear and comprehensive guidance in place for prescribed medicines, homely remedies and also 'when required' medicines. Body maps were in place and completed to show where topical medicines should be applied.

We spent time observing medicines being given to people who used the service. We saw the service used a monitored dosage system which meant people's daily medicines were put into special boxes which have a separate compartment for each dosage time of the day. Prior to giving the medicines staff carried out checks to ensure they were giving the correct medicine to the correct people.

We saw medication administration records (MARs) were in place for everyone who received prescribed medicines and these had been completed in line with guidance. Where people were prescribed 'when required' medicines an instruction sheet was included in people's care records. The instruction sheet contained details of the prescribed medicine, strength and the reasons for use as well as the maximum number of doses that could be administered in a 24 hour period.

Regular reviews of accidents and incidents that had occurred within the home were carried out to establish if there were any trends. The registered manager confirmed there had been no identifiable trends over the previous twelve months.

We saw the service had procedures in place to deal with emergencies. We found all the people who used the service had emergency evacuation plans in place which were kept in people's care files. In addition there was an emergency bag which had information that would be required if it was necessary for the home to be evacuated. For example, the names and contact details of people's next of kin, and also details of GPs. This meant in the case of emergency people could still receive continuing care because important information was available when needed.

Good

Is the service safe?

We spent time looking around the home and reviewing the cleanliness. We saw the home was clean and tidy with a relaxed and homely feel. We saw the service had an infection control champion who took responsibility for ensuring the service was kept clean and the chances of spreading infection were minimised.

The registered manager told us there was a whistleblowing policy in place. The policy meant if staff had concerns about poor practice or observed something which they felt was inappropriate they would be able to raise their concerns without fear of persecution or reprisals from other members of staff. We asked staff if they were aware of the home's whistleblowing policy and if they felt complaints or concerns would be appropriately dealt with. Staff told us they knew about the policy and were happy that if they did raise a concern the registered manager would listen to them and would handle their concerns in the correct way. We saw evidence of a staff member raising a concern with the manager and saw an investigation was carried out.

Good

Is the service effective?

Our findings

Staff employed to work in the service were required to carry out training which helped them to carry out their roles effectively.

The registered manager told us staff were required to carry out an induction when they started work in the service. Training in mandatory areas like infection control, moving and handling and safeguarding were included in the provider's induction process. We also saw staff were given additional training for more specialised areas like end of life care, dementia care and medicines administration. Staff files we looked at contained certificates which showed training staff had received and the dates of updates. For example first aid training needed to be completed every three years with annual updates recommended.

We spoke with five members of staff who were on duty at the time of our inspection. Staff we spoke with told us they received regular training and told us if they wanted any additional training they could request it.

Staff working in the home were expected to have regular supervisions and appraisals. We saw staff files had evidence of supervisions being carried out. Supervisions were used to review staff clinical practice and knowledge. Notes were kept of meetings held and concerns and areas for improvement were recorded and discussed. We also saw staff had annual appraisals which were used to assess the work people had carried out over the previous year and to discuss any improvements or training requirements. In addition both the registered manager and the operations manager spent time discreetly observing staff and their daily practices to ensure they were working in accordance with the home's policies and procedures.

We looked at the care records of five people who used the service. We found care plans were written in a way that was easy to understand and gave staff a good knowledge of the person they were caring for. We saw care plans included signatures which gave staff the permission to provide care and support for people who used the service. Where people had not been able to sign their care plans a member of their family or other representative signed on their behalf. Alternatively a member of staff placed a note on the file to say the person was unable to sign. This meant people were given the choice about whether they wanted help and support.

Some of the people who used the service had made forward planning decisions in relation to their care. We found people had decided not to any intervention if they were to stop breathing. Where this was the case we saw Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms had been completed following discussion with healthcare professionals. We saw these forms were put in the front of people's care files meaning they were easily accessed when needed.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards of (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We spoke with the registered manager about MCA and DoLS. The registered manager was aware of her responsibilities and was able to show us evidence that staff received training in both of these and were aware of people's rights. We saw evidence of DoLS applications being submitted and staff being made aware of people who had DoLS in place.

We saw some of the people who used the service had mental capacity assessments carried out and where people were found to have a lack of capacity appropriate records were kept and best interest meetings were held with family or other representatives who knew them, to ensure people received care and support that was most appropriate for them.

We looked at the meals that were offered to people who used the service. We found there was a four week menu plan in place which gave people mealtime choices that were both healthy and nutritious. Some of the people who used the service required special diets due to food allergies, medical conditions and difficulty chewing and swallowing. For example people with diabetes or requiring low sodium diets. Where this was the case we saw care plans contained appropriate information about people's needs. We also saw information relating to people's dietary needs was recorded in the kitchen and all recipes used included details of ingredients used and any potential allergens. This complied with Food Information Regulations which came into force in December 2014. These regulations mean information must be available for all meals and allergenic ingredients.

Good

Is the service effective?

Where people had difficulty chewing and swallowing they would normally have been provided with food that had been pureed however we found the provider had spent time researching alternatives and introduced a revolutionary idea from Germany. Pureed meals were mixed with a gelling agent which helped to add moisture and improved the texture, and were then placed in moulds so they looked more appetising. Meals were presented in a way that made them look more like the traditional food they started as. For example broccoli was shaped as a broccoli stalk and chicken shaped as a chicken leg. This meant people who required pureed meals had their dignity protected because their meals looked more like the meals being provided to others. We also saw the provider was trialling another product which turned fluids into foam. This was used for people who were receiving end of life care and would normally only be able to have moist sponges to help keep their mouths moist. The product meant people could have the foam placed in their mouths and it would melt away without leaving any liquid, it was also flavoured meaning it could help retain people's dignity by preventing bad breath. Both products stimulated people's natural instinct to chew. We saw the provider had arranged tasting sessions for families and healthcare professionals and found the feedback to be positive. One healthcare professional said, "Revolutionary approach to soft diets", also saying they looked forward to being able to promote the product to others.

We observed how staff interacted with people who used the service during lunch. We saw people received meals they had requested and they were hot and well presented. People were assisted in a sensitive and respectful way with staff asking people if they wanted help with their meals. We saw staff taking time to make sure people were managing and helping where appropriate. We saw meals were relaxed and people were able to enjoy their meals without being rushed.

People who suffered from dementia were located on the first floor and we saw the décor reflected individual's needs. For example we saw people's bedroom doors were painted different colours and they all had a number and knocker to make them more like the front door of a house. We also saw an area had been decorated with bamboo wallpaper, a garden bench, plants and streetlight to make it look like a garden. We also found the area was spacious and uncluttered meaning people were able to move around freely.

We saw the provider had made arrangements for healthcare professionals like opticians, dentists and chiropodists to visit the home and provide relevant care. We also saw, where there were concerns about people health, referrals were made to specialists and people who used the service were supported to attend appointments. This meant people's wider healthcare needs were monitored.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us they were happy with the home and the care provided. One of the people who used the service told us, "I know all the staff and they are so cheerful, you could not wish to be in a better place", and the relatives of another person told us, "This is a good home with caring staff, we have no concerns about care"

We spent time observing staff and how they interacted with people who used the service. We saw people were treated respectfully with staff waiting patiently for people to finish an activity. We witnessed staff sitting with people and talking to them about how they were feeling or if they were expecting visitors. We also saw some of the people who used the service took comfort from holding the hand of staff. Where this was the case we saw staff were happy to do this and it was evident that people felt relaxed around staff members.

People who used the service had care plans in place that were written in an individual and person centred way. Care plans contained information about people's family, and the home situation they had left, as well as work history, communication needs, and any areas of concern. For example one care plan identified that the person had a history of falls and another showed the person may exhibit behaviour that could challenge the service. We also found information relating to people's preferences, such as, the time they liked to go to bed and get up in the morning and where they preferred to eat meals. This meant people were cared for in a way they wanted.

We saw staff had received training in dignity and respect and the home had a dignity champion in place. There was a notice board on the ground floor of the home which, at the time of our inspection was being used as a dignity board. We saw this notice board displayed information to staff, people who used the service and visitors about what they could expect while in the home and also what dignity meant to people in the home. Staff were seen treating people in a dignified and respectful manner and were heard complimenting people on their clothes and hair. People who used the service showed their pleasure at these compliments by smiling, saying thank you and responding positively to staff. We also saw staff knocked on doors prior to entering people's rooms and often heard them call out to ask if it was okay for them to enter. These things meant people's dignity and privacy was maintained.

We found information was available for people who used the service and visitors to the home explaining how to make a complaint, planned activities and details of advocacy services people could access if they wished. We saw evidence that people who used the service had accessed advocates with one person having a Lasting Power of Attorney (LPoA) in place to deal with financial and health and welfare issues.

We saw people who used the service and their relatives or representatives were encouraged to participate in planning their care and we saw evidence of this in care plans which showed support needs had been discussed and the level of support provided was a result of these discussions.

People who visited the home told us they were always welcomed and were able to visit at any time. We saw activities were arranged that were often for relatives to attend but relatives were encouraged to participate in the regular activities held in the home. For example during our inspection we saw the family of one of the people who used the service had arranged a birthday party. Although this was hosted by the family staff and others who used the service were invited to attend. We also saw the weekly quiz was attended by visitors and staff who were actively involved and encouraged people who used the service to participate.

Some of the people who used the service were coming to the end of their life and systems were put in place to ensure this was as comfortable and dignified as possible for them and their families. We found evidence that people's end of life wishes were discussed and recorded in their care files. Details were kept of funeral plans and preferred funeral directors as well as details of funeral services and how they wished to be interred. We saw DNACPRs had been put in place for some of the people who used the service and these were kept in care files. Where people were receiving end of life care we found families were made welcome throughout the day and night and were supported by staff.

In addition we saw some of the care staff were trained in Hands on Empathy, Aromas, Relaxation, Texture and Sound (HEARTS) therapies. We were told by the registered manager that HEARTS was developed for end of life care in

Good

Is the service caring?

hospices and it used to create peace, calm and tranquillity in care settings. We saw some of the people who used the service had given consent for this technique to be used. Records were kept of every treatment used and the reason it was offered along with the outcome. For example we saw one person had difficulty sleeping and one of the care staff provided them with a hand massage whilst in bed, this resulted in the person smiling and drifting off to sleep.

Good

Is the service responsive?

Our findings

We found people who used the service were asked to participate in planning their care. We saw prior to going to live in the home, the registered manager visited people to discuss their care needs and the assistance they wanted. Where people had difficulty communicating we saw people who knew them well were asked to help in planning their care.

We found care plans were comprehensive and provided staff with enough information to give them a good knowledge of the person and their abilities. For example one of the care plans we looked at showed the person needed to wear a leg brace and for this reason they preferred to wear trousers. Another person was identified as requiring lots of emotional support, and staff were to ensure the person didn't become socially isolated. This meant staff knew they should provide extra support to encourage the person to socialise and to monitor their moods.

People's care records were regularly reviewed to ensure people's care needs were properly managed. Changes to people's health care needs were accurately recorded and care plans clearly reflected these changes, ensuring staff were aware of any additional support needs. For example one person had been identified as losing weight consistently over a period of weeks. Following referral to a dietician the person was required to have fortified meals and drinks. We found details were fully recorded in the care plan so staff could monitor what the person was eating and report any concerns.

We found risk assessments were written and linked to people's care plans and were reviewed at the same time as care plans. Risk assessments identified areas where people's safety could be compromised and what steps were taken to mitigate those risks. We found risk assessments were written in a way that allowed people to maintain as much independence as possible and allowed for calculate risks without putting people in danger. For example we saw one person was at risk of falling but in order to maintain their independence without placing them in danger they were encouraged to use a medical aid to support them when they moved around. These things meant staff were able to respond appropriately to people's changing needs.

We saw care plans contained information relating to the care they received from other services. For example if people were patients at hospital a copy of the discharge record was kept in their care records to ensure all relevant information was available. We also found, where people were referred to other healthcare professionals like speech and language therapists or dieticians records were kept of all assessments. People who used the service were supported to attend appointments and we saw any recommendations made were appropriately followed.

Some of the people who used the service were prescribed medicines that meant they needed to have regular tests to ensure their medicines did not have any negative effects on their health. We looked for evidence of these tests in people's care files and found appropriate checks were carried out with the results recorded in care records. Where needed we found changes were made to people's prescriptions and these changes were noted in care records and the MAR charts were updated to show the new dosage.

We saw the provider had a formal complaints procedure in place. People who used the service were provided with a service user guide giving details of how they could make a complaint. In addition details of how to make a complaint were available in the main reception area of the home, ensuring visitors to the home were also aware of how they could make complaints.

We looked at the home's complaints file and found any complaints were recorded in the file along with the date the complaint was received. We saw written complaints were retained in the file and where a verbal complaint had been made this was written up and kept in the complaints file. We saw all complaints were reviewed, investigated and a written response was given.

We spoke with twelve people who used the service and the relatives of seven others. All the people we spoke with told us they knew how to make a complaint and felt any complaints would be appropriately dealt with. None of the people we spoke with had ever made a formal complaint and one person told us, "Small issues are raised with staff and sorted straight away".

The provider employed an activities co-ordinator to work in the home. During our inspection we saw a morning exercise session taking place and an afternoon quiz. We saw there was a good activities programme which was posted on notice boards for all people who used the

Good

Is the service responsive?

service and their visitors to see. The registered manager had made arrangements for two miniature ponies to visit the home every month and also took her own dog into the home. One of the people who used the service told us, “We all look forward to them coming. There is also a dog which walks around the home and it is nice to stroke it”.

Although the home did not have its own transport they were able to access a minibus that was owned by the group. Outings were arranged with people who used the service and we saw photographs of outings that had previously been organised. Further regular activities included monthly church services and a weekly visit from a beauty therapist.

Where people did not want to join in with organised activities we saw they were able to spend time with others or in their rooms. We saw one person sitting with a member of staff who was reading a magazine with them and discussing the articles. All these things meant people were given different ways to pass the time and help them stay both physically and mentally active.

Good

Is the service well-led?

Our findings

At the time of our inspection the service had a registered manager in place. 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.

All the people we spoke with told us the home was well run and the staff were very helpful. One person who used the service told us, "I like it here. They're very nice". A member of staff told us, "It's a nice home to work in".

The home had a calm and relaxed atmosphere and throughout the inspection we saw staff interacting positively with people who used the service. The registered manager told us the home operated using the '6Cs'. These are, care, compassion, competence, communication, courage and commitment. People who used the service and staff working in the home told us they felt supported by the registered manager and said they regularly saw her walking around and she always stopped to talk. One person told us, "[The registered manager] is canny. You can speak to [the registered manager] about anything" another person told us, "Oh yes, [the registered manager] is very good, she runs a tight ship".

We spoke with the registered manager about planned improvements or changes she wanted to make to the service. We were told that the quality of the service is under constant review and they are always looking for ways to improve.

We saw regular meetings were held for people who used the service and their visitors with additional meetings being held for staff. Meetings were used to discuss planned activities and outings, meals and any areas of concern. We saw minutes of meetings were recorded and were displayed on notice boards in the home.

The registered manager had an open door policy and this was evident during our inspection as we saw people speaking with the manager throughout our time there.

We found the home had good links with the local community and received visits from religious representatives and local schools.

We spent time looking at the providers policies and found there were a variety of policies in place including equality and diversity, safeguarding, medication and whistleblowing.

We saw the provider had a quality assurance system in place which consisted of a number of things used to ensure the care and surroundings of the home were kept to a high standard. Regular audits were carried out for several areas including medication policy compliance, resident care standards and health and safety. We found the health and safety audit covered a variety of areas which included emergency arrangements, working environment and the storage of hazardous substances. Where audits were carried out we saw any problems or areas which required improvement were noted in an action log which gave details of the action required, the person responsible for the action and the required date of completion.

The registered manager had processes in place to ensure repairs and maintenance were carried out around the home. There were also contracts in place for the maintenance of medical equipment, lifts and other items used in the home. In addition we saw portable appliance testing, fire safety checks and legionella testing had all been completed.

The Operations Manager of Helen McArdle Care carried out regular visits to the home and carried out quality monitoring inspections which were used in conjunction with the homes internal audits to ensure staffing levels, training and performance and the environment were kept to the required standard.

We looked at the statutory notifications submitted to the Care Quality Commission and compared them with the accidents and incidents records held in the home. We found all appropriate notifications had been completed and safeguarding concerns had been referred to the local authority. All these things meant the provider was taking steps to ensure people lived in a safe environment and received good care.